HOUSE OF COMMONS

Justice Committee

Oral evidence: The Coroner Service, HC 282

Tuesday 17 November 2020

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Watch the meeting

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

Questions 118 - 190

Witnesses

I: His Honour Judge Mark Lucraft QC, Chief Coroner for England and Wales; Mr Derek Winter DL, Deputy Chief Coroner for England and Wales; and Her Honour Judge Alexia Durran, Deputy Chief Coroner for England and Wales.

II: Alex Chalk MP, Parliamentary Under-Secretary of State, Ministry of Justice.

Examination of witnesses

Witnesses: Judge Lucraft, Mr Winter and Judge Durran.

Q118 **Chair:** Good afternoon and welcome to this session of the Justice Committee. We are continuing our inquiry into the Coroner Service in England and Wales. Welcome, in particular, to the Chief Coroner, His Honour Judge Lucraft. We are very pleased to see you; thank you very much for coming to see us. You are also, of course, the Recorder of London. Many congratulations.

Judge Lucraft: Thank you.

Q119 **Chair:** We will hear more of that in a moment. I know that you are going to be joined by two of your colleagues.

Judge Lucraft: Yes.

Q120 **Chair:** We have the two deputy Chief Coroners, Mr Winter and Judge Durran.

Mr Winter: Good afternoon.

Judge Durran: Good afternoon.

Chair: Good afternoon and welcome. We start off with members making declarations of interest. I will start with mine. I am a non-practising barrister and consultant to a law firm. Judge Lucraft and I are old friends and colleagues from the Bar. We have done cases against each other when we were both a little bit younger. It is very good to see you.

Rob Butler: I was a member of the Sentencing Council in my role as a magistrate. I was also a non-executive director of HMPPS prior to my election.

Maria Eagle: I am a non-practising solicitor, Chair.

Andy Slaughter: I am a non-practising barrister, Chair.

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

Q121 **Chair:** Richard Burgon is probably joining us later, who is a non-practising solicitor. I can say that for him to save having to interrupt.

Let me start, Chief Coroner, with this scenario. At the moment, you are wearing two hats. Perhaps you would like to set out for us your experience of being Chief Coroner, and then subsequently being appointed Recorder of London, and your successor being appointed. What are your observations, to start with?

Judge Lucraft: I became Chief Coroner in October 2016, so I have been in post for just over four years. In those four years it has been really quite a busy period. We had the tragic events in 2017 of the attacks on Westminster Bridge, London Bridge and Borough Market, the Manchester Arena attack and the terrible fire at Grenfell Tower, all of which had a coronial input.

As you will know, I conducted the inquests in relation to Westminster Bridge and London Bridge and Borough Market. Sir John Saunders is currently carrying out the public inquiry in relation to the Manchester Arena attack. Of course, the Grenfell fire has led to a public inquiry.

The coroners of England and Wales would have had the first dealings with those situations when they arose. Coroners perform a vital public service as judicial office holders, tasked with the independent reviews of all deaths reported to them. Deaths certified by a doctor, a general practitioner, and increasingly overseen by a medical examiner, as being from natural causes do not, as a matter of routine, get referred to a coroner, but a coroner is looking at many cases and dealing with them.

In my four years, I have had to do my very best, I hope, to make sure, as we do not have a national coroner service but a Chief Coroner, to bring guidance to coroners. Part of the job of a coroner, which largely goes unseen, are those cases that are referred to a coroner that never end up with an inquest. There are, normally, in England and Wales somewhere in the region of 30,000 inquests a year. If I tell you that in 2019 there were 530,857 registered deaths, and that of that figure 210,900 deaths were referred to a coroner, you will see that many of the deaths that are investigated by a coroner do not lead to a court hearing with an inquest. It is that part of a coroner's job that, I suspect, goes largely unseen by many members of the public.

Q122 **Chair:** That is about 80% of the deaths.

Judge Lucraft: Absolutely. A very small fraction of inquests ends up with a jury inquest—about 1.8%. It is a very small fraction of all the deaths that the coroner is looking at. Their work will be, largely, dealing with very sad situations. The families that they are dealing with are going through grief. They have recently been bereaved. It is an unexplained death. I suspect the last thing that anyone really wants is for the death of a loved one to have to be referred to a coroner, who is then going to have to look into the circumstances of it. At a time when someone is grieving, that is not the easiest situation for a judge to get involved with.

Unlike my other job of sitting in a criminal court, where the parties contest a case before me, a coroner's inquest is a fact-finding exercise. We do not refer to people as being "parties". We refer to them as "interested persons". That is to try to take away from an inquest any suggestion that it is an adversarial process, with competing forces trying to argue one side or the other of a case. That is not to say that some inquests do not become reasonably heated, because for some people they can be the only public opportunity to examine and probe into how their loved one died.

Going back to your question, the past four years have been very busy. I have mentioned some of the key events that have happened in those four years, but alongside that it has been a matter of dealing with the everyday cases, as one might call them.

Of course, this year there has been the pandemic, which has meant that coroners have been exceptionally busy, not just dealing with death referrals; many of them are involved the local resilience forum in England and Wales. They are looking, as part of that forum, at how we cope with excess deaths and how we deal with managing that process throughout. It has been a very busy four years, not just for me but for all the coroners whom I have led.

Q123 **Chair:** I understand that. We are going to pick up on some of the pressures on the service in a moment.

You made the point that a great deal of a coroner's work is unnoticed almost. It is under the radar, especially the 85% of deaths that do not require an inquest, which the public probably do not understand or are unaware of necessarily, unless, sadly, they have a direct dealing with it. Is there anything more or should anything more be done to raise the public's understanding and awareness of the service? Let me give you one example. Many of my constituents contact me and they do not understand, as you pointed out in your evidence, that your role is limited to the four findings of fact.

Judge Lucraft: Yes. To some extent, members of the public only come across a coroner when the death of a loved one is referred to the coroner. They might know there is a coroner, but they will not actually understand their role or function until that time when the death is referred. Coroners, with their support staff, try to do their very best to explain what the process is. There can be quite difficult conversations, occasionally, where a post-mortem may be required. Not only those with very strong faith concerns about the invasion of the body but most of us do not like the idea of a loved one being examined post death to see what has happened.

Of course, for a coroner properly to carry out their functions, a post mortem needs to be done in certain cases. It requires quite a skilful hand on the part of the coroner, the coroner's officer or the other staff to explain to families, "I'm very sorry, but there does need to be a post-mortem here. We need to find out what has happened." It is very important for society to understand why people have died in certain circumstances and to learn from those deaths in circumstances that may prevent other people meeting a similar position.

In terms of the public understanding, I do not quite know how one can best address that. We have tried in leaflets, which are now provided to people, to explain what the role of the coroner is and how they would carry out that function in a particular set of circumstances.

Q124 **Chair:** There is some publicity about delays for burials, for example, on faith grounds. Are you satisfied that that is always being handled in the way that you would wish it to be?

Judge Lucraft: The picture varies across England and Wales. Most coroners now are expected to run, effectively, a 24-hour, seven-day-a-

week service. Again, that differentiates them from many other judges. As we know, people don't die during office hours. They will die at all times of the night or day and at weekends. Many coroners run a very effective out-of-hours service. Many are very sensitive to the particular concerns that faith communities have of wanting, where possible, to have a burial very swiftly after death. I have spent quite a bit of time in my four years meeting representatives of the faith communities to explain to them what the role of the coroner is, and where there may be circumstances in which there has to be a post mortem or there is going to be a delay. I know from the feedback I have had from those visits that they have welcomed the opportunity to hear what the process is, to have explained to them the circumstances in which a post mortem might be required, but with a clear understanding that, where that is not a part of the investigation and the body can be released quickly, it will be.

There are situations in which people want to have an out of England order, as it is called—the body is going to be buried overseas. Again, there is normally a very good working position, with coroners able to answer those requests out of hours. I am the first to accept that it is by no means perfect across the whole of England and Wales. There are always improvements that we can make in that regard.

Q125 **Chair:** It is a localised system. So your power is essentially guidance and training.

Judge Lucraft: Yes. There is some strength in the local system, in the sense that the senior coroner knows their communities very well. We are a diverse country. We live in different ways, but we have communities as part of local authorities in some areas that we don't in others. The localised nature of the senior coroner is quite important. Having said that, I am personally in favour of us moving towards a national system, as I have set out in my annual report.

Q126 **Chair:** I think your predecessor said we have the Chief Coroner but we do not have the other elements of the system that had been previously recommended in place.

Judge Lucraft: Absolutely. In part of the annual report, which was published a few weeks ago, there is a revised model coroner area. Guidance is set out in that report as to how a model area should be set up and run. Resourcing differs enormously between different parts of the country. Local authorities will fund a coroner service in differing ways. Some have the latest IT and the latest courts, but others do not. I see a properly funded national service as one way of addressing some of these inequalities on the resourcing that is currently provided.

Chair: That is helpful.

Q127 **John Howell:** Other parts of the judiciary are subject to mandatory practice directions. Would these be at all helpful for the Chief Coroner to have at his or her disposal?

Judge Lucraft: There are currently 40 sets of written guidance that I have issued, or my predecessor issued to coroners. They are called guidance notes. To some extent, the role of a coroner, as I have explained, is slightly different from that of other branches of the judiciary. For example, there is a guidance note on second post mortems. That is really covering a large part of the coroner's work that is outside their work in a court. Whether you call it guidance or a practice note, the aim is to provide a clear path to coroners in making judicial decisions on various aspects of their work.

During the course of the Covid pandemic, I have issued a number of guidance notes on specific parts of the work of coroners dealing with Covid and the running of their courts in that process. That guidance is in place. I have called them guidance notes rather than practice directions. Of course, even if a practice direction is given by another branch of the judiciary, it is up to the individual judicial office holder to look at that practice direction and see whether it applies to the particular case that they are dealing with, and then to make their independent judicial decision based on that. There is guidance there, albeit they are called guidance notes rather than practice directions.

Q128 **John Howell:** What is your view of the decision not to introduce appeals to you as Chief Coroner?

Judge Lucraft: Part of the 2009 Act, when it was first envisaged, did have this route of appeal to the Chief Coroner in respect of conclusions from inquests. If we were to go down that route, you would need a Chief Coroner with a rather larger secretariat to deal with it. I mentioned that there are 210,000 deaths referred to coroners. You might want to limit that appeal route to situations that arise in an inquest, but every time a coroner makes a decision, whether it leads to an inquest or not, that is a judicial decision. If you are contemplating potentially having 210,000 cases subject to a routine appeal to a Chief Coroner, it would be quite a massive undertaking.

I know that applications for judicial review are not necessarily the most popular way of considering appeals, but they seem to work in the sense that they occasionally throw up interesting issues for the High Court to determine about a coroner's decision or coronial practice. Personally, I am not in favour of allowing an appeal for every coronial decision because of the impact that could have.

Q129 **John Howell:** So you would not allow appeals to a senior coroner from area and assistant coroners.

Judge Lucraft: The senior coroner runs an area. Derek Winter, who is one of my deputies, is the senior coroner for Sunderland. If, for example, Derek's decision were to be appealed and considered by another coroner, that could, as I see it, lead to all sorts of difficulties because it might be thought by members of the public that that is another coroner supporting their fellow coroner in a decision. The better route is by applications for

judicial review, which are then considered by the High Court, and guidance may follow some of those decisions, as it has during my four years.

Chair: If either of the two deputy Chief Coroners wants to come in at any stage, please indicate. I know that you, Chief Coroner, might want to ask them to pick up particular points as we go along. Andy Slaughter, you wanted to follow up on this point.

Q130 **Andy Slaughter:** Yes. Thank you, Chair.

Continuing on the issue of appeal, we all understand that an appeal process would require substantial additional resources. At the same time, review is an expensive remedy. Let me push you on the issue of the appeal process, because I get more complaints about the way coroners conduct themselves than any other part of the judicial system. I do not say that because coroners are making worse decisions necessarily, but, first, I think it is the lack of an appeal route, and, secondly, it could also be that coroners seem to be the masters of their own jurisdiction—at least a senior coroner would be. If you are stuck with a coroner who is not performing well, that tends to produce many complaints.

Finally—this is a question in several parts—you mentioned the fact that 80% of cases will be decided by a coroner, not at an inquest. There must be marginal cases. Should there be any right of review of those cases, because often MPs are brought instances of suspicions of unexplained deaths that have not gone to an inquest and they would like to be able to challenge that in some way?

Judge Lucraft: I am sorry if you get complaints about coroners' inquests. I am the first to accept that we do not always get everything right, whichever branch of the judiciary we come from. Very often, as I have mentioned, coroners deal with people going through a grieving process. They can be somewhat disquieted by the fact that the case has been referred to a coroner.

However, I have sought—we have a very extensive training programme—to educate coroners in making decisions that are explained very clearly to individuals. The example you give is of a decision not to go to an inquest. If that is a contentious issue, I would expect the coroner who is dealing with the case to give a reasoned judgment on why they have chosen not to go down that route. Of course, that decision is one that is susceptible to judicial review. The difficulty is, if you were to say, in that situation, that there would be an automatic right of review to the Chief Coroner, that would involve a significant additional resource requirement. That would have a knock-on effect of delay in that process. Those are just features of it.

The training we have conducted recently has taken a fictional inquest, stopping the film at various stages, and then simply inviting groups of coroners and syndicates to discuss the situation. That is all designed to improve the judicial craft of the coroner to improve their interaction with

families. The vast majority of inquests—as I mentioned, there are about 30,000 each year—take place with just the coroner and the family in a court setting. There are no groups of lawyers present representing other interested persons. It is simply that very small setting.

In the figures and in your postbag from those who have written in from your area, one needs to have some context—the sorts of situations coroners deal with. The training is in place. I have always accepted that we can all improve our judicial skills. I would hope, in the four years that I have been in post, that that has happened, but it is a process that will continue under my successor so we make sure that many more people leave the process content with what has taken place rather than disquieted.

Q131 **Andy Slaughter:** Thank you. Possibly because of pressure of work, coroners' offices are quite often poor at responding. Would you like to see a requirement to give reasons where reasons are asked for?

On the question of appeals, bearing in mind resources—this is for a future occasion—there being more money in the system than now, in principle there should be a right of appeal, or are you against that principle?

Judge Lucraft: Taking your first question, I would like to think, if I am sitting as a judge in my jurisdiction at the Old Bailey and I make a decision, that I am required to give a reasoned judgment as to why I am making it. I would expect any judicial office holder who is facing a challenge to the decision they are making to give a reasoned decision. That decision very often for a coroner may not be in a court setting but may be in a letter explaining to a family why, for example, they have decided not to proceed to an inquest. It does not need to be a lengthy document, but it does need to set out the gist of what the decision is and the reasons for it.

If I were to ask Derek or Alexia that question, if they were dealing with a particular point in an inquest, both of them would say, "That is what we would expect to be doing." That is best practice going forward. I will endeavour to make sure that we instill it in all coroners that their decisions should be reasoned and set out for families.

In relation to the appeal process, my preferred option is that we retain the jurisdiction of the High Court to look at applications for judicial review. If you are going to look at a broader range of appeals from decisions of coroners, that will bring with it quite a requirement of manpower, resource and finance. I am not saying that I am against it--if you were to fund it properly. My real point is that it is quite an undertaking if you do that because you are left with a potentially difficult situation in terms of which decisions can be capable of being appealed to the Chief Coroner and which cannot. If you have to triage those, you are effectively having to triage, potentially, the decision in each of the cases referred to a coroner.

Q132 **Chair:** Are you satisfied with the way the procedure under section 13 of the Coroners Act for applications works?

Judge Lucraft: You will have seen from the annual report that one of the recommendations made initially by my predecessor, Sir Peter Thornton, which I have followed up on, is a simplification of the section 13 process. There is a good argument for making an appeal a much more streamlined process. Rather than needing an application before the High Court, it could, in many situations, be dealt with administratively. There is a compelling argument to amend the statute so that that could happen.

I have made some fairly modest suggestions in the annual report, one of them being—I have mentioned the figure of 30,000—that a significant number of inquests take place in a court with a coroner and only a coroner's officer. Rather than have a hearing and a determination in court, there is a compelling argument for those types of cases where a determination could be made by letter, which could be made public and sent to the families, not to require a court hearing.

Q133 **Paula Barker:** I am interested to understand what you think have been the most important changes since the 2009 Act was implemented.

Judge Lucraft: I suggest that Derek Winter might answer that question, because Derek, as I have mentioned, is the senior coroner for Sunderland and was in post before the Act came into place. He could, probably, speak from a senior coroner's perspective about the most significant change that the Act has brought about.

Mr Winter: It has been helpful that we now have an Act in place that directs coroners on what types of case they need to look at. One of the greatest effects of the Act was to allow us to discontinue an investigation when we found out, usually after post-mortem examination, that the death was natural. Those cases, otherwise, went through to what seemed to be an unnecessary inquest. That was a great move forward for coroners.

The move to have a Chief Coroner was another fantastic move to get consistency in the guidance. All coroners endeavour to follow that guidance. The lawyers who come along to the few inquests where they do appear know what the ground rules are. That sets the tone. It is important that we have an understanding and that everyone refers to Chief Coroner's guidance 17 about conclusions, previously referred to as verdicts.

We now come under the Judicial College for our training. That is a professional endeavour. The Chief Coroner, with the Judicial College, will set the course programme for coroners, who get two days' residential compulsory training every year. Coroners' officers take advantage of that as well. It is an opportunity for the Chief Coroner, with his training committee, to look at current topics.

The judge mentioned that we went through a whole inquest and discussed the twists and turns that occurred. We look at current matters that are headlining, as it were. As a result of the report by Dame Elish, we invited her to training, but we compromised and I did an interview with her, which we then shown to all 600 coroners' officers and all the coroners—area coroners, senior coroners and assistants.

We have invited Inquest to training on a number of occasions now. We have invited the current support service volunteers to training, and families have spoken to us. Everyone would like to think that we do things perfectly well, but until someone tells you otherwise you do not know to improve. That is important.

The Act was a watershed for coroners. Those improvements have been fantastic for bereaved families and for the participants at the inquest hearings.

Q134 **Paula Barker:** You mentioned consistency in having one Chief Coroner, the Judicial College, compulsory training and so on. How consistent do you think the improvements have been across coroners' areas? You have suggested that it was. Have I understood that correctly?

Mr Winter: It is better than it used to be. We have fewer coroner areas. We are down to 85 from possibly 110 some years ago. That will drive consistency because there is one leader of that local service. The target is around 75 coroner areas. With that leadership and management, senior coroners, who have that responsibility, can drive those changes, provided they have the resources to do so.

Here in Sunderland, I am very lucky with a well-resourced coroner's court from my local authority and local police. We have the Coroners' Courts Support Service volunteers, who are fantastic. Much can be done to make many improvements to the service. People need to know that, if they are coming to an inquest in Sunderland, it is going to be the same experience for them in London. The Coroners and Justice Act and the rules and regulations gave everyone the ground rules that we all had to work to. That is the same for the Chief Coroner's guidance as well.

Q135 **Paula Barker:** You touched on improvements—obviously, many improvements can be made—but if you were speaking about one key part of the system that required improvement, what do you think it would be?

Mr Winter: We are on a journey with that currently because last year the notification of deaths regulations codified the deaths that had to be referred to coroners. Before October 2019, most coroners had local reporting criteria. Working with the National Medical Examiner, a team of other senior coroners, GPs and the Ministry of Justice, regulations came out to set out what is a natural death and what is an unnatural death. We have a cause-of-death list prepared by the Royal College of Pathologists.

We have Ministry of Justice guidance alongside those regulations so that doctors are very clear about what they should refer to the coroner. Many

coroners, as evidenced by the Covid pandemic, are now operating remotely. We have portal reporting, so the days where the doctor would have to wait in a queue for the telephone to be answered are going as people get better resourced. The portal report will bring the data into our IT systems automatically. We are able to generate the forms and send them to the registration services and families electronically with electronic signatures. Huge strides have been made to improve the service.

One of the things that did surprise me with the reforms was that many families ask for CD recordings of their inquest hearings. They pay £5 and we burn the disc. They promise not to put it on social media, and they can have a permanent record of that inquest. Many families take up that opportunity. It is about coroners making sure that families are aware of their rights to disclosure, not to wait for the family to ask for it, to give them timely disclosure and to put them at the heart of the process because it is their loss.

Paula Barker: Thank you very much. That was very helpful.

Q136 **Rob Butler:** I am going to pick up on the overarching theme of consistency, but I would like to move specifically to the issue of appraisals. I understand, judge, that you have introduced an appraisal system. Could you tell us more about it? Is it one national form that everybody does, or does each senior coroner in an area devise his or her own?

Judge Lucraft: No. It is one form that we put together. It is borrowed largely from the district judge appraisal system. I took the view that the best way of identifying training needs was to appraise each assistant coroner. We have devised a system of the senior coroner for an area appraising their assistants. It is to be done annually.

I brought in this system initially as a trial for a year. The idea was, after the first year's appraisals, to look at the forms that came back, see what worked and see whether the form needed tweaking. I also started looking at how we would appraise the salaried coroners. In fact, Derek was a guinea pig as one of the senior coroners I had appraised.

As you have heard mentioned several times, the resourcing, not only in terms of individuals, IT, courts and all the rest of it, varies across the country, but the appraisal is looking at the same set of core qualities that you would expect a coroner to have. As I have mentioned, a large part of the work of a corner is not in a court setting—it is not at an inquest—but it is dealing with the decisions that are made in the office. It is dealing with how you interact with families. You have to appraise that part of the job as much as you have to appraise what happens in the court setting.

The form goes through a number of headings that coroners are expected to identify. The person being appraised does a self-assessment, and then they are appraised by their senior coroner. The idea, in due course, is

that we will roll it out annually for each assistant coroner, to be followed by an appraisal system for the salaried coroners. It has been slightly put back because of Covid. That was the plan.

Q137 **Rob Butler:** Given that there is not a national coroners service at the moment, it almost seems it is a half-step towards at least trying to have consistency in the required qualities of assistant coroners at this stage and then senior coroners.

Judge Lucraft: Yes.

Q138 **Rob Butler:** And, presumably, taking action if those standards are not being met.

Judge Lucraft: In identifying the training needs, there may be localised needs. Somebody may, for example, be appraised on something that they do not handle particularly well. You can deal with that by saying, "Have you thought about doing it this way?", or saying to me, "Chief Coroner, this has come up on three or four of the appraisals that I have conducted in my area. It might be worth you putting a module on this topic for every coroner to be trained in at the next training course." That is very much what I have in mind.

You will know that part of my remit is not to deal with judicial conduct matters. We have a particular office that deals with that. I do not see appraisals as a way of my interfering with what should be properly assessed by an independent office on judicial conduct. I see this as identifying training difficulties, issues where somebody may not necessarily be able to step up to doing more complicated forms of inquests, because you are appraising, as assistant coroners, people who might have been appointed in the last 12 months as well as people who have been assistant coroners for 10 or 15 years. You would expect with some of the more recently appointed to spot one or two things that need to be fine-tuned and addressed by further training. If you are still seeing those issues in someone who has been doing the job for 10 or 15 years, more difficult conversations might need to be taking place.

Q139 **Rob Butler:** Are those the conversations that would sit with you or not, because then we are talking about performance, are we not, which is not quite the same as conduct?

Judge Lucraft: It is not. If they are about performance, those questions do come back to me. If they are about individual judicial conduct, then I cannot. The idea very much for appraisals was not to wait to be told that I should be appraising coroners, but to grasp the nettle and say, "We are going to appraise coroners," because we can learn a great deal by looking at what we do, what we do quite well but what we can do better. An appraisal helps that.

Q140 **Rob Butler:** What has been the feedback in those areas where that has happened, or do you think that is already starting to engender, almost in and of itself, enhanced performance?

Judge Lucraft: Some coroners have said to me, "I have learnt a great deal out of doing this appraisal. I have realised where locally I need to be addressing some particular concerns with my assistant coroners." I have learnt a great deal because an assistant coroner has said, "I do it this way." It has made me think, "Gosh, that is a very good idea. Why don't I do it that way?" It has been a two-way process. Many coroners have told me that they derived quite a bit of benefit out of doing the appraisals, as did those being appraised.

Q141 **Rob Butler:** Is there an element within that appraisal process of the experience of bereaved people, because some of the evidence that we have heard during this inquiry has been that that can be patchy? Victim support and the National Homicide Service referred to inconsistencies. They talked even about a postcode lottery. You would want to eradicate that, would you not?

Judge Lucraft: Very much so. Derek mentioned in part of his answer that we have engaged very much with people to come and assist us with our training. Inquest has been along. We have had people who have gone through an inquest themselves address coroners' officers and coroners just to look at these points where there may be less than a perfect service in at some areas that can be improved by listening to the people who have gone through these difficult situations.

You will know that Bishop James Jones wrote a very searching report about the Hillsborough inquest process, both the first inquest, many years ago, and the more recent inquest under Sir John Goldring. I invited Bishop Jones to speak to all of the senior and area coroners, and he explained some of the issues that had been flagged up in his report. It seemed to me vital that as coroners we listen to people who are critical of the way in which an inquest has happened, which has not been great, and we learn from that. I believe that there is no better way than inviting these people to be part of our training programmes so that we, hopefully, improve and there are fewer complaints about issues going forward.

Rob Butler: Thank you. My colleague, Maria Eagle, is particularly keen to pick up on that point, so I will pause and allow her to come in.

Q142 **Maria Eagle:** Thank you. I am glad that you have raised the issue of the Rt. Rev. James Jones's report into Hillsborough. I am a Liverpool MP, and my entire 23 years in Parliament have been spent trying to help Hillsborough families, many of whom are my constituents. Often forgotten are the survivors of Hillsborough who witnessed many terrible things but did not themselves get either physically injured or lose family members. It has traumatised the whole city.

Although I accept there are many inquests where the experience of bereaved people is good and has helped, I want to explore what you are trying to do with these other instances where there is distress. Problems with Hillsborough are perhaps the most serious, because, as you have said, it has gone on for more than 30 years with two different sets of

inquests. I can tell you the coroner's proceedings and what has come out of inquests have been a major cause of severe trauma, and in some cases worse than trauma for those involved. For example, bereaved relatives who are perfectly innocent people have been caught up in it.

What steps have you taken to improve people's experience of what can be a very traumatic set of circumstances in having to go to an inquest about the sudden loss of a loved one?

Judge Lucraft: The way we have approached it is very much to do this through training. Bishop James Jones, very kindly, came to speak to all of the coroners. He made many recommendations in his report. My education and training committee and I have looked at how best we address some of the failings that were identified. The best approach I can suggest is that this has to be done through training of all coroners. We have to make sure, when we say we are putting the bereaved at the heart of the inquest process, that we follow that by actions as well as by words.

For example, one of the pieces of guidance that is in the process of being drafted is on pen-portrait material, which the Bishop speaks about in his report. I took the view that that should be the subject of guidance from the Chief Coroner.

In more recent inquests, it has played a key part in the process. We probably all saw some of the pen-portrait material at the beginning of the Manchester Arena inquiry. Pen-portraits now take the form not just of people reading testimonies but often of a video or music being played. It is important in every case, whether it is a high-profile case or not, that the family of that deceased person is treated the same.

I am grateful that both the Coroners' Courts Support Service and Inquest have engaged with me on this process. I sent them a draft and they commented on it. The final version will be published before very long. That is just one very small example of one of the points that the bishop highlighted in his report.

We have sought to address the other issues that he highlighted and will continue to address them going forward. As I have accepted in my written evidence and as I have made clear in my annual reports, it is not a position where I can say that everything is perfect. It is not, because it involves humans. We all, sadly, make mistakes at times. I am very keen that we learn from these reports—that we do not simply ignore them but apply them as best we can. The approach to dealing with the issues that the bishop identified is through training and guidance.

Q143 **Maria Eagle:** My experience of these things extends beyond Hillsborough to other disasters. It seems to me that, where there are many deaths in an incident, things often go wrong or coroners' inquests cannot quite cope. Things spiral out of control in terms of what the bereaved relatives think about the proceedings. Do you think there should be particular rules

and different ways of doing things that relate to public disasters, if I can call them that, which involve a number of deaths? To what extent do you think you have a role in setting out different expectations for inquests that involve a public disaster and many deaths rather than just—I do not wish to belittle it—a single death in a particular incident?

Judge Lucraft: Quite often incidents with multiple deaths—I gave an example of an inquest I covered myself—lead to the appointment of a judge as the coroner. One of my deputies, Judge Durran, is sitting as a coroner on an inquest in Kent that does not involve multiple deaths but does involve the types of issues that have required a judge to be appointed. There are cases, and certainly cases of multiple deaths, which end up being dealt with in a slightly different way through the process of my appointing a judge or inviting the appointment of a judge to deal with it. The best examples are the events in 2017, which have led to the inquest that I did and the public inquiry that Sir John Saunders is currently engaged in. Those do, of themselves, tend to lead to learning points going forward.

I was conscious today, when coming to Portcullis House, having dealt with the Westminster Bridge inquest, that there were various points that were identified about the security in this building that I recommended. My private secretary said to me that perhaps it would be tempting to turn up and say, "I've come along to check whether the Palace of Westminster has seen through the recommendations that were made in the report." I did not take up that chance, but it is a good example of where there were a number of deaths and the inquest has gone through a slightly different process and come up with the sorts of recommendations that that particular inquest did.

Q144 **Maria Eagle:** Do you think that the adversarialism that can develop in some inquests, which happens particularly in cases with complex sets of circumstances in which there are multiple deaths—I tend to call them public disasters, but they can include terrorism and the kinds of cases that you have just referred to—creates circumstances in which, in my experience, many relatives of the deceased suddenly find themselves at a disadvantage because they do not have representation, and lawyers on behalf of public authorities try to spread blame? Do you think they become very adversarial rather than having the inquisitorial nature that inquests are supposed to have? What remedy can we have for that?

Judge Lucraft: I suggest that my deputy, Alexia Durran, might answer that, partly because she put her hand up just as I was saying something just now. There are quite a number of issues, but I suspect Alexia will cover them.

Judge Durran: To be honest, I put my hand in the air because part of Maria's question was about the handling, as she describes it, of multiple-victim deaths. I was going to invite Judge Lucraft to speak to our DVI cadre and the training that a number of coroners undergo. There are coroners on call when there is a major incident and they are involved in

managing the very beginning, where things have, perhaps, in the past gone wrong. I was going to ask Judge Lucraft to talk about that in reassuring you that the larger disasters that take place are managed with extraordinary care and extraordinary training, which is a major advance since the time of Hillsborough. I hope I can pass the baton to Judge Lucraft on that point.

Judge Lucraft: Certainly. Part of my role is to have this oversight of national incidents. The DVI cadre is a group of specialist coroners who are on call 24/7, 365 days a year. It may surprise some of you to know that they are on call not just for national incidents in the UK, but for incidents across the world that involve UK nationals. There is always a coroner who is on call. They will deal with the arrangements for that incident, whatever it might be. It might be a terror incident or something such as flooding where a number of people have died, but they will be available.

That is a significant change. It is quite a select group on that cadre, but it covers the whole of England and Wales. They are a fantastic group. We have specialist training to make sure that the lessons that were not learned on these incidents before are not missed. We have a very good working relationship with UK DVI in the Metropolitan police. We have some of the world leaders, I am pleased to say, in DVI disaster victim identification training, both in Howard Way and in Pete Sparks from the Met police who run that. They help us to keep our coroners up to date. Coroners, including myself, have travelled extensively around the world, not only to share our learning but to share the training that is given to coroners and police officers in this country with our friends across the world.

In answer to your question about the lessons from before, in my four years I have been to Rome, Portugal and to Interpol in Lyon to explain the role of the DVI cadre and the DVI coroner at a time of national emergency. Many other countries are interested in the way in which we have enhanced and developed the role of the coroner in those situations. That is, in a sense, an answer to the first part of your question.

I do not know whether Alexia wants to deal with the follow-up question, but it is where we, effectively, try to take away from coronial proceedings the adversarial nature, which is the point that you were particularly wanting us to address.

Judge Durran: I am not sure if I am the best person to ask about that. At the risk of passing the buck again, in trying to remove the adversarial aspect, I was going to pass over to Mr Derek Winter because he has been involved—I know it is not yet at its final stages—in drafting toolkits that will be provided and available to advocates who are participating in inquest procedures to help them, as you say, manage the adversarial aspect and make sure that it does not become an opportunity to air

repeated grievances between different representatives who appear at inquests.

Derek is leading on toolkits for advocates as a way of ensuring, as has been the theme throughout the evidence, greater consistency in the approach of coroners and in managing, occasionally, the advocates who appear before them. I don't know whether Derek wants to come in further on the question of toolkits.

Mr Winter: It is really important that we recalibrate the tone of inquests. On Friday last week the Supreme Court gave a landmark ruling in the case of Maughan, which set the standard of proof for all coroner conclusions, previously verdicts, as on the balance of probabilities. That includes suicides and unlawful killing.

Lady Arden, in giving the lead judgment, made it very clear that inquests are not criminal trials. I have been working with the regulators—the Solicitors Regulation Authority and the Bar Standards Board, together with a group of experienced inquest lawyers—to develop a toolkit, a set of competencies and standards. It is a bit like the Youth Court toolkit that is now available on the various regulators' websites, because this is a specialist area of advocacy, which requires a certain tone to the proceedings.

That should be rolled out in the spring. It complements a protocol that Government lawyers should sign up to, which is in the MOJ guide to coroner services. The idea is to have those standards and competencies for everyone to work towards so that no one can feel disadvantaged or bullied. There is nothing wrong with robust questions—people are accountable—but the manner in which those questions are put is very important. We will align that toolkit to coroner training to improve their judgecraft as well.

Judge Lucraft: Let me follow up on an issue that you have asked about, namely, how the coroner controls the court and makes sure it does not become too adversarial. One of the other pieces of guidance that was issued this year is in relation to a coroner instructing either counsel or solicitors to an inquest. If, for example, one takes a healthcare-setting inquest where there are complex issues relating to the cause of death—it may well be that a number of health trusts or doctors are represented before the coroner—very often the coroner has no person to help them through quite a maze of technical terms and legal responsibility. Part of the guidance was designed to encourage coroners, in certain types of inquest, to have a counsel or solicitor to help them, partly so that the family can see there is somebody helping the coroner who may ask questions that might otherwise have been difficult for the family to pose to the clinicians or others who had been involved in the case.

Q145 **Chair:** That is very helpful and useful. There are a number of important issues that we need to get through.

Judge Durran: The only reason I am putting my hand in the air is, as Judge Lucraft indicated, that I am in the middle of an inquest and I have taken an hour out to participate at this Committee. I am very grateful for the invitation, but I am afraid I will need to depart—I have a jury waiting for me. I am sorry to have to leave you at this point.

Chair: That is understood. We are grateful for your time and evidence. That is much appreciated.

Q146 **Richard Burgon:** My question relates to occasions where effective participation in an inquest has been hampered by a lack of legal representation for some parties but not others. In some circumstances, bereaved families need legal representation at an inquest. This is invaluable support that families need to help them to navigate complicated proceedings that are adversarial in practice, whatever the intention. However, barriers to this support include the narrow requirements for when publicly funded legal services can be used and requirements on families to meet very stringent legal aid funding conditions. In the panel's experience, how do barriers to legal aid, and in particular cuts to legal aid, impact on the ability of bereaved loved ones to understand and play a full role in inquests?

Judge Lucraft: My previous annual report was before the Lord Chancellor had carried out the review of the provision of exceptional aid for inquests. That review having happened, it is clearly a matter for him to consider rather than for me as a judicial office holder to comment on the provision of legal aid.

To some extent, your point is a very good one. The role of a coroner, as I have tried to explain, is to fact-find on four key issues: who, when, where and how somebody died. Part of the role of the coroner is to ask the relevant questions and to help all persons who are before that inquest to get to the answers to those questions.

Clearly, if state parties present before the coroner and the family are unrepresented, there would be a concern about whether they might feel, however good the coroner is in asking questions, that they are not being funded with legal aid in the way that perhaps they ought to be.

I have huge sympathy and support for the family in those situations, but the question of whether legal aid should be provided is for the Lord Chancellor to consider rather than for me as Chief Coroner to comment on, having invited the Lord Chancellor to consider the provision of legal aid under the exceptional rules in a previous report.

Chair: We have the Minister coming shortly. He can be asked about that.

Q147 **Richard Burgon:** That is useful. I understand the distinction. Thanks for that answer. Do you believe there are occasions when effective participation in an inquest has been hampered by a lack of legal representation for some parties but not others?

Judge Lucraft: It would be very difficult talking in isolation about individual inquests. I know, for example, of many inquests that I conducted, whether somebody was represented or not, where I had an extremely good advocate asking the questions to assist me in the exercise as counsel to the inquest.

In answer to your question, that was why I was keen to get that piece of guidance out, because there are situations in which the questions that need to be asked may well be asked by the coroner as part of that process. Whether an individual interested person has been represented or not, the key questions ought to be asked. It is part of the training that Derek and I have spoken about that we need to make sure that coroners understand their role where family members are not represented but those who are appearing for interested persons are represented. It is a case of balancing that as best one can.

Mr Winter: Can I just add to that? There are occasions where coroners will write letters of support for funding applications. Coroners are trying to level up, to use a popular phrase, not just making sure that the family's questions are put but, if there is good reason for representation, to support that. Beyond that, there is not much more that coroners can do.

Chair: Understood. There is an equality of arms and perception of equality, is there not, sometimes, which is important?

Q148 **Miss Dines:** In my practice at the Bar it was quite obvious at times that participants in inquests who were not legally represented often left disquieted. Mr Burgon has asked my question, but let me expand a little. What can we or you do, as professionals, to assist families in preparation for the process where they are not going to be represented that will make it appear fairer and more inclusive for them so that they will not leave disquieted?

Judge Lucraft: Let me go back to one of the things I said quite early in this session. We are dealing with families at a very raw time for them. They are grieving and they find the process very difficult. Part of my role and part of the role of all coroners is to make sure that families are at the heart of the process and understand what is happening.

We are very lucky in that in about half of the coroners' courts in England and Wales we have the Coroners' Courts Support Service present. They do a most fantastic job through volunteers to help support the families through the inquest process. My hope is that, in due course, we will have them at every coroner's court in England and Wales. In the time that they have been established, which goes back to 2003, they have helped more than 400,000 individuals.

That is part of the process. It is not just necessarily having legal representation. It is demystifying, if that is the right word, where a family may not understand what it is that the coroner is seeking to achieve.

In essence, what a coroner is doing is very straightforward. There are the four questions: who, when, where and how somebody met their death. Who, when and where are often very straightforward. It is the how that can pose more difficulties. I am very keen that we do all that we possibly can, through training, guidance and the provision of literature, if that would help, to families who often, as they come to this process, not wanting to and not expecting to but it being forced upon them, to make sure that they have a clear understanding of what the coroner is doing. That involves the coroner being at the heart of explaining, where he or she can, to the families what the process will involve and what the pinch points might be.

Q149 **Miss Dines:** Can something be done by way of providing materials formally before an inquest rather than expecting organisations to take that on board in preparation? Is there a process that would be efficient and possibly quite cheap to deliver that would put families in a far better position to be ready for the whole process?

Judge Lucraft: Yes. It may well be that Derek has some first-hand experience of what goes on at an ordinary inquest. Many coroners now have a fairly standard checklist of materials that will be provided to a family without them needing to make any requests. Where these things can become more complicated is further down the line. I know, for example, that in Sunderland Derek will have a checklist that he will provide, as a matter of routine, to all the families who come into his service because of a death that he is dealing with.

Mr Winter: In every case and referral we ask every family if they have any concerns that they wish to bring to my attention. If you don't ask, they may not tell you. Hopefully, the coroner's officer who takes them through the process from the start to the end, to the conclusion of the inquest, will keep people informed and make sure that they write their concerns down; that they get timely disclosure. In the more complex cases, coroners will have pre-inquest reviews so all interested persons understand what the scope of the inquiry is going to be. Then, hopefully, families will not be surprised. The coroner will take time to explain the process and the procedure and to help families to frame the questions to witnesses. It is a very difficult job sometimes asking relevant questions. People, sometimes, have the habit of making statements, but they should be encouraged to participate at every stage and to understand what coroners can and can't do, so we are very clear about managing their expectations.

Finally, feedback is always appreciated. On my website we have a feedback section. In court we have feedback forms to give out to families and doctors because we want to know what we have done well, obviously, but where we could develop. There are many initiatives to try to help families.

In one coroner area, Rochdale, senior coroner Joanne Kersley now has a bereavement nurse embedded in her team, which is an enormous benefit

for people who participate in the death investigation process, not just the inquest.

Q150 **Miss Dines:** What effect does the health and social care duty of candour have at inquests in encouraging openness where liability is an issue for the bodies that are involved?

Judge Lucraft: It may well be, because Derek is more experienced in dealing with those particular types of inquest than me, that I suggest he answers that question first and I will chip in at the end.

Mr Winter: The duty of candour is a very helpful development. One of the things that coroners should be doing, in my view, is forming a working and meaningful relationship with the chief executives of the various health trusts and GP communities to get word out about what the coroner's expectations are at an inquest. It is far better for people to come along and say, "We have fallen into error. Things could have been done better," than for that admission to be, essentially, extracted out of them. It is better to put hands up, learn lessons and move forward.

In my experience, most families when they come to the coroner's court tell me that they just don't want this to happen to somebody else. That is what it is about. Families need to hear that from all participants if there have been problems. Then coroners can write the PFD reports and try to encourage change for the better.

Q151 **Dr Mullan:** The duty of candour talks about a clear requirement to disclose harm and so on. I appreciate this is limited purely to medical experts, but it is a common occurrence that in the coroners' courts you might be asking for consultants or senior medical leaders at a trust to answer questions about the care of someone at the trust. The evidence that we have heard is that that can widely vary the extent to which a coroner is able to interpret and understand that evidence and the extent to which they will reach out and seek independent advice in relation to the quality of care somebody might have received. I am interested in your views on how effectively you think coroners' courts as a whole are dealing with that quite common scenario.

Mr Winter: Experts, of course, are expensive, so we have to be cautious with public money. If it is required, we tell the local authority of an unusual item of expenditure and they have to fund that. We would get an estimate of costs, write a proper letter of instruction to the expert, agree that with the family and the interested persons, and set the parameters of the expert's report. My experience is that we are seeing more experts in court. Our routine medical advice will come from medical examiners, who are being rolled out across the country gradually, so we can tap into that resource as we have lost doctor coroners.

Q152 **Dr Mullan:** I take your point about costs, but some of the evidence we have heard suggests it is not necessarily about costs. Sometimes it is about culture. There is a view that, if a consultant from a hospital comes

along and asks questions, automatically that opinion is given weight. While I can understand that, perhaps relatives will not always understand. It is your view on that issue that I would like to hear—not so much the cost of the resource, but do you think that is correct?

Mr Winter: If a hospital procedure is implicated in a death, I would bring in a pathologist independent of that hospital to carry out the post-mortem examination and to make sure that there was nothing to worry about. I would not have that connectivity to the trust that I was investigating. There are different ways we can approach that problem. I am not medically trained. I have picked up medical knowledge over the years, but I rely on the expertise of local doctors, pathologists and independent experts to help families understand.

Sometimes you are right. If you get an independent expert who answers all the queries of the family, you may not have to spend two days in court if the family accepts what somebody outside of that trust environment has put forward. There are difficult decisions for coroners to make in putting all those things into the balance.

Chair: You mentioned prevention of future deaths reports, which I understand Mr Slaughter wants to come in on.

Q153 **Andy Slaughter:** Yes. Thank you, Chair.

After the equality of arms or lack of equality of arms point, a point that is complained of or people are most concerned about is what happens after the inquest. What lessons can be learned from it? The prevention of further deaths reports is an excellent initiative. How can we improve the use of those reports—some coroners seem to take them more seriously—to see them through, to make them more comprehensive, to make more general applications for them and to publicise them better, so they are then taken up through the media or elsewhere? Is there a central point where they are gathered together? Do you have a role in ensuring that they are properly publicised? Do you have the resources to do that? They seem to be a very important part of the system, which is underdeveloped and which more could be made of.

Judge Lucraft: You are absolutely right. Prevention of future deaths reports are a vital part of the coronial process. Very recently I have reissued the guidance to coroners in relation to prevention of future deaths reports. The reason for my doing so is twofold: first, to better ensure a consistent approach across England and Wales to issuing such reports; but, secondly, to put the reports themselves in a more consistent format. With the guidance as one of the annexes, I have attached some what might be thought to be model prevention of future deaths reports in certain types of cases.

Currently, all prevention of future deaths reports are published by me on my page on the judiciary website. We go through each report that comes in. We have to redact a certain amount of personal irrelevant material. Part of the refreshed guidance is to encourage coroners to leave that

material out in the first place and to focus on the matters of concern, which is what a PFD report is designed to do.

With my team, we are hoping to publish these reports on a different platform in due course, which will make them more easily searchable by those who are interested in researching PFD reports and the responses that are submitted in reply to them. We publish both the report and the responses that come in following the report.

I expressed a view a while ago. Dame Elish Angiolini, to whom reference has been made already, produced a very searching report on police deaths and recommended the creation of an office of article 2 compliance. It seemed to me that one of the things that such an office might do, if it came into being, would be to follow through with the recommendations or the matters of concern raised in a PFD responded to in a report, because once the report has been issued and a reply given, that brings to an end the coroner's role on those PFDs.

In my annual report, I have sought to identify particular trends in reports where I think they are of concern to the country as a whole. It seemed to me that, if we were to go down the route of looking at an office for article 2 compliance, this may be something this office could do to follow up with particular Government Departments or across Departments to say, "These points have been flagged by coroners in England and Wales on these various occasions. This is what they have said are matters of concern. These are the responses that have been made, but where do we see this being policed going forward to make sure the lessons are not lost?"

In echoing something that was mentioned earlier, families who go through an inquest process want those lessons to be learned if there are things that can be improved so that other families don't suffer a similar position to them. I believe that PFD reports are an extremely valuable part of the armoury of coroners. The responses are equally important, but we need to make sure that we don't let those lessons fall between different stools and that we follow them through. I would suggest, if you wish to do so, that this Committee looks at how we make sure that the lessons flagged in these reports are followed through by Government.

Q154 **Andy Slaughter:** Thank you. That is all very good news to hear. Dealing with your first point of more consistency, if you are going to have a common platform, do you have the resources to set that up and do you know when that is likely to happen?

Separately, following up review is clearly the missing element at the moment. I do not understand what the timetable for that would be or the body that would do that. Would that be wholly independent? Who would it report to?

Judge Lucraft: If I take your points in turn, the guidance was reissued earlier this month. The plan was to have training for all coroners in

relation to prevention of future death reports as part of the next round of training that we provide to all coroners. It is encouraging them to make sure they are all applying the guidance so that we get a more consistent picture across England and Wales.

Your second point was whether I have the resource and the timescale. With my head of office we have been looking at a number of options. We have not yet come to a final view. Our plan is, probably, to recruit a dedicated member of the team to make sure that all those reports get published, and get published more quickly, on the best available platform we can find to make them easily accessible, not just to coroners and other people who are interested. I know many academics often email me to ask, "Is there a way that we can access prevention of future deaths reports?" You can currently, but I am trying to make it better.

You asked me for timescales. It is slightly difficult. As you probably know, I will not be the Chief Coroner for that much longer. It is one of those jobs that I will leave to my successor. I would like to think that it will be within a reasonably tight timeframe.

In terms of the follow-up, the point I was making is that Dame Elish Angiolini, in her report, which was published a few years ago, suggested as one of her recommendations an office of article 2 compliance. If such an office were set up—it is beyond my powers to say that it will or will not—it may well be sensible for it to be charged also with following through on PFD reports and, most importantly, the responses to them.

Chair: Thank you very much. We are coming towards the end, but I know that Dr Mullan wants to raise an issue that has been raised with us in evidence on pathologists.

Q155 **Dr Mullan:** We understand from evidence we have received that there is a challenge with securing pathologists to work in coroners' courts and to undertake the work that is vital to your hearings. Have you experienced that, and do you have any ideas or suggestions about how that situation might be improved? We understand that some of it is to do with the rates of pay, but you might have other suggestions.

Judge Lucraft: There is a shortage of pathologists. It is a key feature that I have mentioned in my annual report. Each time I have made a report I have said that we need to ensure that we have a good body of pathologists able to do coronial investigations. The lack of pathology skills, I suspect, is partly a consequence of what a pathologist gets paid to carry out that activity, but also whether there are sufficient people interested in doing the work. We have seen an increase in scanning. That can assist many coroners with what might be termed "relatively straightforward post-mortem investigations". I know that faith communities, in particular, welcome scanning, which means that there does not need to be a more invasive post mortem.

Part of the suggestion I have made in the annual report is that we have regional centres of excellence for pathology skills. That is probably a key way going forward. That idea, I confess, is not my original idea. It was put forward by my predecessor, Sir Peter Thornton, but it is one that I think is a valuable tool for us to look at as a way of dealing with this issue.

If we are not careful, we are going to find increasing difficulty in getting pathologists willing, able and prepared to carry out pathology on behalf of a coroner. Where it is a homicide case, it is not so much of a problem because the Home Office pathology list is often deployed and they come and do their extremely valuable and good work, but this is routine work, where many coroners are finding it increasingly difficult to find pathologists willing to do their work.

The problem with that, Dr Mullan, is that it leads to inevitable delays in getting, first, the samples looked at by somebody and then getting a report, because, if you have fewer people doing it, it can lead to considerable delays in getting that work done. It is something that I have extensively covered in my annual report. I would certainly suggest that that is a good place to look to see what the proposal is going forward.

Mr Winter: Could I add to that and ask that you look at the report of Professor Hutton, who turned his attention to coroner autopsies when he was considering forensic pathology? He advocated very strongly regional centres of excellence, which some areas of the country do have and are trying to work towards, but it does have significant resource implications.

Q156 **Chair:** Thank you. I know, Chief Coroner, that you have already set out your support for a move to a national service. Would an inspectorate be useful?

Judge Lucraft: I am very happy about an inspectorate. I see no difficulty with that and it would bring many positive aspects to it.

Q157 **Chair:** As a final point around a national service, you mentioned building relationships, Mr Winter. For example, if you have a trust in front of you, you make sure that you use a pathologist from outside the trust to avoid potential conflicts of interest. A point that has been made to us is that with the local authority you have to balance a delicate relationship because they, in effect, provide the pay and rations, buildings and wherewithal for you to do your work, but there may be occasions when their conduct or the conduct of their agents is germane to an inquiry. Is that an argument for moving to a national system?

Mr Winter: We still have the separation of powers with our local authority partners. A good collaborative relationship with your funding local authority is key to getting good resources, staff, premises and IT. Those local relationships might still have to continue if we were in a national service. It is really important that coroners and local authorities

work together. That is what the new model coroner area encourages in detailed terms.

Q158 **Chair:** So the model is important.

Mr Winter: Yes, the model is important.

Q159 **Chair:** Is there consistency across the field in that relationship?

Judge Lucraft: I suspect the answer is that it is very important for a senior coroner when they are first appointed to develop relations with their counterpart in the local authority, but that person will probably change in the course of a senior coroner's post. As we all know, local authorities go through dips and troughs, with other pressures on their scarce resources.

Of course, the one thing that is not going to stop happening, sadly, is death. The coroner is going to have a key role. It is very important that that relationship is understood; that the coroner is an independent judicial office holder. They very often have to make difficult decisions that may have ramifications for their funding authority. That relationship needs to be one that is respected and regarded both by the senior coroner with the local authority but by the local authority back with the senior coroner.

I have an annual conference with all local authority representatives and there is very good dialogue, I am pleased to say. People understand the pressures on both sides. Sometimes it is the individual humans in the job who can have a slight falling out, as we know in everyday life normally. I am fairly confident that most of the time people respect, regard each other and have a very good working relationship.

Q160 **Chair:** We know that you have stayed on in post because of the Covid pandemic. Has that pandemic produced stresses and strains for the system?

Judge Lucraft: It has produced a number of stresses and strains. I mentioned earlier that many coroners, as well as dealing with the deaths in their particular areas, sit on local resilience forums. They are dealing with work outside their own particular field, but they work with close counterparts in the local authority. I do not have the statistics because they are collected annually, but, anecdotally, I know from conversations with coroners that the number of death referrals since March has gone up. There have been situations where coroners, their support staff, and coroners' officers have needed to shield or work away from the office.

One of the differences between the coronial jurisdiction and the Crown court, where I otherwise sit, is that the Crown court can sit entirely remotely. For a coroner to sit in court, a coroner has to be in court even if all other parties are remote. That adds a particular pressure. Clearly, there will be a backlog of jury inquests simply because finding spaces large enough to hold jury inquests is an issue. There will be a backlog of

some other inquests where the key participants in that inquest hearing will themselves be frontline medical workers. It would not be right for a coroner to take them away from their frontline medical work at the time of a pandemic to give evidence at an inquest when their work, clearly, should be devoted to assisting others who are suffering with Covid-19 or they are doing other essential work as a consequence.

It has, inevitably, been a busy time for coroners. It has had a consequence on the running of their jurisdictions. We have had throughout the period—initially twice weekly, but now every 10 days—what I call my "Coroner Cabinet". A group of coroners from around England and Wales meets periodically to make sure that we are all apprised of what is going on and to offer support to people. It is a difficult time for all of us. If you have a high-pressure job with many death referrals being made, by making sure that coroners know there is that support network we can hopefully spot trends and difficulties going forward.

Chair: I understand. I am sure the Committee will want to pass on our thanks to all your colleagues, and to you and Mr Winter for the work you have done under these particular pressures and difficult circumstances. It is very much valued by all of us.

In thanking you both, gentlemen, and Judge Darran, for your evidence today, I say, personally, thank you, Judge Lucraft, for coming to see us and thank you for your work as Chief Coroner. We very much look forward to seeing you perhaps wearing your Recorder of London hat at some point in the future.

Judge Lucraft: It has been a most fascinating four-and-a-bit years. If you had asked me what the job entailed when I took it on, I suspect what I have ended up doing is very different from what I thought I would be doing. It has been a very rewarding job. I have met some fantastic coroners in the course of that time, who, for a lot of the time, go unnoticed and unheard, but they do a difficult job in testing circumstances.

Chair: Indeed. We will not ask whether the building passed any of the recommendations. We will find out about that later. Thank you very much for your time, for your evidence and every success in the future.

When convenient, we will move on to the Minister.

Examination of witness

Witness: Alex Chalk MP.

Q161 **Chair:** Thank you very much, Minister, for coming to join us again. It is always a pleasure to see you.

Alex Chalk: It is nice to be here.

Q162 **Chair:** You have had the opportunity to hear what Judge Lucraft said in the latter part of his evidence. To cut to the chase, and perhaps you can elaborate on this, what is the purpose of the coroner service from the Government's point of view? Perhaps you would like to say something about how it stands in its current circumstances.

Alex Chalk: Thank you very much for inviting me to give evidence. If I may, I will open with some brief remarks. First of all, I want to express my gratitude for the opportunity to give evidence. As you know, I have been in this post since February 2020, through a period that has been enormously challenging. I want to begin by echoing the remarks of gratitude that you made at the end of the previous panel. It has been difficult for everyone, but certainly for the coroner service.

By way of clarification in terms of the role of the Ministry of Justice, as Committee members will know, coroner services are not part of HMCTS but are, rather, administered and funded by local authorities. That means that the MOJ does not have operational responsibility, albeit it is in charge of coronial law and policy. You will know that our remit is England and Wales rather than beyond that.

Turning briefly to the Coroners and Justice Act 2009, a major piece of reform for the coronial system, the intention was to deliver a more consistent service, but its true effects have been developed progressively.

The central point that you made just now, "What is the point of all this?", is extremely important. What is the principle? Of course, there are other nations that do not have anything like it at all; it is in the common law jurisdictions but not elsewhere. It is to ensure that deaths, where they are violent, unnatural or unknown, are appropriately scrutinised both out of respect for the individual themselves and those who are bereaved, but also so that we, as a society, can have wider public confidence that the facts of those deaths and, in particular, the answers to the four statutory questions, which we all know—who, how, when and where—are well established. We think that that serves the individual interest, but it serves the public interest as well. The mortality data can help feed into public policy. In simple terms, how do you respond to these sorts of very sad incidents? It identifies trends and establishes issues to which policymakers can respond.

I will not take too long, but I would like to reiterate my thanks to all coroners, their officers and staff, as well as the Chief Coroner, who has just given evidence, for their ongoing work to ensure that death investigations can continue. This has been a very tough time for all coroners and their staff. They have made a significant public service contribution in testing circumstances. The point was made just now that their support to local resilience forums has been particularly helpful in organising the response. We will be pleased to consider the Committee's recommendations to further improve the services when you publish your report.

Q163 **Chair:** Thank you very much. One of the things you mentioned was what can be learnt from the four statutory questions. That gives essentially a clue, does it not, that there is a contribution to broad public safety as well? Are you satisfied that that is currently being achieved, or are there ways in which that might be bettered?

Alex Chalk: The whole point of the 2009 Act was to bring together some coherence across the piece so that, where there were lessons to be learnt, they could be applied in an effective way. One of the bits of evidence I heard just now was the reference to PFDs—preventing future deaths. It is important to underscore that those are reports and not recommendations. One has to make sure that one understands them for what they are.

There is a very good reason for that. If the circumstances of the incident were highly technical—I was involved in prosecuting a case where some people ended up, very sadly, succumbing to carbon dioxide in the storage of apples, for example—it may be that the recommendations will be very technical. That might go beyond the expertise, with very great respect, of an individual coroner. Therefore, they are not intended to be specific, point-by-point, "This is the level of CO_2 that you should have in one of these canisters," for example. Instead, they are reports to shine a light on what has happened so that appropriate lessons can be learnt. As the Chief Coroner indicated, they are collated on his website so that they are available. As we all know, whether it is in coronial matters or elsewhere, sunlight is the best disinfectant.

Q164 **Miss Dines:** Minister, in general terms, what is your overall assessment of the Coroners and Justice Act 2009, and how good and successful has it been in achieving its aims from the start?

Alex Chalk: It has been a really good and successful piece of legislation. It is worth remembering that it had a long gestation. This was a piece of legislation that was first mooted back in the early 2000s by a senior civil servant, Tom Luce, and Dame Janet Smith. It enjoyed a lot of cross-party support because the suggestion was that this was creating the office of the Chief Coroner to bring some greater coherence.

The important point I want to make is that that piece of legislation was not a "lights-on" piece of legislation. In other words, you pass it, the job is done and it has been achieved. This legislation created a living instrument, in particular, through the work of the Chief Coroner. We have been very fortunate in our Chief Coroners. They have taken the opportunity to do things like, first, publish guidance notes. A significant number were published in the course of this pandemic, but plenty more were referred to in the annual report and elsewhere. Also, when looking at training, a great deal is now done to provide that coherence. Newsletters go out to coroners as well. Whether it is the training, the supervising role or the guidance, it is bringing together a much greater degree of coherence than ever existed before.

My strong sense is that this is a living instrument that has a long way further to run. The key new frontier that we are starting to expand into is the role of medical examiners. Medical examiners were mooted some time ago, but they are now starting to come to the fore. If you look at the report of the Chief Coroner, he has observed that they could, in turn, work very well with Chief Coroners, potentially, even to reduce the number of cases that are referred on, because they act as early input to provide that greater degree of coherence to the system. So the short answer is yes, it has worked well, and it has further yet to go.

Q165 **Miss Dines:** Moving on to a slightly different question, did the 2015 Ministry of Justice review identify extra burdens on local authorities? If yes, how and when will the funding be forthcoming?

Alex Chalk: The 2015 review, as you know, was not published in the event. I want to address that, if I may. That was a decision made by a predecessor. Of course, I have come here to explain the position. As you may know, as a Minister, you will face a number of issues that come in your order of priorities, so you have to prioritise certain issues. At the moment, through Covid, whether it is getting the courts up and running or ensuring that legal aid practitioners are protected and so on, for reasons that were a matter for the Minister at the time, that particular report was not prioritised.

The position now is that a great deal has changed. We have a new Chief Coroner; there are new area coroners, new assistant coroners and new deputy Chief Coroners, plus the coronial areas themselves have changed. At that time, there were something in the order of 120 coroner areas; we are now around 85 and heading south. Because of that change, the verdicts from that, for want of a better expression, will be of very limited import.

Your question was whether it identified issues in respect of local resourcing. It is no secret that some local authorities have been more successful in providing local resources and others have been less successful. To some extent, 'twas ever thus. We have seen in respect of Covid that some local authorities, and indeed some coroner areas, have been able to respond more promptly than others. That is a fact. In other words, what was observed in 2015 may well be a similar theme that is observed now.

Let me make this final point. Whether you are talking about a local devolved system of the type we have now or about a centralised and more homogeneous system, as some have called for, there will still be local variations. I see that very much in terms of the response to Covid at the moment. There are some parts of the country in respect, for example, of the Crown courts or the magistrates courts where they are reheating quite successfully, and other parts where the progress is more slow. That is a function of life, I am afraid, and to that extent there is going to be an element of regional variation.

Q166 **Miss Dines:** Are there any particular areas that have stuck out as being particularly good or particularly poor in terms of that support and the burdens placed on them?

Alex Chalk: Particularly in respect of coronial areas, you have to be careful about comparing apples with pears. Why? Because a local coronial area might have, for the sake of argument, a hospital, a prison or even a specialist hospital or specialist prison; therefore, there are different demands. Other areas may simply not have those pressures.

Kent gave evidence to this very inquiry, and I was pleased to see that they have restarted inquests. On 2 November they started a jury inquest, which is good to see. I noted that in Durham they have been successful in finding accommodation to ensure that jury inquests can continue, which is welcome. What I do not want to do, if you will forgive me, is to start pointing the finger at less successful practice, because one needs to look at every case on its merits, and there may be local circumstances that are particularly relevant.

My final point is that we recognise that local authorities have faced real challenges through this pandemic. That is precisely why we have allocated £4.6 billion to assist local authorities. That will not, of course, more's the pity, go entirely on coronial services, but it is none the less a very significant pot of money. To put it into context, it is not far off the entire annual prisons budget. We need clarification as to the vast sums of money that are being allocated to support local authorities.

Q167 **Chair:** Wearing my former local government Minister's hat, it is unring-fenced money. There is a statutory duty to provide coronial services for a top-tier local authority, is there not, but, of course, the money is not ring-fenced?

Alex Chalk: Yes.

Chair: Therefore, the risk is that, depending on the other spending pressures on the local authority, never mind the demand pressures that you mentioned, Minister, some will be better equipped to deal with the pressures than others. Does that concern you?

Alex Chalk: That is absolutely right. There is no doubt that, if you have devolution, there is the rough with the smooth. The benefits of devolution are that you allow local autonomy because people know their areas best. The risk is that, when they make those decisions, you may not like them much. But the way you get through this is by having an excellent cadre of coroners, assistant coroners and area coroners.

One of the encouraging things that was picked out by the Chief Coroner in his annual report is the calibre of people who apply for these roles. One of the points he was at pains to mention—I thought, respectfully, that this was absolutely right—is the importance of building that local relationship. He indicated just now that he met with local government leaders, but it is for individuals as well to establish those relationships

with council leaders. Of course, there will be exceptions, but, by and large, in the overwhelming majority of cases, if you have those coroners who are mindful of the different spheres of responsibility, if you have those local government leaders who recognise the constitutional importance of respecting the judicial independence of the office and ensuring that it is properly resourced, in the main, that operates tolerably well.

I am not suggesting that there will not be occasional bumps. What one has to weigh that against, in so far as the Committee is, quite properly, considering a national system versus a local one, is that there are a number of local authorities that cherish and jealously guard that local autonomy, whether it is the City of London Corporation or many others. You can be sure as eggs is eggs that, if you were to come in with your size 12s and say, "That's it. We're sweeping all that aside. We're going for this central model," that would create its own hue and cry.

There are benefits to be had from the devolved system because of this apples and pears point, but it works if the individuals have the calibre, outlook and approach to make these human relationships work. Overwhelmingly, that is what we see.

Q168 **Richard Burgon:** Good afternoon, Minister. We have heard about the variations in funding, but are the local variations in funding, and consequently in the standards of service, acceptable?

Alex Chalk: Inevitably, there will be some variations. That is absolutely the case. If you look at other centralised systems, if you think of HMCTS, there are variations there as well because they reflect the local circumstances. Where it becomes a problem is if you have a situation where a coroner says, "This is absolutely absurd. I can't do my job. I am a judicial office holder and you are not giving me the kit. I need the IT, the space, the officers or the support." The question is whether we have a system that is breaking down because those local authorities routinely don't do so and disrespect the coroners. The answer is no. If you are saying to me, "Does that mean that there is absolute perfection and there are not occasional wrinkles?", no, of course that is not the case.

The question would be—this is the exam question—whether it is worth the powder and shot to start sweeping all that aside, recognising that inevitably there will be some advantages for the sake of a centralised system. I think that would throw up new problems of its own. That is to say nothing of the fact—I make no apology for mentioning this—that it would be extraordinarily expensive to do. Frankly, if I had £100 million or whatever it was, I would want to give that to legal aid. I hope they will forgive me for saying that. It is important to recognise that every model has its advantages and disadvantages. Overall, particularly because of the involvement and the calibre of the coronial officers and their staff, it is working well.

Q169 **Richard Burgon:** Thank you, Minister. The Minister can be reassured

that he will be forgiven for talking about giving an extra £100 million to legal aid—

Chair: He would probably take it.

Richard Burgon: —because those who would be offended in Government will know that, sadly, it won't happen on his watch.

The Justice Select Committee has heard extensive evidence about the varied quality of coronial services in different parts of the country. For example, senior coroner Louise Hunt told the Committee—these are her words—"Those councils with financial challenges will be less able to support their coronial services and the families involved in those cases."

Minister, given the role of successive Conservative Governments in implementing a programme of austerity, in which Government funding for local authorities has decreased by almost 50% since 2010, according to National Audit Office statistics, do you agree that austerity is to blame for part of this disparity?

Alex Chalk: On this issue of funding to local authorities, it is important to recognise the very significant sums of money that have been allocated to local authorities recently. I accept that in previous years it has not been a protected Department in the way that Health and Education has. Equally, we have to recognise that ours is a country—we have to face some home truths—that last lived within its means in 2001. When we talk about the austerity agenda, we have to recognise that in every one of the years since we have lived beyond our means. But put that to one side.

I think it would be an unfair caricature of the system to say that it is somehow dysfunctional because there are these unacceptable discrepancies. In fact, I take some comfort and encouragement from the conclusions of the Chief Coroner's last report, namely, the sixth and seventh joint annual report. He says at paragraph 181: "There is still much to be done." That is agreed. "The Chief Coroner is confident that the system will develop and improve further for the benefit of all who come into contact with the coroner system."

We have to recognise in this context the extent to which the climate and environment for bereaved people has been transformed beyond all recognition. What was, perhaps, a very forbidding environment has become much more sensitive. The training that exists for advocates, again, has already been transformed and is being transformed further. The amount of standardisation that is taking place in terms of how coroners respond is like night and day. This is a system that is evolving very positively. While it may be possible to identify specific concerns, one has to step back and look at the overall context. The overall context is that it is operating really positively.

Q170 **Dr Mullan:** Thank you, Minister, for attending today. We have heard from a number of witnesses about the challenges with accessing pathologists. Whether it is the rate of pay or the number of people within the profession, they struggle to find people. The evidence we heard

earlier today, which you might have heard, is that that leads to delays in proceedings as they wait for the work to be done by an available pathologist.

What are the Government planning to do or who are you working with to secure an increase in the availability of pathologists? Will that be a headcount or a willingness to undertake work?

Alex Chalk: Thank you very much, Dr Mullan. Yes, I did hear that point. The Chief Coroner, respectfully, is absolutely right when he says that this is a point that has been mentioned in more than one annual report. It is an issue. There is no question about that. I am not going to sit here and tell you that it is not a problem.

The position is, and you will be well placed to have direct experience of this, that while the fees, which I have had a chance to look at, are not particularly generous, putting it bluntly, the reality is, the more we have looked into it, that it is not entirely about money. Part of the issue is that there are not enough people wanting to be pathologists. The conversations I have had have suggested there are a number of reasons for that. I am told that some of the practical exercises that used to exist on undergraduate degrees are not available. There is inconsistent access to CT scans and so on.

We recognise there is an issue. You asked what we are trying to do to fix it. We keep the issue of fees under constant review, although it is important to acknowledge that the pathologists who do this work will be employed and paid a salary through the NHS in the normal way and then they get piecework for a post mortem that they do. That will have some impact. Unless you have the pathologists, you are pushing on a piece of string essentially. There is no point in doing that. We are working together with DHSC and also with the Home Office, who are the providers of forensic pathology services, to see what more can be done.

Let me make this final point. I mentioned at the beginning the national medical examiners, who are being rolled out initially within, as you know, hospital trusts, but the idea is that it will move beyond that. I have some guidance here that has been provided. The indication in the report from the Chief Coroner is that he thought there was even some possibility—of course, I now cannot find it—that there might be an impact that it would assist in reducing the pressure on the requirements for post mortems.

We will have to see. I am sure he will accept that it is quite difficult to know which way it will go. It could, conceivably, increase the number. On balance, it is more likely to reduce that pressure. Even if it reduces it a bit, I entirely accept that this is a pinch point and it is something that the Government are very much aware of, and we are working across Government to see what progress can be made.

Q171 **Dr Mullan:** Thank you for that. I recognise, as I have mentioned myself, that it is not just about fees. I think you would agree with me that the

lack of movement in the fees for a considerable amount of time makes it difficult. You are asking someone to undertake hours of work in a way that is not comparable to their income in their ordinary roles. That, inevitably, is going to be a significant factor, I would imagine.

Alex Chalk: I have looked at the fees. I am not suggesting they are a king's ransom at all—far from it. That is something we are looking at.

Q172 **Maria Eagle:** Minister, I am glad that you have a positive impression of the impact of the legislation because I was one of the Justice Ministers in 2009 who took it through the Commons. I am interested in initiatives to ensure that bereaved people are kept at the heart of the coroner service. I wonder what plans, and when, you are going to implement.

Alex Chalk: On your first point, you are absolutely right. I went back and looked at some of these debates. I saw that Jack Straw played his part and Dominic Grieve was on the other side. The atmosphere was overwhelmingly quite collegiate, although there were issues about secret inquests, which seemed to be the principal bone of contention. On this principal point, there was a lot of cross-party agreement.

On the issue of bereaved people, this is so important. Even since 2009, a lot of attitudes have changed and people recognise that bereaved people and people across the court system, including witnesses, need to be treated sensitively. In terms of what is changing, the single biggest thing that has changed is probably this document, "A Guide to Coroner Services for Bereaved People", which I would commend to the Committee. If you have not had a chance to read it, it does bear some scrutiny.

I will not read the whole thing, but the guide contains plenty of sections that are set out in very simple terms. For example, take section 2: "Starting an investigation. What will the coroner do? Who reports the death to a coroner? What will a coroner do when a death is reported?" Then we come to legal advice. "If there is going to be an inquest, will I need a lawyer? Do I need a lawyer? Where can I find a solicitor?", and so on and so forth.

Also, on this really upsetting issue, the chances are that the people who are going to be involved will be deeply traumatised and upset. At section 9 of this document, there is a lot about bereavement support and the organisations that can provide help and advice: the Bereavement Advice Service; Brake; The Compassionate Friends; the Coroners Courts Support Service and so on. That shows a step change in terms of attitude. That is point 1.

Equally, there is a recognition among practitioners—I speak as someone who did one inquest myself—that this cannot be something that is conducted insensitively by counsel and solicitors. That is why the BSB and the SRA are looking to provide guidance. That is why you see that the MOJ in January of this year held a conference for people to attend,

effectively sending the message out, "This is how we want inquests and inquiries to be carried out." Yes, there must be robust questioning; yes, people must be held to account, but, equally, we have to remember that this is not adversarial but inquisitorial. We want to get to the truth and answer those four questions rather than necessarily confecting or inflaming confrontation. That is important. All of that really helps the bereaved, because, if they see people slugging it out unnecessarily, that is not what they want to see and it inflames an already sensitive situation.

Q173 **Maria Eagle:** I have come across many cases—Hillsborough is an extreme version, but there are other examples—where things have become extremely adversarial, particularly when one side or often state actors are legally represented and families of bereaved people are not. One ends up with a very adversarial situation. That is how it feels to bereaved relatives.

The report from 2017 of the Rt. Rev. Sir James Jones into lessons to be learnt from Hillsborough is now three years old. What steps are being taken by the Government to implement its findings?

Alex Chalk: You are absolutely right. Bishop James Jones's review was from 2017, as indeed was Dame Elish Angiolini's independent review. A great deal has happened since that time, and I will not rehearse the points that I have made thus far.

In addition to this guide, a "Protocol for Lawyers" was published earlier this year. I talked about the conference earlier. A toolkit for inquest lawyers is under construction with the MOJ to improve the quality of advocacy at inquests. We also heard that an appraisal system for coroners is being rolled out. The BSB and the SRA are working together to provide inquest-specific information to lawyers. Also, the MOJ has re-established a stakeholder forum to engage with other Government Departments to see what more can be done to assist bereaved families.

Let me address this point, because I know it will come up and, respectfully, I absolutely get this point about the adversarial nature in very big cases, when you think of Hillsborough or London Bridge. I declare an interest on this. As a Back Bencher, I had a constituent who very sadly was bereaved in the London Bridge attacks. I say this up front; let's get this out in the open. I lobbied the Minister and said, "I really think there should be legal aid for the families here." I accept that you have to be very careful about this issue when it comes to certain very limited cases—they do exist—when there could be a perception of inequality of arms.

There is exceptional case funding, and where convention rights are invoked there is a discretion to do that. I do not sit here and say that there should never be legal aid for families. It will be very much the exceptional case, because the courts and the coroners are well equipped, either of their own motion or because they can instruct counsel to the

inquest, to deal with these specific questions without the need for counsel. However, there will be certain cases when I can see that the public interest balance is changed. They are the exception. They need to be taken on a case-by-case basis.

My final point, in respect of the London Bridge tragedy, is to get on the record my sincere gratitude to those lawyers—barristers and solicitors—who gave their time for free, pro bono, to represent a number of those families. That was absolutely in the finest traditions of the legal profession. I know they have the gratitude of the individuals, but they certainly have mine as well.

Q174 **Maria Eagle:** I am interested to hear of your experience. As I have said before, I have spent 23 years helping bereaved Hillsborough families. That is, perhaps, the most egregious example of inquests gone wrong in the past. It is certainly by no means the only one. There will be cases such as Hillsborough. There are ongoing disasters that happen repeatedly over time and will no doubt, unfortunately, continue to happen, as one can never stop any disaster from happening, and there may be instances, as you say, when it is right for legal aid to be available. Perhaps you should consider, Minister, enabling legal aid to become available more broadly. I come across people telling me that there are more examples than you might think of things going wrong at inquests, such as inequality of arms and proceedings becoming adversarial when one would hope that they do not.

I know that you did a review of legal aid for inquests that reported in February 2019, and the decision was not to institute general legal aid availability for inquests, but you were going to look into further options and work with other Government Departments to look at that. What has the result of that been 18 months on from that determination? What has come out of your work with other Government Departments?

Alex Chalk: I stand by now, and I did stand by then as a Back Bencher, the idea that there should not be blanket legal aid, because I do not think that necessarily helps in every case. Indeed, if you look at some of the evidence that I reviewed, a summary of which has been given to this Committee, there is not an overwhelming judicial clamour for legal aid in every case, because that does not necessarily help the coroner answer the questions in the case. The issue is: are there, however, examples where it would be an affront to justice for the families not to be represented? We have a system—the exceptional case funding system—which has developed considerably, even in recent times, to provide that important route to getting representation. As you will know, Ms Eagle, exceptional case funding exists, whether it is in the criminal courts or in the coroners courts, to ensure that for those people whose convention rights are involved—it might be article 2, the right to life, or it might be the right to a fair trial, liberty and security, slavery or whatever it is—the opportunity exists to invoke and protect those rights.

It is worth considering, in the period that you referred to, that the last year of figures shows—forgive me if I am out by a few—that, of the 420 or so applications for exceptional case funding, 280 were granted. That is something a little over 60%. It is not the case that we are saying to people as a Government, "There you go," and fobbing people off by saying that exceptional case funding is in place, knowing fine well that no one is going to get it. That is not the case at all. It is available and people do use it.

My point is that I would not concede the idea, notwithstanding that I am probably one of the most pro legal aid people you could find—that blanket legal aid is doing anyone a service, because all you are going to be doing is mopping up a whole load of resources where they, perhaps, might not be going as far as they could be going in, say, social welfare law or other areas of legal need.

Q175 **Maria Eagle:** Is there a happy medium between having to rely on the discretion of exceptional circumstances—which may or may not come out properly—and having a legal right, in that where cases become adversarial, perhaps at that point, there can be a more general right to legal aid? Even though these proceedings are supposed to be inquisitorial and should not require it, there is absolutely no doubt that at times they do,

Alex Chalk: In terms of a solution, I was interested to hear just at the end there something that I knew to be the case, but I thought it was important to get it out in the open. Sometimes coroners will write and say, "Hold on a minute. I am sitting here in this coroner's inquest and I can tell you it is getting pretty adversarial. In my view, the parties will be assisted by legal aid." Those hearing such representations do not have to abide by them, but I think that in appropriate cases they will want to give great weight to those representations. It will ensure that if those people, in whom I have complete confidence to be doing justice and ensuring that they are completing their statutory duties, say that legal aid is required, although it would not be automatic, those representations ought to be given appropriate weight. That is certainly the steer I would give from this seat.

Q176 **Chair:** It would be important that those representations are made early before it gets too far down the track in the proceedings.

Alex Chalk: Yes, that is right, be it pre-inquest reviews or whatever. Experienced coroners will have a strong sense of the nature of the case. They might immediately be aware that, for the sake of argument, because of the status involved, there are question marks about the involvement of the intelligence agencies and what took place. In those circumstances, an experienced coroner may well have a sense of how this is likely to unfold. My view is that there would be a very small but, none the less, extremely significant cadre of cases where the case for legal aid is very strong, if not compelling.

Q177 **Andy Slaughter:** I am tempted to have one more go at this. Minister, is there not a gap between the blanket approach and the exceptional circumstances that you are talking about? It is not unusual now to have inequality of arms, such as the withdrawal of legal aid in many areas, such as family law, for example. What is particular about the coronial service is that often the state is represented and often you have several different arms of the state or, indeed, other interests, which seems to me to be unique. You can have an unrepresented family against, perhaps, several sets of lawyers. Even with all the best efforts that you and the Chief Coroner have indicated, there is still that obvious disparity. Should we not have legal aid provided in coronial proceedings where the state is represented in that way?

Alex Chalk: I am in favour of saying that that is a very strong factor that ought to be weighed in the balance in favour. Do I think it should be an automatic presumption? No. I think that creates too much inflexibility, because one can contrive some circumstances where the key issue is not going to be one that particularly touches on the role of the state, notwithstanding that they have been given interested-party status.

I cannot do better than to refer to the submissions for this very inquiry from the Chief Coroner himself. For the purpose of the note it is at paragraph 97. He says that there ought not to be a need for lawyers in many legally straightforward cases. I accept that that is not what Mr Slaughter is necessarily referring to.

He goes on to say in the final sentence that there are also arguments that could be advanced that simply adding more lawyers into the system would not necessarily uniformly help bereaved families in all cases. I thought those were carefully chosen words, and the Committee will interpret them as it will, but some might be forgiven for saying that the message coming out is that, if you bring in a load of lawyers in certain cases, you must be quite careful about choosing the appropriate circumstances. The point is that there is a danger that a very upsetting and difficult case can detonate and become extremely difficult, with lasting implications for bereaved people and so on, but there are other cases when it is appropriate.

I am not in favour, respectfully, of the proposal of making it an automatic right simply because the state is represented, although I quite accept that that is likely in the overwhelming majority of cases to be a particularly compelling factor militating in favour of a positive decision.

Q178 **Andy Slaughter:** Can I ask you one other question in relation to possible resource matters, which the Chief Coroner could not deal with? He dealt with the issues of both prevention of future deaths reports and the fact that we might need a better platform to exhibit them, and a review process. Do you agree with that and are you prepared to resource it?

He also dealt in a more limited way with the appeal process. Do you see merit, even if resources are difficult, in having some form of appeal

beyond judicial review in the coronial system?

Alex Chalk: Forgive me, Mr Slaughter, I did not hear the initial part, but I am told it is to do with prevention of future deaths reports. I listened very carefully to what the Chief Coroner said about that. I thought that those were suggestions that, respectfully, had real merit, which we will consider in the fullness of time. What was the second point?

Q179 **Andy Slaughter:** If you can hear me, the first point specifically was whether you will progress with both a better platform for prevention of future deaths reports and also an independent review of those reports, and whether they are being properly carried out.

The second point was on appeal. Do you see the merits of an appeal process in coronial decisions beyond judicial review?

Alex Chalk: On the platform, yes, possibly, although those PFDs are all on the website. You can look at them; they are open and transparent. If I may say so, the bigger issue is how you go about enforcing some of this stuff. I absolutely get that point. That is an important issue.

The question for policymakers is: do they set up a new bureaucracy or do they take the view that there is a risk of confusion and duplication? If you think about specific examples, supposing it relates to an accident at work, there are already other bodies in existence to consider it, such as the Health and Safety Executive. If you are thinking about something that happened on a road, it might be that the Highways Agency would look at that, or that a local government ombudsman might consider the matter. If it happens on MOD property, you will see there are other issues. If it happens in a prison, there is the prisons inspectorate.

It is important that lessons are learnt. My goodness, if you are a bereaved person, what you don't want is some PFD being created, with everyone patting themselves on the back saying, "There you go, job done, case closed." You want to make sure that the lessons are learnt.

How one goes about doing that effectively is a subject for legitimate discussion. We have certainly not closed our ears to anything. The only point that I would weigh in the balance is that one has to be mindful of avoiding duplication when there are already agencies that will be tasked with the response.

My final point is that, if we in the MOJ are subject to a PFD, there are a whole load of protocols that we will be taking internally over and above responding within the 56 days under the statute to ensure that lessons are learned and things do not go further. It is something that would have to be considered quite carefully. Again, if you set those things up, that potentially means that other areas come under resource pressure as well. You have to weigh these things up, but I certainly heard that point.

On the issue of appeal, we think it is about right at present. Arguments could be made either way. The situation, as you well understand with

your legal background, Mr Slaughter, is that these decisions are amenable to judicial review. Not everyone wants to tip off to the High Court to review decisions. I recognise that. It is a hurdle to cross. Equally, we want to make sure that there is not endless either satellite litigation or appellate litigation. But those people who can point to a real error of law or procedural impropriety can get that remedy. You will be well aware that, with the permission of the AG, they can take a case to the High Court. Indeed, a number of permissions were granted last year.

We always keep these matters under review. Our feeling at present is that this strikes the right balance between ensuring it is workable, that there is a proper level of finality, but, equally, that those who need to seek redress because things go wrong on those rare occasions have the mechanism by which to do so.

Q180 **Chair:** Mr Chalk, you rightly paid tribute to and recognised the expertise and hard work of the Chief Coroner over the last four years. In relation to appeals, he made a point, which he does recommend in his annual report, about simplification of the section 13 application procedure, where you have to go to the Attorney, which he agreed with me was clunky. Given the high standing of the outgoing Chief Coroner, is that something that ought to be pretty compelling in the minds of Ministers when looking at the situation?

Alex Chalk: Without wishing in any way to influence what you put in your report, if that was something that found its way into your report, it is something that I will be particularly looking out for.

Chair: Mr Slaughter, do you want to deal with some Covid matters? Then Mr Butler and I will come in at the end.

Q181 **Andy Slaughter:** I will be brief, Chair. We struggle a bit when we look at various parts of the jurisdiction to get the statistics. I think that is true of the coroner service as well. Do you know what the backlog currently is in terms of inquests, and specifically jury inquests at present, in relation to the effects of Covid—what it is now and how that compares to what it was before March of this year?

Alex Chalk: Thank you very much for that. There is some extremely helpful data published in this report—"Report of the Chief Coroner to the Lord Chancellor"—which you may have seen. I am going to have a quick look now. If you go to page 9 and paragraph 21, it refers to a table that sets out over a period between 2016 and 2020 the number of cases that are outstanding by more than 12 months. I can see the Chair nodding. Clearly, that is something that has come to the attention of the Committee.

In summary, in total, there were 2,278 cases in England and Wales not completed within 12 months of being reported to the coroner as at 2019. If you go to the relevant annexe, annexe B, that shows what has happened in specific authorities. For the sake of argument, in Bedfordshire and Luton, of the 2,191 deaths that were reported in 2019,

we can see that the number of cases over 12 months is 23, up from 12 in 2017. In the Black Country, of the 5,183 deaths reported in 2019, there are now 18 cases over 12 months, which is up from six in 2017. There is no doubt that this has led to an increase.

I know some have suggested, and even some of the witnesses who have given evidence to this Committee, that you need to junk juries for the period of the pandemic. We are very windy about that, putting it bluntly, because it would have wider read-across. If you get rid of juries in inquests, there would be a number of people who would say, "Hold on. Why aren't you doing this for criminal trials?" A lot of people would have deep misgivings about that because of the concern that this could set a very difficult precedent.

The reality is that juries and pandemics do not go well together. Is the proper policy response to get rid of them or to suspend them, or is it to say that we are going to have to work with our coroners, whether it is through guidance notes or a number of measures we have taken in the Coronavirus Act, for example, which means that Covid cases do not automatically have to be reported to the coroner? That means you can have death certificates issued by people who have not even attended the body. Are those the sorts of mitigations we put in place? Of course, we have thought very hard about this, but we take the view that the single biggest lever that we could pull, which would be to get rid of juries, is not the appropriate policy response, however tempting that might be, because of the read-across to other areas, quite apart from anything else.

Q182 **Andy Slaughter:** That is very positive to hear. As a corollary to that, in order to make sure there are not undue delays, are you at least looking at how different coronavirus services are performing? Are you taking any measures to ensure that longer waiting times are reduced, particularly for jury inquests?

Alex Chalk: You bet. Absolutely. We are looking closely at which areas are doing particularly well and which have been able to co-operate and collaborate. One of the great advantages, and one of the reasons why I particularly pay tribute to the Chief Coroner—although he has been, if I may say so, a little diffident about it—is that he has been very active in the course of this pandemic to ensure that best practice is rolled out. It is set out in the report that I was just looking at.

It is worth having a quick look at some of the guidance notes that he has put out in respect of Covid. For example, between March and June 2020—I am looking at page 20—guidance notes 34 to 39 are about the circumstances in which inquests should take place, and I have hard copies with me, which I will not trouble you with. Actually, let me give you one: guidance note 39, which is recovery from the Covid-19 pandemic. This is a very long note that has a number of vital and helpful bits of detail about infrastructure, witnesses attending, adjustments

made in specific cases, facilitating the attendance of family members and so on.

The guidance is there; the coherence is there. Performance is uneven, but it is uneven in respect of HMCTS as well. The short answer is yes, we are watching; yes, we are observing who is doing well and responding well, and we are seeking to do everything we can to try, with the help of the Chief Coroner, to roll out that best practice and to assist those who are finding it more difficult.

Q183 **Rob Butler:** Minister, we heard a lot during the evidence session with the Chief Coroner about the efforts to achieve greater consistency. He has publicly called before for a national coroner service. From your personal perspective, what do you see as the advantages and disadvantages of such a national service?

Alex Chalk: I have touched on this already. I do not want, necessarily, to repeat myself. The very brief headlines are as follows. You have experiences as a distinguished magistrate and also representing them at a senior level. There is definitely an advantage to localism. One of the great thrusts of public debate at the moment is what you might think of as an impetus towards devolution, which is for very good reasons. But it is particularly relevant in respect of coroner areas, because, while one coroner area might be relatively straightforward in so far as there are no particular local institutions, there might be others that have a prison or, for example, a specialist children's hospital. That is relevant because, if there are deaths, you might need specialist medical practitioners, consultant paediatricians or whatever.

There is some serious merit in having a local system, but you have to balance that with avoiding a fragmented system where, in effect, coroners are kings and queens of their own castle, doing their own thing and paddling their own canoe. Plainly, that is not a helpful system.

The way you strike this balance is through the guidance notes, training and also, frankly, reducing the number of coroner areas. When we have more than 120, bringing in that kind of coherence is extremely difficult. We are now down to 85. I think we will come down further than that, and considerably below that. It means that the legislation, as I indicated, is not a "lights on" piece of legislation where everything is done at the moment Her Majesty signs it. This is a piece of legislation that lays the ground for an evolving situation. Although it will have shortcomings, as any system does, I think there are fewer shortcomings than you would have if you had to go through the massive disruption of folding all of this into a national system.

By the way, when all the magistrates courts were folded into HMCTS, that caused enormous angst, cost, difficulty, delay and problems. It is not immediately obvious to me that, right at this time, that ought to be the road we are going down in circumstances where we have not fully squeezed the lemon, if you like, of this piece of legislation. It has a lot

more to give in the proper public interest priorities that we all have, namely, a consistent and compassionate service. It is well on the way to improving both of those, and we want to see it go further.

Q184 **Rob Butler:** Presumably, you would not want to see the postcode lottery that has been referred to, for example, by victims' representatives. You would want to ensure greater consistency of service to the bereaved, in particular. If you are not going to go for a national model as recommended by the Chief Coroner, do you believe, for example, that the practice notes and, perhaps, the appraisal system need to have more force? Perhaps a parallel could be the sentencing guidelines, because those have been implemented—one could say imposed—across all magistrates courts.

Alex Chalk: This is important. People will sometimes object or be dissatisfied with their experience in a criminal court, say. That experience, as I know as a prosecutor or someone who has spent time in court, will often turn upon the particular interaction they have had with a certain individual. Was that prosecutor kind, thoughtful and compassionate when speaking to that witness before they went to give evidence? Did that judge handle the situation appropriately? Were they given special measures directions?

Of course, in the criminal context, you have a great degree of homogeneity. The question, very often, is whether those individuals do their job properly, and whether they are sensitive and have been properly trained. As you indicated, what we have through the appraisal scheme for coroners is a step change in the ability of coroners to provide that uniformity. It is a far less fragmented system than existed in the past. You ask whether it needs more teeth. If someone came along and said to me, "There are a load of coroners who are sitting and saying 'I don't care what the Chief Coroner says. I am going to continuing paddling my own canoe and I don't care two hoots about it,'" you would have a point. But that is not what we are being told. By dint of the fact that we have been very lucky with our Chief Coroners, who have been, very obviously, extremely capable and professional people, they do have an authority that others respond to well.

The final point on that—I want to underscore it because it gives me real confidence for the future—is that, in his report, the Chief Coroner said that he was really positive about those who were seeking to join as area coroners and assistant coroners. That gives me real confidence.

My final point is that, even in a centralised system, people will have bad experiences. One should not assume that, therefore, every time someone has a bad experience, the solution is to have a centralised system. There is a danger of misdiagnosing and misidentifying the problem.

Q185 **Rob Butler:** What about having a small inspectorate that would work across, whether it was a national or non-national system, as now? The Chief Coroner seems to be open to that suggestion. Would you be?

Alex Chalk: I am certainly open to it. It is a big deal to set up an inspectorate. You have to do so if there is a very clear public policy requirement for that to take place. There is an inspectorate of the CPS, which is a massive organisation. There is an inspectorate of prisons, as we know. From that point of view, of course there is a precedent for it. One can see there is a perfectly legitimate argument. Whether it is proportionate is something one has to consider.

Are the systems in place—the appraisal scheme, for example—if you are a coroner and you behave in a totally inappropriate way, for that coroner to be disciplined? The answer is yes, through the normal judicial chain of command, for want of a better expression.

Those safeguards exist. Can someone say to me that this is manifestly inadequate? I have not seen an overwhelming body of evidence to say that those checks and balances are not there. The Chief Coroner, if you ask him, will say, "Of course we are open to being inspected and scrutinised. We think that is a good thing." I would be very surprised if he said anything different.

What I have to consider, sitting here, is: do we think that there is a case for diverting resources away from the courts, away from legal aid and away from witness care, to put into that inspectorate? With endless resources, I can immediately see the point, but we have very difficult judgments to make. I do not want to mislead the Committee in saying that we have been deafened by the drumbeat of people who are saying, "This has got to be your priority." That deafening drumbeat is not there, even though, on its own terms, of course I see the merit of it.

Q186 **Chair:** Has the Ministry made an estimate of the costs of a national coronial system?

Alex Chalk: Back in 2003 or 2004, when this debate was happening—the one we are having now about whether we should have a national system or the existing one—some estimates were made about what the costs would be. The cost of setting it up was thought to be around £32 million, and by the time it got to 2010 the suggestion was that it had almost doubled to about £62 million. By now, I have no idea, but one assumes that means we are at the thick end of £100 million or so.

One should be clear that to do that would be very considerable. To put that into some sort of context, one of the things I am proud of—of course, it is never enough—is CLAR phase one, the Criminal Legal Aid Review, to try to address the issue of criminal legal aid practitioners and to get some emergency funding in. We are putting in up to £51 million. That pays for people to get paid for reviewing unused material, sometimes the very material that leads to the innocent walking free. They get paid to review that between the hours of 10 pm and midnight; that is when most people look at unused material. The sum of £51 million is significant. If you are then going to pay £100 million in circumstances where to do it would be unbelievably disruptive, I suspect the City of

London Corporation—I don't want to verbal them—might have something to say about it. Other people would have something to say about it.

My general experience of being in the courts is that what tends to matter more than an overarching structure is the interactions that you, as a witness, a defendant or a complainant, have with the court staff, with the prosecutor, barristers and judges. That is the key point here. If we can get high-quality people into the coronial service, which has been very good and continues to be good, ultimately, that has to be the centre of effort. We do not close our minds, eyes or ears to anything, but I also think we have to be clear-eyed about what makes the biggest difference to court users.

Q187 **Chair:** So it is really a cost issue.

Alex Chalk: No, I don't think it is really a cost issue. It is both. Of course, cost is an issue. One should be aware of that. On a cross-party basis, back in 2009, the view was taken that striking a balance between devolution and consistency was best served by this route, and that remains the calculation. Of course, one considers issues of cost. Any Government who do not think carefully about how to spend £100 million are not doing their job properly. This is the taxpayers' money. Particularly in the MOJ, if you put it in context, our entire annual budget is about £10 billion. A figure of £100 million is a very significant proportion of that. There would be a huge number of legal aid lawyers out there saying to me, "What on earth are you doing? Why are you spending on a system that everyone agrees, although it is not perfect, is working and getting stronger and better? Why are you spending all that?" I think people would ask that question.

Q188 **Chair:** The sum of £100 million is a guesstimate.

Alex Chalk: It is a complete guesstimate. Please don't quote me on that.

Q189 **Chair:** I did take it that way.

Alex Chalk: It is a complete guesstimate. It may be more.

Q190 **Chair:** The final point is that we might say, okay, we understand that, Minister. In that event, why is it that the Brodrick Committee in 1971, Tom Luce and Dame Janet Smith in relation to Shipman, and two successive Chief Coroners, have all said that we ought to move to a national system?

Alex Chalk: Everyone has a view about where the balance strikes. As I said, there will be plenty of people who would argue to the contrary. You have, quite properly, advanced a list there. Equally, there are an awful lot of parliamentarians who took a different view and have taken a different view over a consistent period.

The point is this. If you are to do something as radical as that, you have to be very sure, it seems to me, that it is worth smashing up the existing system to replace it. The case has to be, if not unarguable, absolutely

compelling. It seems to me that we are a little way short of that. Of course, we need to consider it in the round. Let us, please, not lose sight of the fact that this country, and particularly the coronial service, has moved on enormously since 2010. This piece of legislation has evolved; it has adapted, not simply because of the black letter on the page but because of the skill, dedication and application of coroners. For that, both I and the Government are eternally grateful.

Chair: Thank you very much. We echo your tribute to the work of those who work in the coronial service. That is certainly shared by us all. Thank you very much, Minister, for your time and evidence. The evidence session is concluded. The Committee stands adjourned.