HOUSE OF COMMONS

Justice Committee

Oral evidence: The Coroner Service: follow-up, HC 490

Tuesday 30 January 2024

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Watch the meeting

Members present: Sir Robert Neill (Chair); Tahir Ali; James Daly; Rachel Hopkins; Dr Kieran Mullan; Edward Timpson.

Questions 1 - 70

Witnesses

I: His Honour Judge Thomas Teague KC; Derek Winter DL; and Her Honour Judge Alexia Durran.

Examination of witnesses

Witnesses: His Honour Judge Teague, Derek Winter and Her Honour Judge Durran.

Chair: Welcome to this session of the Justice Committee, where we are doing a follow-up inquiry on our previous work in 2021 on the coroner service. Welcome to the Chief Coroner and his two deputies. We are grateful to you for coming to give evidence to us today. Before we move on to introductions, we have to deal with declarations of interest. I am a non-practising barrister and former consultant to a law firm. I am also vice-president of the Local Government Association.

James Daly: I am a partner in a firm of solicitors and a practising solicitor.

Edward Timpson: I am a barrister with a current practising certificate but not undertaking any court work at present. I am a former Solicitor General, a former chair of CAFCASS and a former chair of the national Child Safeguarding Practice Review Panel. My brother is chair of the Prison Reform Trust. The Chief Coroner and I were both members of the same chambers in the past.

Rachel Hopkins: I am a vice-president of the Local Government Association.

Q1 **Chair:** Thank you very much. Judge Teague, would you and your colleagues like to introduce yourselves?

His Honour Judge Teague: I am Judge Thomas Teague, the Chief Coroner for England and Wales. I was appointed in December 2020 and am leaving office at the end of May.

Her Honour Judge Durran: I am Judge Alexia Durran. I have been a Crown court judge for very nearly 10 years and deputy chief coroner since 2019, I think.

Derek Winter: I am Derek Winter. I am senior coroner for the city of Sunderland. I have held that post since 2003 and, along with Judge Durran, I was appointed deputy chief coroner in 2019. Our term of office expires in December.

Q2 **Chair:** I think you are the first two deputy chief coroners, as I recall.

Her Honour Judge Durran: That is correct.

Derek Winter: We are.

Q3 **Chair:** Perhaps I can start with you, Judge Teague. We are very struck with the fact that you made a deliberate point of visiting every coroner's district in England and Wales—you did a tour, for want of a better word. Can you summarise why you did it and what you found?

His Honour Judge Teague: Certainly. I should warn you that I can summarise it but it is a fairly lengthy summary, because it was a very useful exercise; but I will do my best. I will make it a high-level summary as far as I can.

First of all, I want to express my gratitude to the senior judiciary for enabling me to undertake the tour, by releasing me from other duties. It meant that I am the first Chief Coroner to undertake such a tour, and I am very grateful for that opportunity. As you said, I visited every single one of the 80-plus coroner areas in England and Wales. On almost every occasion, I was accompanied by a senior official. There were two or three where that was not possible, but overwhelmingly I was accompanied by a senior official.

The purpose of the tour was to assess the state of welfare in the coroner service and, perhaps, to a lesser extent, morale, in the wake of the pandemic; but it quickly became apparent that you could not separate welfare from some of the other problems. I discovered, for example, that, where you tended to find evidence that welfare had suffered, there were underlying difficulties to do with funding, and so on. I did what I could to try to find solutions to some of those problems. That was the purpose of the visits. I began in January 2022 and the tour concluded in the first half, or about the middle, of March last year.

As for my findings, let me start with welfare and morale, because that was the purpose and I can deal with them quite quickly. Morale was surprisingly high, and I think it remains so. By morale, I mean the sense of vocation that everybody in the service has, as opposed to the question of welfare, which I think is distinct. The reason it was high is that there is a deep sense of vocation throughout the coroner service. On each visit I would of course always speak to the senior coroner, as the person in charge, and to any representatives of the local authority, and, occasionally, the local police force, if they were available; but I spent the bulk of my time with coroner's officers, because they are at the sharp end. Without in any way minimising the stress on senior coroners, they are the ones who have borne the brunt of the pandemic. I found a deep sense of calling to serve people at the most vulnerable and painful time of their lives.

That is something that will need to be borne in mind. I have no doubt that you will hear justified criticisms of particular occasions when coroners or coroner's officers have perhaps not behaved with the sensitivity that they should. There is no doubt that there have been such incidents; but, of course, nobody goes into this service for wealth, glamour or power. They are motivated by that deep spirit of service. It is a unique vocation, and that is safe; it is preserved.

Welfare is different. It varies across the country. Broadly speaking, welfare suffered most in areas where there were reasons for that, to do with under-resourcing. That brings me to the main findings of the tour. In

my view, the coroner service in England and Wales is, with very few exceptions, chronically under-resourced and underfunded. There are some areas with adequate numbers of coroner's officers and staff, and acceptable premises. There are many areas where there are nowhere near enough coroner's officers. One of the questions that I asked at each visit—and I must warn that this is a very crude measure of overwork—was, "What is your individual case load; what is your inquest case load?" On one memorable occasion when I asked that question the entire coroner's officer team burst into tears. On most other occasions it became clear that the individual case loads were far too heavy; there were just not enough coroner's officers. So staffing is a problem in most, or virtually all, areas. In some it is a very serious problem.

Accommodation is another common problem. That is not universal, but I encountered premises that were so dilapidated that they were frankly not fit for occupation. I mean, by that, sets of offices with huge sheets of old dried paint peeling off the walls, multiple buckets placed around the floor catching water that was coming in through the ceiling, and heating that did not work—that kind of thing. Nobody, of course, should be required to work in those conditions. Some were not as bad as that but were nevertheless far from ideal, so that, for example, the coroner's officers could not be co-located with the coroner. In my view, it is quite important that a coroner's officer should be able to knock on the door of the senior coroner and say, "I've got a problem; can I talk to you about it?" So material resources were a problem, particularly in terms of accommodation.

I do not think that information technology is a problem. They pretty much all, with one or two exceptions, seemed to be pretty well equipped in that regard, but accommodation is serious. Even where it was physically of an acceptable standard, it was quite often insensitively sited. On one memorable occasion an assistant coroner was sitting in court as I made the visit, and she had to keep rising because the bereaved family were of course present, and there was whooping and cheering outside. I do not blame people: they had gone to celebrate a civil wedding—but it was audible inside the courtroom. Quite rightly, the assistant coroner said, "I am sorry; we are going to have to rise for a bit." She had to do that more than once in the course of the morning. I found other places where similar things happened.

Q4 **Chair:** It was some sort of civic office and it is next to the register office.

His Honour Judge Teague: Yes. A lot of it depends on where the service is seated in the local authority. Different local authorities put things under different headings. We may come to that later. You also have people going to register births. If there is an inquest on the death of a baby, that is obviously not suitable. Nobody does this out of malice. It is because they do not think about it, or can see no alternative, and so on and so forth.

A more fundamental problem, which certainly feeds into the staffing difficulties, is that in my view the tripartite governance structure that still exists in a majority of coroner areas is archaic. It is now out of date. It has served its purpose and should be replaced. I did what I could during the tour to persuade local authorities in those areas where they still have police involved—Perhaps I should explain about the "triangle of responsibility". You have to imagine a triangle, with the senior coroner at the apex. At the other corners are, on the one hand, the local funding authority and, on the other, the local policing body. It is a recipe for paralysis and delay, because everybody has to agree on everything and it takes time. There are two bureaucracies involved.

My experience was that most, although not all, of the serious problems I found in individual areas were in those where they were still trying to operate the triangle of responsibility. It just does not work. It is a historical hangover. It dates back to the late 19th century when local authorities were first put in charge of coroner areas. In those days there were a much larger number of districts, as they were called, far smaller numbers of deaths, and a part-time coroner, who would also typically be the local solicitor. He—and it would be a "he"—would work out of his office and be able to rely on the assistance of his clerical staff for a lot of the administrative work, and he would have the assistance of a local bobby, a local police officer, to do the investigation.

Q5 **Chair:** Peter Grimes, almost.

His Honour Judge Teague: Yes, exactly. This was fine in those days. I think that what has happened is that, particularly in this century but, really, ever since the 1880s, there has been an incremental process of reform. Even the 2009 Act was not really a big bang. The reforms have come in bit by bit. That has meant that people have never had to sit down and think, "Hang on, we're leaving our governance structure out of this, and it's increasingly unfit to cope. What are we doing to do?" Typically, people would say, "We need a few more assistant coroners. Let's get a few more officers from the local police force. Let's see if we can find another room for a second court." Ultimately, that is persevering with an outdated system that is not fit for its intended purpose.

During my visits I tried, with some success, to persuade local authorities to transfer coroner's officers from the employment of the police force to the local authority. There is sometimes resistance—not always—from coroner's officers initially but, when I spoke to people who had been through the process, they said in every case, "This is the best thing that ever happened. Things are much better."

To give a quick example of the nature of the problem, in the tripartite system, if a coroner's officer retires, you have to go to the police to satisfy them first that you need another coroner's officer; then they have to go through their processes to select one. If you are lucky, that can be done in six or nine months. By that time, somebody else may have gone off sick and you are running on the spot.

I have probably said enough about that—

Q6 **Chair:** Before you move on, in my experience coroner's officers used generally to be recruited from the police force.

His Honour Judge Teague: Yes.

Q7 **Chair:** That is still the case, is it?

His Honour Judge Teague: Yes. Some of them are provided by the local authority, in those areas that do not operate the tripartite system. Where you have the triangle of responsibility, not necessarily all, but usually all and certainly in some, of the coroner's officers will be provided by the local police force. They may or may not have served in the past as officers—they may be police administrative staff; but they come from the police force and they are subject to police line management. If I may, I will move on from this for the moment, because we can come back later to some of the detail of this, if you like.

One thing that I also noticed was that, rather counterintuitively, I was repeatedly told—I had anecdotal evidence—of a rise in the number of referrals during the summer. That is not what you normally expect; you expect an increase in referred deaths to occur over the winter, but this was in the summer. The cause may be something to do with recent changes in medical practice that mean that doctors do not always see patients before they die. Whatever the cause, it has absorbed a lot of the working time of coroners and their staff. I think that that has a knock-on effect when it comes to dealing with the work that coroners should be dealing with. If a natural death comes to a coroner, they should not really have to deal with it. If it comes about because of some problem with doctors not seeing patients, or whatever it may be, it is absorbing their time when there are cases that they should be looking into. This has had a knock-on effect on delays.

I just want to make this point to the Committee: I have provided information in my evidence, based on the most recent published evidence from my office, which is broadly in line with what the official statisticians from ONS say. They can analyse trends, of course. You will recall that I have sounded a note of warning about the likelihood of future rises. I have to tell you that we have access to unpublished evidence that tells me that we have to expect further increases in 12-month-plus cases. There is some indication in the most recent data, which is incomplete, that we may have passed the peak; but I cannot say that we have. I am quite sure that there will be a significant increase in the next published data. I think it may be two or three years before we get any clear idea whether it has peaked—because there are fluctuations.

The good news about it is that the advent of medical examiners in the community will help, because they will remove that element of natural deaths finding their way to coroners. We also have a plan to deal with it, which is, essentially, to do what we did last time—to target a small

number of areas that are, apparently, particularly underperforming, and see if we can help them to do better. I think that those things, combined in the longer term with the fact that some work is now being done to try to address the problem of delays with pathologists, may help; but in the short term we have to brace ourselves for further increases in 12-month-plus cases. I need to make that clear.

The final thing I will say—I warned that it would be a lengthy answer—is a positive thing, and returns to something that I said right at the start. That is that with very few exceptions I was deeply impressed by the quality of coroner's officers particularly, but of coroners and other staff as well. They are struggling in the most difficult circumstances with insufficient resources, and the refrain that I kept hearing over again from teams of coroner's officers was, "We don't want to let the families down."

Q8 **Chair:** That is a very clear introduction for us, and we are grateful to you. It is stark, in places, as you say, Judge. From that unpublished data, and bracing ourselves for an increase in the 12-month cases, is there any underlying trend that drives that? Are there any drivers that you can establish for that?

His Honour Judge Teague: It is extremely difficult. The answer is no, really—not any that can be worked out. I suspect that when ONS statisticians get hold of their more detailed data they will be able to identify trends, but I will explain why I say no. Looking at individual areas, it is very difficult to understand why in some areas there is a very good trend. There are some areas where there has been a significant reduction, year after year, from 2021 down to this month. Some areas have managed it. Other areas have gone the other way and some are going up and down—fluctuating quite wildly. I have to say it is unpublished data; these are snapshots taken at a particular time and it is very difficult to deduce trends, anyway, but the contradictory nature of the internal material makes it very hard to attribute any particular cause to the national picture. One suspects that there are lots of things going on in different places.

Q9 **Chair:** You have a very small private office to support you.

His Honour Judge Teague: When we are at full strength, we have six officials. We are currently two down but normally we have six. We do not have access to the apparatus that other national leadership judges' private offices have, of HMCTS. My officials have to deal individually with 80 local authorities, or consortia of local authorities, all operating in different ways. That is why, with the best will in the world, it is completely impossible for us to do the sort of exercise we would like to do with all areas. The only way we can do it is to be highly selective, pick out the worst performing and see what we can do to help.

Derek Winter: Chair, would it help if I could perhaps pick up on those multifactorial issues that affect a coroner's ability to deliver the investigation within 12 months?

Chair: Yes, please.

Derek Winter: The judge has touched on accommodation. If you only have one court available and there is a need for two, you cannot get on with cases. Local authorities struggle to provide the accommodation—particularly those that may be subject to section 114 notices. Some coroners have to have spending controls approved. That will slow down the ability to deliver the service.

The Chief Coroner touched on the unusual rise in numbers in the summer months. I think that, in the fullness of time, the data may prove that there have been a lot of what we call uncertified deaths in the system. A doctor can say, "This death is natural, but I haven't seen the patient in the last 28 days"—or that a colleague or a locum doctor has. To get the case through to register the death, the coroner will say to the registrar, "I know about this case. My duty to investigate does not arise." That means that the family can have their funeral and get their death certificate. Coroners are having to deploy those tools more than we have ever had to. That causes congestion in the system.

We were given some additional powers recently to do investigations without a post-mortem, where we can discontinue. The other mechanism that coroners have had to deploy is the use of inquests without post-mortem examination, with a conclusion of natural causes. In the last available statistics there were over 5,000 natural causes conclusions. That is taking the coroner and the team away from dealing with the more substantive investigations that the Coroners and Justice Act 2009 was meant to capture—the violent, unnatural or state detention deaths. Those three tools at the coroner's disposal have meant that families can get their funeral and death certificate. I estimate that there may be up to about 20,000 of those referrals that should be in the medical system.

The injection of optimism is that the new medical examiner system will become statutory sometime this year, and those 20,000 cases will go from the legal forum into the medical forum. It will take time to work through, as the judge has explained. Some of those cases will turn into investigations because the medical examiner will find things that are of concern that a coroner should look at; but the medical examiner system will guarantee scrutiny. The coroner system should be doing investigation. That will take a little while to work through.

Chair: That is very helpful.

His Honour Judge Teague: Perhaps I could just quickly add one further finding—that there was not the right balance between fee-paid and salaried coroners. It is quite important. I have spent a lot of time trying to persuade local authorities to appoint more area coroners who are salaried, rather than relying on a large number of assistants, some of whom may not be able to sit very much. It has had some success and I was pleasantly surprised by the number of local authorities that were willing to consider it and have done it. The balance is already much better

than it was; but there is no point in appointing more coroners if they have nowhere to sit and they do not have the staff—the officers—to carry out the investigations. That is the problem.

Q10 **Chair:** In all of those matters you have to rely on your powers of persuasion rather than any direct managerial force.

His Honour Judge Teague: Yes, exactly.

Q11 **Chair:** Understood. Going back to the report that we did in 2021, which I know you have read, one of the assumptions that we were working on was that bereaved families should be at the heart of the coroner service. I think you have expressed it slightly differently in your written evidence, Judge, and have said that it is the deceased who is at the heart of the service, and that the family are, if you like, standing in the shoes of the deceased. Is that a significant distinction, and, if so, why?

His Honour Judge Teague: I think it is, and, Chair, you have expressed it exactly in the right way as I would like to. I think it makes a difference. First of all, to say that the bereaved must be at the heart of the process is true, but it needs a bit more definition. For example, it cannot mean that they are able to dictate the outcome of an inquest. I do not think many people would think that, but one has to be careful about it. Secondly, and perhaps a little more subtly, it cannot mean that they have a kind of free-standing right to ventilate whatever issues they choose to raise, whether or not they really relate to the purpose of the inquest.

The reason I have put it in the way I have is that the legal focus of a coronial investigation is on the deceased. There are four statutory questions that the coroner is there to answer: who was the deceased, when did the deceased die, where did the deceased die, and by what means or how? If we start from the legal focus, which is well defined, we can see a principled reason for placing the bereaved at the heart of the process, if not the outcome. They are able to speak for the deceased, whose voice would otherwise not be heard. That is why I put it in the way I do.

You sometimes hear people talk about having a level playing field or equality of arms. I prefer to use different metaphors. Those metaphors are fine in the context of adversarial proceedings. In the context of an inquisitorial process, I prefer to think in terms of access to justice and effective participation. That is what we have to ensure. We have to make putting people at the heart of the process a reality.

As you know, Lord Justice Clarke identified, in his report after the Marchioness disaster, four important principles: the "provision of honest and, as far as possible, accurate information at all times"; "respect"—significantly—"for the deceased and the bereaved", which I suggest echoes my view; "a sympathetic and caring approach throughout"; and, finally, "the avoidance of mistaken identification". He of course was writing in the context of mass fatalities where the primary issue is

identification. With the alteration of that one last word, you could, and I think you should, apply that to all inquests. The alteration would be to say "the avoidance of mistaken conclusions". With that amendment it would apply to all, but, in my view, it still would not be enough. That gives the bereaved access to justice. It ensures that they are kept informed and treated with respect and sympathy, and that the outcome is correct, but I think you need to go that step further and ensure that they can participate effectively on behalf of the deceased, whom they in a sense represent.

There is a final point about why I think making the distinction is significant. There will be rare cases where there isn't a perfect alignment between the interests of the deceased and those of the family. An obvious case, which I have experienced myself, would be where the family are at odds with each other, but one can think of other circumstances. I think that my way of framing the principle—that it is the deceased and by extension the bereaved who should be at the heart of the process—makes it clear that the bereaved are there for the deceased, not for themselves. That lends great dignity to their presence and involvement and helps to explain why they must be able to participate, but it also helps to define the limits of their involvement and participation.

Q12 **Chair:** You use the phrase "effective participation", which echoes a recent academic publication, "Voicing Loss", which uses the same sort of phrase.

His Honour Judge Teague: Yes, it does. I think it is a fundamental principle. That, I think, is what we have to aim at. It is the coroner's duty to try to ensure that a family is able to participate effectively.

Q13 **James Daly:** Judge Durran, can I ask you a question in relation to what Judge Teague has just said? I have had constituency matters, as I am sure colleagues have, where the issue of publicity in a case being heard by a coroner is a matter of contention. When a tragedy has happened, where a young person may have committed suicide, the parents, guardians, friends or family are there listening, and the details of the young person's tragic circumstances are publicly available information within the coroner's court. If the local newspaper prints those things—the facts of 16 or 18 years of a life coming down to some tragic circumstances—I know from my own postbag that that is of grave concern to family members.

What is your general view in respect of the issue of publicity? Going back to what Judge Teague said about who is at the heart of this matter, sometimes it is not just about publicity but remembering a person, not the circumstances of one particular day but potentially the circumstances of a very happy life.

Her Honour Judge Durran: There is a lot in that question. The first thing is that coroners courts are open courts. The press is often present and it has a right to be present and to report. Certainly, sensitivity is

encouraged when dealing with a case where the conclusion may be suicide.

If I may pick you up on your terminology, the expression "committed suicide" is one we encourage all coroners to avoid, because it stems from the time when attempted suicide was a criminal offence. We try to avoid the use of that term. We encourage reporters to report sensitively. In terms of the prevention of future deaths reports, which is the other way of reporting on the Chief Coroner's website, very often we will redact methods of suicide so that they are not shared more generally in the media, but it is very difficult to control something that happens in open court to someone who, as a result of the fact they are deceased, no longer has a right to anonymity.

Q14 **James Daly:** I suppose that what I am asking you about is where we are with the law and whether that should be changed in relation to rights. Obviously, the public interest is served if you have an inquest into the Manchester bombings, for example. There is a clear public interest. I am not asking you to comment on this, but as a politician I am struggling to understand where the public interest is in knowing the individual circumstances of a person who has done a very personal act in very personal circumstances, and why that should be public information at all.

The further question is: should we as a Committee be looking at that issue, or recommending to whoever it is we recommend these things—the MOJ or whoever—to look at that issue and we need to give coroners greater powers to say it is not appropriate in these circumstances for any of this information to be reported by the local media?

Her Honour Judge Durran: My experience generally has been that the press is sympathetic, but at the moment a coroner has no power to restrict the reporting of proceedings that take place within open court. Undoubtedly, at times that has caused concern. Sometimes, what is said in a court is not necessarily what is said within a family. Sometimes, there are obvious attempts to keep something of the circumstances of the deceased's death from the wider members of the family, but I have to say that, beyond a very handful of occasions when we have had concerns raised with the office as a result of what is contained within a prevention of future deaths report, I have not been aware of any volume of communication with the Chief Coroner's office to suggest that press reporting is a concern.

Q15 **James Daly:** In circumstances where I have dealt with these, probably it has been with the individual coroner's office in correspondence. Judge Teague, I personally believe that coroners should have the power to be able to instruct media outlets not to report in certain cases. Certainly, if the family is making a recommendation that that is what it would be most comfortable with, there should be a public interest test that overcomes that, because what you are saying here about the victim and family is meaningless unless you have that power, in my opinion.

His Honour Judge Teague: I respectfully agree with what Judge Durran has said, but I would add that I cannot get involved in matters that are really for policymakers. However, the provisions we have for restricting publicity were not designed for coroners courts; they were designed for other jurisdictions, and they are not always easy to adapt in the context of a coroner's inquest. The result can be that coroners have to adopt, frankly, workarounds to try to avoid things being mentioned in the first place. Some of those are potentially questionable. It is a matter for policymakers in the end, but there may be something to be said for looking at this question, because I think there is a point there. The system we have was designed for criminal, civil and family courts, not really for coroners courts.

Derek Winter: Being the only practising coroner here, I can resonate with your constituents' concerns. Some families when coming into court see the reporters at the back of the court and get very anxious. We have notices all around the court building confirming that the press is entitled to sit in court and report. The Samaritans have a very good set of documents and processes to encourage the press to report responsibly, but you make a good point. It might be for politicians to look at the impact on the family who we are putting at the centre of an important process. Unfortunately, we can re-traumatise people when they come back to the inquest court and so sensitive handling is really important. We are lucky to have the Coroners' Courts Support Service volunteers as well, and we try to manage families' expectations all the time before they come to court so that they know what to expect. Sometimes, the media do not turn up, but we have to be conscious of that.

His Honour Judge Teague: They have a legitimate claim. It is very important to have open justice, as we all know.

Q16 **Rachel Hopkins:** I understand that many volunteers from the Coroners' Courts Support Service now help bereaved people to navigate the system in over half of all coroner areas. The CCSS is a charity with no funding from central Government. Do you think its services should be available in all coroner areas?

His Honour Judge Teague: Without a doubt. This was something I found on my tour. For some particular reason—I think it was just chance—during the early stages of my visits to the areas I met people from the Coroners' Courts Support Service. They do incredible work. What they do is absolutely remarkable. The tone and atmosphere of the court building where they are present is quite different—it is noticeably different—from elsewhere. With respect, I also think you are right in identifying that the problem is funding. The answer to that must be a matter for policymakers and I am not going to go there, but I am conscious that it is a charitable organisation. I have had the privilege of meeting Christopher Blue, the new chair of the trustees. I am very keen on it. I would love to see it in every single coroners court, if at all possible, but funding is likely to be the problem.

Q17 **Rachel Hopkins:** I appreciate the comment about funding, but are there any other obstacles to it being rolled out?

His Honour Judge Teague: Not that I am aware of. During the tour I did not myself encounter any resistance to the idea. It may exist, but I did not myself encounter evidence of resistance to their presence. I cannot really understand why there would be and, having seen it for myself, I have absolutely no doubt on the point at all.

Q18 **Rachel Hopkins:** Do you have any additional thoughts on how your office could support any of that? Are you literally saying that a bit more funding would be of benefit?

His Honour Judge Teague: The funding question, of course, is not for me. I give training conferences in March. We have had senior representatives from the service at those conferences, and they sometimes have a stand. I try to make a point of mentioning whoever is there by name when I address the conference just to make sure that people know who to look for and will go and find them. I do not know whether Derek has any view on that.

Derek Winter: I think the volunteers are fantastic. One of the benefits of having the volunteers at court is that they look after families and witnesses, and can use their radar when people are getting upset to take them out of court if that is what they want. The volunteers can take some pressure off coroner's officers who have to marshal witnesses and work the recording equipment. It is just another thing that a coroner's officer is perfectly capable of doing, but if you are under-resourced volunteers are a blessing. They are not a sticking plaster, because they bring their own expertise. These are properly trained bereavement volunteers; they have to go through some rigorous checks to get where they are.

The Coroners' Courts Support Service was actively involved with the Bar Standards Board, the Solicitors Regulation Authority and Chartered Institute of Legal Executives when we did the competencies. They made some videos about how they would like to see lawyers behave in the inquest court and try to help manage expectations, in the same way as the judge made a video, as did I and others involved in the inquest world—for example, Professor Leslie Thomas KC. We had a lot of people to try to recalibrate the inquisitorial tone of inquests. The service was an integral part of that because it had a broader view, being in about half the courts.

His Honour Judge Teague: Can I sound one note of warning about this? I remember visiting one area where the coroner's officers were under pressure and members of the CCSS very helpfully stepped in with small tasks, like starting the recording equipment and that kind of thing, which is fine. But the danger is that, if the senior coroner then goes to the local authority and says, "I need another coroner's officer," the answer will be, "You're managing fine; you don't need one." What is happening then is that the good will of volunteers is being substituted for

what should be provided by the funding authority. That is the only note of warning I would sound. That is not in any way the fault of the CCSS, or a criticism of it.

Q19 **Dr Mullan:** You mentioned at the start the question of a level playing field and equality. You have described it as access to justice. Before we go on to that, could you outline succinctly why you think an attempt to avoid the inquisitorial nature of it is so important to the coronial process?

His Honour Judge Teague: I think it is absolutely essential. We have to keep a clear distinction in our minds. One of the problems in the past has been imprecise use of terminology, which has led to misunderstanding and an unnecessarily polarised debate. You hear people say that inquests are adversarial. Very often, they use the word "adversarial" in a sense that is very different from the sense in which I would use it. They may mean "contentious" or "controversial". There is no doubt that some inquests are controversial and contentious; we all know that, although I would say it is a clear minority. When I use the word "adversarial" I am talking about who controls the process, and that is why it is an important distinction. In adversarial proceedings, in the strict legal sense of the word, it is the parties who control the proceedings. The prosecution in a criminal case decides what charges to bring and what evidence to adduce; the defendant decides whether to give evidence and call witnesses, and does not have to do either. The same goes for civil proceedings, so the parties are in charge.

In inquisitorial proceedings it is the judge who is in charge. We talk about "the coroner's inquest" in a way you would never talk about "the judge's trial". The coroner is there not to adjudicate but investigate. It is a public judicial investigation, and the difference matters in all sorts of practical ways. I can think of one practical example straightaway. In adversarial proceedings where there is a burden and standard of proof, you manage cases very differently. If you want submissions on a point, you will say to the party who bears the burden of proof that they must provide their submissions by such and such a date, and then you say to the other parties that they have a further period of 14 days, or whatever, to consider what has been written and then reply. Inevitably, that builds in delay, but it cannot be avoided in adversarial proceedings.

My view is that in inquisitorial proceedings the correct approach is to case- manage much more aggressively. I do not apologise for using that word. Set short time limits and enforce them. I think the coroner should not be saying that the hospital trust will provide submissions by such and such a date, the family can have another 14 days, and the police force can have so much. They should say that all submissions should be provided in seven days, by 4 o'clock on Friday. In that way, you can drive forward the case and make clear that the coroner is in charge; it is an investigation. The danger, if you slip into adversarial habits, is that you cede control of the process to lawyers.

As is often said—it was said as long ago as 1982 by Lord Lane—there are no parties to an inquest; there are interested persons who assist the coroner to carry out a public investigation. There are no parties; there is no prosecution, defence or indictment. It is an investigation.

I do think that terminology matters for that reason. If we start to use language imprecisely, it can affect our thought processes and the way we deal with cases. That is why I say it is more consonant with the notion of an inquisitorial process to think in terms of access to justice and effective participation.

Q20 **Dr Mullan:** Maybe one of the challenges is that in a court process you are always seeking to be contentious and it operates in that way. I am not sure you can necessarily draw such a clear distinction with all coroner's inquests. I can think of constituency cases where the relative is seeking to achieve clear accountability by the healthcare provider. They would not see a huge difference; they would see the healthcare provider as seeking to defend their position as not having been negligent, and they would see their role as ensuring that the coroner has the facts and information that show the contrary. I think those 14 days in the example you have given would be very important in some circumstances for them to be able to go away as lay people and get an expert opinion. In the case I have referred to, the expert opinion that the family secured was very important and had a big impact on the process.

While I sympathise enormously with the general flow of how these things might work, do you not recognise that, in reality, there will be inquests where a public body is seeking to defend its conduct which inevitably perhaps have more in common with an adversarial process than an inquisitorial one?

His Honour Judge Teague: People misuse the process or seek to do so— very often large organisations intent on avoiding reputational damage—but it does not alter the nature of the process and the obligation of the coroner to keep control of it and not allow it to become a form of surrogate litigation. There are other channels for ventilating legitimate legal claims and so on.

I come back to what I said before. The focus of this ultimately must be the deceased and the investigation into the death of a person. The danger is that, if the coroner allows the process to be sidetracked in order to assist some parallel litigation that may be either threatened or in progress, paradoxically, the family gets sidelined because the focus shifts from the deceased perhaps to some extraneous dispute, in some cases not even involving the family, between, for example, a doctor and a hospital trust, or two different large organisations.

The focus procedurally always has to be on investigation. I quite acknowledge that, unfortunately, people sometimes try to exploit the process, but it is incumbent on coroners to remember that the apportionment of blame is no part of the process. This has been said by

the courts again and again. The coroner is prohibited from even expressing an opinion about anything other than the four questions to be answered. The conclusions or determinations reached by a coroner must not even appear to determine any question of civil liability, or indeed criminal liability, on the part of a named person. We have to respect those limits. Frankly, if organisations or others try to weaponise the process for their own purposes, I would expect coroners to take a stand against that and remind them that this is not what this is all about.

My colleague Mr Winter has just referred to the competencies or, as I call it, the toolkit. That was designed precisely to try to help coroners keep the process on track; it is designed to ensure that lawyers are not able to get away with importing some extraneous agenda.

Q21 **Dr Mullan:** I am not saying it is always necessarily the case that families are doing it as a form of litigation. They just might want to ensure that in the inquest itself the findings to their mind are accurate and reflect what happened, not because they might want to go on to sue someone. On that note, accepting everything you said, when it comes to bereaved families there is frequent lobbying. This Committee and MPs regularly hear about equality of arms, which perhaps is not the best phrase. I have given one example of my constituent who had to pay privately for an important medical opinion. While you can comment on the policy of legal aid, do you think there are advantages or disadvantages to families being able to contribute to the process in the way they would if money was no object for them?

His Honour Judge Teague: As you rightly say, I cannot get involved in matters of policy. It is for policymakers to decide the availability of legal aid. I will say this. I do think that any system that is adopted should be as flexible as possible. Rigidly linking the provision of legal aid with any criterion that you care to choose is likely to generate an incentive to manipulate cases to enable legal aid to be obtained. The result can be that in some cases where it is not really necessary it is awarded at great expense, while in other cases where the family really would need proper legal representation they don't get it. I would like to see a suitable element of discretion in any system. That is probably as far as I can properly go before I am treading on your toes.

Q22 **Dr Mullan:** In running the process, are there times when you think that if they had had some advice it should be a lot quicker and simpler, and lack of advice is making it more expensive and difficult?

His Honour Judge Teague: That can undoubtedly happen, and it happens in other jurisdictions as well. I agree with that. However, I think that it is for coroners—they do not always do it, but I am sure the great majority do—as part of enabling that effective participation to look out for the family, make sure they know what their rights are and encourage them to exercise them.

Q23 **Dr Mullan:** Mr Winter, is there anything either of you want to add to

that?

Derek Winter: I think it is really important for effective participation. After the last appearance before this Committee, Chief Coroner guidance was issued on disclosure which reinforced the need for timely disclosure so that families were not at a disadvantage when they came along to the inquest. They could put their concerns in writing and give them to the coroner. The coroner could, not necessarily acting as their advocate, sift out the relevant questions to assist the family, because organisations and public bodies inevitably appear through lawyers and the families will naturally feel at a disadvantage. The disclosure guidance was unofficial but it was a good reminder for coroners of what they should be doing in a timely fashion, and then families can prepare. That is the important thing. Families do not always come to an inquest. It is a unique experience for them.

The other important point to mention is that since our last appearance we have issued guidance for coroners to use counsel to the inquest in certain types of case. The benefit of counsel to the inquest is that the coroner has a lawyer with the other lawyers and can talk to the families. The families can feel part of those corridor huddles that sometimes lawyers have and can express a view. Counsel to the inquest can, therefore, manage things outside the court as well as inside it. They can make sure that the family has proper disclosure and, if they do not understand a legal concept, not advise them but try to put it into some sort of context, so their effectiveness is improved. More and more coroners are using counsel to the inquest in appropriate cases. That is an expense that local authorities have to bear. Coroners do not have to ask for permission to do that, but we have to notify the local authority about any unusual item of expenditure coming their way. There are more and more cases where that is happening. It is an indirect benefit to families separate from legal aid, but I thought it was worth making the point.

Her Honour Judge Durran: Can I add that lawyers are not always the panacea?

James Daly: I agree with that.

Her Honour Judge Durran: Speaking as someone who sits for most of the time in the criminal jurisdiction, where most of the lawyers who appear in front of me will appear for the prosecution one week and for the defence another week, my experience at the criminal bar is that generally they work together to help the court and resolve matters where they sensibly can.

My limited experience as a coroner sitting in an inquest—and it is very limited—is that lawyers are always instructed to represent the family, the police or the hospital trust. They either work for the hospital or family, or vice versa, so they come embedded with the idea that they represent the family or the hospital and they are on different sides. That attitude does not work because they do not always co-operate with each other to find

resolutions and sensibly deal with the evidence. I am not sure it is right to think that lawyers are necessarily going to improve or reduce the adversarial impression of an inquest. Quite often, I think it goes the other way.

Q24 **Dr Mullan:** I guess the argument is that perhaps if the hospitals did not have a lawyer then the family would not have one either.

Her Honour Judge Durran: Precisely.

Chair: As an old criminal hand, I am not going to disagree, Judge, with that. We have to get to a number of important topics. I am conscious that when we get to the end of this debate there will be a number of Divisions, one after another. Each takes about 15 minutes and we have to suspend the sitting, so if Members and witnesses can keep things, as Mr Speaker says, as punchy and pithy as we can, we will get through the important topics.

Q25 **Tahir Ali:** Could you explain the particular requirements that faith groups have within the context of the coronial process, and how that impacts on the work of coroners?

His Honour Judge Teague: In particular, members of the Jewish faith and Muslims have a religious requirement for prompt burial. Guidance was issued some years ago to address this. It is a difficult problem. Everybody, for one reason or another, would like prompt burial, or cremation where it applies, but there is a particularly deep-seated reason on the part of members of certain faiths. I have always made it perfectly clear—the guidance certainly makes it clear—that it is appropriate for coroners to give proper weight to a request for prompt burial that is based not on utilitarian grounds but deeply held religious convictions. Therefore, when priority can be given, it should be. Of course, it cannot always happen, and it is not possible for the religious wishes of relatives always to prevail. That is clear. There may be criminal proceedings in hand, the need for a post-mortem and so on.

I will try to keep this brief. I have frequent contacts with representatives of faith groups, both Jewish and Muslim. I have visited the Gardens of Peace, a very moving cemetery in east London. I am very conscious of their requirements. I also speak at the Muslim Burial Council's annual conference when I can. I have been very pleased by the kind reception I have received. In particular, people I do not know come up to me to say, "I want you to thank such and such a coroner because they always deal with our cases very well."

It is not always possible. There are occasions, particularly with out-of-hours provision, when there is a problem; that can lead to delays. Keeping this as brief as I can, that usually comes down to funding. You have to have a member of staff who can be paid to operate out of hours. Some areas fund it and some do not. When they do not, it is very frustrating and hurtful to the bereaved. I find it frustrating. I want you to

know that I do engage with those individual areas; I go along and do what I can, but I am not always successful. Mine is a soft power and I cannot force anybody to do anything. That is how I would explain it.

Q26 **Tahir Ali:** How are coroners dealing with the needs of faith groups? If they are not, how do the families raise that issue?

His Honour Judge Teague: They can raise it as they do through their faith representatives with me. There are other things we are trying to encourage, such as the expansion of scanning as an alternative to fully invasive post-mortem examinations, by the way. But, in the end, if people raise it with me, all I can do is what I do do—it can sometimes be quite a difficult exercise—which is to make, sometimes, a very frank visit to the area where there is a problem and speak to the local authority, coroner and everybody else. However, in the end, unless the funding is available for the appropriate out-of-hours system, I am afraid it will not happen. There are problems in some areas.

Q27 **Tahir Ali:** For example, if I have a problem in the Birmingham and Solihull area, I cannot get in touch with the coroner, because part of the coroner's duty is judicial and part is non-judicial. At what point does it become judicial, and at what point does it remain non-judicial?

His Honour Judge Teague: Most coroner's decisions are judicial. I hope you will forgive me if I do not talk about individual areas because I do not think it would be right for me to do that in this forum.

Q28 **Tahir Ali:** But it is important to get that message through to you, because where there are difficulties there is no mechanism of challenge and the families are often spoken to in a very bad manner and treated very badly. How do we deal with that? That is important.

His Honour Judge Teague: Clearly, that should not happen.

Q29 **Tahir Ali:** When a constituent comes to me, the system has failed if I cannot write to a coroner to say, "A death happened a week ago. Can you indicate to the family how long it will take?"

His Honour Judge Teague: It is always possible to write to my office. I am not making promises that I will be able to achieve anything. I have to be frank about this. I have soft power and that is it, but I do get my hands dirty in these situations—I do. I can assure you that I go along and have some very uncomfortable conversations. If you find that you cannot get satisfaction in the way you would hope, by all means write to my office. I will do what I can, but I cannot make promises. There are also faith representatives.

Q30 **Tahir Ali:** In some areas they exist; in others they are there by name but do not represent everyone, so families have a very difficult situation in getting in touch with faith organisations. In a city like Birmingham, where over 300,000—one third—of the population of a million are Muslim, getting a faith representative does not work, but there are cases, not live

cases, where there may have been a delay which could have been avoided with better communication, and that is not happening. When they come to us and we write to the coroner, we are reminded of the Commissioner for Standards' letter to treat coroners and their staff as judges. They simply say we cannot write to them. The admin bit starts at the time of death, but I would say that the judicial bit starts at the inquest.

His Honour Judge Teague: It starts before that. For example, a decision whether to request a post-mortem examination is clearly a judicial one.

Q31 **Tahir Ali:** For example, if there is a faith organisation and a Jewish member of my constituency says the body has been lying at the funeral directors for two weeks and has not even gone for a non-invasive procedure and there is no communication with the coroner's office, who do we turn to—yourselves?

His Honour Judge Teague: Yes. I do not know whether Mr Winter has any suggestions.

Derek Winter: Some areas are overwhelmed with work. The judge made the point in the early stages of this meeting that, if you are not resourced to do something, you cannot deliver that service; you only get out of the service what you put in. Ultimately, meetings with the coroner are sometimes a possibility, and representations to the local authority, because the primary responsibility to set up the infrastructure is usually with the local authority. There are lots of competing demands on coroner services, but I see it personally as an important function to reach out to my faith groups and other people and organisations in the community. Coroners have to do all of those things to make the system work in their areas. That degree of communication can be important, but if it is not succeeding there is a limitation to what the Chief Coroner's office can do. Ultimately, it is for the local authority.

Coroners have to have the service available for things that cannot wait until the next working day. Some local authorities take the view that, unless the coroner's duty to investigate is triggered in some form, that is not something they might fund. There are all of these imbalances in the system which still need to be ironed out. If we are to provide a genuine 24/7 service, that means somebody will have to be paid to be on call—a coroner's officer, a coroner, a registrar of deaths—and the system has to be set up to achieve that. It is not impossible, but it will take good will and finance to achieve it.

Q32 **Tahir Ali:** Should the delays or failures be reported in an annual report? Is an annual report an annual report?

His Honour Judge Teague: Do you mean delays in the sense of 12-month-plus cases?

Q33 **Tahir Ali:** Specifically, rapid release for faith organisations where they

have not been released within, say, three to five days and have gone on unnecessarily for up to three weeks.

His Honour Judge Teague: The contents of an annual report, which are laid down by Parliament, are matters for policymakers. We will comply with whatever we are asked to deliver, but I do not think it is for me, as it were, to express an opinion about what further matters ought to be included in the report than are already in it.

Q34 **Tahir Ali:** An annual report was combined into two years for my local area, and last year's has not even been published.

His Honour Judge Teague: Is that a local report?

Tahir Ali: Yes.

His Honour Judge Teague: I see. I cannot comment on that.

Q35 **Tahir Ali:** But who do we raise it with? We cannot get in touch with the coroner because they are judges; we cannot write to them.

Chair: I understand the frustration.

Tahir Ali: What do we do?

Derek Winter: I can understand that frustration, but the local authority has that responsibility.

Q36 **Tahir Ali:** Many years ago when I was a councillor the response from the coroner's staff, local-authority employed, was very rude to members of bereaved families. The director at the time got involved and gave them training, and that improved considerably. They have gone back to that system. I am not ashamed to mention Birmingham coroners where families have been saying, "Give some indication of how long we can expect," and they have been told, "We can't tell you; sorry; we can't say," and the body has not been released from the mortuary of the funeral director for a fortnight.

His Honour Judge Teague: You are very welcome to approach my office about it after this hearing and we will see what we can do, but I will not comment on individual areas; it would not be right for me to do so.

Q37 **Chair:** It is a function of the current system. Not being a national one, that is the best you can do.

His Honour Judge Teague: I should make it clear that you are talking about a local report.

Q38 **Tahir Ali:** Yes, for Birmingham and Solihull. Again, it should be an annual report. At a minimum, you would expect the coroner to meet local Members of Parliament on a regular basis—whether it is on an annual basis—so that matters can be taken back and provided, but that communication fails. Do you expect the coroner service to be reflective of the diversity of the city?

His Honour Judge Teague: Of course.

Q39 **Tahir Ali:** My local one is not. There are two area coroners and seven assistant coroners, and not a single Muslim there.

His Honour Judge Teague: If you mean "reflective" in the sense of the coroners or coroner's officers necessarily representing the make-up of the population, that is a different matter, but it certainly should reflect it in terms of making sure it addresses the needs of the local population.

Q40 **Tahir Ali:** It cannot address the needs if it is not reflective of that. If you look at—

Chair: I do not want to cut you off. I know it is a really important constituency issue for you, but I do not think our witnesses today can help on it.

Tahir Ali: I take that point. It is not a constituency matter, but it is a Birmingham-wide matter.

Chair: I do get that.

Derek Winter: Local authorities make the appointments of senior, area and assistant coroners. The Chief Coroner's office has some oversight of that, but the appointment is still a local authority one.

Q41 **Chair:** That may be a reason for us to put something in our recommendations for the future, if I can put it that way, as to how we might strengthen things, but at the moment you cannot help us much more. I understand that.

Derek Winter: I cannot tell you anything more.

Q42 **James Daly:** I have just one question regarding what Mr Ali said in general, not in terms of any area. If faith burials happen on a Friday night or over the weekend, are coroners contracted between 9 to 5, Monday to Friday? There is a large Muslim population in my constituency, and in my experience there are problems with getting bodies released in a timely manner at weekends when they could be very straightforward deaths and could be released in line with religious practice. Is that a problem that has been brought to your attention generally throughout the country, or is there a difficulty on a Saturday as compared to a Tuesday?

His Honour Judge Teague: In a moment I am going to ask Mr Winter to deal with the nuts and bolts of how it is set up, because he is a very experienced senior coroner. You have to have out-of-hours provision, and the need for it varies hugely from one coroner area to another. There are many coroner areas where it works very well; it is funded and there is no problem. As I say, I attend conferences and events, and I get people coming up to me—I am very pleased when they do—who say, "We're very happy with what happens." I know it does not always happen. Ultimately, it is a question of funding. I will ask Mr Winter, if he doesn't mind, to deal with the aspect of what happens on the ground.

Derek Winter: Most death reports come to a coroner in an area through an electronic portal. You can pick up the death referral on your phone, your tablet or your laptop 24/7. I am fortunate that I have an on-call coroner's officer. If we have a faith death at a weekend, the first thing you have to look at is to triage that death. Can you get hold of a GP summary? You may not be able to get hold of one. You may get information from the family that is very relevant, but ultimately you are dependent on other parts of a structure to see whether your duty to investigate is triggered. Sometimes it might be very obvious; it could be a road traffic collision. You know that it is going to take more effort to get the body released in a timely way.

I have a structure. Coroner colleagues in Leicester have a structure. In Darwen in Lancashire, they have a structure. Many coroners have those structures. Some, sadly, are not as well resourced.

Weekends are not a complete bar to getting a prompt release, but we need information to be secure about the purposes of the release before we can do it and to see if we can get a registrar to register the death. Sometimes there are demands for a body to go out of the country, and we will make every effort to do that in a timely fashion. It really is important.

Chair: We probably need to move on.

Q43 **Rachel Hopkins:** Reflecting on some of the things that we have just been talking about, as you will know, the Government do not intend to unite the coroner service into a single service for England and Wales. Do you think it would be better to have a single service?

His Honour Judge Teague: I will say this. It must be, of course, for policymakers to decide. There are some advantages to the local service. It can more nimbly perhaps reflect local conditions, which do vary. However, there are considerable advantages to a unified system. On a practical level, it can be very difficult to move resources around. If a particular area is struggling and you need more coroner support in that area, we have various workarounds that we can sometimes use by transferring cases and so on, but it would be a great advantage to be able to say, "This area doesn't need every single coroner at the moment. We can move a coroner across."

Similarly, something that comes into my head now is that, when it comes to appointing assistant coroners, they are appointed to individual areas. In my three years, I have overseen 64 assistant coroner competitions, 36 area coroner competitions and a dozen senior coroner competitions. We are, in some respects, like a mini-Judicial Appointments Commission. If we had a unified system, you would be able to run a nationwide competition once a year and you would have the flexibility of being able to deploy coroners where you wanted. My answer would be that there are considerable advantages to a unified system. It must, of course, be for policymakers to decide what system ultimately has to be adopted.

Chair: Understood.

Q44 **Rachel Hopkins:** You and your office have drawn up what you would call a "model coroner's office" setting out what an adequately run service would look like and how it should operate. Do you want to give us a brief summary of what it would look like?

His Honour Judge Teague: A very brief summary would be that it would have to be properly accommodated. It would have to have the coroner's officers co-located with the coroner. It would have to have adequate accommodation, adequate IT provision and adequate court space. In my view, unless it was a very small area, it would have more than one salaried coroner so that you have that collegiality, which you cannot have with the lone coroner struggling to manage with a lot of part-time assistants. Those are the key features.

It would be sensitive to local needs. It would be respectful of the inquisitorial nature of the system and would robustly case-manage cases to get them through as quickly as possible so that grieving families are not forced to wait for answers any longer than is absolutely necessary. That would be my summary.

Q45 **Rachel Hopkins:** How well do you think the current arrangements across the country reflect that ideal?

His Honour Judge Teague: I have to come back to the tripartite structure, which is archaic and often an obstacle, and I have to come back to the chronic underfunding that has left the service in most parts of the country with no resilience, with the obvious results when the pandemic struck. Of course, there is the day-to-day work that still carries on. It is not so much turning a super-tanker around; it is imagining a super-tanker that has suddenly had to switch off its engines and has to get to its destination by a certain date, and then after a pause you have to restart the super-tanker but one of the propeller shafts is cracked. You are not going to get to your destination no matter how long you steam. You are not going to get to your ultimate destination when you originally planned because you do not have the resilience. I am afraid that is the situation that prevails in many areas—not in all but in many.

Q46 **Rachel Hopkins:** What action do you think the Government could take to help with the current situation?

His Honour Judge Teague: If you do not mind me saying so, that does invite me to tread on areas of policy.

Derek Winter: We are going to revise the model coroner areas on the ever-expanding to-do list. It needs a revision to reflect the current situation. It has been influential with some local authorities and police forces, I have to say. Some do not give it the respect it should have. That notion, all of those plans, will feature in the Chief Coroner's conference with local authorities in March, and we will be inviting some police forces

to that as well. We can do things in the background to try to improve the situation.

Q47 **Rachel Hopkins:** Reflecting briefly on local authorities, we know that many of them are under significant pressure with their finances. A number have issued section 114 notices, unfortunately, and we know that there are likely to be more in the future. What is your take on the impact that that will have on coroner services? Do you have concerns about future bankruptcies?

His Honour Judge Teague: Do you want me to answer that?

Chair: Whoever wants to do it.

His Honour Judge Teague: I am very concerned. There comes a point at which underfunding imperils the rule of law. That is not an exaggerated statement. A judge in whatever jurisdiction has to know that he or she can decide the case on the merits of the case—on the justice of it. If as a result of chronic underfunding you get to a situation where a coroner's decisions are partly dictated by economic necessity, judicial independence no longer exists, and that imperils the rule of law. That, I am afraid, is a point which we have already reached in some areas.

Derek Winter: At last year's local authority conference, we had a speaker devoted to the subject of the separation of powers and the rule of law in judicial independence, so we got the message to local authorities. Some are very good, but some are lagging significantly behind on the concept.

Chair: That is very clear.

Rachel Hopkins: Thanks.

Q48 **Edward Timpson:** Chief Coroner, you have set out very clearly your concerns about what you call the historical hangover of this triangle of responsibility and what you have tried to do to remedy it on your tour—with some success, it sounds. Is there anything else that you think could be done to try to accelerate some of that reform through the Ministry of Justice, other Government Departments or local authority bodies that currently exist like Solace, the chief executives one, to try to ensure that the learning that has already developed from those that have done it could be spread more quickly and more consistently?

His Honour Judge Teague: It is possible through organisations with which I do not necessarily have direct contact. The problem at the heart of it is that it requires consent. The negotiations can be very protracted. Money is involved. If coroner's officers are being transferred from the employment of the police to the local authority, who will pay in the short term? Will there be some special arrangement?

I have discussed this at the annual conference that I hold for local authorities, and recently for the first time I have started inviting police

force representatives precisely to get this message across. It has not been done before. We did not have as good a take-up last year as I should have liked, but I hope that this year's March conference will see more senior police representatives attending.

I am not sure anything else can be done because it requires quite complicated negotiations. Anything to publicise the merits of the process, of getting rid of the triangle, is a good thing. In the early stages of my tour, I encountered teams of coroner's officers who were about to undergo the process of transfer to local authority employment and were apprehensive about it and quite resistant. As the tour progressed and I encouraged more of those arrangements to be abandoned and to move people over to the local authority, I encountered more cases of local authority employees who had been police employees enthusiastically embracing it.

By the end of the tour, in one area that I visited, as soon as I entered a room full of coroner's officers, they said, "Can't you get us transferred across to the local authority?" So the resistance from people on the ground has pretty much gone. Some police forces would probably be quite attracted by the idea of jettisoning a responsibility that they may see as interfering with other more important responsibilities. It is a very complex process in each individual case. That is the difficulty. I do not know whether that answers your question.

Q49 **Edward Timpson:** That is very helpful. When it comes to recruitment, it seems to me that there is quite a convoluted way of trying to ensure you have the numbers and experience of coroners you need in each of the 80 local areas that exist. You alluded earlier in an answer to the suggestion of you having, essentially, lots of mini-Judicial Appointment Commissions.

His Honour Judge Teague: Yes.

Q50 **Edward Timpson:** Looking at it as a potential national service in the future, would part of that be that the recruitment of coroners could be the responsibility of the Judicial Appointments Commission? How would that help you with recruitment, retention and experience?

His Honour Judge Teague: There would be practical difficulties, I anticipate, with involving the Judicial Appointments Commission, because that uses judges who are already working and they are needed in their own jurisdictions. I suspect that we have to find another way. We need more judicial involvement in the process of appointments, maybe from retired judges, so not necessarily through the Judicial Appointments Commission.

I think it can be done under the existing system. My view is that, although it is the local authority that appoints a coroner, it is the elected members, strictly speaking, who make the appointment, and therefore when there is an interview panel, which sometimes incorporates an elected member but usually does not, they are making a recommendation

to the elected members. I can see no principled objection to such a panel including an outsider in the form of an experienced judge or retired judge to help in the advising process. It takes nothing away from the right of the authority to make the appointment.

Q51 **Edward Timpson:** Another aspect of the service and making sure that coroners have the skills and knowledge they need to do the job and fulfil all the criteria that are required will simply be through dealing with inquests and gaining experience on the job, but there have also been suggestions around performance management and looking at appraisals of coroners. First of all, do you think that is appropriate, and, secondly, if there is a case for it, what is the best way of achieving it?

His Honour Judge Teague: As long as it does not impinge on traditional independence, it is appropriate. We have a system of appraisals for assistant coroners. I would very much like to have a system of appraisals for more senior coroners, but we just do not have the resources to run it. The important thing is that the appraisal is the appraisal of how they do their work, not their decisions, because anything else, of course, would involve usurping the function of a proper appellate court, which is the body that has responsibility for judging traditional decisions.

Her Honour Judge Durran: Mr Winter and I do a very large amount of the reviewing of the local authority selection process for interview. We also review and very often draft the questions that are asked at interview. The Chief Coroner has said that we have overseen more than 65 competitions for assistant coroners. Very often, there are more than 100 applications for maybe two or three positions, and the calibre of the applicants is extremely high. People want to do this job and they are very able. That is an encouraging part of it.

Newly appointed assistant coroners undergo a four-day induction course delivered through the auspices of the Judicial College, and that gives them a very good grounding. You are right that there is an appraisal system for assistant coroners. Not only have I sat as a circuit judge but I have also sat within that time as a tribunal judge in the first-tier tribunal for mental health, and it has appraisals for tribunal members. It is a very valuable way of helping people to improve their overall performance. It is not about criticism; it is about encouragement. To a degree it has been delayed a little bit by the pandemic, but it has a place already within the coroner service that is appreciated.

Mr Winter was involved with a pilot programme in relation to appraising senior coroners. It should be seen as improving their skills and not their decision making. Some of the decision making is catered for in other training delivered in the Judicial College, so we are not ignoring the fact that coroners may need help in training not only in the way to make decisions but more often in how to express their decisions. The appraisal part is there, albeit it was one of those things that I am afraid has slightly taken a back seat as a result of the pandemic. The positive side of recruitment is that a lot of very capable people want to do it.

Q52 **Edward Timpson:** That is good to hear. Finally, looking at the infrastructure around coroners, something you would find in other services is an inspectorate, which does not happen for coroners, and there may be good reasons for that, historical and otherwise, but there have been calls for it. It was slightly before my time on the Committee, but that may have been one of the recommendations that was made.

Chair: It was.

Edward Timpson: Is that something that you think could be helpful? Obviously, it would depend on the powers and the remit of an inspectorate, but is that something that you could see in a national system?

His Honour Judge Teague: Not necessarily in a national system. In the absence of a national system, it could be very useful, always subject to the proviso that it must not trespass on judicial independence. It was an inspectorate that would deal with the administration, financing, management and so on of coroner areas. In the absence of a national system, it could perhaps provide, incidentally, some of the advantages that are missing from the system that we have. I would have thought that with a national system operated under something like HMCTS the need for it would be less. It must in the end be a matter for policymakers, but the answer to your question is that, in the absence of a national system, I can see advantages in an inspectorate, certainly.

Q53 **Edward Timpson:** Is that something that others would echo? From a practical point of view, knowing the workload of coroners, how much of that feedback would be helpful in ensuring that they work effectively and efficiently as possible?

Derek Winter: It has some really good advantages. Some coroners have called on coroner colleagues from another part of the country to go and give them some advice about their infrastructure and to make improvements. There is an informal network already in place, but a formal inspectorate could make inquiries and bring a good objective overview about a coroner area. If they are lacking accommodation and they need two courts but they only have one, that would be very influential on a funding local authority. All of the gaps in service provision could be identified by somebody who is independent, and then that could be taken forward. There would be clear advantages as long as they did not stray into the performance management of the coroner's judicial function.

Edward Timpson: It will all involve funding, of course. Thank you.

Q54 **Chair:** Looking at some of those delays, if I might come back to that, to which you referred, Judge, you are obviously concerned about the current delays with inquests. We talked about the explanations; we have dealt with that. Apart from funding, are there other obvious solutions, as Mr Winter suggested, going to those cases where perhaps—

His Honour Judge Teague: That will come. From April, as soon as we have the new medical examiner system fully rolled out, we should find that the numbers of cases will go down significantly—as Mr Winter said, in the tens of thousands. The complexity of cases may increase, and that would be a sign that the system is working. Medical examiners would detect cases that are quite complex and that are presently perhaps being missed.

Many of the causes of delay are outside the control of coroners, though not all. We know that some action is being taken to address the shortage of pathologists. It is a long-term project, but, after much urging by me and other senior leadership judges, an official-level interdepartmental steering group is now trying to solve this problem. That, I hope, will come in due course.

There are, however, other difficulties such as disclosure problems, often in the hands of large organisations, which are not efficient at making disclosure, again to a large extent outside the control of coroners. Within the control of coroners, I come back to robust case management. We have to do our part. We cannot be complicit, even unwittingly, in the marginalisation of bereaved families by allowing large organisations or others to take over the conduct of the investigation. I come back to the importance of respecting the inquisitorial process and ethos, and making sure that the coroner always retains control and robustly exercises that control to exclude what is not relevant and to drive each investigation forward to a rapid conclusion.

Judge Durran referred to this a few moments ago. I echo what she said about the next generation of assistant coroners. They will be the area and senior coroners of the future. We have excellent senior coroners now. The majority of them are very good. Some are so good that they could hold their own at any level in the judiciary. But many of them grew up under the pre-reform system, and there are some—a small number—who still perhaps retain an element of the pre-reform culture.

We will have a more consistently high standard in the future. The new assistants are of very high quality, as Judge Durran said. They have grown up, largely if not entirely, under the reform system, and I have high hopes for them.

Derek Winter: There was a recent Court of Appeal decision which united everybody that the inquest is a relatively summary inquisitorial process. We need to rein that back in with good case management, as the judge has said, because delay means the families do not learn the facts for a long time, they cannot get their death certificate, and it delays the delivery of a prevention of future death report. There are three outcomes from delay.

Q55 **Chair:** You have mentioned pathologists. You are satisfied with the approach that is being taken there.

His Honour Judge Teague: Ministers at the Ministry of Justice are clearly taking the problem seriously. It will take a long time. There are many factors involved in the problem and it will take time, but it is being addressed.

Chair: Mr Ali, I think you wanted to come in on medical examiners.

Q56 **Tahir Ali:** Yes; you mentioned medical examiners earlier. I think they are due to come into play in April this year.

His Honour Judge Teague: From April.

Q57 **Tahir Ali:** From April. Can you explain how the new system of medical examiners will interact with the coroner service?

His Honour Judge Teague: Yes. I shall hand over again to Mr Winter in a moment for the detail on this because of his experience running an area. The net result should be that all deaths receive scrutiny, and the public will have that confidence that all deaths will receive scrutiny. A high-level summary is that natural deaths, putting it very broadly, will be scrutinised by medical examiners, and unnatural deaths—the deaths that have to be investigated by coroners—will continue to be investigated by coroners. That is the broad effect of it. I hope that answers your question.

We already have the medical examiner system in hospitals and other institutions. It still has to be finally rolled out in the community. I have regular contact with the national medical examiner. We get on very well and we collaborate closely. About two years ago, we organised joint training between coroners and medical examiners to make sure that the system got off to a smooth start as far as possible. That training, I have to say, was very successful and we had extremely good feedback from both sides.

My experience is that the system is working well. I am not saying that there aren't any problems here and there, but broadly speaking it is working, and I expect that it will work well. It will have the effect of reducing the number of referrals and getting rid of those natural deaths that should not be coming to coroners. I have to warn that of the remaining cases we may well find that there are more complex cases coming through. That is as it should be.

Q58 **Tahir Ali:** Has any work been done on the impact that the introduction of medical examiners will have on the coroner service?

His Honour Judge Teague: We are preparing for it, yes. We have to anticipate what the effect will be. The preparation has been the joint training that we have undertaken, and, as I say, that is very good. At very regular intervals I meet Dr Alan Fletcher, the national medical examiner, and we try to iron out any problems as they arise.

Derek Winter: On the ground, there is a lot of activity between the Department of Health and Social Care, the Chief Coroner's office and the Ministry of Justice to try to get the final part of the statutory scheme ready. Yesterday we talked to the IT providers about the new system and how the new workflows would work in practice. It is all well and good written down in a statutory instrument, but you need to work through those workflows and have the impact of the new forms. There are meetings tomorrow to try to get this ready, because it will be of benefit to everybody.

The medical examiner system will scrutinise every death certificate. They will speak to every family. They will check the wording on the certificate. They will look at the medical records. If everything stacks up, the death can be registered without reference to the coroner.

Q59 **Tahir Ali:** As long as it is not Fujitsu or Oracle!

Derek Winter: There are two different providers in the world of coroners.

Chair: Let's not go there.

Her Honour Judge Durran: The Chief Coroner has said that we are already working with the medical examiner system that is in place in hospitals. If you are looking for evidence that it will bring the coroner service more complex cases, one of the roles that the Chief Coroner performs is where someone has died and their body has been cremated because it was thought it was a natural death, but subsequently there has been an investigation in the hospital or something has come up at some later stage and the Chief Coroner has to make a determination as to whether or not a coroner should investigate where there is no body.

Very often we see requests coming in from coroners saying, "This case has come to us. The medical examiner in our hospital has drawn this case to our attention because it seems there have been failings in care. Will you allow us to open this case?" It is anecdotal because I deal with a lot of them. I have seen a very large volume in the last 18 months of cases where coroners are saying, "This was signed off as a natural death and now we are being asked." Because the medical examiner has been prompted by families who have felt that the care was not what they expected and it has turned out that there have been inadequacies, we have directed coroners to investigate. It is bringing more cases into the system and they are inevitably more complex.

Q60 **Chair:** Thanks very much. There are a few other topics we will try to deal with, if we may. At the moment, the only routes of appeal against the decision of a coroner are either an application under section 13 of the 1998 Act or a judicial review on the standard JR grounds of procedural Wednesbury reasonableness, are they not? Is there merit in looking again perhaps at the proposal of section 40 of the 2009 Act, which was never brought into force—the idea of a direct route of appeal to the Chief

Coroner?

His Honour Judge Teague: It was never brought into force, and it has now, I think, been for appeal. This is a huge topic. If you confine it to section 40, I share the view of my predecessor that it would be very expensive. Because the Chief Coroner would be the person who would be hearing appeals, I also take the view that it might alter the nature of the relationship between the Chief Coroner and the coroner service at large because he or she would be seen as a potential overturner of decisions.

Looking at it more broadly—and I have to preface this by making it clear that I am not trying to discourage people from challenging decisions of coroners—I do not support the idea of appeals as such. Appeals are appropriate in adversarial jurisdictions where one party appeals and the other responds. You have an aggrieved party. You can have people aggrieved by a decision of the coroner, but you have to decide who is going to be the respondent. Should it be other interested persons, and, if so, which ones? It may be that the person who is most pleased with the decision being challenged did not actually argue for it. Why should they be put to the expense of resisting the appeal?

If there is to be an expansion of challenges and the basis for challenging the decisions of coroners, it should be done analogously with, or as part of, the judicial review route. In other words, it should be a challenge brought to a court to which, effectively, the coroner would respond. The coroner responds to judicial review proceedings and remains neutral, usually. I do not think it is appropriate to have an appeal system as such. I do not think it is just terminology. As the courts have repeatedly said, there are no parties to an inquest.

It is a matter of policy for Government and Parliament to decide, but, finally, if you were to decide that you wanted to expand the route of challenge, and in principle there is no reason why it should not be done, it is worth bearing in mind that coroners take umpteen judicial decisions day in, day out, and once you open that door the cost and the resultant delay are likely to be colossal. It would effectively alter the nature of the coroner service. I am not saying it cannot be done, but if it is to be introduced it has to be properly funded, and there would have to be, I would have thought, a considerable expansion of staff and coroners to enable work to be got on with quickly with a steady stream of challenges—I will put it that way rather than "appeals"—whether it be to me or to another court, or to the High Court in the background. Every time there was such a challenge, you would have to await its outcome.

This is meant to be a summary process. As Mr Winter reminded us earlier, it has been described by Lord Burnett quite recently as a relatively summary process. That is how Parliament has set it up. Parliament can change that. The addition of a significant additional route to challenge decisions will have the effect of very drastically changing the nature of the service. That is the only warning I want to give. I do not express a view about it, but it has to be appreciated that if that is

introduced it will import delay, it will increase cost very considerably, and we have to be prepared for that.

There are, on the other hand, potential merits in retaining the summary process that we have. It is not meant to be an exhaustive investigation; it is meant to be a sufficient investigation. It is meant to get to a quick result. It is because of its occasional failure to do that that I get very concerned about delays. I think that speed is possibly the single most important thing in the context of inquests. They should not be exhaustive. In the nature of things, they have to be concluded quickly. That is why I find the delays we now face so frustrating, I have to say.

Q61 **Chair:** Can I put this to you, though? The suggestion is sometimes made that, precisely because it is not a national service, because it has that triangle of accountability and there is variability, an understandable frustration is frequently felt by families or other interested parties in that there is a sense of a lack of accountability when things go wrong, which is the minority of cases—and a marked minority. When that happens, they can be sensitive either for the reasons that Mr Ali referred to or because of some public interest where there are large numbers of fatalities or specific, individual cases. Judicial review, or a section 13 application, is quite a cumbersome and expensive route for them to go down. Is there some means whereby we could perhaps find a more proportionate approach without going down the section 40 route for the reasons that you mentioned?

His Honour Judge Teague: It might be possible to devise something analogous to judicial review but in some way streamlined that would not require such a cumbersome leave process. I understand the frustration. There is one answer to the frustration that people feel of a lack of accountability. Part of it stems from inconsistency of practice.

Chair: Absolutely.

His Honour Judge Teague: If we can get rid of that inconsistency, that will reduce some of the pressure for more appeals, but you would have to define it very carefully. It would in practice have to be limited to a particular type of decision, because there are so many strictly judicial decisions taken on paper very often day in, day out, and if they were all potentially subject to challenge, even under a streamlined system, it could be done but the resourcing implications are huge.

Chair: Understood. Okay.

Q62 **Edward Timpson:** Throughout today's evidence and in your written evidence, which you very kindly provided for the Committee, have been the reports to prevent future deaths, whose purpose can be misunderstood and what the role of the coroner is and is not within that context. Could any of you who wish to do so just say a little more about exactly what it is the report is there to do and how you as coroners go about ensuring it fulfils the responsibilities that you have around public

safety?

His Honour Judge Teague: Can I start and then perhaps invite my colleagues to address particularly that last part of the question about how you go about applying it in practice? The ability to make a report for the prevention of future deaths is an important part of the coroner's jurisdiction, but it is ancillary; it is not the mainspring, to use a phrase used in a judgment in 1996. In keeping with the nature of inquest proceedings, it is deliberately a summary type of power.

It was at one time a power; it is now a duty, as you know. Essentially, if you have a criminal investigation and that gives rise to a concern that there is a risk of circumstances that could lead to future deaths or there is a risk of future deaths continuing, and the coroner is of the opinion that further action should be taken, the coroner is under a duty to issue a report or to report the matter. However, in reporting the matter, what is really happening is that the coroner is alerting the person who may have power to do something about it to the existence of the problem.

We sometimes hear reference to recommendations. I am afraid that the reporting media do not always get this right. This raises expectations in the minds of the public, understandably, but there is no power to make recommendations. The coroner has no power in statute to do so. The coroner has no power to follow up a report. There is an obligation on the recipient of the report to respond within 56 days; many do not. All the coroner can do is write a polite letter saying, "You haven't responded. Do you want an extension of time?", because that is the only power the coroner has once the report has been issued.

That in a sense is as it should be. I am not advocating a situation in which nobody can monitor the outcome of these reports, but it certainly is not the role of a judge to do so. Coroners are judges; they are not regulators. They cannot prescribe solutions, as has been said repeatedly in case law and by senior judges in other contexts. If you were to ask coroners to make specific recommendations, they would then have to make much more specific inquiries into the likely remedial action and how it should be carried out and so on and so forth, and that would again have the effect of lengthening the process and making it less summary than it is. It is an ancillary, important but summary part of the jurisdiction.

Derek Winter: Those are valid points. At an inquest hearing, sometimes the concerns have been addressed, and then there is no need to write the report. The disappointment for coroners is sometimes the inadequacy of a reply or platitudes, and then we are not able to follow that through because we do not have power to do that and we do not want to get drawn into that satellite litigation.

We have to be careful that we do our job. Having heard the inquest, the Chief Coroner will collate the prevention of future death reports on the website and the replies. They are in a searchable format now for all to

see. It is open justice; it is transparent. We have made reference to the fact that some redactions are requested sometimes by families about sensitive information, and we are sympathetic to that, but ultimately it is for others to make the thematic analysis of what is going on. We have some thoughts in the Chief Coroner's office about how we might be able to develop that.

At training, we have covered prevention of future death reports with all levels of coroners—senior, area and assistant coroners. We have had Dr Georgia Richards from Oxford University come along. She has a prevention of future deaths tracker searchable tool where she has done a deeper analysis of PFDs, and that is really good because, in my view, they are a force for good whether they are a topic of national importance or a local matter. Families, when they come along to an inquest, will say to me and many other coroners, "We don't want this to happen to another family." They are not driven by malice or compensation. In my experience, that is what families are saying. If coroners are concerned, that report will be written, and that, as I say, can be a force for good.

His Honour Judge Teague: It should be understood that a report for the prevention of future deaths is not a badge of dishonour. It is disappointing to find organisations that think they may be on the receiving end of one taking the view that it is and seeking to litigate their way out of it. It is in the public interest that these reports should be made, and the recipient, frankly, should welcome them.

Q63 **Edward Timpson:** What struck me was the fairly close correlation of this exercise through PFDs to what used to be called serious case reviews for a child death or a child being seriously harmed, practice reviews—I have mentioned my chairing of the national body that was set up a number of years ago—and particularly the thematic element of it and trying to collate a number of these reviews together to spot any patterns and any issues within practice or process across different organisations.

Do you think there is potential for PFDs to build on the publications that were going on, the analysis that is being made and the academic work from Dr Georgia Richards and others, so that they provide even richer information for organisations that will enable them to be better in the future when it comes to public safety around issues that have been noted by the coroners through their own work?

His Honour Judge Teague: I would say two things about this. The first is that I would like—and I am planning to do so—to issue summaries from time to time that would draw attention to particular themes. We are starting work on the first now. I do not want to stray again into matters of policy, but there is a gap when it comes to what happens after the issue of a PFD. At the moment, it goes on the website, as Mr Winter has correctly pointed out, for the last 12 or 13 months. It has now been in a properly searchable format, which is very helpful for researchers.

Dr Georgia Richards, with whom we work closely, is doing wonderful work. There is no doubt that there is a gap in what happens if somebody does not respond or puts in an inadequate response. How that gap is to be filled or if it is to be filled is not for me; it is for Parliament or the Government to decide, but others have pointed to it and it undoubtedly exists.

Her Honour Judge Durran: It is also important to note that, if you are going to produce a thematic report identifying issues, that may involve an expertise greater than we currently possess in our office. It is very easy to make superficial assessments. Not long after I became Deputy Chief Coroner, I was asked to speak at a conference set up by the ministerial board on deaths in custody. I did that job of looking at the Chief Coroner's website for prevention of future death reports relating to deaths in custody.

It is very easy to say, "We see certain problems time and time again." As we have talked about already, there are delays and some inquests may have taken many years to come to the coroner reaching their conclusions, and that may skew some of the information. It is the difference between private prisons and His Majesty's Prisons. It is very easy to say, "The problem seems to be this," but I do not think we have the expertise necessarily to draw those threads together to say, "This is what the problem is."

One has to exercise a degree of caution in saying that we can properly conduct a thematic analysis of reports across a myriad of sectors, because it is not just deaths in custody; it may be deaths in care homes or in mental health institutions; it could be hospitals. What I am saying is that I am not sure we have either the expertise or, I regret to say, the resources to undertake what is undoubtedly an important exercise. I am not quite sure that as currently comprised we are necessarily up to the task of producing a report that will have the benefits that you identify.

His Honour Judge Teague: That is why I referred to them as summaries. What I will be producing, I hope, is a summary. It cannot be more than that. One also has to caution against thinking that anybody can necessarily extract much more information than is currently being extracted from prevention of future death reports for precisely the reasons I have given. They draw attention to a problem; they do not offer solutions; they are often not responded to. It would be most unwise for any researcher to regard them as a reliable source of statistically useful information. They are not always consistently issued. It is a very crude system. I do not mean that in a critical way. It is a very rough-and-ready way of enabling a summary jurisdiction to perform a useful additional function. It flags up problems, and there is a limit to what you can extract from that.

Q64 **Edward Timpson:** Do you think the inconsistency is potentially holding some of this back? Only 58% of coroners have written a PFD and one

third of all PFDs are written by just 30 coroners, so there is quite a huge dichotomy across the system. Is that something that we should be concerned about?

His Honour Judge Teague: I do not think we can be complacent about it. We can only partially explain it. One has to remember, of course, that there are huge differences between local areas. If you do not have a prison or a teaching hospital in a coroner area, you will not be issuing in that particular area prevention of future death reports. There are huge areas.

The other thing that has to be borne in mind, as the High Court made clear in the case of Dillon not very long ago, is that there is a subjective element in the test for the duty arising. It is very easy to say, "Well, there is a duty to issue a report," but the duty depends on the existence of a concern that can be the subject of a difference of opinion. More than that, it depends on the opinion of the coroner as to whether action is necessary. The court made it clear that it would be possible for two different coroners on very similar facts to reach different conclusions about whether it was necessary to issue a report, without either being wrong. At the same time, there are huge inconsistencies and it concerns me.

I would caution against any assumption that the more prevention of future deaths reports that are issued the better. It may be that the best areas are those that are producing a manageable number. If you have an area that is producing a huge number, you would have to ask whether the duty is arising that often. It is a matter of concern if coroners are never issuing them. That would need some investigation.

It is not something we can do. It is a rough-and-ready system. My private office has the very limited resources I have mentioned. It is completely impossible for us to conduct some kind of investigation into this and work out what is going on and what should be done about it, I am afraid.

Derek Winter: We covered it at continuation training for coroners in the last year and we will revisit PFDs next year. Chief Coroner guidance is being revised, and coroners have to use a template report so that everybody should be able to identify what the concerns are without having to read through a morass of paperwork. We are trying to concentrate the minds of coroners on producing meaningful reports so that everybody understands what they are saying, and hopefully the replies will address those. Very often they do not, if we get them at all.

Her Honour Judge Durran: You have made the point from your background and your experience that, if there has been a serious case review and there has been an investigation, it may well be that by the time the coroner hears the inquest into that they have heard evidence of what has been done as a result and that therefore they are not going to issue a prevention of future death report because, in fact, the issue has

been addressed. It may be that as a result of the inquest taking its time to reach its conclusions the issues that were a proper cause for concern have, in fact, been addressed by the point at which the inquest has been concluded, so there is no need for a prevention of future death report. Very often, that is what we hear from coroners. They say, "There wasn't a need to issue a report because I was satisfied that it had been addressed." One should not always be looking for a report. It may be a sign of something that has worked well that there has not needed to be a report, ultimately.

Q65 **Edward Timpson:** That is certainly the case, I found, in other similar fora. It is more nuanced than perhaps it first looks.

Finally, if I may, Chair, you may also be familiar with the charity INQUEST, which has been advocating a national oversight mechanism. Is that something that you think would potentially be helpful, and, if so, in what way?

His Honour Judge Teague: I have already referred to the gap. I work closely with Deborah Coles, who has been helping to deliver training to coroners on this very topic in relation principally to prison deaths this year. What should be done about the gap is a matter of policy, and I do not think I should express an opinion. I will say this. INQUEST has correctly identified an important lacuna, and at the moment it seems to me that nobody is in a position to exercise some kind of consistent oversight of not just PFDs but also recommendations made by other bodies.

The final point I would make is that, whatever mechanism is devised for meeting or closing the gap, it ought not to involve coroners doing it because it is not the function of a judge to regulate. They make the report and that is it. It must be for others to fill the gap. I agree that a problem exists.

Q66 **Chair:** Thank you very much. You have referred, Judge Teague, to the number of interventions that you have made using your powers of persuasion, if I can put it that way, as well as your superhuman efforts to get around the country. Given that, so far, the Government do not seem to be minded to move on a national service, and taking on board some of the things that are being done about training, better practice and so on, are there other powers that you think you need to carry out your functions, or do you have adequate powers?

His Honour Judge Teague: Given the system that we have, I have the powers that I need. I have wondered whether there should be an ability for the Chief Coroner to make procedural rules similar to the powers that exist for other leadership judges, but my view is that Parliament probably declined to confer that power for the very reason that it is one thing for a leadership judge whose jurisdiction forms part of the national judiciary and comes under the Courts and Tribunals Service to have a power to make procedural rules because the apparatus exists to disseminate them

to make sure that everybody is prepared for them and to apply them. When you are dealing, as we are, with 80 different governance structures, it is very difficult to see in reality how useful a power to make procedural rules would be. It is one thing to say, "Everybody must do this or everybody must do that," but if they all have completely different working methods the reality is that it would be a nightmare. My provisional view is that I probably have the powers that I need as things stand.

Q67 **Chair:** Do your deputies have anything to add to that?

Derek Winter: I would agree with that.

Q68 **Chair:** We will take that as consent, then. Finally, Judge, you told us earlier that you are coming to the end of your term as Chief Coroner. I want to thank you on behalf of the Committee and Parliament as a whole, and the public as a whole, for your service in that role, and in particular the commitment that you showed in making that tour of a service that is often undervalued and underappreciated. We are very grateful to you.

His Honour Judge Teague: Thank you very much. I am not going to delay the Committee, but I will just say this. The coroner service has been described as a forgotten service more than once. The very title of this Committee's investigation as a follow-up investigation to one that took place three years ago shows that this Committee has not forgotten us. The bereaved families of England and Wales and the coroners, coroner's officers and staff of England and Wales and the public should be grateful to this Committee for that.

Q69 **Chair:** You are very kind. Are you going to continue on the bench?

His Honour Judge Teague: I have a statutory inquiry to finish, but after that I am going to retire.

Q70 **Chair:** Okay. We wish you the very best for the future.

His Honour Judge Teague: Thank you very much indeed. Thank you for listening to us.

Chair: Indeed. Thank you too to both the deputies for your time and evidence today. The session is concluded.