HOUSE OF COMMONS

Justice Committee

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

Tuesday 20 February 2024

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Watch the meeting

Members present: Sir Robert Neill (Chair); Tahir Ali; Rachel Hopkins; Edward Timpson; Karl Turner.

Questions 71 - 117

Witnesses

I: Deborah Coles, Director, INQUEST; and Dr Georgia Richards, Teaching Fellow in Evidence-based Medicine, Oxford University.

II: Roey Burdon OBE, Founder and Board of Trustees Hon. Secretary, Coroners Courts Support Service; and Angela Geer, CEO, Coroners Courts Support Service.

Written evidence from witnesses:

Inquest (TCS0039)

The Coroner's Court Support Service (TCS0056)

Dr Georgia Richards (Centre for Evidence-Based Medicine) (TCS0058)

Examination of witnesses

Witnesses: Deborah Coles and Dr Richards.

Chair: Welcome to this session of the Justice Committee and welcome to our witnesses. We have two panels today and are continuing our inquiry into the coroner service, which is a follow-up to our previous report. We just have to deal with formal declarations of interest, as we do at every session. I am a non-practising barrister and a former consultant to a law firm.

Edward Timpson: I am a barrister with a current practising certificate, but not currently undertaking any direct court work. I am a former Solicitor General, former chair of CAFCASS, and former chair of the national Child Safeguarding Practice Review Panel, and my brother is chair of the Prison Reform Trust.

Q71 **Chair:** Can I ask our two witnesses to introduce themselves and their organisation for the record?

Dr Richards: I am Dr Georgia Richards. I am a research fellow at the University of Oxford, where I teach in the medical school. I am also the founder of the preventable deaths tracker.

Deborah Coles: I am Deborah Coles, the director of the charity INQUEST, and formerly a member of the Independent Advisory Panel on Deaths in Custody.

Q72 **Chair:** Thank you both very much for coming to help us today. We are grateful for the written evidence, which we have taken on board.

There are a lot of aspects to the inquiry, but today we will concentrate particularly on prevention of future death notices, or PFDs. We have seen from the evidence that both your organisations have provided that there is quite a bit of variation in the use of the notices between coronial areas; indeed, more than that, there seems to be a difference of approach between individual coroners. What is your take, as practitioners in the field, on how useful they are? Do you think they contribute to the prevention of future deaths? It is not always easy to measure.

Deborah Coles: I really welcome the Committee's attention to this, because, for us, it is an important area. PFDs have a public interest importance, because they can inform improvements to public health and safety. INQUEST has tried, particularly through facilitating legal representation for families at inquests, to maximise the preventive potential of these processes for bereaved people and for the public interest.

We have seen that coroner's reports to prevent deaths have been important in shining a light on systemic areas of concern in areas like deaths in state care and detention, as well as in other areas of public importance such as fire safety, terror attacks, NHS failings and university

student deaths. Some have translated into policy change and reviews. A very recent example, with which I am sure you are familiar, followed the inquest into the death of the headteacher Ruth Perry. The coroner recognised that the experience of the Ofsted inspection directly contributed to her death. The coroner presiding over her inquest made a PFD that resulted in the suspension of Ofsted inspections and a review of mental health training and support for inspectors. I particularly noted that the new Ofsted chief inspector described the PFD as an important moment for their organisation, and one that they will be taking seriously and responding to fully.

That is a positive example, but one of the challenges is the fact that it is difficult to see what impact the reports have on policy and practice. There is no oversight, monitoring or analysis of what action or, indeed, inaction has followed such reports and their implementation. There is an accountability gap. It is morally pretty reprehensible that, in our experience, bereaved families have had to be proactive in trying to see how organisations have responded to the reports.

Q73 **Chair:** And you would say that that is the problem with the system. You have identified its value—

Deborah Coles: Yes. There are a number of other problems.

Q74 **Chair:** What are the other issues?

Deborah Coles: Another issue concerns the approach, and inconsistences when coroners make prevention of future death reports. One problem area, on which your Committee has commented before, is inconsistency and a kind of postcode lottery in our system. Some coroners really embrace the preventive potential that a PFD report can bring. A similar death can occur and a coroner will decide not to make a PFD, because an organisation has told them that changes have been made. I raise that point because I think that one of the values of PFDs should be learning at national level, not just at local level. One of our concerns is that many organisations approach inquests as an exercise in reputation management and defending policies and procedures, even if those led to preventable deaths, and have been more concerned about avoiding PFDs than about recognising the value of the reports in learning, improvement and change.

One of the challenges is around the coronial approach. One reason for my mentioning that I am a former member of the advisory panel is that we were involved in a piece of research where we chaired meetings with coroners and other stakeholders. In the report that I believe they submitted in evidence, practice is shown to be inconsistent, both in coroners' use of the reports and in the problematic nature of responses and how they translate to meaningful action, and Georgia will speak to that issue.

Q75 **Chair:** Georgia, you are probably the only person who has produced any

significant data on this. Can you help us as to what drives the inconsistency? Have you found explanations for it?

Dr Richards: Yes, definitely. There are different types of variation; there is warranted variation, where we have explanations, and unwarranted variation, where what drives it is a little more nuanced. We have collected and collated nearly 5,000 PFD reports. We have run the preventable deaths tracker. As to our insights, and what the format of the reports enables us to say, ideally we would like that to be driven by mortality rates, inquest rates and how coroners practise, but we see a bit of randomness at the moment. We do not have concrete evidence to support what is driving the variation.

I can, if you want, touch on the initial question about the effectiveness and impact of PFDs. The bits of evidence that Deb was talking about relate to what we call low-quality evidence. Those are individual case reports. Our research has shown, with a big systematic case series of nearly 5,000 reports, that coroners repeatedly raise the same concerns. Similar deaths occur and nothing is being done about them. Our research shows that the concerns are repeated and the same deaths are occurring, and that there is no local or national approach to address them formally and systematically.

I am an epidemiologist, and we can design studies that could look at the effectiveness of PFDs. We could tell taxpayers, the Government and the public how many lives are saved through PFD reports, if resources were available for us to design the studies. We could tell you, "In 2023 we saved five lives"—or 100 lives—"through PFD reports." We just need the resources to design those studies and carry them out, so that we can give you the evidence and say, "This is what is driving variation and this is the effectiveness and impact of PFDs." I can talk more about that.

Q76 **Chair:** We can come back to that. The variation in whether or not there is a PFD seems rather random. What about the quality of the PFDs and their content and structure? Is there variation and can you discern any trends or underlying basis for it, or anything that points to a pattern?

Dr Richards: Yes. Unfortunately, the variation is driven by missing data. We have missing essential information, such as the age of the deceased and the year of death. The Chief Coroner, in his oral evidence, alluded to the fact that delays in the backlog of inquests are going to continue. It is important that we have clear data on when deaths occur, because regulations come into play and actions will be taken at different time points. To examine the effectiveness, we need good demographics—who the people are, their age when they passed away, and when the death occurred—so that we can think about what strategies have been used, and could be used in future, to prevent such deaths. Missing information is the most crucial thing that is driving the poor quality, but, of course, there are inconsistencies across 81 areas. The Chief Coroner has a template—

Q77 **Chair:** Yes, that's right. How often do they fit the template and how much of the time don't they?

Dr Richards: So-so; it is variable. There are some fantastic coroners who always use the most up-to-date template and report age and year of death, but, of course, it is not standardised across the country.

Q78 **Chair:** Do either of you generally find that it goes to the right people—the right organisation?

Deborah Coles: I think the short answer is no. There is a real problem. I will pick up on the demographics. Georgia makes an important point and I would extend it to look at the area around protected characteristics, where there is a real issue. The strength of the reports should be the ability to interrogate them and look at work that needs to be done on policy interventions. Another thing, which was picked up in the IAP research, is that you often see very generic cut-and-paste responses, which often repeat the very policies and procedures that failed to protect the life of the individual. You have to question the point of such ways of responding.

I acknowledge that overall a lot of coroners take the PFD function very seriously and share our frustration that the reports end up disappearing into the ether. I know that you had a session with bereaved families, but it is difficult to put across the psychological impact for families who have engaged in the processes and then learn of another death in similar circumstances. Their objective in going through the process is, of course, truth and accountability, but it is also to try to protect other lives. The frustration for INQUEST is seeing the pattern of deaths that Georgia alluded to being repeated with no meaningful change.

Q79 **Chair:** It is a lack of follow-up and enforcement, in a sense.

Deborah Coles: Yes.

Q80 **Chair:** Where would that best sit, do you think?

Deborah Coles: As you are probably aware from our submission, we have recommended that there should be an independent body for the oversight and follow-up of reports that come out of inquests and recommendations that come out of other investigations and inquiries into state-related deaths. We call that the national oversight mechanism. We see it as very much complementary to the preventable deaths tracker.

We consulted heavily on that mechanism because of the frustration at there being no proper oversight, as I said. There is nowhere one can go to find out what has been done in response to these reports. The independent public body would be tasked with collating, analysing and following up on the reports. It would ensure that there was a publicly available database. It would enable thematic analysis to be done, and reports to be made. We see it being accountable to a parliamentary Committee—potentially, yourselves or the Joint Committee on Human Rights—so that there would be an opportunity, in an annual report, to

bring together the learning that comes out of investigations and inquests. That is simply not being done by anybody at the moment; hence our frustration.

Q81 **Chair:** We'll follow that up in a minute. Georgia, from your perspective, should there be some form of sanction for organisations that do not respond or follow up? Is there any evidence to suggest that that would be helpful, or what form it might take?

Dr Richards: Yes, definitely. We need a national oversight mechanism, which is where Deb's work comes into place. There are examples of sanctions to look at in other areas and jurisdictions, particularly Australia. I am an Australian scientist and we have a big national coronial information system in Australia. There are other jurisdictions and evidence bases to draw on in relation to sanctions.

Q82 **Chair:** Do they have a sanction element in the Australian system? I know they have big databases.

Dr Richards: The Australian system doesn't have a sanction, purely because when an inquest is held in Australia the information feeds into the national database. Coroners in Australia write recommendations; in England and Wales, they just raise concerns. The recommendations go into the database so there is no PFD function to say action should be taken, but the database system is used by Government departments. It is actively used on the ground and change happens because of the wide access to the data. It is a different function, and it is a much nicer way.

Yes, we could implement sanctions. It would probably cost the Government a lot of money to do that. There are a lot of more cost-effective things we could do. Sanctions are certainly an option but the power of who makes those sanctions would be a little bit complicated, and it would be up to politicians to decide on that. There is evidence for probably lower-cost, more easy-win alternatives.

Chair: That is very helpful.

Q83 **Edward Timpson:** When you look online at the PFDs that are published—it started in 2013, I think, so we have seen some progress—you get, in most cases, a standardised read-out of some of the facts of the case where the coroner has identified something where public safety comes into play, and suggests what the body should do to rectify it. One of the most recent related to the East of England Ambulance Service and the end-of-shift policy, and how that got in the way of a timely response to a tragic accident. You spoke before about seeing the reports online and there being repetitive issues. Is that the sort of issue that you are seeing? What would you now expect, off the back of the report about the East of England Ambulance Service, to be done outside that service, so that, potentially, other ambulance services across the country could learn from what went wrong there?

Dr Richards: There are two parts to that. I cannot speak to specific cases, because I would need to read more about the specific inquest and the details of the case; but there are learnings directly about how when a particular death has occurred in a region the actions taken there could be applicable at national level. It is not necessarily for me, as an academic epidemiologist, to make those calls, but there could be a role in disseminating those potential lessons.

One part is the lessons—or the concerns raised—from the report itself that need a more national dissemination, because we don't know whether those issues are occurring in other local regions. The second learning aspect is what actually happens on the ground and what changes are implemented: could we learn from the responses that come from that? The local ambulance service might implement three new things: training, increasing staff and changes to how they code when people call 111. They might take three simple steps locally, but we do not know that that has happened. At a national scale all services could implement those three actions.

The lessons are twofold. If another region has the same death, there is no way for it to find the report swiftly and see what was written in the response, and what they did. They can't implement that. There is no way to share the information across the organisations. That is where the second aspect to do with responses comes in, with the need to detail what happens on the ground at national level.

Q84 **Edward Timpson:** Do you want to add anything, Deborah?

Deborah Coles: In our submission we talked about the frequency of prison deaths, for example, where the same issues come up time and again around the quality of the ACT process—the suicide prevention guideline process—the response to cell bells, or issues to do with healthcare. Time and again, the same issues come out in different reports and there is failure at national level to respond effectively. That is what is so frustrating.

We did a review as part of our evidence to you. Another growing concern for us is the non-self-inflicted deaths of people with learning disabilities or mental ill health who die following a choking incident. We are aware of 15 such cases since 2015, the issuing of nine PFD reports, and concerns about monitoring and management of risk. Yet people are still dying. That is the frustration, and that has informed the fact that we think there is a need for far greater analysis, dissemination and action in response to the reports.

Q85 **Edward Timpson:** That is interesting, because it is quite reminiscent of the debate that we had about 10 years ago, in relation to serious case reviews when there was a child death or a very serious incident involving a child. That led to the formation of the national Child Safeguarding Practice Review Panel and a repository where all the reports go to a group of experts in different fields, such as health, social care and the

police, as well as to trying to spot themes and provide off the back of that an authoritative practice report for everybody to learn from, not just those in the area where it happened. Do you think that that sort of arrangement—maybe not identical but certainly a way to try to pull together a lot of the knowledge and learning coming out of individual prevention of future death reports—would ensure that we do not lose what could be valuable in trying to save other lives in the future?

Deborah Coles: In essence, that is why we have recommended the oversight mechanism. We think it is vital to have that thematic analysis and learning. Prior to 2013, when the post of Chief Coroner started, the Ministry of Justice would produce what were called rule 43 bulletins. That was before the prevention of future death reports. The bulletins did some limited analysis, but they served a purpose. Since 2013, because of the problem with resources, the Chief Coroner's office has not been able to do any kind of analysis. He, and all the Chief Coroners I have spoken to, have recognised that their office cannot do that, so at the moment there is an accountability gap. As you rightly say, there are potentially lifesaving reports, and learnings from those reports, that are not being used in a way that could help to protect lives.

Q86 **Edward Timpson:** Do you think part of it is, first, the lack of knowledge around PFDs, but also the status they have when they are looked at or interpreted by the key organisations that could learn from them? You gave the example of the terrible death of the headteacher and the suspension of Ofsted inspections off the back of it. My summation of that is that there was a huge amount of media reporting, which is likely to have had a significant influence, probably more than the fact that the PFD existed. What can we do, or what could the Committee recommend, to try to improve the status and ability of any of the suggestions in PFDs—they are not called recommendations at the moment—so that they have the clout and follow-through that we need to justify their being written in the first place?

Dr Richards: If it is okay I will answer that, because it follows on from your initial question and the previous question where you gave the example of child deaths. I work in drug safety and particularly on opioids—strong pain medicines. In drug safety we have pharmacovigilance. Many of the people in this room will be taking medications. We have systems in place where we monitor on a daily basis the data that comes in on harms from medicines, and harms from many different interventions.

We could do the same. I am an epidemiologist with expertise in safety and pharmacovigilance, and we could design a simple, low-cost tool that could tell us of signals such as those you mentioned around child deaths. The approach needs to be data-driven. We have expertise in the UK, in the room, and we are already doing this in other fields and disciplines. It is about letting epidemiologists, academics and computer scientists who have the skills turn coronial information into data so that we can set up simple, easy-to-use systems like pharmacovigilance where we can detect

signals in data and say, "In this region we see a number of child deaths with this particular issue." It is exactly what happened during covid.

We have the skills and ability in the UK to do that. It is simple. We just need to make sure of the data. We don't know what is in PFD reports. The information is just not usable. That is why we created a tracker—to turn coronial information into useful data. We have the skills, and we can do these things. It is just getting information to be data.

Q87 **Edward Timpson:** I think I heard from your answer the reason why you set up the tracker, as well as your clear passion for the subject. What does the preventable deaths tracker website do—painstaking hours of effort, which I think have also been self-funded—from a practitioner's point of view, to access something that might be relevant to them in their practice, that the Chief Coroner's website is currently unable to do?

Dr Richards: At the moment, when a coroner writes a report, it is sent to the Chief Coroner's office and published as a PDF document online. Two changes have occurred since this Committee last met. One is to make it filterable, so it is a new website where you can search. Also, since January 2023 the full reports are now published on the website as free text so that you can search for specific types of death or for specific drugs; for example, you can type tramadol or opioids and see what cases come up.

It does not do what the tracker does. We provide statistics. Before the tracker we did not know how many PFDs had been published over the last 10 and a half years. We now know that the mean number is 460 PFDs being published every year. That is important to know, because, for example, during covid we saw a drop-off. No one was doing that, apart from the data that we provided. We are able to show which coroners and coronial areas are writing reports, so it gives an idea of geographical variation. We are also providing insight into responses—who is and is not responding—based on what information is published on the judicial website.

The final aspect, and probably the most important, which is what you are asking in terms of practitioners, is that we conduct lots of research. I am based at Oxford in an academic institution. Yes, we do research for a living, but our research is showing insights into different types of deaths. We have looked at self-inflicted deaths, opioids, falls, sepsis and cycling-related deaths, and the list goes on, with more than 25 research projects.

I will give an example with coroners of how the tool actually helps practitioners on the ground. Since December, I have been helping different coroners and coroner areas to see if their PFD reports are actually published on the website. You would think that might be a simple thing, but we found that many, many PFD reports, from 2015, 2016, even last year, were not published. I am able to identify information that is not there, responses that are not there and I have been working with

coroners to do that. Coroners are some of the practitioners that it can help.

Another aspect is that I get emails on a daily basis asking for data—even this morning. Last week, I got an email from the Scottish Government asking for data. I get data requests on a daily, weekly basis: "Georgia, could you please send me data on deaths involving elderly people who have suspected dementia who have had a car crash?" They are really specific data requests that I get on a daily basis. I physically cannot respond and provide the data on a daily basis, but I am the only person in the country who can provide it at the moment. It is crazy that that is the case.

Q88 **Edward Timpson:** Deborah.

Deborah Coles: Your question was whether there was one thing the Committee could recommend. Obviously, I would say that it would be to support the cause for an independent oversight body. Despite the best efforts of a lot of people and the Chief Coroner's office, the reality is that there is no proper oversight, follow-up and analysis. That is a real missed opportunity.

The system that we have at the moment is simply not fit for purpose. In Georgia's work and in the work of INQUEST, we have been in situations when we frequently remind coroners of similar reports that have been made into deaths across a wide range of areas—deaths in mental health settings and prisons, or deaths following police contact, by way of example. The reality is that, without proper collation, analysis and follow-up, I don't think those reports can have impact.

That also speaks a little bit to the culture and the fact that at the moment reports are simply not taken seriously. As I said earlier, there are some coroners who, in a properly conducted inquest, where a family can play a meaningful role, can perform an important function. A coroner will invest a lot of time and energy in writing a report only to see that if it gets a response it is lucky because, as Georgia's research shows, the responses are poor. The only other way that we know whether the report has been acted on is when there is another death. There is nothing worse than being in an organisation working with bereaved people to have another death occur that just mirrors the issues that came out of a previous death. That, to my mind, shows that the system is not working.

Q89 **Edward Timpson:** Thinking about the utility of the tracker, where it is at the moment and the potential, where it can go in the future, there are two aspects. One is what capacity and capability it has to improve its utility; for example, Deborah, it is what you were just saying about people's attitudes towards it, and seeing it as something they have to comply with to a certain level and then forget about, rather than seeing it as something to use to learn, develop and improve their practice.

If I was to sign up to the tracker and choose certain elements of my

practice—maybe I am an ambulance worker—I would want to know of any cases that come in relating to ambulance services, or health services more generally. Maybe I see particular types of people through my service and I want to know about certain injuries, something where I can tick boxes and then I would get alerts, telling me, "This case has been published which is relevant to your practice." Is that the sort of utility you would like to move on to?

Dr Richards: Yes, exactly. At the moment, it is being run by me. Yes, I am employed by Oxford to teach in the medical school but that doesn't cover anything that I do regarding the preventable deaths tracker. I self-fund the existence of that URL, the domain, the hosting, everything like that. What we need to fund is the dashboard that you are talking about. If people email me, "Georgia, can I have data on this specific request?", they can go on to the website, sign in and start putting in variables of interest. It might be ambulance officers or it might be road traffic accidents or whichever type of deaths. They can sign up for alerts and get notified of those deaths. Definitely, that is where we want to go.

We have examples in the department where I work. Ben Goldacre's team runs a trials tracker, which does something similar. They run open prescribing, which does something similar. I sit within a department in Oxford that has examples from other areas that inspired the tracker and could be built, but we need resources to build them. We need computer scientists and back-end developers, and we need to fund hosting, because we have to host the data. There are a few technical things that need to occur for it to get to that point, but that is definitely the direction where we want to go; we just don't have money to fund it.

Q90 **Edward Timpson:** Have you approached anyone, either in the public or private sector, to support the tracker and put it on a sustainable footing—the Ministry of Justice, for example?

Dr Richards: Yes, I have approached academic research grants, like the NIHR and the MPS Foundation. As an academic, we can apply for research grants. I haven't approached anyone in the private sector, but over the last three years, I have actively spoken to many, many, many public organisations, to the point that I am saying the same thing over and over again to NHS England, CQC, HSSIB. I could give you a list of all the different meetings I have had that have not led to anything.

I know the tracker has the potential to benefit many different Departments—the Department for Transport, the MOJ, Health, and lots of different health areas in the Department itself. It is a cross-cutting tool. It's not just healthcare, it's not just different sectors. It could actually benefit many different Departments. That is like the Australian system. It is funded by multiple different departments that actively use the data all the time, because they fund it and they find it useful, but we are not there yet.

Q91 **Rachel Hopkins:** We have heard a lot about your proposals for a

national oversight mechanism. I want to make sure that we do not forget the bereaved families. Many of them have told us that they don't want to see it happen again, and others to be affected by it. I wonder if you could elaborate a bit more about how a national oversight mechanism would support them.

Deborah Coles: Certainly. We consulted with families. INQUEST's work is directly with bereaved people. We see at first hand the impact of the system and the many problems with the existing inquest system. As I said previously, a properly conducted inquest can have important preventive potential and that is what families want; they want to see changes made.

The mechanism that we proposed, as I said, would be having a public body that would collate, analyse and follow up and make public what has actually happened to the reports and recommendations that come from post-death processes. It is important to say that PFDs are but one example. One thing we have not touched on is that, in the absence of coroners making PFDs, there is an issue, which I mentioned, about organisations trying to persuade coroners that change has already taken place. One thing Georgia and I have spoken about is the danger of losing the national learning that comes out of that. It may well be that somebody has said that they have addressed an issue at local level. First, there is no way of testing that, and, secondly, there could well be learning for, let's say, another mental health trust or a prison in a different area.

One of the things the national oversight mechanism would do is that it would have transparency and it would be accountable to bereaved people, so that there was somewhere they could go. What is really shocking at the moment is that rarely are bereaved families contacted by any organisation and told what changes are being put in place after a death. I find that astonishing when you think about some of the deaths we have worked on and the appalling failures identified, yet they have to chase down to try to find out what actually happened.

Families have fed back what they want from a process. Our view would be that there would be some kind of advisory board and a way for families to feed into the national oversight mechanism. The mechanism would be an important hub for a whole range of people to utilise. It could perform an important function for coroners and academics. As Georgia said, there are examples where that is being done.

INQUEST had a meeting a couple of years ago with the Domestic Abuse Commissioner, Nicole Jacobs, around the large number of deaths that were domestic homicides. They have recently set up a mechanism for monitoring the response to domestic homicide reviews, of which there are just over 400. They have been working with Manchester University but are also developing a system whereby they draw out the thematic issues and then follow up what has actually happened and how they have impacted at local and national level. It is interesting, and we will be

keeping a close eye on it. It is an example of what is possible and how we can best utilise the learning that comes from death.

At the end of the day, we are talking about people, and families losing loved ones in often preventable ways. The idea that we are not doing more as a society to make sure that changes and improvements are made to safeguard lives in the future, for me, raises important moral questions about the state of our democracy and the fact that we look to these systems, or families have to look to these systems, to get answers, yet they are not translating into change on the ground.

Q92 **Rachel Hopkins:** Reflecting on that, there are some regulatory bodies already that have oversight in certain areas, whether in healthcare or in policing. Do you have any thoughts on why they could not take on that role?

Deborah Coles: At the moment, we have a plethora of inspection, oversight and regulatory bodies. We have done the work of developing the national oversight mechanism proposal, and the follow-up on prevention of future death reports and the recommendations that come out of post-death inquiries are not within the remit of any of those organisations. We have discussed the proposal with quite a lot of them.

By way of example, the prisons inspectorate goes into prisons and sometimes follows up on the action plans that have come out of a death in prison, but that can be four years after a death has actually occurred. In their annual report, they very often point to the fact that prisons have just not followed through. We know the state of prisons in this country; but that is an aside.

It doesn't fall within anybody else's remit. To be honest, it is something that requires independent scrutiny and oversight, and can be used to assist all those organisations in their important work.

Q93 **Rachel Hopkins:** Georgia, you mentioned Australia earlier. Do you want to elaborate on other jurisdictions where any sort of national oversight mechanism has prevented further deaths? Is there anything you want to add?

Dr Richards: Sure. I will touch on the Australian system a little further, to give further insight, because it is not just an Australian system. It is international; it is an Australian and New Zealand system. Often when I talk about this, people in the UK say, "Well, it's not possible in the UK. Our population is three times the size." Australia has a state-based system like the US, and in each state there are different political parties. In 2000, 24 years ago, politicians from different parties sat down, agreed on a funding model, and agreed on a system and a structure to create the NCIS, the national coronial information service. The NCIS is a New Zealand and Australian-wide system, hosted by the state of Victoria but funded at an international level by those two different countries. That shows you that the UK is 24 years behind in terms of coronial data. There

is lots of evidence from Australia and New Zealand to support the huge impact that the NCIS database has had.

I have a bit of evidence here that I can provide to you that shows how it was started and how it is structured. There are advisory boards, and there is how the funding flows and who uses the database, because lots of different Government departments use the data. It has been a part of the system for 24 years and the UK can do the same. It would not take much to establish something like that, which is the reason that we created the tracker.

Q94 **Tahir Ali:** My question was going to be about which other countries you would look at in terms of taking a lead and how we can match up to them. You have answered that in part. Are there any other countries that you would direct us towards on setting standards for PFDs?

Dr Richards: Definitely, yes. There is a colleague in Australia, Hugh Dillon, who has just done a PhD on that. He has a whole chapter in his PhD that compares four different jurisdictions, Australia, New Zealand, the UK and Canada or one of the regions in Canada.

Chair: Yes, Canada.

Dr Richards: They don't have a national system but they have a state-based system. I would be delighted to share that chapter with you. I think Hugh submitted evidence to the Committee as well. There are definitely other jurisdictions to look to and I recommend that the Committee looks at how those systems function in other countries and what could be learned from them. I am very happy to share that chapter and Hugh would be happy to do the same.

Q95 **Tahir Ali:** At the last session, we heard some powerful statements from the families themselves. Making the change is almost a no-brainer. Is finance the barrier or is it bureaucracy, red tape, that is in the way?

Dr Richards: A bit of both. I will add another factor, which is data literacy. PFD reports are there; they are published, they are available. But no one is using that information except the tracker. The bit around families is that people and organisations respond, not always perfectly, but some organisations write good responses and they share what they have done. All that needs to happen is some small funding, because actually that information is sitting there and we can pull out the learnings from the responses and say, "This is what has been done to improve deaths in these regions."

I would add that to the list. Yes, we have funding limitations as well as potential political limitations, but we also have, in the small, small coroner service—it is a really small, very ancient service—the issue of data literacy. It is 2024 and we are still working on paper and still manually emailing things. The whole PFD system and the whole publication of PFDs is driven by emails, which means that data goes missing, reports go missing, responses go missing and we don't really

know what is going on. I would add data literacy. In order to fix that, we need an interdisciplinary team; we need to work with the coroner service, alongside computer scientists, epidemiologists and people who have the skills to analyse and pull out the data, which the tracker shows is possible.

Q96 **Chair:** Thank you very much. That has been very helpful. Are there any other areas that you think our report should look at? We have talked about future deaths, and we have talked about the oversight mechanism. As you know, in the past, we have recommended that there should be a move to a national service.

Deborah Coles: Indeed.

Q97 **Chair:** There are things like pathologist availability and the treatment of bereaved families. Any other particular areas?

Deborah Coles: I will add a few. I know that our colleagues from the Coroners Courts Support Service are giving evidence after us, so I give a shout-out to them and the need for funding that.

Another thing I want to flag up is around the fact that we don't have a proper complaints and appeals process. There is the ongoing issue of non-means-tested public funding for deaths involving other state bodies. An issue that is causing us a lot of concern at the moment, and I alluded to it in my evidence, is the way in which organisations often approach inquests as reputation management. We see a culture of defensiveness at inquests, as well as a lack of candour and the culture of public bodies. One of the things that I would like to see is an enforceable duty of candour on the part of public officials and authorities, something you mentioned in your last report, and certainly the Government's response to the Bishop's review was very disappointing.

Chair: Bishop Jones's review.

Deborah Coles: The lack of honesty and openness that we see during inquest processes not only has a devastating impact on the families but undermines the opportunity for learning. I would definitely like to see that openness.

As a final point, perhaps to illustrate that in a little bit of detail, you will probably be aware that there is a public inquiry going on into the deaths of mental health in-patients in Essex. That started off as an independent review and it had to be converted to a public inquiry because of the lack of candour and the non-co-operation of staff. That to me, in a way, provides a very strong and compelling reason for candour.

Chair: Thanks. That is very helpful. Thank you both very much for your time. We are very grateful to you both. Thank you, Georgia, for volunteering to send that further information to us.

Let's move to our next team of witnesses. We are pushed for time

because there will be votes coming up shortly, so I want to get started.

Examination of witnesses

Witnesses: Roey Burden and Angela Geer.

Q98 **Chair:** Thank you both very much for coming to help us today. We are going to have votes at some point, so I want to get straight into the session as quickly as we can. For the record, can you introduce yourselves and your organisation?

Roey Burden: I am Roey Burden, founder trustee of the Coroners Courts Support Service.

Angela Geer: I am Angela Geer, chief executive of the Coroners Courts Support Service.

Q99 **Tahir Ali:** The Coroners Courts Support Service now operates in over half of all coroner areas. Can you describe the work of the volunteers, what training they receive and whether their work is valued by the families and the coroners courts themselves?

Angela Geer: Do you want to kick us off, Roey?

Roey Burden: Yes, you can talk about the training; we'll halve it. The volunteers are recruited by us to look after families and witnesses—in fact, anyone who attends a coroner's court for an inquest. They have a lot of training, which Angela will describe to you. They meet and greet people as they come in, take them to sit down somewhere and explain the layout of the court and the procedure of the inquest. They take the family into court and sit with them during the inquest, and if a member of the family becomes distressed and runs out, the volunteer will go with them, allowing the rest of the family to see the inquest. At the end of the inquest, the volunteer will sit down with the family, and see that they have all the necessary documentation and whether they need any help. Sometimes the family like to talk—sometimes they don't—and in that case the volunteer is there for them.

Q100 **Tahir Ali:** Are there limits to the support that can be offered, or do you deal with every family that comes in?

Roey Burden: We deal with every family.

Q101 **Tahir Ali:** Do you have volunteers with specialist knowledge, for example, for families with faith or religious needs?

Roey Burden: They are aware of it, but, unfortunately, although we have tried recruiting ethnic volunteers, it is incredibly difficult. We attended a mosque to talk to people, and we didn't get anywhere. When we were setting up in Bradford, we knew that it was a very ethnic population and we concentrated on them; we advertised in a magazine that went out to them specifically. We did everything we could, and we

have really tried, but I am afraid we just don't get them. It is not for lack of welcoming them.

Q102 **Tahir Ali:** I suppose it is about making the communities aware and seeing who would come forward.

Roey Burden: Yes. We really do our best on that, but it is incredibly difficult.

Q103 **Rachel Hopkins:** We know that you would like the CCSS to be available to all bereaved families across the country, not just in the areas you are already in. How would you like to make that happen? How do you think we need to make that happen?

Angela Geer: Clearly, it is our aspiration to be in all coroners courts across England and Wales. We are limited in doing that as a result of funding, which is the challenge for the most part. That aside, the work we do in the courts is valued and recognised by bereaved families and the coroners themselves. The work we do is not just the meet and greet stuff in the court but about supporting a family, whether the immediate or extended family, and helping them to come to terms with what has been a harrowing experience.

When we talk to bereaved families, they talk about being present at an inquest as the third worst day of their lives. The first worst day is the death of the loved one; the second is the funeral, the final goodbye; and the third is reliving everything from the moment of death—all the harrowing experiences, anxieties, fears and so on. We train our volunteers to take cognisance of all of that. It is about basic communication skills and having a depth of knowledge that allows them to signpost to other charities and organisations that can support post inquest.

Our training includes sensitivity to others' cultures and faith groups. As Roey said, it has been very difficult for us to harness the support of volunteers from some communities, and we have a lot of work to do there. That is part and parcel of our aspiration as we move forward. We want to move into other courts so that we are represented across the country. We want to be sure that we are representing the communities from which we draw our volunteers. Diversity is very important to us.

Q104 **Rachel Hopkins:** What do you think are some of the blockers to being able to be in every coroner's court in England and Wales?

Angela Geer: There are a number of reasons. One of the blockages is awareness. We do not have a very high profile, despite the fact that we are in 44 courts, and that has a lot to do with the fact that we are probably one of the country's best-kept secrets. Unless you have been through an inquest and you have been supported by our volunteers, you would not necessarily know about us. That reflects the fact that death is still one of the subjects that people do not want to talk about, and certainly death as a result of something harrowing, whether it is a

suicide, a death in custody, or whatever. It is something that people don't talk about. As a charity, we certainly have a lot of work to do to raise our profile.

The other obstacle is funding. We have no statutory right to be in a court; we are there at the invitation, and the grace and favour, of the coroner. Subsequently, we are at the mercy of local authorities as to whether or not they fund us and to what extent. Our fee-based operation is very flexible, so we are probably the cheapest service that anybody could possibly get.

Those are the two big obstacles. Unless we address both concurrently, we will struggle to get into every court. You probably all know that we have the support of the Chief Coroner and his officers, but there needs to be more than just an articulation and a narrative of support; we need something more grounded.

Q105 **Rachel Hopkins:** You mentioned local authorities. What help do you get? You said it is flexible whether you get financial support or a contract, so what would you need, from either local or central Government, to be able to deliver your voluntary services?

Angela Geer: Ideally, it would be fabulous if there was a central system, but we know that because of the way the coroners courts are organised that is unlikely to happen, so we are looking at something more local. Because of local variations, local authorities respond differently. We have a benchmark of how much it costs us to set up a service within a court. From thereon in, it depends on the number of inquests, the number of volunteers who are needed and the amount of training. Costs vary a little, but, again, they are not horrendously expensive things to do; it is quite simple. At the end of the day, we find that local authorities' contributions towards our costs cover the volunteers' expenses and not much beyond that, not the overheads or the training.

Q106 **Rachel Hopkins:** What support do bereaved families get in areas where you are not there?

Angela Geer: I suspect very little. Unless we are there, there is no support, because we are the only charity that is doing this. Within those 40-odd courts, we have supported over 500,000 individuals over the last 20 years. There is a really nice case study, which Roey will tell you about, in connection with families where there is no CCSS but families are looking for support. I think she is going to talk about Heather's story.

Roey Burden: Do you mind if I read it to you?

Q107 **Chair:** Please do.

Roey Burden: It is an email she sent to us after she had been to court: "I just want to pass on my thanks for your wonderful service and support from both your helplines and especially the volunteer who accompanied

me to my inquest." We were not present in that particular court, but we found a volunteer from a nearby one who went with her.

She continued: "The inquest was in August, into the tragic death of my partner, who suffered severe depression and took his own life. I am his long-term partner and badly needed to try to understand what happened, to get answers and find the truth about what could and should have been done in his treatment. I got through the whole process thanks very much to all the preparation that your volunteer gave me, and by the fact that he was there the whole time, ready to listen to me and just, well, be there for me. The second day, he was my only support, and it would have been pretty awful if I had just been on my own. He was also so helpful afterwards, taking me out for a coffee, helping me unwind, get it out of my system, and be safe before I set off home driving. So I do not know much about him, but please pass on my thanks. I will be making a donation to your website. I know it won't cover all the costs, but it might help. I will be telling everyone how marvellous you are, particularly the members of the suicide support group that I joined."

Q108 **Chair:** That is very powerful.

Roey Burden: They come in all the time like that. To sit down after an inquest, when you are really suffering, to write and say thank you, says a lot.

Chair: Indeed. That is very helpful; thank you.

Q109 **Edward Timpson:** Could I drill down a bit more into the financial model that you have to work to and probably have to constantly flex on a day-to-day basis? You mentioned donations. We know that some local authorities provide funding, and some don't. Could you give us a sense of what proportion of your funding comes from various sources?

Angela Geer: Yes, I am happy to do that. Quite simply, the donation, as local authorities prefer to call it—the fee that they provide—covers 40% of our actual costs. The other 60% comes from fundraising. That is quite simply how it is. As you can appreciate, in the current economic climate, fundraising is somewhat of a challenge, not just for us but for all charities.

Q110 **Edward Timpson:** You mentioned earlier a benchmark cost to set up a service. What sort of amount are we talking about? Perhaps some local authorities—you never know—with nothing better to do are listening to this session and thinking, "Oh, it's going to cost us hundreds of thousands of pounds; we can't touch it with a bargepole," so perhaps you would like to give us a sense of what it is.

Angela Geer: Absolutely. The benchmark figure that we use—our starting point—is around £5,000.

Q111 **Edward Timpson:** How many local authorities are currently paying at least that level of fee?

Angela Geer: All of the local authorities we work with, apart from three or four, are paying that on an annual basis. We have a set-up cost, which is to kick-start the service, and then there is the ongoing cost per annum. That roughly stays at about the same amount as the set-up. For an average court, we are talking about less than £10,000.

Edward Timpson: Okay, and you cover 43 areas.

Angela Geer: We cover 44 coronial areas, and we are in 49 courts. Some areas have more than one court.

Q112 **Edward Timpson:** Have any local authorities withdrawn financial support?

Angela Geer: Yes.

Q113 **Edward Timpson:** How many, and for what reasons?

Angela Geer: There are two that we are most familiar with at the moment—our current ones, which are most relevant for your purposes. One is Westminster.

Roey Burden: She decided that she did not want the service any longer because she is doing all the inquests virtually.

Q114 **Chair:** That is the coroner.

Angela Geer: The second court is at Flax Bourton in Avon, where their fees were £7,000 per annum. They could not afford it and declared that they would have to withdraw. Roey negotiated that down to a £2,000 annual fee.

Chair: The bell is going.

Edward Timpson: May I get one short question in?

Chair: Yes.

Q115 **Edward Timpson:** We have heard a lot about regional variation in the coronial service itself. Is that the experience of your volunteers? Do they report back to you how differently some bereaved families experience the inquest compared with others, despite their best efforts to try to help them through that process?

Angela Geer: Without a doubt, all courts are different. They are so individual, and it is down to the individual coroner how he or she runs the court. It also reflects the circumstances. The environment in which people are working will impact not just those who work there but the bereaved families. Our volunteers do their utmost to provide the most appropriate service for a bereaved family, irrespective of the environment in which they are working. As far as our volunteers are concerned, it is very much about putting the bereaved family at the heart and centre of everything they do. Hopefully, they are achieving the policy aspiration of putting the bereaved at the heart of the service.

Q116 **Edward Timpson:** Is the helpline that you mentioned earlier available only in the areas where you have volunteers, or is it a national helpline?

Angela Geer: It is a national helpline. It complements our court service. We take both national and international calls on that helpline. The international stuff concerns things like deaths overseas, bodies that need to be repatriated, or just general inquiries about the coronial system and the inquest process here in the UK if you are coming from outside.

Q117 **Chair:** That is very helpful; I am very grateful to you. We are a bit truncated because we now have a series of votes, and that can sometimes take a long time. You have dealt with a lot of the material. If there is anything else you want to send to us, feel free to do so.

Angela Geer: Thank you very much for your time. We appreciate the opportunity to speak to you.

Chair: We are very grateful. Although it was a shorter evidence session than the previous one, it was none the less powerful. We wanted to deal discretely with particular topics, and I hope that has given you a chance to explain what you do and why. I think most people would be very grateful to you for it.

Angela Geer: Thank you.

Chair: It is much appreciated. We will be in touch if there is anything further that you can perhaps help us with. The session is concluded.