

Defence Sub-Committee

Oral evidence: [Beyond endurance? Military exercises and the duty of care](#), HC 598

Monday 1 February 2016

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Members present: Mrs Madeleine Moon (Chair); Richard Benyon; Mr James Gray; Johnny Mercer

Questions 220–277

Witness: **Judge Peter Thornton QC**, Chief Coroner of England and Wales, gave evidence.

Chair: Your honour, it is very good of you to give us your time and come here to give evidence. We are eager to hear what you have to bring to the inquiry. We will start with the first question from James Gray.

Q220 Mr Gray: First, forgive me, because my understanding of the coronial system is pretty low-grade and entirely based on my own experience. I am a Wiltshire MP, and there have been a great many cases in Wiltshire over the years. First, for the benefit of the whole Committee, will you explain how you see your role in regard to service deaths and in particular whether you believe you have a responsibility over all service deaths?

Judge Thornton: No, but may I just put it into context for a moment? Briefly, there are 500,000 deaths a year in England and Wales. That is the extent of my jurisdiction. It does not include Northern Ireland and Scotland; it is just England and Wales. Most of those deaths go straight to the registrar as natural causes. Those make up 55%. Some 45%—that is 220,000—are referred to the coroner. The vast majority of those are signed off by the coroner reporting them to the registrar as natural causes as a result of preliminary inquiries with or without post-mortem.

Q221 Mr Gray: You are speaking about civilian deaths.

Judge Thornton: Yes, I am speaking about civilian deaths to put it in context. In the end, we are down to 25,000 inquests a year in England and Wales, of which a very small number are military deaths. One thing about the coroner service that it is important to remember is that it is very local. It is a local jurisdiction. Coroners are appointed and funded locally. Accommodation, office and court are provided locally, and how the coroner starts a case is as a result of him being made aware of a body within the jurisdiction. The localness of the coroner service is important in that context.

It is not a national service, although there is some national statutory framework. In one sense, I am the only national element of it, in that I am trying to provide leadership to implement the statutory reforms of 2013 and to develop my own reforms and modernisation and so on. I have a special statutory duty in relation to military deaths. Section 17 of the Coroners and Justice Act 2009 requires me to monitor all cases and to train coroners for those cases.

What I have done, and I said this right from the start, is provide a cadre of coroners—there are now 10; I have revised it recently—who conduct this type of service death inquiry where necessary. The guidance says that I will look at each case. Coroners have been reminded that they must refer each case to me, but I will say, “Should this be done by the local coroner? Is the local coroner sufficiently experienced or do I need a member of the cadre?” Obviously the wishes of the family are important.

Q222 Mr Gray: So your responsibilities in regard to military deaths are different from those in regard to civilian deaths, in the sense that you have a direct responsibility under the law to supervise the way that they are handled.

Judge Thornton: Yes. It is the only type of death for which I have a special statutory responsibility, and it is very important.

Q223 Mr Gray: This may be difficult to answer, because at the peak of Afghanistan, it would have been a great deal more than it is now, but what sort of numbers are we talking about?

Judge Thornton: The number of cases referred to me by coroners since July 2013 has been 18. Eleven of those have been—

Q224 Mr Gray: Since 2013? So in the past 2 years, there have only been 18.

Judge Thornton: Yes.

Q225 Mr Gray: What happened to all the other military deaths that occurred?

Judge Thornton: Some have been relatively minor. There is no such thing as a minor death, but something like a road traffic case. We are talking about those in active service or of particular significance.

Q226 Mr Gray: Sorry—my brain hurts. Surely, in 2013 we were still fully active in Afghanistan. There must have been quite a lot—

Judge Thornton: There were nine deaths in 2013 in Afghanistan—three in a Mastiff vehicle. In 2014, there were six. In 2015, there were three—two in the Puma death in October last year, and one shooting from 2012.

Q227 Mr Gray: Had we gone back to 2007 or 2008, you would have been talking about several hundred.

Judge Thornton: 2010 was 103, and 2009 was 108. Those were the highest figures.

Q228 Mr Gray: Most of those inquiries tend to be concentrated in the place where the body lands. In other words, for a long time they were concentrated with the Wiltshire coroner.

More recently, because of Brize Norton, they are all carried out by the Oxford coroner. You mentioned that there were 10. Does that not result in the risk of a backlog in the places where the bodies are repatriated?

Judge Thornton: I do not think that there is a backlog. I will come to the reason why these take a little bit of time. In 1983, the Home Office put out a circular saying that if there are multiple deaths, they should come into one place and be heard by the coroner in that area and, if there are single deaths, they should usually be transferred to the area of the family. That practice goes on today. Nearly all repatriations from abroad come through RAF Brize Norton and go to the Oxfordshire coroner. If it is a single death, he will then inquire of the family. If they are somewhere else, for example, in Manchester, they might prefer to have their local coroner. If they are happy for the inquest to take place there, I will then assess whether that particular Manchester coroner is suitable for that inquiry and, if necessary, the Oxford coroner will make a formal transfer agreed by the local Manchester coroner.

Q229 Richard Benyon: Can you tell us the reasons for setting up this cadre of specialist coroners? Were there any difficulties or challenges in the process?

Judge Thornton: In the first place, specifically because section 17 of the Act specifies monitoring cases and training coroners. That was the particular reason. There would be a small group of coroners, where necessary, who could do these cases with experience and skills. We have had training and that can be repeated where necessary.

Q230 Richard Benyon: You say that the number of investigations this cadre has conducted is 18.

Judge Thornton: Eleven out of 18.

Q231 Richard Benyon: Eleven out of 18.

Judge Thornton: Yes, and there are two additional cases to the 18. A judge has been nominated in the inquest that started today—the Cheryl James case at Deepcut. Another case was the case of Private Gavin Williams—the beasting case—in which I was able to use an assistant judge advocate, who is also an assistant coroner, to relieve the local coroner, who in fact is a cadre coroner, from taking seven weeks or more out of his work schedule.

Q232 Richard Benyon: Thank you. Your guidance note on the cadre says that they will be used for, “‘service deaths’ as defined by Section 17(2) of the 2009 Act, relating principally therefore to death on active service.” That can include training and preparation for active service with death on operations. Can you give us an example of a service death where the specialist cadre might not be used? You have already stated road traffic accidents. I think we understand that that is when a death occurs that is similar to any civilian casualty, but are there any that are slightly more in the grey area, where you have to make more of a decision about where that line is?

Judge Thornton: Not usually. I will ensure that the local coroner, if the family wish to have the inquest locally, is sufficiently experienced in this type of case. A lot of coroners in England and Wales do have that experience, but I would have to be sure about that.

Q233 Richard Benyon: Could they be used for an investigation or inquest into a death during a military selection event?

Judge Thornton: Yes.

Q234 Mr Gray: Could be or would be?

Judge Thornton: Would normally be. Arguably, it is not entirely clear whether that falls within section 17, but I take it fairly broadly.

Q235 Richard Benyon: Do you believe this figure of, did you say, 11 coroners?

Judge Thornton: Yes, 10 in the cadre; 11 cases out of the 18.

Q236 Richard Benyon: Ten in the cadre. Has that number changed? Do you see the number of trained coroners changing, for example, as litigation inquests relating to Iraq and Afghanistan are completed?

Judge Thornton: I don't see the number changing at the moment because, mercifully, there are fewer deaths in Afghanistan and Iraq, but we will have to wait and see.

Q237 Richard Benyon: That leads to my next question. In the event of fairly major conflict, would you be able to upskill coroners? God forbid that we had to do that, but could you increase the size of the cadre? Could you find enough willing recruits?

Judge Thornton: Oh yes.

Q238 Richard Benyon: So it is an area of interesting work for them.

Judge Thornton: Yes, there are plenty who would like to join the cadre.

Q239 Richard Benyon: At its inception, members of the cadre receive training with a particular focus on service death investigations and inquests under the 2009 Act, as we have discussed, and the associated rules and regulations. What further areas of training have they received, or has it all been totally within the Act?

Judge Thornton: It was totally within the Act. There has not been training recently because of the number of deaths being low—very modest—which is good. We can do training at any time. I have good relations with the Defence Inquest Unit at the MoD. We liaise about these things. I have a meeting with the director, Sue, at the DIU. The training is as and when required.

I would also say that since 2013, apart from the specialist training, for the first time coroners and coroners' officers across England and Wales have compulsory training on a regular basis: residential training once a year; induction training for newly appointed coroners; and residential training for coroners' officers. That gives me the opportunity to try to bring some consistency into what has been a very local service.

One complaint about the coroner service when I was first appointed was its lack of consistency from area to area. I am trying to bring in consistency through training, guidance, discussion, working with local authorities and, in a specialist area, working with specialists.

Q240 Chair: Richard, may I cut across you for a second? In your discussions with the cadre of coroners, have they asked for any particular additional training or opportunities to observe military events? Have they felt there were areas where they would usefully like to expand their understanding and knowledge?

Judge Thornton: They haven't asked for it but some of them have been on it. They have been to Warminster, as I have. We were given special training about equipment, vehicles, medical issues in theatre—a wide range over a three-day period. We learned a lot. You have not yet asked me a question about it, but I should say that from time to time, coroners not only explain the unexplained but, where necessary, they report to prevent future deaths: regulation 28 reports. From time to time at Warminster, a senior officer would say, "Looking at IEDs, we used to use this device to find them but, as a result of a coroner's report, we changed it. This is the new piece of equipment that we use." That is how the coroner service should work in this area.

Q241 Richard Benyon: Do you think there is any difference with—one can only speak in generalities here—the family of a deceased serviceman or woman who has been killed, either on operations or in training? Do they have any particular needs that are different from the wider group of victims' families?

Judge Thornton: Probably not. Coroners would tell me that the responses of families in this part of my work are variable. Some take against the military as a result of the death. Some are still very much in favour of the military, despite the death. There is a variable reaction. They are well looked after. They are given a special ceremony at Brize Norton. They have the visiting officer who liaises with them like a police officer would with civilian deaths. They have the coroner's officer who, as soon as the coroner process starts, will liaise with them. They should be informed early of the process and kept up to date on the process and given full explanations.

I have had a day's course with bereavement organisations. There were about 100 people from different organisations, which were not just military. What they want is early explanation, good explanation and good continuing explanation about the process. We try to do all of that. We ensure that they are looked after. The Royal British Legion has been hugely helpful in providing assistance and free legal advice. That has worked well in inquests.

Q242 Richard Benyon: Thank you. I have a last question. Having this cadre is still relatively new. How do you measure its effectiveness? Do you include such assessments in your annual report?

Judge Thornton: The effectiveness is probably measured by others. Families, in particular, we always put at the heart of the process. Their responses are important. On how the process works, the recent Salisbury inquest, for example, had a judge advocate who was also an assistant coroner, and that process worked well, I think, as far as I can judge. I am not able to assess it. If I hear bad things about a coroner—I have not heard bad things about a cadre coroner—I would do something about it. I would certainly discuss it with anybody. My door is open.

Q243 Chair: The Committee will observe a two-day selection event in Lymington. Returning to the issue of additional training, I assume that your special cadre would be

involved if there was a death at a selection event. Would that be something that would come under your cadre's jurisdiction?

Judge Thornton: Yes, but in the first place I will always look at the individual event and assess the scale of that. I will look at the local coroner, if the family would like the inquest locally. They may be familiar with the local coroner. They may have heard of the local coroner or be satisfied with them, but I will ensure that I am satisfied with the local coroner in the first instance. If it is something particularly difficult or complex, I will discuss it with the local coroner and if necessary deploy a member of the cadre.

Q244 Chair: Have you or any of the cadre had the opportunity to observe a selection event?

Judge Thornton: In short, no, I don't think so.

Q245 Chair: Do you think that might be useful?

Judge Thornton: It might be useful.

Q246 Mr Gray: If you were doing an inquiry into one of these deaths, presumably the coroner as part of his inquiry might say, "I want to go and see one of these."

Judge Thornton: Yes. It is not uncommon to see the remains of aircraft and helicopters or to go the site of the event—obviously not if it is abroad, but if it is in England or Wales and if it is appropriate. These things do happen from time to time. If the coroner wishes to see something extra, they can ask. I am sure that that will be provided. The MoD has been very helpful over that kind of thing.

Q247 Chair: Can you tell us, your honour, what it is about service deaths that makes you feel that they require different treatment under the coronial system? Outside of the Act, what do you think motivated that desire—

Judge Thornton: I suppose that it is a personal thing. They are important to the country, to Government, to the military, and to the families whose members have in some cases given their life for their country. I think those words probably speak for themselves.

Q248 Chair: Have you prepared specialist guidance for the cadre of specialist coroners? Have they been given separate instructions and guidance in relation to their inquests?

Judge Thornton: Just separate training.

Q249 Chair: How would you say that the approach to service deaths has evolved since the Coroners and Justice Act 2009?

Judge Thornton: I think the difference since the Act came into force in July 2013 is that there is oversight of the Chief Coroner, and closer monitoring of every case, not just by the coroner, but by the Chief Coroner as well. There is of course the special cadre and there is training for that cadre. As I said earlier, there is compulsory general training now for all cadres, so there is greater awareness of what best practice is and should be. Since 2013, there have been particularly good relations with the DIU. That is very important. Coroners tell me that they have good relations with the DIU and that there is good disclosure: in the first instance to the coroner; then the coroner decides what can be

disclosed to the family and what can be disclosed publicly, so there are three stages. I think that that has worked particularly well since 2013.

I have laid great emphasis since 2013 on families really understanding the process. That has got through and they are getting better at explanation. As we develop, the inquests are thorough, full, public, and, of course, independent investigations. That is important, too.

Q250 Chair: Could you say a little about the relationship with the family and whether there is an increasing role for the coroner to provide information during the whole process of the investigation and inquest? Do coroners explain the process, the terms used and the information and evidence that they have received?

Judge Thornton: Every coroner has a duty to explain the process and to engage with the families, usually through the coroner's officer who is allocated to the case and therefore becomes familiar to the family and will be there at the inquest. Every coroner has a duty to provide sufficient disclosure of materials to a family along the way. That is an important process. For example, some things may not be given publicly in evidence; I do not mean they are given privately, but there will be reference to voice recordings or something of that kind. The family, if they wish—not if they do not wish, obviously—may be shown the material or the transcript of the voice recording. They can listen to the voice recording and see some camera or video work, if they want to see it. It is important that they have that opportunity.

The other thing that is absolutely important in all inquests, including service death inquests, is that the family are asked if they have any concerns. Every coroner should be asking the family, “Do you have any concerns? What are your concerns?”

Q251 Chair: It is a hugely emotional and distressing experience for families.

Judge Thornton: It is a very emotional experience.

Q252 Chair: We have heard concerns from solicitors that the picture of a fatality given to families at the beginning when a death has occurred and what they have set in their minds is not necessarily the same picture that they see emerging at the time of the inquest. Would you say that that was an accurate concern, and why do you think that happens?

Judge Thornton: I listened to the evidence that they gave about that.

I am not sure that I can say. Families may experience information that is outside the ambit of the coroner from different sources: from the visiting officer, from the Royal Military Police, from various inquiries, including the service inquiry.

Ultimately, the information is not all there, it is not all put together, until the final inquest. It may be that what is given sometimes piecemeal to a family does not reflect the final picture. I can see how that might happen. It is important that great care is taken. If I could just draw a comparison, when there is a shooting by the police of a citizen, it is not helpful if the local police give out one statement, the IPCC give out another, and then there is an investigation and further statements are given.

Great care has to be given to a family because the first impressions will be huge for them. That will stick in their mind and will be the explanation that they are living with for all that time until the inquest comes.

Chair: Thank you, that is most helpful.

Q253 Johnny Mercer: Under section 16 of the Coroners and Justice Act 2009, coroners must notify you of investigations that have been completed or discontinued within a year. What information do you have in respect of that on service deaths, and what are the common reasons for it?

Judge Thornton: I don't have the numbers. I could provide the numbers and will give them in writing, if you would like that. It requires a big trawl through quite a large number of cases.

There are a number of reasons why inquests are not completed very quickly. The normal rule is that inquests should be completed within six months, or as soon as practicable thereafter. That is not practical in the majority of these cases.

Q254 Richard Benyon: Is that six months after the death or the start of the process?

Judge Thornton: After the death is reported to the coroner, which is usually pretty close. That is the normal rule. We are not talking about military inquests; we are talking generally. That is not going to apply here, first, because there is usually a service inquiry that will take six to 12 months or more. In the case of the Lynx helicopter crash that was more than 12 months.

There may be other inquiries and the coroner has to wait for them. They are providing, in effect, the vast majority of evidence. If it is a death overseas, the witnesses may be on a tour of duty. They may be at the beginning of a tour of duty and you have to wait six months, to the end of that tour, then they have to come back and have time to breathe when they return before they go and give evidence. That may in itself also take time. These cases—just as with a prison death, where there is a prison and probation ombudsman report—will usually be more than 12 months.

Q255 Johnny Mercer: You mentioned earlier that the reason for setting up this court was that these deaths were important to the country and the Government. Forgive me, but that has always been the case. What has changed that meant that we needed to bring this in? Did it have anything to do with the fairly damning criticism coming from coroners' courts about service deaths from 2005 onwards? It would seem quite ironic that we had this run of reports that said that things were going wrong and they should not be, and then suddenly this cadre of coroners gets set up to preside over military inquests. Do you see what I am saying?

Judge Thornton: I do understand.

Q256 Johnny Mercer: From a cynical perspective, granted, to someone who has lost a child and feels aggrieved by the military, that may look slightly suspicious. What would you say to that?

Judge Thornton: From my point of view at least, it is simply what Parliament decided. Parliament decided to give special emphasis to this type of death. They didn't say, "We'll

have a number of different categories of death: prison deaths, police deaths, police in-custody deaths, certain mental health and hospital deaths.” Parliament simply said in section 17: service deaths, active service. I think it was primarily with a view to active service. There was a special concern about these cases, and I think we have given that since 2013.

Johnny Mercer: Thank you very much.

Q257 Chair: You could also argue, if that level of public cynicism was out there, that Parliament was right to respond in the way it did, to alleviate some of that cynicism. As someone who sat on the Coroners and Justice Bill Committee, I can assure you that that cynicism was there. That was what we were trying to address; I remember that well.

Judge Thornton: Yes. I am sure that cynicism was there, but it has to be removed, and that is part of my job—not the cynicism, but the reasons for it.

Q258 Chair: But the reason for your job being created was that cynicism, that feeling that this needed to be given a different focus, given someone who would oversee and who would increase the standards of consistency. Personally, I think you have done a good job of that.

Judge Thornton: The Ministry of Justice has a review at the moment on the workings of the Coroners and Justice Act 2009, including the role of the Chief Coroner, and I do not know the results. We shall see in due course, but hopefully there will be positive signs. Although you cannot change everything locally overnight—I don’t have the money, the funds or the resources—I hope that nationally there has been an improvement, maybe a generational change, but that is underway.

Q259 Chair: Good. Paragraph 5 of schedule 10 deals with investigations already begun and states: “A reference in this Schedule to conducting an investigation, in the case of an investigation that has already begun, is to be read as a reference to continuing to conduct the investigation.” Has paragraph 5 been used in respect of a service death?

Judge Thornton: There is nothing really special about that. All that it means is that, in this context for example, if a single overseas military death came into Oxford, and the Oxfordshire coroner made a transfer to Manchester, the powers of the Manchester coroner would be for an investigation already begun. As soon as the coroner in Oxfordshire is made aware of the death and the body is repatriated he has jurisdiction. He opens an inquest and the investigation has begun. He will have a post mortem examination in the John Radcliffe hospital, then he will make the transfer, if appropriate.

So the investigation has begun and it is a continuing investigation in Manchester. The powers exercised by the Manchester coroner to require a witness to attend or somebody to produce a document would work under paragraph 5 in schedule 10 in that way.

Q260 Richard Benyon: In the preparation of regulation 28 reports to prevent future deaths, how do coroners take into account the nature of service in the armed forces and the unique risks that service personnel face?

Judge Thornton: I am sure that they do, but the focus is on the evidence received in court, in writing or from witnesses, and if they have a concern—the word in the Act—about something that has or has not happened that could lead to a future death arising in similar

circumstances, they have a duty to report. Before the 2009 Act they had a discretion to report. Now, if they have a concern, they must act on that concern and express it, but they are only allowed to make general recommendations. They can say, for example, “Please review your policy on this, please review your training on this, please review the equipment and devices that you have used”, but they cannot say, “You should now use this piece of equipment. You should alter it in this way. You should now make your training include this”, because the Act does not allow that. In certain parts of the common law world they will do that, but they have extra resources, which we do not have.

Q261 Richard Benyon: You don’t feel that there is mission creep—this word, “lawfare”, that we are all hearing more. There has been criticism of people sitting in air-conditioned offices, coroners courts or wherever, many years after an event trying to second-guess the decisions made by a commander at a difficult moment. That was particularly the case with the Snatch Land Rovers—they should not have had Snatch Land Rovers in that theatre, but something happened and a commander had to make a decision. Some people said that it was difficult late in the day—years later, perhaps—and that that was the wrong decision and you should be censured for that. Is that a concern?

Judge Thornton: I think my answer is that that is probably straying into a political arena that is outside the scope constitutionally of my remit.

Q262 Richard Benyon: I think that that is a very good answer—you should be a politician.

Chair: A very political answer.

Q263 Richard Benyon: In paragraph 54 of your guidance on regulation 28, you see a role for the chief coroner in taking some reports and responses further. You have touched on that, but how do you monitor responses and reports on service deaths, and how would you take forward any concerns that you might have, particularly with the MoD and the armed forces, to make sure that the recommendations that you and your colleagues make are followed through?

Judge Thornton: I have not taken anything further forward from the MoD. Before coming to the Committee, I refreshed my memory of a recent report by a coroner and the MoD’s response, which was very full. I think it is a matter for Government whether the implementation of those proposals in that response are carried out.

It is difficult for me to deal with the reports and extract something, then act on it, because in essence I have no powers, and there are a lot of reports: 600 reports a year; probably twice as many responses. I have only four members of staff at the moment, but if anything was brought to my attention and anyone—any family—said, “Please follow this up or do something about it”, I would look at it and take it up.

We publish all our reports, sometimes with redaction, on the judiciary website. They are there for everybody to see. They are public—both the reports and the responses. For example, I received a note the other day from NHS England London region, enclosing its report, which it had derived from coroners’ reports about the deaths of vulnerable adults and children, and explaining what it was going to do about that. I thought that that was excellent, and a very good use of reports. However, I think my role is somewhat limited.

Q264 Mr Gray: I think that perhaps this has been covered fairly extensively, but on relations with the MoD, presumably there is difficulty there because of a separation of power to some degree. How do you find general relations with the MoD, how much does it welcome your comments, and so on?

Judge Thornton: I am happy to say that they are good at the moment. Before coming here, I spoke to a number of coroners, and I said, “Are you having any difficulties with the MoD, the Defence Inquest Unit, or anywhere else?”, and they said, “No, good relations at the moment.” That always depends on people, but they seem to be good people, and the important thing from the coroner’s point of view is not just good people but making sure that they get sufficient disclosure of material as coroners so that they can do a full inquiry.

Q265 Mr Gray: And they find that reasonably satisfactory?

Judge Thornton: Yes.

Q266 Mr Gray: Isn’t there an inbuilt instinct in the MoD to think, “If I reveal this particular piece of information, that may well result in the inquest coming down against us and saying we were wrong, and therefore let’s try and cover things up.” Surely there must be some instinct to try and do that.

Judge Thornton: That is always possible, but it does not seem to be exhibiting itself at the moment.

Q267 Mr Gray: But you are aware of the risk and therefore you would be alert to that possibility.

Judge Thornton: Well, I think a coroner would be, because a coroner would say, “Why haven’t I received that document? That is the one document I really need, and nobody’s mentioned it.” It is the coroner’s duty to investigate. You referred, Madam Chair, to schedule 10 powers, and they can always be used, but it is for the coroner. The coroners have told me that, at the moment at least, things are good.

Q268 Mr Gray: Finally, tell me about funding. You have a small staff, but is there special funding set aside for the coronial service as a whole to deal with service deaths? Is it ring-fenced? Is it big enough? What would happen if there was a significant increase in the number of inquests required because of hypothetical warfare?

Judge Thornton: The Oxfordshire coroner receives certain payments through the MoD and the MoJ which are sufficient for present purposes. If there is an increase in the number of service deaths, there would have to be an increase. There is nothing laid down, but I would expect that money to be forthcoming, otherwise every inquest across England and Wales is paid for by the local authority, and you can imagine what they say to me at the moment about money.

Q269 Mr Gray: I was going to ask that. Presumably Oxfordshire and, until recently, Wiltshire Councils’ facilities are being used, aren’t they?

Judge Thornton: Yes.

Q270 Mr Gray: Are they content with the payment being made for inquests into service deaths?

Judge Thornton: I think Wiltshire was, and I think Oxfordshire is. I did ask the two coroners and they were satisfied—it is all Oxfordshire at the moment.

Q271 Mr Gray: But if, tragically, the number of inquests required increased, that would have to be revisited.

Judge Thornton: Yes.

Q272 Chair: Chief Coroner, you have been very full in your answers, and I thank you for that. Is there anything that, when you were coming here today you thought, “Oh, I must make sure I talk about that or explain that.”? Is there anything that you would like to add to your evidence that you feel it would be helpful for the Committee to know or understand.

Judge Thornton: The one thing that is probably most important is that the families really are at the heart of this process. It is not just a question of saying it. It is easy enough to say, but actually making sure that works right from the start—it is not just service deaths, but all deaths that we are looking at. We are looking at deaths of holidaymakers in Sousse, Tunisia; in hospitals; and in care homes. These are deaths that affect families, and service deaths are very important deaths which affect families. Starting with that premise, the process must engage them sufficiently, ask them for their concerns, give them full explanation as early as possible and make sure that they are, throughout, involved in this process. If that is done, then things will work well, broadly speaking, and that is a good starting point and a good ending point.

Q273 Chair: You have powers to give recommendations. Do you think your powers ought to be increased so that it is not just a recommendation, it is something that is mandatory?

Judge Thornton: I suppose everybody who has powers of some sort wants to have them increased.

Q274 Chair: Are there additional powers, in relation to service deaths, that your cadre has felt would be helpful to have?

Judge Thornton: I think you have to be careful about coroners recommending too much. They hear the evidence, they make recommendations about what they have heard in the evidence, but they may not have heard the full story in relation to that piece of policy, piece of training or piece of equipment, so it is not right that their recommendations should go too far. I think at the moment the process works reasonably well.

Q275 Chair: Is there additional training or access to information and understanding of how operations are conducted, how training takes place or how selection takes place that you feel it would be helpful for coroners to have?

Judge Thornton: Can I go away and think about that? I haven’t thought about it recently because of the small number of deaths, but one should always be prepared. I have to say I have spent rather more time on mass fatality incidents and the possibility that such a thing should happen, but I will go away and think about it if I may.

Q276 Chair: Every death, especially an unforeseen death as a result of military activity, whether it is in training, theatre or selection, is hugely distressing, and I think you addressed that extremely well. In looking at the deaths that you have examined since 2013, have you

become aware of any trends that have caused you any concern or that you feel particular attention should be paid to?

Judge Thornton: To be quite honest, the cases have been, on the whole, so different, so fact-specific, that it would not be right to say that there are trends. I get more deaths in custody, and there are the usual trends, which is a lack of training, a lack of understanding about protocols—all the right protocols are in place, they are just not sufficiently trained about or understood, or the records are not usually in the right place at the right time, particularly as somebody enters prison. For my purposes at present, there are no such similar trends that I would wish to emphasise. Obviously, with training inquests recently, one cannot say that there are trends, but there are important issues there which I think are being addressed. With Reservists, and how much Reservists should be treated as Regulars in certain aspects of the training and how they should be kept different, is not a matter for me: it is a matter for the military. They have heard what the coroners have said in specific cases.

Q277 Chair: Chief Coroner, I thank you very much for your evidence today. For those who do not follow the coroner service, you have made a great deal of difference since the 2009 Act, and we thank you for that. There was quite a lot of controversy about whether or not the Chief Coroner post would be established and I know that, as someone who pushed for it, I was extremely pleased—

Judge Thornton: I had to go back to my day job for two years before I was reinstated. Thank you very much for those words: I appreciate them.

Chair: It would also be good if you could go back to that specialist cadre and thank them for the work that they do, because for those military families it is important that they know that there is that understanding of the military life, the military task and the military ethos that is there within the inquests. I thank you for making sure that that is there. Especially, I think we would all like to thank you for that particular focus on the families, because the distress of the families has come through several times during the course of the inquiry.