His Honour Judge Thomas Teague KC, Chief Coroner of England and Wales

Written evidence to the Work and Pensions Select Committee inquiry into safeguarding vulnerable claimants

Introduction

1. I am the Chief Coroner of England and Wales, HHJ Thomas Teague KC. I am grateful to the Committee for the opportunity to submit written evidence to its inquiry into safeguarding vulnerable claimants.

2. The coroner service in England and Wales is a small but important part of the justice system. Its primary purpose is to investigate violent or unnatural deaths, deaths of which the cause is unknown and deaths that have occurred in custody or otherwise in state detention. Coroners exercise a fact-finding 'inquisitorial' jurisdiction. Unlike most courts and tribunals in England and Wales, which have an adversarial system in which the participants ('parties') resolve a pre-existing dispute in the arena provided by the court, the coroner's court acts on its own motion to investigate an individual death to the required statutory standard.

3. As Chief Coroner, I am an independent judge whose role is to fulfil the specific statutory functions set out in the Coroners and Justice Act 2009 (the 2009 Act) and provide overall judicial leadership of the coroner service. My role is not to act as a Chief Executive, as each coroner is an independent judicial office holder with responsibility for investigations and inquests in his or her area. It is the individual coroner who makes decisions about such matters as the scope of inquiry and evidence to be gathered for and adduced in an inquest. The Chief Coroner has no general power to direct coroners in their work and does not have disciplinary powers over coroners (who are subject, like all judges, to the Judicial Conduct Investigations Office in that regard). In short, the power - such as it is - that the Chief Coroner is able to wield is a form of 'soft' power, relying on the exertion of influence through persuasion, advice and encouragement.

4. A coronial death investigation is a form of summary justice designed to provide answers to four statutory questions, namely who the deceased was and when, where and how (usually confined to meaning 'by what means') the deceased came by his or her death. Where the enhanced duty of investigation arises under Article 2 of the European Convention on Human Rights, the coroner or jury must examine the wider

circumstances in which the death occurred, but still cannot express an opinion on any topic other than the four statutory matters to be ascertained. The attribution of blame forms no part of the coroner's role. The 2009 Act expressly prevents inquest determinations from being framed in such a way as to appear to determine any question of civil liability or any question of criminal liability on the part of a named person.

5. Coronial investigations are inquisitorial, with the coroner (assisted by Interested Persons) examining evidence to discover the truth about how the deceased died, rather than adjudicating between competing versions of events. As Lord Lane said in 1982[1]:

> *"It should not be forgotten that an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use."*

What triggers the undertaking of an inquest?

6. An inquest is part of a coroner's investigation. It is the formal hearing that usually takes place at the end of the investigation process.

7. A coroner becomes involved in considering a person's death when the coroner is notified that there is a body of a deceased person in their coroner area. Anyone can notify a coroner of a death, so coroners will sometimes be notified by bereaved families, members of the public and the police. However, there is a statutory obligation on particular individuals and bodies to notify coroners of deaths, including:
   i) registered medical practitioners who come to know of a death to which certain circumstances apply (see the Notification of Deaths Regulations 2019); and
   ii) registrars when they are informed of a death and particular circumstances apply (see regulation 41 of the Registration of Births and Deaths Regulations 1987).

8. When a coroner is notified of a death, the coroner will do one of three things:

   i) confirm that they do not need to investigate;
   ii) conduct preliminary enquiries to determine whether an investigation is necessary; or
   iii) commence an investigation.

[1] See R v South London Coroner Ex p. Thompson (1982) 126 S.J. 625

9. Section 1 of the 2009 Act provides that a coroner is only under a duty to investigate a death if the coroner has reason to suspect that the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died in custody or otherwise in state detention. If a death is a community or hospital death and it is clear that it is natural, the coroner will not be under a duty to commence an investigation.

10. There is one exception to the need under section 1(1) of the 2009 Act for a body to be within the coroner's area when a report of death is made. Section 1(4) of the 2009 Act allows a coroner to investigate a death if they are directed to do so by the Chief Coroner where the coroner has reason to believe that:

    i) a death has occurred in or near their coroner area;
    ii) the circumstances of the death are such that there should be an investigation into it; and
    iii) the coroner would not otherwise have jurisdiction because of the destruction, loss or absence of the body.

11. This enables investigations to take place where a person has gone missing and the evidence suggests suicide or homicide, where someone has drowned but their body cannot be found, where a person's manner of death has been so destructive that their body cannot be recovered etc. It is also commonly used where a death at first appears natural and the body is cremated without a report to the coroner, but evidence then comes to light that suggests an investigation is needed.

12. During an investigation into a hospital or community death, if it becomes clear before the inquest that the deceased died from natural causes and the coroner thinks that continuing the investigation is unnecessary, the coroner must discontinue the investigation. In those circumstances, there will not be an inquest. Instead, the coroner will complete a form setting out the cause of death and confirming that the investigation has been discontinued, and the death can then be registered.

13. Coroners may also suspend an investigation and adjourn an inquest. In some circumstances, suspension and adjournment are obligatory (the most common of these is in connection with criminal proceedings relating to the death). Sometimes the coroner's investigation will then not be resumed because further investigation of the death is unnecessary, and in those cases no inquest will take place[2].

Who can request that an inquest is carried out?

14. As I explained above, anyone can report a death to a coroner.

15. Once a death has been reported, it is for the coroner alone to decide whether to

[2] See Chief Coroner Guidance No. 33 for more information: https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-33-suspension-adjournment-and-resumption-of-investigations-and-inquests1/

investigate and whether an inquest is required. The coroner will, however, consider the views of the Interested Persons when making these decisions.

16. The term 'Interested Person' is defined in s47(2) of the 2009 Act, but in broad terms an Interested Person is an individual or organisation able to participate actively in an investigation by virtue of their relationship to the deceased, their involvement in the circumstances of the death, or because they have been granted the right to do so at the discretion of the coroner.

17. The coroner will provide information and disclosure[3] to Interested Persons during an investigation and seek their views to assist with decision-making. If the coroner is minded to discontinue an investigation, Interested Persons are able to make submissions explaining why an inquest should be held.

18. If a coroner decides not to proceed with an inquest and an Interested Person disagrees with that decision, there is the possibility of the Interested Person bringing a legal challenge[4].

The stages and processes involved in conducting an inquest

19. The first stage in an inquest is its opening. At the opening of the inquest, the coroner should set the dates on which any subsequent hearings are scheduled to take place. To comply with rule 8 of the Coroners (Inquests) Rules 2013, the inquest should normally be listed within six-months of the date on which the coroner was made aware of the death, or as soon as is reasonably practicable after that date. However, where the date for the inquest cannot be fixed (for example because the case is complex and a case management hearing is needed), a pre-inquest review hearing may be listed instead.

20. The coroner will often receive evidence at the opening of the inquest relating to the identity of the deceased person (i.e. their date and place of birth, name and surname, sex, maiden surname if a married woman, date and place of death, occupation and usual address), as these details will be needed for death registration. Wider evidence may also be taken about matters such as the general circumstances of the death, how the body was found, whether a post-mortem examination has been conducted and the provisional cause of death, although a conclusion will not be reached at that stage.

21. Usually, the coroner will then adjourn the inquest until a later date, to enable the coroner to gather the information needed for the final inquest hearing (for example, witness statements and expert reports). However, in some straightforward cases, a coroner might open an inquest, hear the inquest and make their findings and determinations in one hearing.

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[3] See Chief Coroner Guidance no.44: https://www.judiciary.uk/guidance-and-resources/guidance-no44-disclosure/

[4] See this House of Commons briefing on challenging coroners' decisions: https://researchbriefings.files.parliament.uk/documents/SN00525/SN00525.pdf

22. Where a case is complex, the coroner may hold one or more pre-inquest reviews before the inquest to deal with matters of procedure and other preliminary issues (for example, the scope of the inquest, what documents will be required, and which witnesses and experts will give evidence).

23. In some circumstances, inquests can be held in writing instead of at a public hearing. The considerations relating to inquests in writing and the processes that should be followed when conducting them are explained in Chief Coroner guidance[5].

24. Where there is an inquest hearing, it is for the coroner to decide how the hearing will be managed. Chief Coroner guidance[6] provides a basic template that is likely to be suitable for most cases (the majority of inquests being fairly brief and simple hearings). The main elements of an inquest are:

    i) the admission of evidence (including the questioning by the coroner and Interested Persons of any witnesses who are in attendance);
    ii) the coroner's summary of the evidence and findings of fact;
    iii) the coroner's determinations and conclusions;
    iv) any decision to issue a prevention of future deaths (PFD) report.

25. Inquests are usually held without a jury, but there are some circumstances in which a jury is required[7]. In jury cases, the jury makes the findings of fact, determinations and conclusions.

The conditions under which PFD reports are issued

26. Issuing PFD reports forms an important part of the coroner's judicial role. Such reports are, however, "ancillary to the inquest procedure, and not its mainspring"[8].

27. Coroners are under a statutory duty to issue a PFD report when an investigation gives rise to a concern that future deaths will occur and the coroner considers that action should be taken to reduce the risk. A coroner has no legal power or authority to recommend specific remedial measures in a PFD report, which should not contain such recommendations. Unfortunately, this is not as well understood as it should be, with the result that media reports often erroneously refer to 'recommendations' by coroners, thereby contributing to the raising of unrealistic expectations in the minds of members of the public. The purpose of a PFD report is just to highlight the risk so that others can consider whether/how to address it.

28. In considering whether the duty to make a PFD report arises, the coroner should

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[5] https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-29-inquests-in-writing-and-rule-23-evidence/

[6] https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-12-the-inquest-checklist/

[7] See section 7 of the 2009 Act.

[8] Re Kelly (deceased) (1996) 161 JP 417.

focus on the risk at the time they make the report (which is usually at the end of the inquest), as opposed to the risk that existed at the time the person died. Coroners should consider any evidence about relevant changes made since the death. If a potential PFD recipient has already taken action to reduce the risk of death, the duty to issue a PFD report may not arise.

29. Where a coroner is told that action is planned or changes are underway, the coroner will need to assess whether the duty to issue a report still arises. This will be fact-sensitive and will depend on the evidence before the coroner. It is for the coroner to decide whether the duty to issue a PFD report arises, having considered the matter as a whole (including any representations from Interested Persons that may be made).

30. In 2020, my predecessor published revised guidance to assist coroners with the detail of the law and encourage consistency of approach in the use of PFD reports[9]. The recent judgments of the Administrative Court in the cases of *Gorani*[10] and *Dillon*[11] have provided further clarification of the legal parameters.

31. In *Dillon* the court made it clear that before the duty to issue a PFD report arises, there must first be a concern (arising from the investigation) that circumstances creating a risk of other deaths will occur or continue in the future. Secondly, and significantly, the coroner must have formed the opinion that 'action should be taken' to prevent that risk of death. The court also confirmed that the coroner must act rationally in coming to the opinion held, but different coroners could reasonably come to opposite opinions on the same facts without either being wrong to do so. In other words, there is no single, objectively correct answer to the question raised by the second criterion in any particular case[12].

32. The court's decision in *Dillon* underlines an important principle, namely that a PFD report must flow from the individual investigation in question and relate to evidence adduced as part of that investigation.

33. In *Gorani*, the court considered whether it was an error of law for the coroner to decide against issuing a PFD report without first hearing submissions from the Interested Persons. The court confirmed that the duty to issue a PFD report only exists when in the coroner's own view there is a risk of future deaths, and there is no obligation on the coroner to hear submissions on that issue (although coroners will often find it helpful to do so).

34. I publish PFD reports and responses on www.judiciary.uk to comply with the principle

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[9] https://www.judiciary.uk/guidance-and-resources/revised-chief-coroners-guidance-no-5-reports-to-prevent-future-deathsi/

[10] R(Gorani) v Her Majesty's Assistant Coroner for Inner West London and Ors [2022] EWHC 1593 (QB)

[11] R (Diarra Dillon) v Assistant Coroner for Leicestershire [2022] EWHC 3186 (KB) (Admin)

[12] The wording in this paragraph is adapted from the explanation provided by Bridget Dolan KC at https://www.ukinquestlawblog.co.uk/pfds-and-subjectivity/

of open justice and make them available for public learning[13].

HHJ Thomas Teague KC

Chief Coroner of England and Wales

[13] https://www.judiciary.uk/?s=&pfd_report_type=&post_type=pfd&order=relevance

Work and Pensions Committee

11 March 2024

His Honour Judge Thomas Teague KC
Chief Coroner
Chief Coroner's Office
(By e-mail only)

Dear Judge Teague,

Coroner inquests involving DWP

The Work and Pensions Select Committee is currently conducting an inquiry into *Safeguarding vulnerable claimants* to examine how DWP supports vulnerable benefit claimants, whether its approach to safeguarding needs to change and what responsibility the Department should have to safeguard vulnerable customers.

As part of this, the Committee is interested to understand the process involved in conducting an inquest in cases involving possible safeguarding misconduct by DWP, acknowledging that the same process is followed regardless of whether DWP were involved in the case.

I would be grateful, therefore, if you could please provide the following information:

1. What triggers the undertaking of an inquest;
2. Who can request that an inquest be carried out;
3. The stages and processes involved in conducting an inquest; and
4. The conditions under which a Prevention of Future Deaths (PFD) report is issued.

I would be grateful for your response to these questions by 25 March. As is usual practice with the Committee's correspondence, I will be publishing this letter and your response on the Committee's website.

Yours sincerely,

Rt Hon Sir Stephen Timms MP
Chair, Work and Pensions Committee

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