Written evidence from The Independent Advisory Panel on Deaths in Custody (TCS0041)

The role of the Independent Advisory Panel on Deaths in Custody (IAPDC) is to advise Ministers and senior officials on how they can meet their human rights obligations to prevent deaths and protect the lives of people detained in state custody. The IAPDC welcomes the opportunity to submit evidence to the Justice Select Committee's (JSC) follow-up inquiry on the coroner service. Our evidence will focus on inquests into the deaths of individuals in custody – in prisons, police custody, immigration removal centres (IRCs), or detention under the Mental Health Act (MHA) 1983 – which often lead to the most complex proceedings.

Summary

1. Coroners' inquests – alongside investigations by the Prisons and Probation Ombudsman (PPO) and the Independent Office for Police Conduct (IOPC) – are an essential means by which the Government meets its obligation to carry out effective and timely investigations of deaths in state custody, required under Article 2 of the European Convention on Human Rights (ECHR). This is particularly so for deaths of patients detained under the MHA which, unlike deaths in prison, police custody, or IRCs, are not investigated by a separate independent body. In 2022, a total of 534 deaths which occurred in custody were reported to coroners.[1] The Chief Coroner's annual report, covering the period between 2018 and 2020, revealed that "[d]eaths in detention remain of particular concern to coroners and many generate prevention of future death reports".[2]

2. The issuing of Prevention of Future Death (PFD) reports is an important part of the coroner's role. As guidance by the Chief Coroner states, they are "vitally important if society is to learn from deaths".[3] As part of the IAPDC's role to provide independent advice and expertise, we completed work – with support from the Chief Coroner's Office and the Ministerial Board on Deaths in Custody – to identify good-practice recommendations and proposals to improve the effectiveness of the PFD process. This involved consultation with coroners, families bereaved by custody deaths, and agencies and services, as well as a sampling exercise of PFD reports covering the detention settings within the IAPDC's remit.

3. Our report, published in September 2023, found that the preventative potential of PFD reports is not being fully realised.[4] It highlighted a number of issues relating to the drafting, publication, and distribution of PFD reports and raised concerns around how the implementation of recommendations from PFD reports is monitored, as well as how learning is disseminated and put into practice. The latter are issues we touched on in our

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[1] MoJ, 'Coroners statistics 2022: England and Wales', 11 May 2023, available here.
[2] MoJ, 'Chief Coroner's combined annual report 2018 to 2019 and 2019 to 2020', November 2020, available here.
[3] Judiciary, 'Revised Chief Coroner's Guidance No. 5 Reports to Prevent Future Deaths', 20 November 2020, available here.
[4] IAPDC, '*"More than a paper exercise"* – Enhancing the impact of Prevention of Future Death Reports', September 2023, available here.

submission to the JSC's earlier inquiry into the coroner service, which sadly indicates that progress has been too slow in these areas.[5]

4. Key recommendations from our report include:

    i. All parties should approach PFD reports in an open, non-defensive way and ensure reports are used to drive learning across services at local and national levels.
    ii. Recipients of PFD reports should ensure their responses are timely, high quality, case-specific, and fully informed by the inquest evidence and findings. They should also make sure that their responses recognise and reflect the significance of PFD reports to bereaved families and consider how families can have the opportunity to better engage with responses.
    iii. Scrutiny bodies should make far greater use of PFD reports than at present, as well as Parliamentary select committees.
    iv. The Ministry of Justice should adequately resource the Chief Coroner's Office to produce a yearly review of PFD reports for custody deaths to identify learning, as well as reporting on the timeliness and quality of responses.

    Please see our report for the full range of findings and recommendations.

5. We recognise that some progress has been made in recent years, including the removal of the means test for Exceptional Case Funding for bereaved families involved in Article 2 inquests. The Government must now work with all those involved in the inquest and PFD processes to build on this progress and ensure adequate mechanisms are in place to identify, disseminate, and embed learning when a death in custody occurs. Bereaved families must sit at the heart of the coroner service and be given confidence that all parties involved will work together to ensure these processes are fully effective and that PFD reports live up to their name in preventing deaths.

What progress has been made towards placing bereaved families at the heart of the coroner service?

6. Families bereaved by custody deaths have an important role to play in inquests, pursuant to the State's duties under Article 2 of the ECHR and more broadly in order to ensure public confidence in the process and maximise accountability and learning. Their engagement with proceedings must be properly supported and facilitated to ensure they are able to understand why their loved ones died. But they should also be assured, wherever possible, that weaknesses and gaps in how life is safeguarded are identified and acted on to prevent similar deaths happening again. Despite repeated commitments to put bereaved families at the heart of the coroner service, evidence from some families suggests that they receive highly variable treatment during proceedings.[6]

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[5] UK Parliament, 'Written evidence from the Independent Advisory Panel on Deaths in Custody', September 2020, available here.

[6] E.g., INQUEST, Family Listening Day – Families' experiences of the coronial process following deaths in police

7. While inquests should adopt an inquisitorial and fact-finding approach, too often they risk becoming adversarial, particularly when organisational reputation is perceived to be at stake. Such an approach can make it difficult for bereaved families to navigate the process and ensure they get answers to their questions. This issue was highlighted in Dame Angiolini KC's review of deaths and serious incidents in police custody.[7] Similarly, our report found on-going evidence of this problem and recommended that agencies and services should avoid an adversarial approach to the question of whether a PFD report should be made and instead to view them as opportunities to learn and improve.

8. A defensive, and sometimes hostile, attitude was also highlighted in Bishop James Jones' review of Hillsborough families' experiences of the inquest process, which called for a cultural change "to tackle the increasingly adversarial nature of many inquests – and instead to embed a culture of openness and learning".[8] In its recent response to the review, the Government acknowledged that while inquests are intended to be inquisitorial, "in reality they can feel very different, particularly when the state is represented as an interested person".[9] It is therefore disappointing that the Government did not accept the review's recommendation for a duty of candour to be placed on all public bodies. The evidence in our report strongly suggests that steps taken since Bishop James Jones' review (on which see further below) have been insufficient to remedy the problem. It is crucial that institutional parties involved in inquests are open and non-defensive and ensure that the public interest in preventing future deaths is prioritised over reputational considerations.

9. We welcome the removal of the means test for legal representation of bereaved families at inquests following custody-related deaths, which came into force in January 2022[10] in response to widespread calls for reform, including from the IAPDC,[11] the (then) Chief Coroner,[12] and JSC.[13] This goes some way to addressing the legal 'inequality of arms' and helps to ensure that families bereaved by custody deaths can participate more meaningfully in the inquest process. However, the removal of the means test is limited to Exceptional Case Funding only, creating an internally contradictory and clunky system whereby bereaved families are still required to go through a means test to access Legal Help. The latter provides funding for vital preparatory work for the inquest, such as providing advice and taking instructions from bereaved families and preparing submissions

custody or prison', September 2023, available here.

[7] Home Office, 'Report of the Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, available here.

[8] Home Office, ''The patronising disposition of unaccountable power' A report to ensure the pain and suffering of the Hillsborough families is not repeated', November 2017, available here.

[9] Home Office, 'A Hillsborough legacy: the government's response to Bishop James Jones' report', December 2023, available here.

[10] MoJ, 'Government response to Legal Aid Means Test Review', March 2022, available here.

[11] UK Parliament, 'Written evidence from the Independent Advisory Panel on Deaths in Custody', September 2020, available here.

[12] Judiciary, 'Report of the Chief Coroner to the Lord Chancellor. Third Annual Report 2015-2016', September 2016, available here.

[13] UK Parliament, 'House of Commons Justice Committee. The Coroner Service. First Report of Session 2021-22', May 2021, available here.

to the coroner on their behalf setting out the issues the family considers the inquest should cover.

10. The Chief Coroner recently explained that "it is only by upholding and defending the centrality of the deceased that we can protect their families against the risk of being marginalised".[14] One way in which this can be done is through pen portraits, which can help the coroner to determine who the deceased was. We welcome guidance published by the Chief Coroner in 2021 which "endorses" pen portraits "to humanise the process and give dignity to the bereaved".[15] Such pen portraits have also been recognised as essential in a series of high-profile judge-led public inquiries. However, evidence from the charity INQUEST suggests that coroners still do not always permit pen portrait material, with reports of some families being denied the opportunity to do so because it was perceived by the coroner to be too traumatic.[16] While the conduct of inquest proceedings is a matter for the coroner, coroners should facilitate the reading of a pen portrait where it is the family's wish to do so, in accordance with the Chief Coroner's guidance and best practice.

11. Bereaved families can also play a role after the inquest process. In our consultation, family members expressed interest in being given a formal right of reply to PFD reports to enable them to have a voice about the matters of concern identified by coroners. While coroners do not have statutory authority to facilitate this, there is scope for services and agencies to engage with families to sensitively explain their response and action taken following a PFD report on a case-by-case basis and, where appropriate and desired, to seek bereaved families' further input and views.

12. Lord Toby Harris' review into self-inflicted deaths in custody of 18–24-year-olds highlighted the importance of addressing delays in the completion of coroners' investigations. As the review points out, "[s]uch delays often have a serious impact on the families, who face a lengthy period of time when very important questions remain unanswered", and it also "frustrates organisational learning".[17] We recognise that the time taken to complete inquests into deaths in custody is in part a product of the complexity of preceding investigative processes and the issues and evidence. However, we welcome the Chief Coroner's commitment to tackling delay.[18] Where there are delays, families should be kept regularly updated on the reason for the delay, progress, and the likely timeframe for the inquest to be held.

Are coroners making consistent use of their power to issue PFD reports?

[14] Judiciary, 'Lecture by the Chief Coroner: Death and Taxes – the past, present and future of the coronial service', November 2023, available here.
[15] Judiciary, 'Chief Coroner Guidance No. 41 Use of 'Pen Portrait' material', July 2021, available here.
[16] INQUEST, Family Listening Day – Families' experiences of the coronial process following deaths in police custody or prison', September 2023, available here.
[17] MoJ, "Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds", July 2015, available here.
[18] MoJ, 'Chief Coroner's combined annual reports 2021 to 2022', December 2023, available here.

13. PFD reports are integral to compliance with the UK's human rights obligations. When an individual has died in state custody, the issuing of a PFD report may be essential to ensuring that the State discharges its mandatory enhanced duty of investigation pursuant to Article 2 of the ECHR. The 2020 Coroner Attitude Survey showed that coroners view the objective of preventing future deaths as one of the three most important functions of the coroner, alongside that of publicly investigating deaths and providing answers to bereaved families.[19]

14. In our consultation with bereaved families, some expressed frustration regarding the basis on which coroners had determined that there was no need for a PFD report to be issued. Our engagement with coroners underlined the importance of obtaining and engaging with the best available evidence relevant to whether the test for issuing a PFD report is met. In order to do so, coroners suggested that they should set clear expectations of institutional bodies participating in inquests regarding the PFD process. The Chief Coroner should consider supplementing his guidance to advise coroners on the importance of ensuring relevant evidence is provided at a sufficiently early stage to ensure a timely and fully informed decision.

15. The statutory duty of candour, introduced in 2014, requires providers of healthcare to be open and transparent when things go wrong with care and treatment. Importantly, it stipulates that patients and families have a right to receive explanations for what happened as soon as possible and a meaningful apology.[20] During our consultation, one coroner suggested that the duty of candour placed on hospital trusts has had a positive impact and that, in their experience, some trusts have become better at admitting mistakes within inquest proceedings. However, the evidence we received suggests that this is far from reflected in all inquest processes in which institutional bodies are subject to the statutory duty of candour.

16. While the Coroners and Justice Act 2009 does not impose a statutory duty of candour in respect of inquests, the Government has set out principles to guide the behaviour of those it instructs in coronial proceedings to ensure they adopt "openness and honesty, including supporting the disclosure of all relevant and disclosable information to the coroner".[21] However, too often agencies and services approach inquests defensively, with a perception that the issuing of a PFD report constitutes a 'defeat'. Similarly, bereaved families we consulted described the approach of agencies and services as "highly adversarial", "fight[ing] tooth and nail" to avoid receiving a PFD report.

17. Government departments, agencies, and private providers must ensure that they approach the inquest process with full candour and proactively provide all relevant information at the appropriate stage and in a timely manner. This will help ensure coroners

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[19] Judiciary, 'Chief Coroner shares the report from the first ever Coroner Attitude Survey and explains how it has shaped his work', March 2023, available here.
[20] Under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
[21] MoJ, 'A Guide to Coroner Services for Bereaved People', January 2020, available here.

receive vital information to inform decision making in this area. We welcome the proposed introduction of a new organisational duty of candour on chief police officers, via the Criminal Justice Bill, to foster a culture of openness and accountability.[22] We also welcome the recently announced review into the effectiveness of the duty of candour for health and social care providers by the Department of Health and Social Care.[23] A statutory duty of candour applicable to all inquest proceedings should be extended to all public bodies and their witnesses.

18. The Chief Coroner's guidance states that coroners should focus on the current position – usually at the end of the inquest – when considering whether they are under a duty to issue a PFD report. However, even when a concern has been addressed locally, a PFD report may well still be appropriately made to a relevant national organisation "to highlight issues more widely" if the evidence suggests that the risk of future fatalities may arise nationally, and if the coroner believes that national action should be taken.[24] On the other hand, as coroners stressed to us in our consultation and as explained in the Chief Coroner's guidance and case law, the PFD jurisdiction is ancillary to the inquest process and inquests are not public inquiries. Coroners suggested that further training, provided by the Chief Coroner's Office, might be valuable to better inform their decision-making on the proper discharge of their PFD jurisdiction, and that there is a need for collaborative learning and training on the purpose of PFD reports more generally.

19. Further, as highlighted above, PFD reports are often published long after the issue in question has been identified and could have been reported on, particularly in the case of deaths in detention. This is often because investigations by other bodies – such as the PPO or IOPC – are carried out first. Coroners cannot issue a PFD report until they have "considered all the documents, evidence and information that in the opinion of a coroner are relevant to the investigation".[25] However, provided the evidence is sufficient at an early stage, interim reports may provide a vital opportunity to raise matters of concern where urgent action is needed. While the possibility of such interim reports is recognised in the Chief Coroner's guidance, limited practical guidance is currently provided and such reports are relatively rare in practice. The Chief Coroner's guidance should be supplemented to further address when it may be appropriate to make interim PFD reports and underscore the importance of doing so where appropriate.

Could the way PFD reports are being used to prevent further deaths be improved?

20. The Chief Coroner's guidance on PFD reports states that reports "should be clear, brief, focused, meaningful and, where possible, designed to have practical effect".[26] We looked at a sample of 20 PFD reports across the four main places of detention. Our sampling

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[22] UK Parliament, 'Criminal Justice Bill', November 2023, available here.
[23] DHSC, 'Duty of candour review: terms of reference', December 2023, available here.
[24] Judiciary, 'Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths', November 2020, available here.
[25] Regulation 28(3) of the Coroners (Investigations) Regulations 2013, available here.
[26] Judiciary, 'Revised Guidance No. 5 Reports to Prevent Future Deaths', November 2020, available here.

exercise identified gaps and cases of best practice not being followed. The table below identifies the number of PFD reports in the sampling exercise that we reviewed against the requirements set out by the Chief Coroner.

Requirements	Yes	No
Details of inquest and jury verdict outlined	19	1
Circumstances of death detailed	14	6
Specific, practical, and clear matters of concern	15	5

21. Our consultation with families underscored the frustration they felt at coroners not drawing on previous PFD reports issued by the same body in what seemed to them similar, relevant cases, often in the same place of detention. Unless they are provided by 'interested persons', coroners are likely to take account of relevant previous PFD reports only where they have capacity to undertake their own research. The Chief Coroner recently made improvements to the online database of PFD reports. We urge the Chief Coroner to build on this progress to ensure that the database is fully searchable by thematic areas and locations, and that deaths in detention are readily identifiable, in line with the JSC's recommendation to ensure "information is well-organised and easily searchable".[27]

22. Further, the impact of a PFD report lies in the responses it can elicit from agencies and services to either demonstrate that changes have been made or commit to making them. However, coroners have no legal powers or duties to follow up on whether the matters of concern have been effectively addressed, and there is no wider system for doing so. This issue was highlighted by the Lord Chancellor Alex Chalk KC MP, then Parliamentary Under Secretary of State at the Ministry of Justice, during his appearance before the JSC in 2020, stating that "the bigger issue is how you go about enforcing some of this stuff".[28]

23. During our consultation with coroners, they described a high level of variation in responses from different agencies to PFD reports, with some appearing to be "cut and paste" and in other cases there being no response at all. Our sampling exercise of PFD reports found an alarming number of recipients who are required to provide a response within 56 days but had failed to do so. Of the responses, few provided specific timescales for the action proposed, and almost no responses included direct reference to the wider national evidence or implications. Recipients of PFD reports should ensure that their responses are timely, high-quality, and case-specific. Actions should be identified in precise terms and with clear timelines. Where no action is to be taken, a clear, informative, and respectfully worded explanation should be provided. Additionally, more should be done to ensure PFD

[27] UK Parliament, 'House of Commons Justice Committee. The Coroner Service. First Report of Session 2021-22', May 2021, available here.
[28] UK Parliament, 'Oral evidence: The Coroner Service', HC282, November 2020, available here.

reports are routinely shared 'horizontally' within or across organisations and detention sectors to make sure wider lessons can be learned.

24. As highlighted previously by the JSC,[29] there is widespread concern that a lack of follow-up mechanisms may limit the impact PFD reports can have. There is no obligation on the coroner, or any other organisation, to do anything further with responses received, such as assess them for their quality or to follow them up. Whether changes are made following a PFD report is often only highlighted if a similar death later occurs in the same establishment or agency. Following up PFD reports and achieving accountability is particularly difficult where there are multiple agencies involved in the care of an individual who has died in custody. In response to the JSC's recommendation on the establishment of an independent office to follow up on PFD reports, the Government recognised "that there is more that can be done in this space to ensure that PFD reports actively contribute to improvements in public safety",[30] yet no progress has been made. We urge the Government to consider what enhanced role independent bodies might play in auditing, following up, and reporting on PFD reports.

25. Relatedly, it was originally intended for the Chief Coroner to have a research function. In its 2004 position paper on reforming the coroner and death certification service, the Government stated that PFD report recommendations (then known as Rule 43 reports), and their implementation, should be reviewed in an annual report of the Chief Coroner to enable "better use to be made of the lessons that can emerge from a coroner's investigation".[31] Limited progress on this has been made in the two decades since. The Chief Coroner's Office should be adequately funded to enable it to produce a yearly review of PFD reports for custody deaths. This should aim to identify themes and trends, and report on the timeliness and quality of responses.

26. The IAPDC would welcome the opportunity to provide oral evidence.

January 2024

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[29] UK Parliament, 'House of Commons Justice Committee. The Coroner Service. First Report of Session 2021-22', May 2021, available here.
[30] UK Parliament, 'The Coroner Service: Government Response to the Committee's First Report', September 2021, available here.
[31] Home Office, 'Reforming the Coroner and Death Certification Service. A Position Paper', March 2004, available here.