WRITTEN EVIDENCE FROM ANNA MORRIS KC (HBL0001)

Further evidence to the Joint Committee on Human Rights on the Public Authority (Accountability) Bill 2017

A. INTRODUCTION

1. I was privileged to give evidence to the oral hearing of the Committee sitting on the 19th July 2023, and I am grateful for the invitation to provide further written evidence to supplement my oral evidence. In my evidence, I endeavoured to answer the Committee's questions about the importance of funding for bereaved families at inquests and how this would strengthen protection for Article 2 ECHR (the right to life). In the following supplementary written evidence, I expand further on some of the key ways in which proper funding for family legal representation strengthens those protections.

2. Also provided to the Committee with my evidence is a briefing prepared by INQUEST, a charity with expertise on state related deaths and their investigation which has provided their expertise to the bereaved, lawyers working on their behalf and to parliamentarians over the last four decades. In their briefing, INQUEST highlight how the current state of imbalance between funding for the state and bereaved families can create delay and unnecessary expenditure.

3. INQUEST also surveyed the INQUEST Lawyer's Group for further information on the current issues affecting families due to the ongoing lack of legal aid. In their evidence, they give clear examples of complex and significant inquests involving state bodies where the family have not been represented. They also highlight the lack of up-to- date information on the annual expenditure of government departments on their own legal costs at inquests.[1] In addition, the Legal Aid Agency does not publish their total expenditure on Exceptional Case Funding in inquests within their public Legal Aid Statistics.[2]

[1] See paragraph 9 of the INQUEST submission.

4. I echo INQUEST's request that the Committee obtain these figures from the Legal Aid Agency, relevant Government Ministries (the Ministry of Justice and the Department for Health and Social Care amongst others) as well as from the 43 Home Office funded police forces and British Transport Police and NHS foundation Trusts in order to assist the Committee's analysis.

5. The Committee could also pose these questions to the Lord Chancellor/ Minister for Justice if he gives evidence to the Committee in due course.

B. PROPORTIONATE FUNDING AND IMPROVING THE INQUISITORIAL PROCESS

6. The coroner's court is one of the key processes by which the State discharges its Article 2 ECHR investigative obligations. One was that it discharges this obligation is by specifically conducting investigations that expressly comply with those obligations. These are often referred to as "Middleton" inquests,[3] where at a preliminary stage in the investigation the coroner makes a finding that on the evidence before them, it is arguable that either the "operational" or the "systemic duty" of Article 2 ECHR has been breached.

7. However, in **all investigations and inquests** conducted by any coroner, whether the inquest lasts 1 hour or 1 year, the coroner has a statutory duty to report matters that arise during the investigation that in their view continue to pose a risk of future deaths.[4]

8. These reports, which are known colloquially as "Prevention of Future Death Reports" are an important function of the coronial jurisdiction that form part of the wider picture of how the state complies with its Article 2 ECHR obligations by identifying systemic or operational issues that pose an ongoing risk to life.

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[2] For example, the Legal Aid Agency – Annual Report and Accounts 2021-22 – available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1091058/LAA_Annual_Report_and_Accounts_2021-22_web.pdf

[3] following the case of *R(Middleton) v HM Coroner for Western Somerset* [2004] 2 A.C. 182

[4] Coroners and Justice Act 2009 Schedule 5 Section 7, and Regulation 28 of the Coroners (Investigations) Regulations 2009.

9. Prevention of Future Death Reports are issued normally to the Chief Executive of a Health Care Trust (or the Chief Constable of a Police) force or other applicable person whom the coroner determines can make the required changes and are published on the Chief Coroner's website. Many state agencies view these Reports as a form of criticism and therefore conduct themselves with institutional defensiveness to avoid both critical findings and a report being issued.

10. In a high number of inquests held across England and Wales, at least one agency of the state is often identified as an Interested Person and is legally represented. This is often in a case where the state agency has conducted its own internal review and identified issues with the delivery of care/ actions of its agents.

11. It is important to note that one of the main bases for granting Interested Person status to a state agency is under s.47(2)(f) Coroner's and Justice Act 2009 where, "a person who may by act or omission have caused or contributed to the death or whose employee or agent may have done so."

12. When so designated, and particularly where there is a chance that the coroner may issue a Prevention of Future Death Report, the relevant Trust, Prison, Police Force or Local Authority is likely to fund their legal "defence" which can lead to them adopting an adversarial approach through legal representative, despite the coronial jurisdiction being an inquisitorial system.

13. Bereaved families have often heard the argument that to provide them with funding for their own lawyers would make coronial proceedings more adversarial. The reality of a lack of funding for bereaved families is that in these cases state bodies can make submissions to a coroner without any counter legal analysis or narrative being advanced. Without proper legal representation, the families themselves cannot be expected to assimilate and analyse complex medical, factual and policy material and provide legal submissions to a coroner.

14. As this Committee has already itself noted in its 2018 report, "Enforcing Human Rights" "*powerful evidence suggests that the justification that legal aid funded representation is not generally required is invalid*."[5] In that Report, the Committee made a recommendation that;

[5] At paragraph 67 of the JHRC Report, citing the evidence of the family of Connor Sparrowhawk, and others. https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/669/669.pdf

> *"If inquests are to remain inquisitorial, families must be given non-means tested funding for legal representation at inquests where the state has separate representation for one or more interested persons."*[6]

15. As the Committee is no doubt already aware, the proposal that bereaved families be provided with funding for full legal representation at inquests has been a consistent recommendation of several significant reviews since the MacPherson Report in 1999. These include[7] –

    a. The Corston Review (2004), a report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system
    b. The Harris Review (2015), an independent review of self-inflicted deaths in custody of 18-24 year olds.
    c. The Angolini Review (2017, an independent review of deaths and serious incidents in police custody.
    d. Bishop James Jones' Review following the Hillsborough Disaster. (2017)
    e. The Bach Commission (2017), - The Right to Justice.
    f. Independent Review of the Mental Health Act (2019)

16. Significantly, it has also been the recommendation of the two previous Chief Coroners, HHJ Peter Thornton KC in 2016 and HHJ Mark Lucraft KC in 2017.[8]

17. At their heart, these recommendations have recognised that proper funding and legal representation for bereaved families improves the inquisitorial process because of the equality of arms and the consequent ability of those representing families to assist a coroner or inquiry in identifying and exploring the issues.

18. His Honour Judge Lucraft, (then the Chief Coroner) presiding over the London Bridge Inquests in 2019 endorsed the observations made by his Counsel to the Inquiry that *"the part played by counsel for the families and their solicitors has been of great*

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[6] At Recommendation 9 of the JHRC Report
[7] For full timeline and references, see INQUEST "Now or Never, Legal Aid for Inquests" (2019) https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=a1ec7dcc-9ed6-405c-8af6-2639438e8d00 at page 9.
[8] *Ibid.*

assistance in exploring the issues and allowing the inquests to be as rigours as they have been."[9]

19. The inquests into the deaths of the members of the public that died in the London Bridge attacks were ruled not to engage Article 2 ECHR. There was therefore no funding for the families of those who died. Six families were represented by one King's Counsel and one Junior counsel, pro bono. In contrast, the Security Services instructed three King's Counsel and several junior counsel, and three different police forces each instructed King's Counsel and junior counsel. Because the engagement of Article 2 ECHR is currently the criteria for the grant of Exceptional Case Funding, the families of the perpetrators of the terrorist attacks automatically received funding for their inquests, as they were killed by state agents.

20. The significant role that legal representatives of bereaved families play in the forensic vigour of an inquest or Inquiry was re-iterated by Tim Suter, Solicitor to the Inquiry in Hillsborough, the Birmingham Pub Bombings and the Manchester Arena Inquiry when he gave evidence to the Public Bill Committee Hearing on the Victims and Prisoners Bill in June 2022:

> **"**. *For a public inquiry, section 40 allows the chair to make the provision for lawyers—for legal representation—at public expense. In that sense, there is already the ability to grant funding. For inquests, I absolutely agree that it goes to equality of arms, and that there must be the ability for bereaved families to be properly legally represented. It makes my job harder, sometimes, but that is a thoroughly good thing—that I can be asked, "Why are you advising the chair or the coroner to take this view? Have you taken this into account?" Having that makes it a proper inquisitorial process—a search for the truth."*

C. <u>REDUCING THE COST OF INVESTIGATONS</u>

21. As the evidence from INQUEST highlights, the risk of a second inquest or reinvestigation is greatly reduced when the scope of an inquest is broad enough to uncover the full circumstances of someone's death. Specialist legal advice and

[9] As cited in JUSTICE, "when things go wrong" at page 80, fn 239 https://justice.org.uk/wp-content/uploads/flipbook/34/book.html#p=87

representation from the outset of a coroner's investigation allows the bereaved family and their representatives to assist a coroner in respect of the proper and full scope of an inquest. INQUEST have identified several examples within their evidence of cases where family representatives have contributed submissions that have resulted in the proper broadening of the scope of an inquest and the identification of legitimate lines of inquiry.[10]

22. The reality is that solicitors and barristers that are experienced in representing families know what materials they can expect a police force/ mental health trust to hold and can assist a coroner in identifying relevant lines of inquiry and disclosure requests, shortening pre-inquest times.

23. Without specialist representation, bereaved families should or could not be expected to make submissions on complex, traumatic material, often involving expert evidence or specialist knowledge of organisational systems and processes. Often submissions on scope require legal submissions, particularly in relation to the question of whether it is arguable that Article 2 ECHR has been breached.

24. The JUSTICE working group, also noted that there would be a collateral benefit to proportionate funding for bereaved families in all cases. They observed that the lack of availability of public funding outside of cases where Article 2 is engaged invariably leads to extensive argument (in often increased court hours) about whether it is engaged. They suggest that the adoption of an equality of arms would address this issue of delay and expense.[11]

25. There is also a clear and significant cost to redressing investigative failures that take place when families did not have legal representation from the outset. The Hillsborough Inquests were the longest jury inquests in this coronial jurisdiction, with estimated costs of over a £100m.[12]

[10] At para 21 of the INQUEST briefing.
[11] JUSTICE, "when things go wrong" Ibid at page 83, fn 251
[12] https://www.dailymail.co.uk/news/article-3900808/Legal-bill-Hillsborough-inquests-hits-100-MILLION.html

26. As I set out in my oral evidence, the first inquests into the deaths of four soldiers that died at the Deepcut Army Barracks between 1995 and 2002 were conducted without Legal Aid available to the families, who had to represent themselves or seek pro bono assistance in the inquests that took place between 2002-2006.

27. In 2012 the families, with specialist legal assistance, launched a claim under the Human Rights Act against the Ministry of Defence, (relying on the investigative duty under Article 2 ECHR) to compel the disclosure of thousands of pages of documents 17 years after the deaths. This disclosure resulted in the re-opening of the coronial investigation and the conduct of second inquests into the four deaths in 2019, presided over by HHJ Peter Rook KC. The families were funded throughout these second inquests and had representation by King's Counsel and junior counsel. The inquests lasted over 6 months and heard evidence from 117 witnesses.

28. Both these historic cases are high profile examples of the significant financial cost of not conducting a full and fair inquisitorial process with families properly represented from the outset. They are but two examples of where the families have had to use civil or public law remedies (which can also incur a public cost) to compel the state to comply with the Article 2 investigative obligation.

29. Another example is the inquest into the death of Donna Neil. Donna was reported dead on 10 December 2018 in her flat in East London. Toxicology reports indicated that she had fatally ingested oxycodone and pregabalin, her husband Martin's prescribed medication. On 3 July 2019 an Assistant Coroner conducted the inquest into Donna's death. He called no witnesses and concluded that Donna had capacity and had made an informed decision to consume an excess of oxycodone and had died of an inadvertent overdose. Donna's mother issued judicial review proceedings of the conclusion and the inquest was quashed by the High Court by Order dated 17 December 2019. A new inquest was ordered, and the matter allocated to HM Senior Coroner. In a written ruling dated 9 November 2021 she found that Article 2 ECHR was engaged in that state agencies knew or ought to have known that Donna's life was at risk.

30. After hearing four days of evidence, HM Senior Coroner returned her conclusions on 13 September 2022. She found that Donna was living hazardous conditions and that

failings on the part of Donna's husband, the London Borough of Newham (LBN) and the East London Foundation NHS Trust (ELFT) all contributed to her death. She also indicated her intention to make a report to prevent future deaths around the failure by ELFT to document, assess and manage the risk around Donna's ingestion of unprescribed medication.[13]

31. There are likely to be many other examples in coroner's courts across England and Wales that are not as high profile where inquests have had to be quashed and new investigations ordered. As well as the financial cost of these insufficient investigations, there is a tragic personal cost to the bereaved families. They suffer not only the injustice of an inadequate investigation into the death of their loved ones, but then must endure the months, years, and decades it can take to remedy the injustice and finally get the answers that they deserve and the public need.

(1 September 2023)

[13] Bhatt Murphy Solicitors, Press Release, *Coroner concludes that gross failings and neglect contributed to death of Donna Neill*, 14th September 2022
https://bhattmurphy.co.uk/files/SRN%20cases/Donna%20Neill%20Press%20release%20FINAL.pdf