



Ministry
of Justice

Final report:

Review of legal aid for inquests

February 2019

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Review of legal aid for inquests

Presented to Parliament
by the Lord Chancellor and Secretary of State for Justice
by Command of Her Majesty

February 2019



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Equalities

We will be publishing an Equality Statement alongside this report to identify the likely impacts of the policy changes that are outlined in this report.

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Foreword

An inquest is a public hearing, conducted by a coroner in a coroner's court, which seeks to establish who the deceased was and how, when and where they came by their death.

Whilst this process can be traumatic for the bereaved family, the search to find out what happened is important in helping them to understand and make sense of their loss as well as ensuring that there is proper accountability.

The Government is determined to ensure that bereaved families are properly supported and able to participate in the inquest process. This includes providing legal aid in cases where it is most needed.

It is important that people have confidence in every part of the justice system. The legal aid scheme is designed to make sure that those who are most vulnerable, and who have no other means of funding support, are provided with assistance.

It is in this light that in 2017 the then Lord Chancellor, the Rt Hon. David Lidington MP, decided that the Ministry of Justice should conduct a review of the current availability of legal aid at inquests.

This report is the culmination of the thorough and wide-ranging review that the Department has undertaken over the last year. It summarises the key points raised by stakeholders as part of our extensive evidence-gathering, including the responses submitted to a call for evidence which we conducted over the summer.

The Government's conclusion is that whilst the vast majority of inquests are inquisitorial and fair, there is a need to do more to ensure that inquests do not become adversarial, that the coroner is fully in control and that the behaviour of lawyers is as it should be, and also that there is a need to improve guidance literature for those navigating the process.

The outcome we seek is a more supportive, accessible and effective inquest system.

Lucy Frazer QC MP

Edward Argar MP

Parliamentary Under-Secretaries of State for Justice

Executive summary

1. Coroners investigate violent or non-natural deaths, deaths of unknown cause, and deaths in custody or other state detention. An inquest is a public court hearing heard by a coroner (a specific type of judge) to establish who the deceased was and how, when and where they died. It is, first and foremost, an inquisitorial process, which means that the coroner's role is to investigate and decide what the facts are.
2. In response to reports which called for changes to the current availability of legal aid for bereaved families, the Ministry of Justice committed to reviewing the existing provision of legal aid for inquests. The Department sought the views of a wide range of stakeholder groups. Evidence-gathering included surveys of senior coroners, consultative group discussions with the legal profession, third sector organisations and bereaved families, and a six-week call for evidence exercise which was held over the summer.
3. The review sought to better understand the circumstances in which families may require legal representation to allow for a fair inquest process, and whether changes need to be made to current eligibility criteria. It also sought to identify measures to make inquests more sympathetic to the needs of bereaved families.
4. This document serves as the final report of the review. It examines the evidence submitted as part of the review, considers the key concerns identified by respondents, and identifies potential areas for improvement to the inquest process as a whole.
5. The options set out in this document seek to improve the current system based around the following principles:
 - Inquests should be inquisitorial;
 - Coroners should run inquests in a way that is sympathetic to the needs of the bereaved, without compromising the delivery of justice;
 - Coroners should control the way lawyers conduct themselves in inquests;
 - Lawyers should know what is expected of them;
 - Families should understand the coroner process and be able to follow proceedings;
 - Families should feel that the process has been fair and properly conducted; and
 - Families should be aware of what legal aid is available and, if eligible, how to apply for it.
6. This report announces a range of changes to the current system with these principles in mind. The report is structured into the following three sections:
 - A. Initial contact and communication with bereaved family members;
 - B. Legal aid for inquests; and
 - C. The Inquest Hearing.

7. Within these three sections, a number of changes are announced, all aimed at improving the current legal aid process and developing a more supportive system for bereaved families:

A. Initial contact and communication with bereaved family members

8. It is clear from stakeholder engagement that bereaved families may face problems accessing information about the investigative process, and there is scope to improve the accessibility of written information available.
 - i. As well as improving the MoJ *Guide to Coroner Services*, we are considering with coroner's offices other ways to distribute, publicise and make the new Guide available;
 - ii. We will also work to provide a separate piece of guidance literature for families, which will set out the legal aid system including existing definitions and criteria for funding in a way that is easy to understand; and
 - iii. We will also develop better signposting of support services at coroner's courts and making sure families know who is in the courtroom and what their role is.

B. Legal aid for inquests

9. Evidence pointed to a number of concerns that stakeholders hold regarding the provision of legal aid and the role of the families in the application and inquests process. In particular, it suggested the current legal aid application process might not be fully understood. Similarly, evidence suggested that there are difficulties in understanding the eligibility criteria for legal aid and the types of cases where funding may be available. We also considered the recommendation to expand the provision of legal aid for certain types of cases – such as death in custody cases, and cases where the state are represented.
 - i. In order to make sure that providers are aware of how the current system works in these cases, we will explore options to raise awareness and clarify the eligibility process in the provider funding pack;
 - ii. In order to improve understanding of the eligibility criteria, we will set this out in separate guidance for families, as mentioned above;
 - iii. In order to address difficulties with the application process, we will look at the procedure for claiming under the Exceptional Case Funding Scheme to ensure it works as effectively as possible;
 - iv. Having considered the impact of additional representatives on bereaved families, the financial considerations, and the impact of a possible expansion on the wider legal aid scheme, we have decided that we will not be introducing non-means tested legal aid for inquests where the state has represented. However, going forward, we will be looking into further options for the funding of legal support at inquests where the state has state-funded representation. To do this we will work closely with other Government Departments.
 - v. The evidence we have gathered will be considered as part of a review into the thresholds for legal aid entitlement, and their interaction with the wider criteria.
 - vi. We will be introducing a provision for the backdating of the legal help waiver, so that all such payments can be backdated to the date of application should a waiver be granted.

C. The Inquest Hearing

10. The evidence suggested that stakeholders thought there is inconsistency in the approach and practice between coroners, and the behaviour of legal representatives. Evidence also pointed to inconsistency in the availability of support services in coroner's courts, and the need to consider improvements to the lay-out of the court.
 - i. In order to make court premises better suited to the needs of the bereaved, we will be considering options for improved facilities at inquests;
 - ii. We will be considering options for expanding support services; and
 - iii. We will also be considering options for improving the conduct of lawyers.
11. We would like to thank everyone who has contributed to the evidence-gathering stage of this review. Hearing the experiences and thoughts of those who have been through the inquest process has proved invaluable, and we hope to use this evidence to make key improvements to the system, and the experiences of those involved in the inquest system.

Introduction

Aims and objectives

12. In 2017 the then Lord Chancellor committed to reviewing the provision of legal aid for inquests and making changes to the Lord Chancellor's Exceptional Guidance (Inquests).
13. In June 2018, we published changes to the Guidance. The changes make clear that legal aid is likely to be awarded for representation of the bereaved at an inquest following the non-natural death or suicide of a person detained by police, in prison, or in a mental health unit.
14. The changes also added that particular consideration should be given to the circumstances of the bereaved, for example the distress and anxiety suffered as a result of the death, when Legal Aid Agency (LAA) caseworkers are deciding whether to apply the financial means test.
15. Additionally, changes were made to ensure that only the individual applicant's financial means will be tested and not the means of family members (as before), helping to ease the burden of the application process. Further details on these changes are explained in Chapter Two.
16. The Ministry of Justice has also undertaken an evidence-based review of the existing availability of legal aid, alongside a broader exploration of the current legislative framework and arrangements in place to support bereaved families navigating inquest proceedings.
17. We initially set out simply to assess the current provision of legal aid for inquests. We looked at the eligibility criteria and statutory tests that applicants are required to fulfil. However, the evidence-gathering process revealed that we needed to look at the coronial system as a whole, and the types of changes needed to better support bereaved people who are faced with attending inquest proceedings, to ensure that they can understand and properly participate in those proceedings.
18. This final report of the review therefore looks broadly at the inquest system. We have analysed the evidence collected as part of this review, and have worked closely with a wide range of key stakeholder groups and other government bodies to produce this final report.
19. This report sets out our findings. It summarises the views and opinions of a wide range of stakeholders, and highlights the areas for improvement identified. It also announces several changes which are already in hand.
20. We have endeavoured to keep the needs of the bereaved at the heart of the proposals, and we hope readers will feel that the policy questions in this report reflect the issues raised by stakeholders who have experienced first-hand what it is like to attend inquest proceedings.

21. The proposals presented in this report are suggested with the aim of ensuring that future changes will result in a more supportive, inclusive, and effective inquest system.
22. One important policy development which is not discussed in this document is the Independent Public Advocate (IPA). Whilst the sole purpose of the IPA is to provide support for families after major disasters, and during the investigations that follow, the IPA has been the subject of a public consultation which ran from 10 September to 3 December 2018 and the Government will publish its response to the consultation, setting out the way forward, in the spring.

Background: inquests and the role of the coroner

23. Coroners and the investigations they carry out have been an important part of the justice system in England and Wales for hundreds of years.
24. Under the Coroners and Justice Act 2009, a coroner will conduct an investigation into a death if the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or other state detention. An inquest, if one is needed (it may not be) is the part of the investigation that takes place in a court room, where the coroner will hear evidence from witnesses.
25. An inquest is a limited form of public inquiry (and in a limited number of cases, a substitute for a public inquiry) to determine who the deceased was and how, when and where they came by their death.
26. Coroners adopt an inquisitorial rather than an adversarial approach. Their role is to investigate a death so as to establish the facts, but they do not apportion blame or determine either criminal or civil liability - indeed, they are prevented by law from determining such liability. In an adversarial process, such as a Crown Court trial, the judge does not decide what the facts are – that is for the jury – but acts as a referee between the prosecution and the defence.
27. Another important distinction is that in a criminal trial the parties are opposed – indeed “adversarial” – with the prosecution seeking to persuade the jury that the accused is guilty beyond reasonable doubt and the defence seeking to persuade the jury that that is not the case. When people raise concerns about inquests becoming more adversarial they mean that the approach adopted by lawyers representing those concerned with the death (known as ‘interested persons’) is more like that of the prosecution and defence in a criminal trial, which might be characterised as point-scoring - rather than assisting the coroner to get to the truth - and that this is having an adverse impact on bereaved families.
28. In some cases, the coroner will make what is known as a “report to prevent future deaths” which reflects lessons learned from an inquest and which is sent to organisations which may have somehow been involved in the death. An example would be following a hospital death where systemic failings have been identified. But here too, the coroner does not apportion blame.
29. A coroner is a judicial office holder – a kind of judge – and like other judges is wholly independent of government. As such it would be inappropriate for ministers or their officials to comment on the decisions made by a coroner or seek to influence a coroner in making those decisions.

30. There is no single national coroner service. Rather, there are currently 88 coroner areas, each typically covering a handful of local authorities. Each coroner area has a legally qualified salaried senior coroner, one or more fee paid assistant coroners and in some larger areas, a salaried area coroner. The senior coroner will be assisted by investigating coroner's officers as well as administrative staff. Coroners, their staff and their accommodation are funded by the local authorities they serve.
31. In England and Wales there are around half a million deaths annually, of which around 225,000 are referred to coroners for investigation. Around 30,000 of these result in an inquest. Of these, about 500 relate to deaths in custody or other state detention, such as a secure hospital.

The 2013 reforms to the coroner system

32. In July 2013 the Government implemented a major suite of reforms in the Coroners and Justice Act 2009 which changed the way coroner investigations and inquests are conducted, with the aim of putting the needs of bereaved people at the heart of the coroner system. Coroner services continued to be locally delivered but within a new framework of national standards to enable a more efficient system of investigations and inquests. The reforms give bereaved people access to most documents seen by the court; bereaved people can expect the coroner's office to update them at regular intervals and explain each stage of the process; and the reforms emphasised the requirement to treat bereaved people with compassion and respect.
33. Perhaps the most important of the 2013 reforms was the introduction of the role of Chief Coroner, who provides leadership, guidance and support to coroners, promulgating best practice and overseeing coroner training. The Chief Coroner, originally HH Sir Peter Thornton QC and now HHJ Mark Lucraft QC, has had a huge impact in recent years. The Chief Coroner has drawn the coronial service together, raising standards and helping to improve the service to bereaved families.
34. Whilst much has been achieved since 2013, with examples of outstanding practice up and down the country, we are clear that there is more to be done to ensure that inquests are sympathetic to the needs of bereaved families. The Government is satisfied that the bulk of the 30,000 plus inquests held every year are held in an inquisitorial manner, with the interests of bereaved families being met, but we know that this is not always the case.

Current provision of legal aid for inquests

35. Both the coronial system and legal aid system should ensure that bereaved family members are placed at the heart of the inquest process. This has long been a priority of the Department.
36. The current availability of legal aid was arrived at on the premise that inquests are inquisitorial. The Government recognises that families might require early legal advice and assistance. In the legal aid scheme this is known as 'legal help' and public funding for bereaved family members is available for inquests into all types of deaths, subject to means and merits tests. Solicitors providing early legal advice may carry out a range of advice and assistance tasks covered under legal help.
37. The Government also acknowledges that for certain types of inquests, families may require additional support in the form of representation at the inquest hearing itself.

Legal aid for representation may be available in these cases via the Exceptional Case Funding scheme (ECF). The ECF scheme is in place to provide legal aid for representation at inquests, subject to means and merits tests, where there would be a breach or a risk of a breach of the European Convention on Human Rights (ECHR) or an enforceable EU law right if legal aid was not made available; or where conditions are met for a ‘wider public interest determination’.

38. This was the position for inquests prior to the introduction of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) – the piece of legislation that sets out the current legal aid scheme – and it remains the position today.
39. Currently, when an application for ECF is received, Legal Aid Agency (LAA) caseworkers will look at the inquest case and, in relation to legally-aided representation at an inquest, make a decision as to whether, in their view:
 - a. legal aid for representation at an inquest is required by a Human Rights Act Convention right (most commonly Article 2 of ECHR) or it is considered appropriate to grant legal aid because of a risk to the rights of the applicant; and / or
 - b. the conditions are met for a ‘wider public interest determination’ that, in the particular circumstances of the case, the provision of representation for the individual at the inquest is likely to produce significant benefits for a class of person, other than the applicant and the members of the applicant’s family.
40. Further details on the existing system of legal aid will be provided in chapter two of this final report.

The case for reform

41. A number of reports published over the last few years have raised concerns about the current provision of support for bereaved families. In particular, the following reports and debates have called for a review of the provision of legal aid for families attending inquests:
 - a. Dame Elish Angiolini’s independent review of deaths and serious incidents in police custody, published in October 2017, called for non-means tested legal aid for families attending inquests into deaths in custody;¹
 - b. Lord Bach’s final report of his Commission on Access to Justice, published in September 2017, recommended funding for legal representation for the family in cases where the state provides representation for one or more interested persons;²
 - c. Similar recommendations have since been adopted in other reports:
 - i. Bishop James Jones’ review of the experiences of the Hillsborough families, published November 2017,³

¹ Rt. Hon. Dame Elish Angiolini DBE QC, Report of the Independent Review of Deaths and Serious Incidents in Police Custody, Jan., 2017

² Fabian Policy Report, The Right to Justice: The final report of the Bach Commission, Sept., 2017

³ Rt. Rv. James Jones KBE, ‘The patronising disposition of unaccountable power’: A report to ensure the pain and suffering of the Hillsborough families is not repeated, Nov., 2017

- ii. the Chief Coroner's Third Annual Report to the Lord Chancellor: 2016-17, also published in November 2017;⁴ and
 - d. There have been a number of debates and representations made in Parliament on the subject of the provision of legal aid for inquests in which Members of Parliament have raised concerns about the existing system and equality of arms for families where public bodies have received legal representation.⁵
42. There have, therefore, been growing calls to increase the availability of legal aid for bereaved families in inquests, driven mainly by concern that in cases where state bodies are represented at the inquest, certain inquests are becoming more adversarial.
43. Typically, these are cases where there is the suggestion that an arm of the state – perhaps a police force, NHS Hospital Trust or Her Majesty's Prison and Probation service (HMPPS) – had some involvement in the death. However, it was clear from the Ministry of Justice's engagement with stakeholders, and from the reports by Dame Elish Angiolini and Bishop James Jones, that there are other aspects of the inquest process – such as coronial practice and support services – that could be improved to make the system for bereaved family friendly, separate to the provision of legal aid.
44. We have listened carefully to the views provided. This work has highlighted the importance of bereaved families being involved in coroner investigations from the outset; of their having regular contact with the coroner's office; and of their being able to benefit from better signposting to sources of advice that are tailored to their needs. Then, in the inquest itself, it is important that families are able to follow proceedings and that they come away feeling that a fair and proper investigation has been carried out. It is particularly important, in cases where there is a suggestion that an arm of the state was involved in the death, that the family do not feel that the inquest was one-sided, that they were at a disadvantage, and that justice has not been done.
45. Bereaved families need better awareness of when legal aid is available, but whilst we accept that in some cases it is right that they should have legal representation we are mindful that a significant expansion of legal aid could have the unintended consequence of undermining the inquisitorial nature of the inquest system. It could also reinforce the commonly held misconception that an inquest's role is to apportion blame, as opposed to finding fact and learning lessons.
46. All the work we have done affirms the need to maintain an inquisitorial system and highlights the crucial role of the coroner in achieving this. The measures set out in this document therefore seek to improve the current system rather than revolutionise it.
47. The views of stakeholders have been vital to the development of the policy set out in this document. That engagement will continue. We have recently established an inquest stakeholder forum to enable stakeholders to come together with the Ministry of Justice to discuss coroner service issues. This forum met for the first time in October. Forum members include government departments, the Chief Coroner's

⁴ Chief Coroner's Annual Report 2016 to 2017, Nov., 2017

⁵ Early day motion 498, Legal Aid for Inquests, 2 Nov., 2017 .; Westminster Hall Debate, Legal Aid: Birmingham Pub Bombings, 27 Mar., 2018

office, representatives from the coroner service and three important third sector organisations - Cruse Bereavement Care, the Coroners' Courts Support Service and INQUEST. The forum will help us make sure that the work we do - such as improving existing guidance and producing new guidance - meets the needs of bereaved families.

Evidence gathering

48. The conclusions and recommendations set out in this report are based on the evidence submitted and analysed from a range of evidence-gathering exercises conducted over the past year, as set out in the following paragraphs.
49. *Official-led meetings:* We have held several official-led meetings with key stakeholder groups that are involved in the inquest process. Efforts have been made to ensure that a cross-section of stakeholder groups have contributed to each stage of the review. Representatives from the following stakeholder groups have been consulted:
 - a. Bereaved family members;
 - b. Charities / third sector organisations;
 - c. Arms-length bodies;
 - d. Legal profession;
 - e. Legal Aid Agency caseworkers;
 - f. Senior coroners; and
 - g. Civil servants.
50. *Surveys:* We have conducted a survey of senior coroners who were asked to provide observations based on their experiences about the types of inquests in which publicly funded legal representation may assist the administration of justice. Questions also centred on how families could be better supported throughout the process, in order to understand and participate properly. Over 50 per cent (48 out of the 89 coroner areas in England and Wales) responded to the survey.
51. We have also conducted a survey of volunteers working for the Coroners' Courts Support Service (CCSS). The CCSS is a charity whose trained volunteers offer emotional support and practical help to bereaved families, witnesses and others attending inquests in a number of coroner's courts.
52. *Site visits:* In order to better understand the inquest process to inform our review, officials attended a number of different proceedings as follows:
 - a. Pre-inquest reviews;
 - b. Inquests where Article 2 is engaged;
 - c. Inquests where Article 2 is not engaged;
 - d. Inquests where there has been state involvement and the state is not legally represented; and
 - e. Inquests where there has been state involvement and the state is legally represented.

53. *Cross-government work:* We have worked with colleagues in other government departments and government bodies to consider existing funding systems in place at inquests where the state is involved. The Home Office and NHS Resolution have been particularly helpful in this work.
54. *Call for Evidence:* In July 2018, the Department launched a call for evidence which closed on 31st August 2018. It looked at the following areas:
 - a. The legal aid application process and eligibility tests;
 - b. The provision of legal help;
 - c. The provision and style of legal representation; and
 - d. Other support available to bereaved people.
55. We asked for the views of the public on the existing provision of legal aid at inquests. This was aimed at capturing the views of anyone who had been, or was currently, involved in an inquest. Chapter one contained questions on the legal aid application process. Chapter two asked questions on the inquest hearing itself. There was a specific focus on Article 2 cases, inquests where there is state involvement, and inquests where there is a wider public interest element.
56. Chapter three looked more broadly at the inquest system, asking more general questions on support for bereaved people, being concerned in particular with how inquests can be made more sympathetic to the needs of the bereaved. Questions covered:
 - a. The conduct of legal representatives;
 - b. The number of legal representatives often in attendance at inquest proceedings;
 - c. The availability and accessibility of advice and guidance literature; and
 - d. Existing support services in operation in England and Wales.
57. We received 74 responses to the call for evidence, from a wide cross-section of stakeholder groups.
58. *Consultative group discussions:* Having analysed the responses to the call for evidence, we identified areas where we felt we would benefit from additional information. To this end, we invited stakeholder groups to attend two consultative group discussions: we held a discussion with bereaved family members, who provided invaluable insights; and we also held a discussion with representatives from a range of professions who had experience in medical negligence cases.
59. The evidence considered in this final report has been taken from all of the above stakeholder engagement activities. Where necessary, the type of stakeholder group and nature of the discussion is mentioned in relation to the specific points raised. However, we have examined the evidence submitted in its entirety, in order to approach the issues regarding the inquests process in the round and identify broader themes and areas for improvement.
60. We would like to thank everyone who has contributed to the evidence-gathering stage of this review. Hearing the experiences and thoughts of those who have been through the inquest process has proved invaluable, and we hope to use this evidence

to make key improvements to the system, and the experiences of those involved in the inquest system.

Structure of the report

61. This report is divided into three chapters addressing the following key areas:
 - a. Chapter one – Initial contact and communication with bereaved family members;
 - b. Chapter two – Legal aid for inquests;
 - c. Chapter three – the Inquest Hearing

Chapter one – Initial contact and communication with bereaved family members

62. Where a death is to be investigated by the coroner, the family's first contact with the coroner's office will typically be when the coroner's office contacts them, after their loved one's death has been reported to the coroner.
63. The bereaved family will be grieving over the death. Their distress may be greater if, for example, the death was violent or occurred in custody or other state detention. They need to know what is to happen and when, in terms of such matters as access to and release of their loved one's body; any post mortem examination that is needed (which may involve opening the body); and the inquest itself. The whole process is potentially stressful, upsetting and confusing.
64. What has become clear from our stakeholder engagement is that:
- bereaved families may face problems accessing information about the investigative process;
 - there are issues with the suitability of some of the written information that is available, and there is a need for more;
 - there can sometimes be issues with the appropriateness of the language used by staff in coroner's offices; and
 - bereaved families may find it difficult getting hold of staff in coroner's offices, with telephones perhaps going unanswered.
65. We need therefore to pay more attention to communication.
66. In 2014 the Ministry of Justice published its *Guide to Coroner Services* which explains what anyone who comes into contact with coroner services should expect and what to do if the service provided falls short of this. The Guide is good as far as it goes but engagement with stakeholders led us to the conclusion that we need a new edition of the Guide which is shorter, simpler, focused on the needs of bereaved families, and which answers questions they are likely to ask. The work to prepare a new version of the Guide is well in hand and stakeholders have commented on early versions. It will be published in spring 2019.
67. Of course, the mere existence of a new version of the Guide will not of itself help bereaved families; they need access to it. The original version of the Guide was distributed by the Ministry of Justice to coroner's offices in hard copy – around 100,000 were originally distributed – and further copies have been (and still are) provided on demand. It is also available on line at Gov.UK. The Call for Evidence and our other recent engagement have demonstrated however that, aside from the need to refresh and refocus its contents, the problem with the Guide is that it is not as widely known about as it should be and that often it doesn't get to families. It was particularly worrying to hear from several respondents to our survey of CCSS volunteers that they didn't even know the Guide existed.

68. We are considering with coroner's offices other ways to distribute, publicise and make the new Guide available. We will continue to produce hard copies, as well as making it available on Gov.uk, but we need to see what else we can do online and by way of publicity in coroner's courts to make sure it reaches its target audience.
69. Another important point about the new Guide, suggested to us by stakeholders, is that we should take the opportunity it provides to signpost bereaved people to the Coroners' Courts Support Service and other organisations that can provide support, such as INQUEST and Cruse Bereavement Care. Signposting people to early support makes good sense and there is a wealth of understanding and expertise available. Whilst some organisations have extensive coverage, the support available is likely to vary somewhat from area to area, court to court, so it is important for courts to make clear, through posters or other means, what is available.
70. Last year, a short and simple two-side leaflet for families whose loved one died in police custody was developed by the Home Office, Ministry of Justice and the Chief Coroner's Office working closely with INQUEST. Published on 12 December, it is available on Gov.uk.⁶ We are considering further leaflets for deaths in other circumstances, such as deaths in prison or a mental hospital.
71. In addition, our newly established Stakeholder Forum, which met for the first time in October, has suggested that we produce a leaflet, for use immediately after a death has been reported to the coroner, on issues such as the post-mortem examination and viewing and return of the body. We think this has merit.
72. It has become clear that there is a need for bespoke guidance on the availability of legal aid in inquests. One of the key concerns that was raised by stakeholders throughout the review was the lack of understanding of the legal aid system. Bereaved families do not feel that they are equipped with accessible materials that explain the current process and, as such, they do not understand the legal aid application process. This can have direct implications for their ability to consider legal aid and whether they would like to make an application for public funding.
73. Currently, the only guidance families can access is the Lord Chancellor's Exceptional Guidance for Inquests, which can be found on the gov.uk website. However, this document is legally drafted and is aimed at setting out the process to legal aid providers and Legal Aid Agency caseworkers. Those without a legal background often struggle to understand it.
74. Whilst families often have access to the MoJ *Guide to Coroner Services*, legal aid is not its main focus and details of the application process are limited.
75. In order to address these concerns, we will work to provide a separate piece of guidance literature for families. This guidance will set out the legal aid system including existing definitions and criteria for funding in a way that is easy to understand. A separate piece of guidance will also mean that families will be able to refer back to the document and digest information in their own time – something that is very important at a time of distress.

⁶ <https://www.gov.uk/government/publications/deaths-in-police-custody-leaflet-for-families>

76. Two important programmes of training, overseen by the Chief Coroner, will take place in 2019/20, one for coroners and the other for coroners' officers. Chapter three of this report discusses the training for coroners, but it makes sense to discuss in this chapter the training for coroners' officers as they are the people, far more than coroners, who have most contact with the bereaved and who have the earliest contact.
77. Our engagement with stakeholders has identified concerns about the language sometimes used in communication with bereaved families. The initial telephone or other contact with the coroner's office is often the source of any conflict and can set a poor tone for the whole interaction that follows.
78. The Coroners' Officer training will focus on language and dealing sympathetically with vulnerable people. Deborah Coles, the Director of INQUEST, will address the coroners' officers and Dame Elish Angiolini is providing video content to be shown at the sessions. The training is compulsory, residential and held over two days. Seven training sessions will be run throughout the year in order to ensure that all officers can attend.
79. Stakeholders have raised with us the idea of bereaved families taking part in training so they can share their experience. Given, however, that training is a matter for the Chief Coroner it would be inappropriate for the present document to comment on this.
80. Stakeholders have also raised the problem, in some areas, of getting hold of staff at the coroner's office. The Chief Coroner's guidance for local authorities, *A Model Coroner Area*,⁷ sets out a recommended model for coroner services and indicates the ideal complement of coroners' officers, but the Government recognises that staffing can and does in practice vary widely.

⁷ <https://www.judiciary.uk/publications/chief-coroners-annual-report-2016-17/>

Chapter two – Legal aid for inquests

81. Legal aid is available for early advice and assistance (legal help) for all inquests. Legal aid for representation at an inquest may also be available via the Exceptional Case Funding Scheme (ECF). The specifics of this application process and eligibility criteria will be considered in more detail throughout this chapter.
82. Evidence pointed to a number of concerns that stakeholders hold regarding the provision of legal aid and the role of the families in the application and inquests process. This chapter considers each of the following key points raised in evidence:
 - a. Funding in Article 2 inquests;
 - b. Meaning of wider public interest;
 - c. Funding where the state has representation;
 - d. Financial means test;
 - e. Legal help waiver;
 - f. Payment for expenses; and
 - g. Legal Aid Agency practice.
83. This section goes through each concern thematically: outlining the current system, the evidence, and then our response to the evidence.
84. Before addressing these key points, it is worth setting out the types of roles families might feel they need to perform as part of the process. In the main, the bereaved families and providers we consulted as part of the review were keen to highlight the types of activities that bereaved families might be faced with undertaking in the absence of a lawyer, as part of an inquest. They pointed to the following activities:
 - a. Question witnesses;
 - b. Acquire necessary documents;
 - c. Understand those documents;
 - d. Access support from individuals and organisations that understand their particular situation; and
 - e. Ask question regarding the actions to prevent future deaths.
85. Stakeholders pointed to several factors that might affect a bereaved family's ability to perform these tasks effectively, without legal representation. The main factors included:
86. The complexity of the case – In particular, stakeholders referred to healthcare inquests, in which understanding of complex medical terms and the relevant caselaw is required, and specific documents need to be requested as part of the inquest.
87. The legal representation of other interested parties – Our evidence has indicated that the presence of state legal representatives can alter the perceived nature of the process and, in doing so, undermine the ability of the family to feel able to participate to the best of their abilities.

88. The emotional and physical ability of family members – Our conversations with voluntary sector organisations have pointed to case studies where family members have required prolonged psychological intervention in the wake of the inquest, in order to secure help to deal with the emotional experience of participation in the inquest process. It was also noted that the personal proximity of the families to the death can prevent them from being able to ask the objective questions that may assist the coroner in reaching a conclusion, irrespective of the opportunities the coroners provide the families during the inquest process.

Representation in cases involving Article 2 of the European Convention on Human Rights (Article 2)

89. Article 2 of the ECHR imposes on States “substantive obligations” both not to take life without justification and to do all that could be reasonably expected to avoid a “real and immediate” risk to life where the State knows or ought to know of the risk of a breach of Article 2 (the “operational duty”), and also to establish a framework of laws, systems, precautions, and means of enforcement which will, to the greatest extent reasonably practicable, protect life (the “systemic duty”).
90. Article 2 also imposes a “procedural obligation” on the State. The “procedural” obligation to conduct a public investigation into a death arises where there are “circumstances that give ground for suspicion that the State may have breached a substantive obligation imposed by Article 2”.
91. The engagement of Article 2 rights affects the type of inquest that is held.
92. There are two types of inquest. The first type (often called a “Jamieson inquest”) is outlined in section 5(1) and (3) of the Coroners and Justice Act 2009.⁸ The purpose of these inquests is to find out who the deceased was and “how, when and where the deceased came by his death”, as well as certain information required for the registration of the death. Often, the focus is upon “how” the deceased came by his or her death.
93. The second type (often called a “Middleton inquest”) is an inquest which engages the state’s obligation to conduct a public investigation into a death in cases where there might have been a violation of Article 2, i.e. if it appears that state agents are (or may have been) in some way implicated.⁹
94. It is in this second category of inquests that the Article 2 obligations may be such that representation for a family member at an inquest is required. Examples of such cases include:
- a. Deaths whilst the deceased was being arrested or taken into detention. It includes deaths of people who have been arrested or have been detained by police under the Mental Health Act 1983. The death may have taken place on police, private or medical premises, in a public place, or in a police or other vehicle;
 - b. Deaths during or following police custody where injuries that contributed to the death were sustained during the period of detention;

⁸ R v Coroner for North Humberside and Scunthorpe, Ex p Jamieson [1995] QB 1

⁹ R (on the application of Middleton) v HM Coroner for Western Somerset [2001] EWHC Admin 1043

- c. Deaths in or on the way to hospital (or other medical premises) following or during transfer from scene of arrest or police custody;
- d. Violent or unnatural deaths from injuries or other medical problems that are identified or that develop while a person is in custody; or
- e. Deaths whilst the deceased was detained under Section 136 of the Mental Health Act 1983 or other legislation.

The current position

95. As explained above, Article 2 of the ECHR may require legal aid to be available for representation where the procedural obligation under Article 2 arises and, in the particular circumstances of the case, representation for the bereaved family is required to discharge that obligation.
96. As such, LAA caseworkers must be satisfied that, were legal aid not made available, there would be a breach of Article 2, or it would otherwise be appropriate to make legal aid available in light of the risk of a breach of Article 2. They consider two questions:
- a. Has the Article 2 procedural obligation been triggered?
 - b. And if so, is funded representation for the bereaved family required in order to satisfy the procedural obligation?
97. LAA Caseworkers must have regard to the Lord Chancellor’s Exceptional Guidance (Inquests) when making decisions on whether to grant funding for inquests.¹⁰
98. As stated in the introduction, the Guidance was amended in 2018. These changes were made during the process of this review and should clarify and increase the availability of legal aid for deaths in custody. The changes included the following:
- a. so that the starting presumption for cases involving a death in custody is that the criteria will be met for the ECF scheme;
 - b. the wording was changed to reflect the policy intention under the Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) as to whose means should be assessed when any application is made.
 - c. the reference in the guidance to ‘violence’ was changed to include as an alternative ‘non-natural’ deaths, with the intention of broadening the types of cases eligible for the ECF scheme.
99. With the aim of alleviating some of the distress and anxiety felt by families involved in the application process, we also made the following changes:
- a. the types of cases in which the Director of Legal Aid Casework (DLAC) might exercise discretion to waive the requirement for financial means testing was broadened; and
 - b. the wording of the guidance was amended to expand the factors included in the decision-making process. The additional factors now include ‘whether the applicant is suffering from emotional distress, severe mental health concerns

¹⁰ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/454835/legal-aid-chancellors-guide-exceptional-funding-inquests.pdf

(potentially arising from the circumstances of the death), whether English is the family's first language, their level of education or if they have a learning disability.'

100. The Lord Chancellor's guidance sets out some of the factors that LAA caseworkers should take into account when they are making a decision about an application in relation to inquests. It is not intended to be an exhaustive account of those factors and applications should be considered on a case by case basis.
101. The provision of legal aid for representation does not depend on the coroner's determination as to whether the inquest itself should be conducted in accordance with Article 2. However, in cases where the coroner has decided that Article 2 is engaged, LAA caseworkers will consider this determination as part of their decision-making.
102. For more complex cases, the coroner is likely to hold one or more hearings before the inquest, known as pre-inquest review hearings (PIRH). At these hearings, the coroner discusses the practical arrangements and preliminary legal matters with interested persons, such as the scope of the inquest, the list of witnesses, and – importantly – the decision concerning the engagement of Article 2.
103. In order to secure the backdating of payment for cases which meet the means and merits criteria where, for instance, sufficient evidence to enable the LAA caseworker to make an ECF determination only comes to light at a later stage of the process, providers should submit a legal aid application before the PIR hearing. Applications for legal aid should be made in advance of the PIRH hearing taking place in order for the original LAA determination to be changed and the backdating of payment to be granted at a later date.

Summary of issues arising from the evidence

104. Stakeholders suggested that the current criteria for the grant of Exceptional Case Funding for representation might exclude other cases where complex legal and medical arguments mean families would benefit from representation. Examples of such cases include deaths of mentally ill patients who live in the community and receive outpatient treatment at an NHS hospital Trust or GP service, and deaths of people with learning disabilities living in the community where the death has raised concerns about medical treatment.
105. Conversations with providers have also indicated that in some cases, families are being dissuaded from making a legal aid application for representation, with providers arguing that the process is too time-consuming and is unlikely to result in funding. It was also suggested that in the above cases where the engagement of Article 2 is not immediately clear-cut, providers did not feel that funding would be available and thus did not consider a legal aid application to be worth completing.
106. Several respondents referred to cases where a determination on whether the inquest itself should be conducted in accordance with Article 2 could not be made by the Coroner at the time a PIRH was being held, due to insufficient evidence to make a determination at that stage. In these cases, a determination on the engagement of Article 2 is often made at a later date, when witnesses have submitted evidence at the inquest hearing or when disclosure is made.

107. This has resulted in families seeking private funding or attending the PIRH(s) unrepresented, even in cases where subsequent evidence later results in the engagement of Article 2. In the evidence received, stakeholders claimed that the technical nature of the issues needed to be raised regarding the engagement of Article 2 means that bereaved family members might not be able to raise these points without a legal representative.

Response to issues arising from the evidence

Types of cases:

108. The evidence suggests that the current system might not be fully understood.

109. In types of inquests where the Article 2 obligation is not automatically triggered, legal aid may still be awarded for representation if it can be shown that the State was arguably in breach of one of its substantive duties.

110. In other words, if LAA caseworkers are satisfied that it would be appropriate to make legal aid available in light of the risk of a breach of Article 2 rights, then funding may be granted.

111. It is clear that there are instances where families are being encouraged by providers not to apply for legal aid, but where their case might have in fact resulted in a grant for public funding had they applied.

112. It is also the case that in cases where it has not been accepted before the PIRH, but the Coroner later decides to engage Article 2, that this will have a positive influence on the LAA revising the original decision and granting ECF funding.

113. In order to make sure that providers are aware of how the current system works in these cases, we will explore options to raise awareness and clarify the eligibility process in the provider funding pack.

Timing and PIRHs:

114. Similarly, the current legislative framework provides for the backdating of ECF to include costs of representation at PIRHs and subsequent hearings where there is insufficient evidence of an arguable breach of Article 2 in advance of the PIRH to enable the LAA to make a decision on funding. (Please note that the backdating of ECF is a different process to the backdating of the legal help waiver, which is discussed later in this chapter).

115. In addition, the preparatory work undertaken ahead of a PIRH would be covered as part of legal help as would any advice in relation to the inquest process provided between the PIRH and the inquest hearing.

116. Again, however, the evidence suggests that the process for securing funding for PIRHs is not well known.

117. Representation at the PIRH may be available via ECF. Therefore, where families have been granted public funding for legal help, the provider will need to complete a separate legal aid application for ECF for representation at the PIRH or at the inquest itself.

118. As stated above, to secure the backdating of payment for cases which meet the means and merits criteria where, for instance, sufficient evidence to enable the LAA caseworker to make an ECF determination only comes to light at a later stage of the process, providers should submit a legal aid application before the PIRH hearing. Applications for legal aid should be made in advance of the PIRH hearing taking place in order for the original LAA determination to be changed and the backdating of payment to be granted at a later date.
119. In order to ensure that providers are aware of the provision to backdate advocacy work at a PIRH, and understand the necessity to submit an application at the time the PIRH is first announced, we propose the inclusion of a paragraph on this matter in the provider funding pack to underline the existing provisions.

Representation at cases involving the wider public interest determination

Current provision of legal aid

120. As set out above, when considering an application for Exceptional Case Funding, LAA caseworkers also consider whether there is a “wider public interest” in the applicant receiving publicly funded representation. Crucially, the test will not be met solely on the basis that there is wider public interest in the inquest itself.
121. Under the test in Section 10(5) of LASPO, ‘wider public interest determination’ is defined as a determination that, in the particular circumstances of the case, the provision of advocacy ... for the individual for the purposes of the inquest is likely to produce significant benefits for a class of person, other than the individual and the members of the individual’s family.
122. The Lord Chancellor’s Guidance on Exceptional Case Funding emphasises that the benefit must be significant and says this will depend on a number of factors:
- The benefits of granting publicly funded representation;
 - Whether the benefits are more or less tangible;
 - Whether they will definitely flow to other people or whether this is merely a possibility; and
 - The numbers of people who stand to benefit from the provision of legal aid funding.
123. LAA caseworkers also consider whether there are suggestions of large-scale systemic failures; whether the coroner would be assisted in uncovering systemic failings by the bereaved family being represented; and whether there are likely to be improvements to systems as a result of the inquest. The guidance suggests that the likelihood of the inquest leading to significant benefits is lessened where:
- other investigations into the death have already made recommendations for improvements to systems; and/ or
 - responsibility for failings that led to the death has already been accepted.

Summary of issues arising from the evidence

124. While data collected reveals a number of cases where families have secured public funding under the ‘wider public interest’ stem of the legal aid system, evidence to the review revealed that there are difficulties in how the criterion is understood. General consensus amongst stakeholders is that ‘Wider public interest is understood by qualified lawyers, but not generally understood by bereaved families.’

Response to issues arising from the evidence

125. In order to ensure that families have a better understanding of the ‘wider public interest’ determination of the ECF test, a comprehensive description of the determination and requirements will be included as part of the new guidance for bereaved families.

Inquests where the state has representation

Summary of issues arising from the evidence

126. In his final report of the review into the experiences of the families affected by the Hillsborough disaster, Bishop James Jones recommended that non-means tested legal aid should be awarded to families at all inquests where ‘public bodies are represented.’¹¹ As set out in the introduction, this recommendation has been supported by growing calls from parliamentarians and members of the public to increase the availability of funding for bereaved families in inquests where the state has representation.

127. Bishop James Jones also suggested that the state should match the type and number of lawyers representing state bodies at inquests, in order to achieve an equality of arms for bereaved family members.

Response to issues arising from the evidence

128. We have considered this option in great detail, asking a wide range of stakeholders whether, in their experience, publicly funded legal representation should be available in cases where the state is legally represented.

129. We have looked at the impact of publicly funded family representatives on the conduct of inquest hearings, and the ability of the family to participate and understand the process. In the main, responses from bereaved families and representative bodies suggested that public funding for families in these cases is required to ensure that there is an equality of arms. However, a number of stakeholders pointed out that it should not be assumed that in cases where the state has legal representation, representation for the family is necessarily required nor that it enhances the results of the coroner’s investigation. They suggested that the addition of further lawyers might actually hinder the process, by making the process more adversarial and legally complex.

¹¹ Rt. Rv. James Jones KBE, ‘The patronising disposition of unaccountable power’: A report to ensure the pain and suffering of the Hillsborough families is not repeated, Nov., 2017

130. We have also looked into the financial implications of this option. We have estimated that this option would result in an additional spend of between £30 million and £70 million.
131. Having taken all of these considerations on board, we have decided that we will not be introducing non-means tested legal aid for inquests where the state has representation. Means testing serves to determine the allocation of taxpayers' money to those most in need. This mechanism upholds the wider policy intention of the existing legal aid statutory framework of ensuring that legal aid is targeted at those who need it most, for the most serious cases in which legal advice or representation is justified. An additional spend of £30-70 million would run counter to this wider policy intention.
132. However, we would like to explore further options for the funding of legal support at inquests where the state has state-funded representation. To do this we will work closely with other Government Departments.

Financial means assessment

Current provision of legal aid

133. Currently, those seeking public funding for legal help and / or ECF representation at an inquest hearing are required to complete a financial means assessment. However, the Director of Legal Aid Casework (the 'Director') has the ability to grant funding for legal help and / or ECF regardless of the results of an applicant's financial means assessment, in certain types of cases.
134. The Lord Chancellor's Guidance explains the discretion as follows:
- 'There is a discretion to waive the financial eligibility limits relating to inquests if, in all the circumstances, it would not be reasonable to expect the family to bear the full costs of legal assistance at the inquest. Whether this is reasonable will depend in particular on the history of the case and the nature of the allegations to be raised against State agents, the applicant's assessed disposable income and capital, other financial resources of the family, and the estimated costs of providing representation.'
 - 'Where funding is granted to provide Legal Representation at an inquest, contributions may be waived in whole or in part. Where it is appropriate for a contribution to be payable this may be based upon the applicant's disposable income and disposable capital in the usual way ignoring upper eligibility limits.'

Summary of issues arising from the evidence

135. Means test application: Evidence highlighted difficulties that bereaved families have experienced when faced with submitting the financial means application, and a considerable number of respondents suggested that families applying for legal aid for inquests should not have to undertake a means test. The main concerns raised can be summarised as follows:
- a. Families are often not in a fit emotional or physical state in the immediate aftermath of the death of a loved one to be able to complete the financial means test application;

- b. Families should not have to complete a financial means assessment if the inquest is one where the Director would choose to waive the financial means test; and
 - c. Families should not have to complete a financial means assessment in cases where the state has paid for the legal representation of state representatives / bodies at the inquest, as this would represent an inequality of arms;
 - d. Concerns about the length of time taken to complete means test applications; and
 - e. Concerns about the complexity of the language and requirements in the forms.
136. More generally, bereaved family members who have previously completed the assessment claimed that the process requires specialist legal knowledge, and it is unlikely that family members would be able to complete the assessment without the help of a lawyer.
137. Evidence also referred to difficulties experienced by providers acting on behalf of families of service personnel, with reference to the benefits automatically received under the Armed Forces Compensation Scheme.

Response to issues arising from the evidence

138. In order to address difficulties with the application process, we will look at the procedure for claiming under the Exceptional Case Funding Scheme to ensure it works as effectively as possible.
139. We have looked into the issue regarding bereaved families of service personnel. We have consulted LAA caseworkers, providers, and civil servants working in the Defence Inquest Unit at the Ministry of Defence. They were unaware of this as a problem, and had not heard of any cases where payments made to families under the Armed Forces Compensation Scheme payment had resulted in difficulties with the financial means assessment applications.
140. However, they did suggest that depending on the timing of the payment received, and the length of time between the death and the date of the inquest hearing, there could be cases where this might occur, as suggested by respondents to the call for evidence.
141. We acknowledge these concerns. The evidence gathered will be considered as part of a review into the thresholds for legal aid entitlement, and their interaction with the wider criteria.¹²

Application of the means test

Summary of issues arising from the evidence

142. We have examined the existing system and considered the various options available for bringing certain types of inquests in scope of LASPO on a non-means tested basis, in response to a number of recommendations from recent reports on this subject.

¹² For more information, please read the Legal Aid Support Plan available via gov.uk

143. Dame Elish Angiolini's independent review called for non-means tested legal be made available to bereaved families at inquests held for deaths which have taken place in custody.
144. Responses to the call for evidence also supported this recommendation. In addition, stakeholders intimated that in cases where the Article 2 obligation was automatically triggered – such as deaths in custody – and the discretion to waive the financial means test results was exercised, families were being made to complete financial applications unnecessarily. They claimed that this was placing unnecessary additional stress on families.

Response to issues arising from the evidence

145. It is correct that in the majority of these types of cases, the financial means results would be waived.
146. As set out earlier in this report, the Guidance was amended in 2018. As part of this amendment, the types of cases in which the Director of Legal Aid Casework (DLAC) might exercise discretion to waive the requirement for financial means testing was broadened.
147. In addition, the wording of the guidance was amended to expand the factors included in the decision-making process. The additional factors now include 'whether the applicant is suffering from emotional distress, severe mental health concerns (potentially arising from the circumstances of the death), whether English is the family's first language, their level of education or if they have a learning disability.'
148. However, the test used by LAA caseworkers to determine whether the legal help waiver and / or ECF waiver can be granted includes consideration of the applicant's financial means test information. This information is considered as part of the 'particular circumstances of the case' which caseworkers consult before determining whether to apply the waiver.
149. As such, without financial information, the discretion to waive the financial means assessment cannot be exercised.
150. We acknowledge these concerns. The evidence gathered will be considered as part of a review into the thresholds for legal aid entitlement, and their interaction with the wider criteria.¹³

Backdating of the legal help waiver

Current provision of legal aid

151. The Director has a discretion to backdate funding for ECF representation to the date that the ECF application was made.

¹³ For more information, please read the Legal Aid Support Plan available via gov.uk

152. However, the Director does not have a discretion to backdate funding for legal help, even where an application for the means assessment to be waived has been successful.¹⁴ Instead, funding takes effect from the date of the determination by the Director.

Summary of issues arising from the evidence

153. Evidence has indicated that the current position on backdating has caused operational difficulties.

154. Without the power to backdate the legal help waiver, providers maintained that families were often forced to pay privately in the early stage of the process, in order to enable solicitors to carry out work pending the disclosure of materials ahead of a PIRH.

155. It was therefore proposed in the evidence gathering process that there should also be a discretion to backdate applications for legal help so that they have legal aid funding for the initial attendance with their solicitor.

156. In response to these concerns, question 2 was included in the call for evidence, which asked respondents: 'Do we need to make any changes to the current legal help process where a waiver is being sought? If so, please provide suggested changes.'

157. The overwhelming majority of responses agreed that there should be a provision to backdate the grant of a legal help waiver to the date of the original application. Given this, we intend to proceed to implementing the power to backdate legal help. This will require changes to the legal aid regulations which will be made by way of secondary legislation.

158. In the absence of a backdating power, providers echoed the concerns raised in our earlier conversations with providers, maintaining that families are either required to pay privately for initial work or providers must carry out the work on an unpaid basis. They argued that this has meant legal help work is increasingly uneconomic for providers.

159. One respondent claimed that "it takes a good three or four hours minimum to complete the application forms for the legal help waiver. That is work for which providers are not entitled to be paid."

Response to issues arising from the evidence

160. We will make a change to the regulations so that all such payments can be backdated to the date of application should a legal help means test waiver be granted.

¹⁴ An exception to this is for cases being funded under an individual case contract.

Legal aid for other costs

Summary of issues arising from the evidence

161. Responses to the call for evidence exercise and our meetings with key stakeholder groups also raised concerns regarding the remit of legal aid funding. Both providers and families referred to difficulties they had experienced in the absence of the provision of funding for the following additional expenses that are not covered under the existing legal aid scheme:
162. Travel, subsistence and accommodation expenses: Bereaved family members who attended the consultative group discussion cited difficulties they had experienced arranging travel and accommodation in cases where the inquest hearing(s) were held outside of their home area. They argued that the costs needed to cover their travel and accommodation, sometimes at the last minute in cases where they were given little warning of court hearings, had added to the distress of the inquest process. They argued that these costs should be included in a grant of legal aid.
163. Expert evidence: Several legal aid providers called for the costs of expert evidence to be included in the grant of legal aid funding, maintaining that expert evidence is an essential part of complex inquests.
164. Public funding for more than one family member: Evidence also highlighted concerns about the provision of legal aid in cases where there are considerable family difficulties. A number of responses to the call for evidence cited cases where family members were estranged, but were both seeking funding for representation at the inquest hearing. They argued that in these cases, there should be a provision for two separate grants of legal aid for the representation to be granted.

Response to issues arising from the evidence

165. Travel, subsistence and accommodation expenses: Under the existing legal aid scheme, there is provision for funded client travel expenses will be paid where it is reasonable for the client to attend court. LAA caseworkers consider the following questions, in accordance to the Costs Assessment Guidance 2018 and Standard Civil Contract 2018:
1. Was there a reasonable need for the journey?
 2. Was the appropriate form of transport used?
166. LAA caseworkers need to be satisfied that funding for travel is considered reasonable and that attendance at court is required. Where travel costs are payable, public transport is usually considered the most reasonable form of travel.
167. Therefore, there is provision for the funding of travel expenses, in cases where it is necessary for attendance, and where there are no alternative funding arrangements in place.
168. Expert evidence: Although this was raised as an issue as part of the review, the Government maintains that the existing system provides for funding of these cases, where necessary.
169. There are mechanisms in place for those giving evidence at an inquest hearing as witnesses to claim their expenses from the Coroner's court.

170. A grant for legal help can be used to cover funding for the instruction and attendance of an expert if this is not already covered by the Coroner.
171. Public funding for more than one family member: Under the existing system, when looking at whether separate family members require funding for representation, LAA caseworkers will consider whether representation is necessary for both members under Article 2. On the one hand, there are cases of familial conflict where multiple family members are seeking funding for separate representation, but where there is no conflict over the underlying issues being considered at the inquest. On the other, there might be cases where multiple family members are seeking funding for separate representation and there is a conflict over their reasons for securing representation and attending the inquest.
172. In either case, LAA caseworkers will consider the facts set out in the Lord Chancellor's Guidance. Decisions are made on a case by case basis, and if there are cases where funding for representation is required for two separate family members, in accordance to the Guidance and Article 2 rights, then the LAA will grant funding for both members. This is also the case for the decision process regarding the provision of travel expenses for more than one family member.
173. The Government maintains that not all multiple applications for funding for separate family members are granted on the basis that there is a familial conflict. This would not fit within the key objectives underpinning the legal aid scheme; to target legal aid at those who need it most, and to deliver best value for money for the taxpayer.

Legal Aid Agency (LAA) practice

Summary of issues arising from the evidence

174. Evidence from our review also highlighted concerns regarding the communications received from the Legal Aid Agency (LAA).
175. In particular, respondents to the call for evidence claimed that in some cases, the language used by LAA caseworkers in correspondence explaining refusals to grant legal aid is not always clear. Bereaved family members claimed that the language used is often incomprehensible to lay persons who do not have legal expertise.
176. Responses also claimed that there have been cases where LAA caseworkers appear to have copied and pasted refusal communication, instead of providing individual reasoning and explanations.
177. Language: Decision letters address the points raised in the legal aid application. Due to the complexity of some of the issues discussed as part of the application and inquest case, including the legal arguments that need to be considered, it will often be necessary to use technically precise legal terminology. In general, the LAA will be communicating primarily with the legal aid practitioner who will then cascade the information down to the client.
178. However, the LAA always intends to communicate clearly and concisely as possible in a way that is appropriate for its specific audience acknowledging that the determinations made are in compliance with public law principles.

179. In response to this review, the LAA will consider the evidence received and will further consider its communication practice in light of the specific comments raised.

180. Content of responses: The LAA has to consider legal aid applications for inquests against set statutory criteria. Caseworkers are required to refer to the Lord Chancellor's Guidance in all cases. Therefore, certain parts of the reasoning for determinations are likely to be similar or the same and this might explain why on occasion, similar or identical reasoning is used in responses.

181. However, the LAA will always consider individual legal aid applications on a case by case basis with determinations made on the specific facts of each application.

Chapter three – The Inquest Hearing

182. The evidence we have seen supports the Government’s view that the majority of the 30,000 plus inquests held in England and Wales each year are conducted in an inquisitorial style and families are able to understand and properly participate in the proceedings. There are nonetheless concerns that in some inquests, particularly those in which an arm of the state may have been involved in the death, proceedings can become adversarial, with inappropriate behaviour from lawyers. At worst, bereaved families may be left dissatisfied and angry with the process and its outcome.

183. Making sure that inquests remain inquisitorial is the main concern of this chapter but it also considers other matters which stakeholders told us they thought were important, including:

- inconsistency of approach and practice between coroners;
- the availability of support services in coroner’s courts to help families understand proceedings; and
- the desirability of making the lay-out of the court and the court building more appropriate to the needs of families.

Making sure inquests remain inquisitorial

184. One option we have considered but rejected was the idea of “delawyering”, in other words reducing the number of lawyers who attend inquests, in particular those who represent the government and other public bodies. Last year we held round-table meetings with Government departments and with three third sector organisations - Cruse Bereavement Care, the Coroners Courts’ Support Service and INQUEST - to explore current practice across departments so as to improve our understanding of the impact on bereaved people where state agencies are legally represented and, from there, to consider potential solutions. The roundtables were clear that, to families, it can seem as if the Government has unlimited lawyers at its disposal and that it takes advantage of this, leading to ‘inequality of arms’ at inquests. There is also the perception that the focus of public bodies’ can be on minimising or denying what went wrong and handling reputational damage, rather than trying to get to the bottom of what happened.

185. There are, however, difficulties in reducing the number of lawyers that act for public bodies. It must be right that, for example, police or prison officers have representation at inquests where there is the potential for their job to be at risk; organisations representing the interests of families accept this. Further, the Civil Service Management Code¹⁵ has a commitment to provide staff called as a witness at an inquest with legal representation. Public bodies are very much aware of the cost of instructing lawyers and consider sharing legal resource where possible, keeping the

¹⁵ <https://www.gov.uk/government/publications/civil-servants-terms-and-conditions> 12.2.3.
“Departments and agencies must also: b. permit civil servants involved in an inquest or fatal accident enquiry as a result of their official duty to be represented by the legal representatives of the department or agency, provided there is no conflict of interest.”

number of lawyers to a minimum. However, different bodies may have different interests and positions and it is not always possible for one lawyer to represent these without a conflict of interest arising. We have concluded that there is little that we can do to reduce the number of lawyers who represent public bodies at inquests but we will continue to keep this issue under review.

186. The Government's view is that the best approach is to make sure that coroners are equipped to control inquest proceedings and that lawyers appearing before them understand both how an inquest should work and what is expected of them.
187. As noted in Chapter One, 2019/20 will see a major round of training, overseen by the Chief Coroner, both for coroners and for coroners' officers. The training for coroners' officers has already been discussed. Like that training, the training for coroners is a two-day residential course and will be run five times to ensure that all coroners can attend. It will take coroners through the inquest process and cover issues such as the vulnerability of bereaved people and witnesses, communication with families and other interested persons, the use of language, the behaviour of counsel and generally controlling the court room.
188. The coroner training will help address some other concerns that were raised with us through the call for evidence and in other recent engagement with stakeholders. One of these, a small but nevertheless important point because it is crucial to families being able to follow what is happening, is that coroners do not always identify who is in court and taking part in proceedings. This is easily remedied and will be covered in the forthcoming training.
189. Another concern was a perceived inconsistency of approach and practice from one coroner's court to another. Examples of this were differences in the way coroners' officers engaged with bereaved families throughout the coroner investigation and the way coroners engaged with families at inquest hearings.
190. The Lord Chancellor takes his constitutional responsibilities and the independence of the judiciary seriously and, as such, the Ministry of Justice's approach to developing policy needs to have regard to the separation of powers; ministers do not comment on the decisions coroners take, nor do ministers or their officials seek to influence those decisions. Part of the purpose of training, and also of guidance that the Chief Coroner issues, is to encourage consistency of approach across the country, whilst at the same time recognising that each case turns on its merits and that there will inevitably (and properly) be variation.
191. Another concern to emerge was about how close working relationships between coroners and other professionals may be regarded as problematic at an inquest. Specifically, some stakeholders commented on families noting (or perceiving) a close working relationship between coroners and NHS staff so that they were left feeling, in cases of a death in hospital, that the coroner's sympathies were with the NHS. Coroners provide a uniquely local form of justice and their work takes place very much in a local context. It is not inappropriate for coroners to have contact with the local organisations with whom they interact when investigating deaths, since there are often issues of general process and administration to be discussed which are not related to individual cases. As with all judges, coroners take the Judicial Oath and the Guide to Judicial Conduct seriously and follow it conscientiously. The Chief Coroner

has provided Guidance on apparent bias¹⁶ and this has featured in previous Chief Coroner training.

192. The Ministry of Justice has been discussing the conduct and training of lawyers with their professional bodies (the Bar Standards Board (BSB) and the Solicitors Regulation Authority (SRA)), looking at what they might do to improve lawyers' conduct in inquests where improvement is needed. Both are currently reviewing their training to provide for different types of advocacy, including inquisitorial, and we will be working with them and the Chief Coroner on this.

193. The regulators take the view that reporting poor practice is key to monitoring lawyers' performance and conduct, but it seems that coroners rarely flag concerns about misconduct for fear that it might lead to disproportionate sanctions. The SRA and BSB assure us that if coroners raise their concerns with them it will not necessarily result in targeted disciplinary action – training is just as likely to be the result. If the regulators had a better sense of what the issues are, and how widespread they are, it would be easier for them to engage with practitioners on what needs to change. The regulators are therefore encouraging coroners to report their concerns about lawyers' conduct and we are discussing with the Chief Coroner's office how this could best be publicised.

194. The Chief Coroner's Office has recently met the BSB and SRA to discuss the option of producing a joint leaflet or communication for lawyers about inquests and the Chief Coroner's expectations about lawyer behaviour.

195. The Ministry of Justice is planning a conference for lawyers in summer 2019, both for those who represent public bodies and those who represent families, to encourage support for the changes we are making and the use of an inquisitorial advocacy style. The idea of a conference was suggested to us by Angela Rafferty QC and Gillian Jones QC, who presented a module on the use of appropriate language at a conference the Chief Coroner held in March 2018 on dealing with vulnerable people. We plan to involve bereaved people in the conference.

196. We are confident that public bodies generally (the NHS, HMPPS etc):

- understand the inquisitorial nature of inquests, and that their lawyers' main duty is to assist the coroner as much as possible, giving evidence and producing any documents which relate to a relevant matter in accordance with schedule 5 to the Coroners and Justice Act 2009 (which provides that they must produce all relevant documents); and
- are keen to learn from inquest findings.

197. The Schedule 5 requirement is akin to the duty of candour that exists in judicial review proceedings in the civil courts.

198. However, as noted above, the perception of families - particularly in cases of death in custody or other state detention - can be different. We have therefore been working with other government departments to develop a protocol of key principles, to which we propose public bodies and their legal representatives will sign up, as to the approach that will be taken in inquests when a public body is represented to help

¹⁶ <https://www.judiciary.uk/wp-content/uploads/2013/09/guidance-no-15-apparent-bias.pdf>

make sure that they assist the coroner in finding the truth of what happened and in learning lessons for the future.

199. The Chief Coroner's training will help coroners control proceedings and the protocol of key principles will further assist with behaviour. In October the Ministerial Board on Deaths in Custody welcomed an early version of the protocol and it was subsequently commended by the new Stakeholder Forum. We are currently amending it in light of the comments received and considering issues such as how to ensure it is complied with.
200. One of the principles in the draft protocol is that state bodies will consider making an apology where something has gone wrong. Whilst an apology may not of itself give a bereaved family all they need – the inquest will look in depth at the circumstances of the death – an early apology can be very powerful and can be welcomed by the family, demonstrating an acceptance of error, a lack of defensiveness and willingness to take the family's concerns seriously.
201. A more radical idea we have considered is that of accreditation for lawyers who appear at inquests. As inquests are the only part of the justice system that is inquisitorial, accreditation may appear attractive as a way of driving standards of behaviour, but this must be balanced by the need to maintain the supply of lawyers; requiring accreditation may drive some lawyers away from inquest work, given it is a low volume activity for many. Moreover, the BSB and SRA, who would be the organisations which would do the accrediting, favour training over accreditation.
202. Accreditation is bound up with the remuneration scheme - there may be potential, for example, to require accreditation for lawyers undertaking more complex and higher value work at public expense. Given the fact that the idea of accreditation is attractive (provided we can be satisfied that it would not reduce the supply of lawyers) we will consider this further.

Support services

203. As noted earlier, a charity, the Coroners' Courts Support Service (CCSS), provides support to bereaved families at inquests. Its volunteers provide emotional and practical support, demystifying the inquest process and potentially making a huge difference to a family's experience. At the moment the CCSS covers 43 of the 88 coroner areas and it has made clear to the Ministry of Justice that it would welcome the opportunity to expand to the remaining 45 areas.
204. In its response to Dame Elish's report the Government said it would consider the case for extending support services to all coroner's courts. National coverage has been a ministerial ambition for some time but it needs to be affordable and there must be a fair and open competition that allows other providers to bid for the work.
205. This year, subject to affordability, the Ministry of Justice will run a competition through which providers will bid for funding to extend support services so that they cover all 88 coroner areas. Our aim would be to complete implementation within two years of concluding the competition.

Making court premises better suited to the needs of the bereaved

206. Our evidence gathering highlighted two issues to do with accommodation at inquests: one was the desirability of separate rooms for bereaved families, keeping them apart from those who may have been involved in their loved one's death; the other was better layout of the courtroom, arranging it in such a way as to make it more welcoming and less intimidating.
207. Local authorities fund coroners' courts, so there is a limit to what central government can do. The revised *Guide to Coroner Services* will explain that separate rooms will be provided where this is possible but that this cannot always be the case. Some local authorities have invested heavily – Manchester City coroner's court has some of the best court and office accommodation in the country, for example – but across the country the picture is variable.
208. Ministry of Justice officials will raise this issue with local authority coroner service managers' groups, whose meetings they attend, and encourage them to take action where the building allows and where the local authority can afford to make changes.
209. The Chief Coroner plans to refresh his guidance to local authorities, *A Model Coroner Area* guidance. As was mentioned earlier, this guidance sets out what a "model coroner area" should look like in terms of, among other things, staffing, administration (including answering the phone to members of the public), accommodation and out of hours cover. We will discuss with the Chief Coroner the potential to strengthen what his guidance says about these matters.
210. Coroners sometimes use courts owned by Her Majesty's Courts and Tribunals Service (HMCTS) for which the relevant local authority will be charged. HMCTS is currently working on a design guide which will say that in buildings that are being refurbished, and where there is the space to do so, consideration should be given to providing separate waiting areas. This may assist those coroners who make use of the HMCTS estate. We will discuss with HMCTS what more could be done.

Additional Information

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If you have any complaints or comments about the process you should contact the Ministry of Justice at the following address.

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102 Petty France
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Email: inquestreviewmoj@justice.gov.uk

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