THE HARRIS REVIEW
Independent review into self-inflicted deaths in custody of 18-24 year olds

Stakeholder Hearing 8
His Honour Judge Peter Thornton QC
Chief Coroner

3 July 2015, 102 Petty France London

ROLE OF THE CHIEF CORONER AND CORONERS

Coroners are independent judicial officers appointed and paid for by the relevant local authority. Coroners are responsible for investigating violent, unnatural deaths or deaths of unknown cause and deaths in custody or otherwise in state detention.

All deaths in custody or otherwise in state detention require an inquest, which is conducted by the coroner. In some custody deaths a jury inquest is mandatory.

Under the new provisions of the Coroners and Justice Act 2009, a coroner, where appropriate, has a duty to make a Report to Prevent Future Deaths (PFD report)

INQUESTS

The coroner service can, for example, play a significant role in identifying the issues that may have contributed to the recent rise in the number of self-inflicted deaths in NOMS custody. The coroner has an important role; they enquire in the first instance, they consider the scope of the inquest on a case by case basis. For example, where there were six deaths in a care home, the coroner was able to raise the suggestion of a public inquiry.

The Chief Coroner (CC) will look at coroner areas where there are fewer PFD reports and a high number of prisons to see why there are not more. In law, the coroner cannot follow up the PFD response, although there is nothing preventing a coroner, if he or she wishes to engage further with a potential responder where the response is not forthcoming.

The CC recognised that families in particular may be unhappy where the conclusion of an inquest is death by suicide. The CC guidance on inquest conclusions regarding suicide is that "suicide" is listed as one of the short form conclusions in current legislation and although it may be unpopular, coroners should stick to it as much as possible in appropriate cases. They may make the wording gentler but they must record a verdict of suicide where this has been found in law. One thing a coroner will consider, in law, is whether the intention to commit suicide was there.

Following a suggestion by the panel that the findings should be on the front rather than the back of the document, so that they are more prominent and not overlooked, the CC noted this as a point to consider. He will take it into account when he produces guidance for the completion of these documents.

There is no central record of inquest findings and the CC will consider having one of these, and how it might work in practice.

There are no plans to introduce a cadre of coroners specifically working on deaths in custody, but the CC has introduced a full day of training for coroners who will undertake this work. The training will be held in May 2015. Although coroners are given broad discretion, the scope of this discretion will be included in the training. Continuation training for coroners will cover Article 2 deaths and will also cover the giving of reasons. The training will lead to a template of good practice and this should provide more consistency.

The CC recognised that there is an issue for families to fund their legal representation at an inquest and has made it clear to government that there are some cases where funding should be provided. For example, where at an inquest multiple agencies are represented by the state (e.g. police, the Local Authority and NOMS), the CC is trying to find a way to redress this balance for families, as the 'exceptional case' exemption in LASPO is not sufficient. The CC has proposed to Ministers that if two or more parties are funded by the state, then 10% of their funding should be given to the family.

DELAYS TO INQUESTS

A cause of the delay to holding a custody inquest is that the PPO report is not ready. This may be due to their lack of resource and an increase in number of deaths. The CC is meeting the PPO to talk about how their reports are used at inquests with a view to speeding up the process of getting the PPO report to the coroner, and may be considering an interim report to avoid delays to holding an inquest.

In cases where a report is being awaited, the coroner should generally give families a preliminary pre-inquest hearing date, even if they cannot be told a final date. If the PPO could let the coroner have an indicative timing for when their report will be ready, the coroner can find court capacity and a venue in advance, which will help mitigate delays. The CC will discuss this with the PPO.

Inquests should be held within 6 months wherever possible. If as case is not completed or discontinued within 12 months the CC will be informed by the coroner.

REPORTS TO PREVENT FUTURE DEATHS (FORMERLY RULE 43 REPORTS)

The CC is aware that, anecdotally, since the change from Rule 43 to PFD reports, there have been more reports written; it is now a duty to make a report where appropriate. The CC is encouraging coroners to write PFDs and has redesigned the template to make it easier and clearer for them to know what is expected, and for the recipient to know what they need to respond to.

Under the Coroners (Investigations) Regulations 2013, all PFDs are sent to the CC and are published on the judiciary website. Ongoing litigation may cause a delay to publication and there may be redactions of names, but the purpose of this is to make the process more open and the documents will be searchable. There is a category, on the website, for Deaths in Custody. The duty, in law, on the CC is to receive the PFD report, not to act upon it.

The Coroner is not entitled, in law, to make specific recommendations in a PFD, as he or she will not be in a position to know the detail of policy. The coroner may not enter into dialogue with the responder. The recommendations that are made cannot require a specific action but can draw attention to issues or areas which should be addressed.

The CC had looked at the eighteen or nineteen PFD reports relating to deaths in custody that he has received over the last year and identified the issues of:

- Poor record keeping;
- Poor communication and
- Poor training.

Regarding 'First Night' the CC observed:

- Insufficient documentation from police to prison custody;
- Insufficient information about medical or other history such as self-harm or domestic violence;
- Insufficient attention paid to information that is available;
- Insufficient information sharing within the prison for example from reception to the wing;
- Insufficient training in the use to be made of the documents to support prisoners, so that meaning of the information and what to do with the information that staff had was not understood;
- Insufficient overall risk assessment, too much reliance on observations and not a sufficiently objective assessment.[1]

The CC recognised that as there are no mechanisms for ensuring that the recommendations in the PFD report becomes learning, there is a gap as long as nobody is responsible for following up on these. The CC has discussed this with Simon Hughes , who he understands is looking into it. It is not the job of coroners to engage with those who respond to the reports, but the CC agrees that there does need to be some mechanism to make sure they are followed up.

The requirement to respond to a PFD report is 56 days and the coroner monitors this. The CC has an overview of the timelines for when responses are expected and he would follow up if there were unreasonable delays.

LIAISON AND DIVERSION

There is no role for the coroner to make a comment about whether the person should have been in prison in the first place; this is for the judiciary and it is not for the coroner to make a comment about another judicial decision. If a high risk of harm has been identified regarding an offender, this should be brought to the attention of the relevant Court.

If there were failings in the custody process, for example, in the very early stages, this could be considered as part of the inquest and the coroner could legitimately consider the facts of how the death came about. The coroner has no duty in all cases to go through the medical history of the deceased; others should be using the information provided and raising the risk.

It is beyond the remit of the coroner to say that someone should have been diverted from custody; this question is too wide for the CC and exists within the political arena.

Coroners take into account the 'Looked After Children' issues, where they are relevant, and any recommendations that follow from this may be for the Local Authority.

[1] The CC said he will provide these details to the Review.