**DEATH IN CUSTODY SYMPOSIUM**

SPEECH

1. Good morning.

2. The coroner's duty to investigate prison deaths is currently enshrined in section 1 of the Coroners and Justice Act 2009, which relevantly provides that:

> "A senior coroner who is made aware that the body of a deceased person is within the coroner's area must as soon as practicable conduct an investigation into the person's death if … the coroner has reason to suspect that … the deceased died while in custody or otherwise in state detention."

3. This is a duty that goes back centuries. I have a copy of the 1843 edition of *Sewell on the Law of Coroner*, which states:

> "…although the statute mentions only inquiries of the death of persons slain,, or drowned, or suddenly dead, yet [the Coroner] may, and ought to inquire of the death of all persons whatsoever who die in prison, that the public may be satisfied that such persons came to their deaths by the common course of nature, and not by some unlawful violence, or unreasonable hardships put on them by those under whose power they were confined", to which an even earlier edition of *Jervis on Coroners* adds: "And it is the duty of the gaoler to send for the Coroner, in all cases of death, before the body is buried; and if he neglect to do so, he is liable to be [fined]."

4. It was, I think, specifically the duty to investigate deaths in detention that led to coroners being hailed by the public as the guardians of the poor. That is because an overwhelming proportion of people in prison were there not on remand or as a judicial punishment, but for debt. Bluntly, they were there for ransom. They were, almost by definition, victims of extreme financial hardship. Indeed, there was a lively debate in Victorian times as to whether the definition of deaths in custody ought to be extended to cover workhouse deaths. So we can perhaps understand how

it happened that in olden times the public, who in those days elected coroners to office, regarded them as the guardians of the poor.

5. Of course, times have changed since then. All the same, the fundamental point remains. A coroner is under a legal obligation to carry out a public judicial investigation into a prisoner's death and to expose any shortcomings (or, worse, wrongdoing) on the part of the relevant authorities.

6. Until comparatively recently, that is where the coroner's obligation ended. For the past few decades, however, the coroner has had an ancillary jurisdiction, in cases where he or she believes that action should be taken to prevent the recurrence of fatalities, to make a written report to the person or authority who may have power to take such action.

7. The Coroners and Justice Act 2009 sought to make that process more robust by converting the statutory power into a duty. The current legislation provides that where anything revealed by a coroner's investigation gives rise to a concern that circumstances creating a risk of other deaths will occur in the future, and, in the coroner's opinion, action should be taken to prevent such circumstances or eliminate or reduce the risk, the coroner ***must*** report the matter to a person who the coroner believes may have power to take such action.

8. It is important to remember that although the provision is now a mandatory one, so that we can correctly speak of a duty, rather than a mere power, to issue such a report, the statutory criteria giving rise to the duty are not quite as sharply defined as we might be tempted to assume. In particular, the duty only arises where "**in the coroner's opinion**" action should be taken. That necessarily imports a subjective element – the coroner's opinion – into the process. In the recent case of *Dillon v HM Assistant Coroner for Rutland and North Leicestershire*, the High Court stated that:

   "The coroner must act rationally in coming to the opinion held, but **different coroners could reasonably come to opposite opinions on the same facts without either being wrong to do so. In other words, there is no single, objectively correct answer to the question raised by the second criterion in any particular case**."

It follows that the statutory duty to make a prevention of future deaths report may arise in one case and yet not do so in another, even where the underlying facts are completely indistinguishable.

9. This is how the courts have interpreted the statute as made by parliament. Now the reason I mention this point is that we need to recognise the limitations of reports to prevent future deaths. While such reports are important, they are not and never have been, a core element of the coroner's jurisdiction, which itself operates within relatively confined limits. As I said in a recent lecture:

"The coroner's court is an inferior court of record. Historically, its purpose has been to dispense a form of summary justice rather than to resolve all the surrounding issues to which a death may happen to give rise. To this day, coroners are subject to an express statutory duty to conduct a coroner's investigation "as soon as practicable". The parameters of the investigation are those in the Act, namely to ascertain four things, who the deceased was, and how, when and where the deceased came by his or her death. Neither the coroner nor the jury (if there is one) may express any opinion on any matter other than those questions or the particulars to be registered concerning the death. In particular, their determination of the four matters to be ascertained may not be framed in such a way as to appear to determine any question of criminal liability of the part of a named person or civil liability. What is more, Rule 19(2) of the Coroners (Inquests) Rules provides that a coroner must disallow any question put to a witness which the coroner considers irrelevant."

10. Given the relatively narrow limits of the coroner's investigation, it is scarcely surprising that the ancillary duty to make reports to prevent future deaths is equally summary in nature. The statute specifies next to nothing about the content of PFD reports. For that, we must turn to the official guidance issued by successive Chief Coroners, which explains that the PFD must state the coroner's concerns and say that in the coroner's opinion action should be taken to prevent future deaths. Put another way, it is a recommendation that action should be taken, but not what that action should be. It is neither necessary, nor appropriate, for a coroner making such a report to identify the necessary remedial action. As Hallett LJ once explained it, "the coroner's function is to identify points of concern, not to prescribe solutions."

11. Furthermore, although there is an obligation to respond to a report within 56 days, coroners have no role in supervising what action may have been taken. If you think about it this is sensible on two fronts: first the report is a recommendation action should be taken but not what that action should be – therefore it would be inconsistent with that limitation if coroners were then required to follow-up. Secondly the coroner has only seen the evidence in the inquest; he or she is not a subject matter expert. In short coroners are not regulators – they are judges - and should not be confused with them.

12. None of that is to undermine the importance or high potential value of PFDs. But we should not overlook their limitations. For example, it might be a mistake for academic researchers to assume that PFDs, and the responses they attract, together form a homogeneous body of internally consistent data that is readily susceptible to accurate and detailed analysis for all statistical purposes. There are roughly in the order of 600 PFDs issued each year. There are around 30,000 inquests. That alone demonstrates that – as a matter of fact – the duty to write a PFD is only triggered in a (substantial) minority of cases. Like many other aspects of judicial practice and procedure in our system, the real value the coroner process adds is a detailed examination of the individual case – or in this case, a detailed examination of the circumstances of a death and the potential to avoid similar deaths in the future. That granular detail can then form part of the picture drawn on by others with the time, resources and skillset to draw out themes, trends or other outcomes.

13. Recognising the need for appropriate caution, however, we nevertheless need to exploit the valuable information contained in PFD reports as efficiently as possible. The baseline is that reports are routinely published – my office has been publishing them since the inception of the modern PFD in 2013. These are placed in the public domain so that everyone – members of the public, government departments and other public bodies, regulators, academics and so on can read them and use them. For public bodies who are the recipients of the report, they help those bodies to be learning organisations.

14. But we have more work to do to make them as accessible as possible. Until recently the way PFDs have been presented has been slightly cumbersome and ‘searchability’ has been limited. Recently the new judiciary website has launched – this has meant the way PFDs look has

improved but more importantly we have started publishing the full content of the report on the judiciary website (as opposed to linking to a document). This is a small change, but it means for the first time the entire text of a PFD report is now searchable on our website.

15. Further work is in hand – if possible, I would like to make technical improvements (such as using a type of standardised form) which will standardise and therefore improve the range of metadata attached to each report, thus making targeted searching easier. I also intend, in 2023, to begin issuing the first in a series of bulletins highlighting thematic learning points.

I welcome engagement by the wider community with PFDs, including academics. There is fantastic work by Dr Georgia Richards at Oxford on a Preventable Death Tracker; her team produce publicly available analysis on PFDs (based on the information in a decade of reports). I see the role of the academic community, my office and bodies like the Independent Advisory Panel on Deaths in Custody as being complementary; Dr Richards and her team have at their disposal academic research techniques which my office does not have the resources or expertise to match and I think it is a very good thing that they and others like them are engaged in translating the learning in individual reports made by coroners in a way that helps public policy makers and others make sense of emerging themes.

16. There may sometimes be unrealistic expectations of PFDs on the part of the public and those to whom such reports are addressed. Coroners themselves may have contributed to this by occasionally straying close to, or beyond the proper limits of the process, perhaps by attempting to make specific recommendations or simply be indulging in language that is not, perhaps, quite as temperate as judicial proprieties dictate. Of course, the High Court supervises the work of the coroner judiciary by way of judicial review; the case of Dillon is an example of that supervision in action.

17. However I am responsible for training coroners and part of the next set of mandatory coroner training events from April this year will focus on PFD reports, including specific focus on the proper purpose of the report. My focus will be on encouraging consistency of practice wherever possible.