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Deaths after police contact in England and Wales: the effects of article 2 of the European Convention on Human Rights on coronial practice.

Abstract:

This paper examines the role of coroners in investigating and reporting on cases of death after police contact (DAPC) in England and Wales. It considers how article 2 (the right to life) of the European Convention on Human Rights (ECHR) has affected coronial processes and practices. It argues that the effects of article 2 represent an evolutionary shift in accountability processes surrounding cases of DAPC in England and Wales, but that this shift has in turn been mediated by aspects of institutional structure in the coronial system. It discusses how this shift demonstrates the dynamic relationship between the coronial system, state and society and how this has continued to evolve as a result of external demands.

I. Introduction

This paper examines how article 2 (the right to life) of the European Convention on Human Rights (ECHR) has affected coronial practice and processes in relation to cases of death after police contact (DAPC) in England and Wales. It reviews literature from practitioners in the coronial sphere, from organisational research connected to the coronial system, and from the relatively limited canon of academic research on coroners' courts. It considers the historical and legal underpinnings of the coronial system that provide its current institutional framework and examines how this framework mediates the effects of article 2 of the ECHR in practice when investigating and reporting on cases of DAPC.

The paper argues that three key areas of coronial practice and processes in England and Wales are affected by obligations imposed by article 2 of the ECHR. First, such cases require that a more thorough and rigorous inquest is undertaken than was typical prior to the implementation of the Human Rights Act in 2000; these are termed 'article 2 inquests'. This has affected the scale and scope of the inquest process and highlighted an increasing array of acts and omissions¹ by state organisations in cases of DAPC (Shaw and Coles, 2007). Secondly, a new type of verdict tends to be recorded in these cases, known as 'narrative verdicts'; these reflect the way in which actions and omissions may be recorded by juries sitting in article 2 inquests and have increasingly highlighted issues such as failures of multi-agency working, communication, training and risk assessment (Baker, 2015). Thirdly, the use of coroners' reports in these cases is now held to be mandatory rather than

¹ Examples of acts include the use of restraint or tasers; examples of omissions include failure to uphold a duty of care under article 2 of the ECHR, or to recognise individuals as coming from vulnerable population groups (Baker, 2015).

discretionary, as was previously the case (Chief Coroner's Office, 2013). These reports are produced by the coroner post-inquest and contain recommendations that may lead to the prevention of further deaths and can be sent to any relevant organisation that has been identified during the inquest. The paper begins by examining how these changes to coronial practice have occurred, and what their significance might be.

The paper focuses on the nexus between coronial practice, criminal justice, and human rights. The issue of death after police contact and accountability is one that is particularly in the public eye with recent cases such as Mark Duggan² in the UK, Michael Brown³ in the US, Robert Dziekanski⁴ in Canada and Roberto Laudisio Curti⁵ in Australia provoking widespread calls for police to be held to account. These cases touch on societal concerns such as open justice, transparency of process, and fairness and legitimacy in the justice system. In common law systems, the state response to allaying these societal concerns tends to be to utilise coroners to investigate and report on such deaths (Matthews, 2014).

Clearly the effects of article 2 of the ECHR are applied to the pre-existing structure of the coronial system. Any changes are mediated by institutional structures in coroners' courts. After outlining recent changes in coronial practice, the paper moves on to consider how structural constraints affect practice by examining the coronial system in England and Wales. This section of the paper examines key issues such as the tension between statute and precedent, the ambiguity inherent in coronial role and function, and how coroners' courts might be best imagined as a regional rather than a national system. These issues affect how article 2 of the ECHR is implemented in practice in the coronial system. For example, the increasing use of narrative verdicts to identify actions and omissions in relation to a case of DAPC occurs within a system that is essentially regional. In order to learn lessons from the increasingly complex verdicts recorded by juries in these cases, it would be reasonable to expect some sort of overview at a national level, and this does not currently exist. Finally, it is argued that the coronial system is historically subject to reform and stasis, and that the evolution in practice wrought by article 2 of the ECHR can be to some extent characterised by both reform and stasis.

² Died after being shot by a police officer in London in 2011, this was widely viewed as the precipitating event that sparked the London riots (Guardian/LSE, 2012).

³ Died after being shot by a police officer in Ferguson, Missouri in 2014. The death caused widespread disorder and rioting in the Ferguson area (USA Today, 2014).

⁴ Died after being shot by a police officer with a taser in Vancouver in 2007. An official inquiry led by a judge found the officers to have shown 'shameful conduct' (Braidwood, 2010, p.14).

⁵ Died after being shot by a police officer with a taser in Sydney in 2012. The coroner stated that the actions of the police amounted to an 'abuse of police powers' (NSW Police Ombudsman, 2013, p.36).

The paper examines how and why these changes have occurred and what they might suggest about state responses to cases of DAPC in the 21st century. On the one hand, the enhanced focus on investigating and reporting on cases of DAPC in the coronial system has been imposed on the state by the obligations of article 2 of the ECHR. This means that more information is being uncovered about these cases, and it appears that juries are being increasingly critical of police and other state agencies (Baker, 2015). On the other hand, these obligations are met through a coronial system that has inherent structural constraints. Thus the increasingly critical tone adopted by juries does not necessarily equate to consequential action being taken by the state. The relationship between the obligations imposed by article 2 of the ECHR in cases of DAPC and their practical implementation in the coronial system is a central focus of this paper.

II. Coroners and death after police contact

'It is the duty of the coroner as the public official responsible for the conduct of inquests...to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny particularly if there is evidence of foul play, abuse or inhumanity.'

(R v Coroner for North Humberside, ex parte Jamieson [1995] QB1)

Coroners have long played a significant role in the investigation of deaths in suspicious or unnatural circumstances in England and Wales. They aim to fulfil a number of functions on behalf of society: to provide an independent examination of deaths in custody; to provide it in a manner that is open to public scrutiny; and to attempt to learn lessons in relation to these deaths so that future preventable deaths may be avoided (Dorries, 2004). As such, coroners have a significant role to play in protecting the public from avoidable deaths and holding state organisations to account in such circumstances (Luce, 2003). The quotation above by Lord Bingham in the Jamieson case, sets out the fundamentally important role of the coroner in demonstrating open justice when investigating cases of DAPC. It acknowledges the need for such investigations to be demonstrably fair and transparent, and the need for processes to be seen to be rigorous and independent. An independent role in publicly scrutinising suspicious deaths is central to the coroner's *raison d'être* (Levine 1999).

In England and Wales cases of DAPC are investigated independently and publicly in the coronial system. The investigation takes the form of an inquest, and is based on fact-finding into the death (Matthews, 2002). Coroners are not expected to ascribe guilt or liability to individuals or organisations. Their role is to establish who died, when and where they died, and how they died (Davis *et al.* 2002). The question of 'how' an individual died can be subject to contention due to the

way in which the word 'how' might be interpreted in relation to the death (Thomas *et al.* 2008). The parameters governing the scope of the inquest are largely dictated by 'how' an individual meets their death. This is one area that has been affected by article 2 of the ECHR and is discussed directly.

Under the 2009 Coroners and Justice Act (s1, (2)) an inquest is compulsory if 'the deceased died while in custody or otherwise in state detention' (Parliament, 2009). This Act is the fundamental statutory instrument for coroners in England and Wales having replaced the 1988 Coroners Act in July 2013. They are further guided in practice by a framework termed 'Coroners Rules' dating from 2013. These replaced the 1984 Coroners Rules that functioned in tandem with the 1988 Coroners Act. These rules are updated by Home Office circulars and the Chief Coroner and reflect current developments in case law and precedent in coroners' courts. Thus coronial practice is guided by statute but also by precedent.

The term DAPC (used throughout the paper) is used by the Independent Police Complaints Commission (IPCC) in regard to 'deaths during or following police contact' as stated in their annual statistical analyses on this issue (see, for example IPCC, 2012). It covers the following categories: road traffic fatalities, fatal shootings, deaths in or following police custody, apparent suicides following police custody, and other deaths following police contact (IPCC, 2012, p. 1). Parliamentary reports from, for example, the House of Commons Home Affairs Select Committee (HAC) and the House of Commons Joint Committee on Human Rights (JCHR) have highlighted the significance of the issue of DAPC over a sustained period of time, and noted the symbolic importance of such deaths to wider society with regard to police being held to account (see, for example HAC, 2013, 2010, 1980; JCHR, 2004; Fulton, 2008). The socio-political focus on these deaths has been mirrored by legal obligations imposed by article 2 of the ECHR and the paper now turns to consider how these obligations have affected coronial practice.

III. *The impact of article 2 of the European Convention on Human Rights*

The most significant changes to coronial practice in relation to cases of DAPC have been effected not by governmental action but by precedents driven by the ECHR. It has affected the coronial system in three distinct ways: first, with regard to the inquest process; secondly in the type of verdict delivered; and thirdly through the use of coroners' reports. The ECHR has major ramifications to the procedural duty of the state when investigating deaths relating to its agents (Wadham, 2004). The convention is viewed as constituting a 'living instrument' in that it should dynamically reflect and react to changes within society. Thomas *et al.* (2008) assert that it does not merely *protect* the rights of citizens, but actively seeks to *enable* an environment where the right to

life is enshrined. The key component of the ECHR germane to this discussion is article 2: the right to life. This is seen as being a fundamental right from which all other rights necessarily follow.

Article 2 states:

1. 'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
 - (a) in defence of any person from unlawful violence;
 - (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
 - (c) in action lawfully taken for the purpose of quelling a riot or insurrection.'

(European Court of Human Rights, 2010, p.6)

It is clear, then, that it is accepted that deaths will occur as a result of interaction with state agents. Consequently, deaths that occur after contact with agents of the state should be investigated with a rigour and thoroughness that demonstrates the state has met the criteria set out in article 2 in actively seeking to enable citizens' right to life. The Human Rights Act (HRA) 1998 is the UK's statutory response to the ECHR. Since its enactment in October 2000 coronial practice must be interpreted in a manner compatible with the ECHR (Davis *et al.* 2002).

3.1 How an individual comes to meet their death

Current coronial practice in cases of DAPC is set out cogently by Matthews (2014) in the thirteenth edition of *Jervis on the Office and Duties of Coroners*, the primary text used by coroners in daily practice. The key change brought about by article 2 of the ECHR is the definition of 'how an individual came to meet their death'. Prior to the enactment of the HRA 1998, this was considered to be 'by what means' they came to meet their death, whereas it is now interpreted as 'in what circumstances' (Matthews, 2014, p.123). The immediate effect of this on coronial practice was to broaden the scope of the inquest to consider a wider range of issues that might have led to the death of an individual. These issues tend to relate to organisational actions or omissions as distinct from individual acts or omissions (Baker, 2015).

Matthews (2014, pp.506-508) notes that article 2 imposes three obligations on the state. First, that it has a 'positive obligation to protect the right of life by law'. This breaks down to two further categories: one being a 'general and systemic duty' in the form of laws and official policies enacted by state agencies that reflect the requirements of the act; the other being 'an operational duty'. Regarding police and cases of DAPC the operational duty is manifest as 'the duty...to take reasonable steps to prevent the risk [of death] materialising.' A corollary of this is the necessity to demonstrate that policies and training are in place that reflect obligations imposed by article 2. The second obligation is that the state should 'refrain from intentionally and unlawfully taking life.' Thirdly, article 2 embodies a procedural obligation that requires the state to investigate such deaths in the light of the two principles outlined above, hence the more rigorous approach adopted by article 2 inquests.

Article 2 inquests are typically heard before juries and have a wider scope of investigation than any other type (Dorries, 2004). Consequently, they are more complex, often more contested and more likely to be subject to appeal via judicial review (Matthews, 2011). One change that reflects the requirements of open justice is that the ECHR demands the state is transparent in disclosing documents and making witnesses available to whichever court hears such cases (Wadham, 2004). The significance of article 2 of the ECHR has been to impose an 'evidential burden' upon the state in terms of how it investigates these types of cases. It requires the state to provide an explanation of such a death that is satisfactory and convincing. However, there is apparently no explicit direction stating how coroners should undertake article 2 inquests (Thomas *et al.* 2008). Evidently, this might be exacerbated by the fact that despite the introduction of a Chief Coroner: 'Coroners are still largely a local and not national service' (Matthews, 2014, p.vii). Whilst there may be a lack of direction from government and legislators, it appears that article 2 of the ECHR is effecting change in the coronial system by way of precedent.

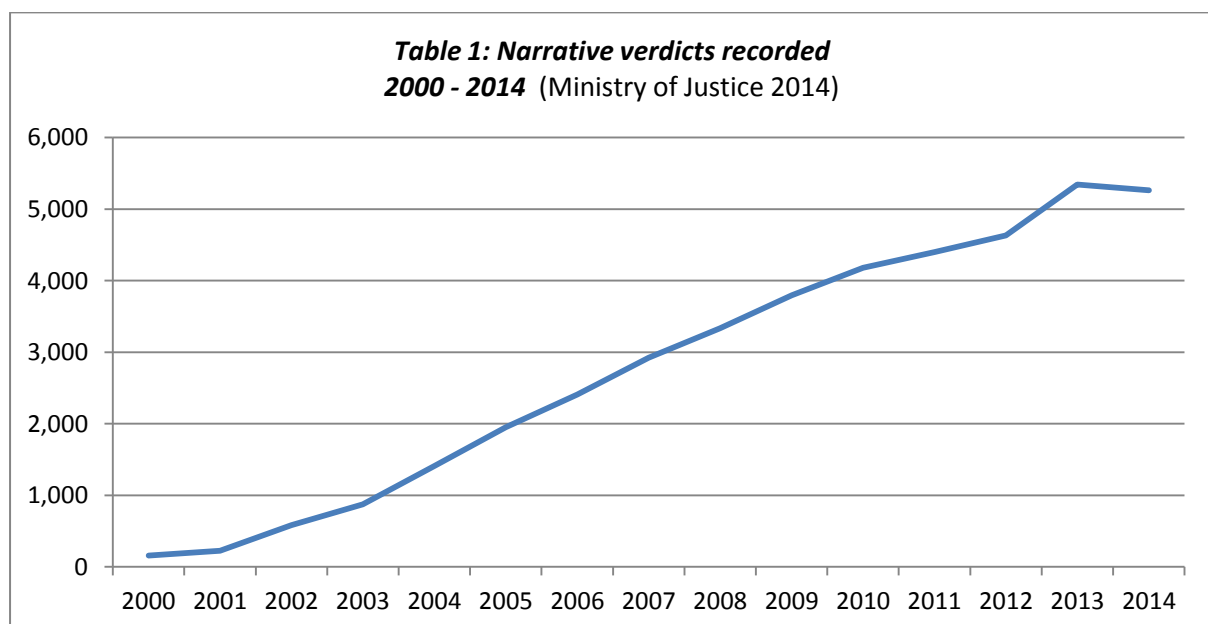
3.2 Narrative verdicts

A similarly unanticipated development since the advent of article 2 inquests is the increasing use of what are termed 'narrative verdicts'. These replace the typically used short-form verdicts⁶ and set out a narrative description of key 'facts found' in the inquest. Narrative verdicts do not have a standardised format and can vary in length from three sentences to three pages (Matthews, 2011). Numerous judgements have been set forth from judges in the process of judicial reviews noting the relevance and appropriateness of narrative verdicts in fulfilling the state's response to article 2 of

⁶ There is insufficient space to list all of these, but common types are 'suicide', 'death by misadventure', 'open', and 'natural causes' (see, for example, Ministry of Justice, 2014; Dorries, 2004)

the ECHR. Most notably in the landmark 2002 case of Middleton, the House of Lords stated that: ‘To meet the procedural requirement of article 2 an inquest ought ordinarily to culminate in an expression, however brief, of the jury’s conclusion on the disputed factual issues at the heart of the case’ (R v Coroner for the Western District of Somerset (Respondent) and another (Appellant) ex parte Middleton (FC) (Respondent) HL 11 March 2004).

As coronial practice is shaped partly by statute and partly by precedent it is important to note the key case that established precedent for narrative verdicts. Colin Middleton died in Bristol prison in 1999. The first inquest into his death was quashed due to an insufficiently rigorous enquiry. In the second, the coroner did not grant the jury the option of ‘neglect’ as a verdict. The jury chose instead to record their findings by hand in a narrative format, stating (in part) that the Prison Service had failed in its duty of care to the deceased (Widdicombe, 2012). Dorries (2004) notes that narrative verdicts function as a statement of findings rather than a label, as is the case in short-form verdicts which are typically used in the coronial system. Indeed in 2013 the Chief Coroner stated that the term ‘verdict’ was to be replaced with ‘determination’, albeit that it still tends to be reported as a verdict by the media (Matthews, 2014). Coroners typically now refer to it variously as a ‘conclusion’, a ‘determination’ or as ‘findings’ (Chief Coroner, 2014). Table one (below) illustrates the increasing use of narrative verdicts in inquests in England and Wales⁷. If two purposes of an inquest are to find facts in public and attempt to learn lessons that prevent future deaths, then a narrative verdict dovetails with these principles in that they record factual details of that death. Luce (2003) supported the use of these verdicts as a way of satisfying public interest and believed that the



⁷ It should be noted that the data in table one represent all narrative verdicts in any type of inquest, not purely those into cases of DAPC.

narrative should involve systemic issues if thought to be relevant to the specific case. However, the Office for National Statistics (ONS) have cautioned that the increasing use of narrative verdicts could create ambiguity in the statistical reporting of deaths as they occur under the umbrella category of 'other deaths' (see Carroll *et al.* 2012; Hill and Cook, 2011). The exercise of narrative verdicts as a state response to the ECHR illustrates a number of themes apparent in the coronial system. First, their use in principle is not codified, but is consistent with the discretion afforded the coroner as an autonomous judicial officer, and the jury, as was demonstrated in the landmark Middleton case. Secondly, their use in practice differs depending on coronial areas, underlining the essentially regional nature of the coronial system. Thirdly, their content is unclear at a central level as they are grouped under the heading of 'other verdict' – this means that their meaning is ambiguous in terms of statistical representation, and their content is effectively unknown to those who have not had direct access to the content of each narrative verdict (Baker, 2016).

The narrative verdict enables juries to consider circumstantial factors if they are able to demonstrate a 'sensible direct relationship' between those factors and the death. If systemic weaknesses are noted, then it opens up the possibility that under article 2 the preventability of death is focused upon as distinct from issues purely relating to the cause of death (Matthews, 2002). Thomas *et al.* (2008) believe this could lead to a process termed 'accountable learning'. This envisages organisations making changes to their policies, procedures and practice based on narrative verdicts and coroners' reports. In essence, this would seek to minimise future loss of life and consequently promote an environment whereby the right to life was actively enabled. The issue of lessons not being learned in cases of DAPC is a persistent theme in literature on this topic (see, for example Fulton, 2008; JCHR, 2004). Whether narrative verdicts might enable the learning of lessons is questionable due to the lack of central oversight of the coronial system. This means that there is no central collation of these verdicts, let alone any analysis of them (Goldson 2006). To date the subject of narrative verdicts has received little attention from academic writers. Exceptions are Scraton (2006) who examined their use in holding the prison system to account for deaths in custody; Carroll *et al.* (2012) and Hill and Cook (2011), who focused on the effect of narrative verdicts on general mortality data; McIntosh (2012), who examined narrative verdicts in relation to providing accountability to children's next of kin; and Pilkington *et al.* (2014), who considered the possible use of narrative verdicts to learn lessons in the aftermath of road traffic accidents. It appears that narrative verdicts are an under-researched area with regards to open justice and cases of DAPC.

3.3 Coroners' reports

In addition to the use of article 2 inquests and narrative verdicts, the third major development under the requirements of article 2 of the ECHR is the use of the coroner's report to prevent future deaths⁸. Coroners have long reserved the right to report to relevant organisations post-inquest with recommendations suggesting potential changes in training, practice, or issues of a technical nature which might reduce future fatalities (Dorries, 2004). This facility exists within Coroners Rules and was discretionary until July 2013 except in the case of a death on the rail system, in which case the coroner was statutorily bound to report to the relevant agency (Levine, 1999). Directions from the Chief Coroner in 2013 indicated that the requirements of article 2 of the ECHR made such a report mandatory if coroners believed it may prevent future deaths. In Davis *et al.*'s (2002) research, coroners felt this function to be a key aspect of their role when promoting public safety and preventing future fatalities. This should be tempered by Luce's findings (2003, p.93) which noted that coroners' reports were used in less than 2% of inquests. It is also important to note that although the coroner may write to an agency, that agency is under no obligation to act on their recommendations, as is also the case in Australia and New Zealand (see, respectively, Corrin and Douglas, 2008; Mok, 2014). In England and Wales there is an expectation that agencies who receive such a report should reply to the coroner within 56 days, although there is no sanction should such a reply not be forthcoming.

From October 2009 the Ministry of Justice began to compile six-monthly statistical bulletins dealing with coroners' reports, the intention being to make them publicly accessible in a nod to more transparent coronial processes (Ministry of Justice, 2010). The first bulletin noted that the majority of these reports were sent to National Health Service (NHS) hospitals. In research into NHS trusts that had received a coroner's report, Claridge *et al.* (2008) found that whilst the principles underpinning these reports were well intentioned, their usefulness in reality was equivocal. Many of the senior hospital staff who received such reports were not aware what the role of a coroner was, or how these reports could be shared or disseminated to promulgate better practice resulting in a reduction of future fatalities. Furthermore, Luce (2003) commented on the divergent reporting practices used. One coroner used the report sixty times in one year whilst one third of coroners in Luce's sample had not used it at all. From 2013 the Chief Coroner undertook to compile an annual report providing an overview of the usage of coroners' reports. At the time of writing, this has not yet come to pass. The last available bulletin from the Ministry of Justice on these reports dates from June 2013 and it is not clear when or if reports for the two years to 2015 will be made public.

⁸ Until 2013 termed 'rule 43 reports' (Matthews 2014).

The two key outputs of the article 2 inquest are both affected by the regional nature of the coronial system in England and Wales. With 99 coronial areas and little oversight or collation of data at a national level, the effectiveness of these outputs in terms of learning lessons that might prevent future deaths must be questioned. In Australia, where the coronial system is organised on a state basis, there is a national overview of outputs from the coronial process in the form of the National Coroners Information System (NCIS) (Dodds *et al.* 2014). It is also notable that whilst article 2 of the ECHR affects all signatories, the only two jurisdictions which use coronial systems to fulfil its obligations are Ireland and the United Kingdom. Thus it might be said that not only is the coronial system regionalised and discretionary, but that the signatories to the ECHR fulfil their obligations to article 2 cases in different ways using different processes. Clearly, this means that the response of signatories to the ECHR at a national level to investigating and reporting on cases of DAPC is not uniform and occurs at the discretion of the national state. Finally, given that this paper considers the socio-legal and socio-political aspects of coronial practice and human rights, it is necessary to note that the current government in the UK came to power in 2015 with a manifesto that included a stated intention to quit the ECHR and introduce instead a 'British bill of rights' (Stone, 2015). Thus, as ever, future developments in coronial practice remain difficult to predict. To some extent, future developments are mediated by institutional structures in the coronial system, and the paper now turns to examine how these structures might affect the changes to coronial practice wrought by article 2 of the ECHR.

IV. *The coronial system in England and Wales in context*

In order to understand how the coronial system currently works, both in terms of its role in state and societal terms, in addition to how it practically functions, it is first necessary to consider its historical roots. Reflecting on her experience of being the coroner conducting inquests into the 7/7 attacks in London, Heather Hallett noted that she was struck by the fact that: 'Coronial law and practice seemed to be a curious mixture of arcane history and obscure legislation' (cited in Matthews, 2014, p.v). This appears to sum up the coronial system in England and Wales neatly: it is the default state response to investigating suspicious deaths, but according to the Home Office appears to be a 'forgotten service' (Dorries, 2004, p.vii). The following section discusses this past in more detail and considers what its institutional legacy might mean for coronial practice with regards to cases of DAPC in the 21st century.

The coronial system is by some margin the longest established element of the justice system in the United Kingdom (Levine, 1999). It dates back to the twelfth century when its role was primarily to investigate suspicious or unexplained death. Coroners were typically located within the

local community and used juries drawn from local people (Sharpe and Dickinson, 2011). The first codification of the role and function of coroners was set out in the 1275 Treaty of Westminster. Dorries (2004) notes that to some degree, all subsequent statutory instruments have been a consolidation of this document. Coronial systems tend to be located in common law systems and as such are found in nation-states whose legal systems have their origins in the English system of justice (Luce, 2003). Coroners' courts are used to investigate unnatural or suspicious deaths in jurisdictions such as Australia, Canada, New Zealand, and the United States. It should be noted, though, that some of these states also use Medical Examiners (ME) rather than (or in addition to) coroners. Medical Examiners tend to focus more on the forensic pathology of cases as distinct from providing the more public medico-legal inquiry that coroners undertake in such states (Matthews, 2014).

The coronial system is unique within the wider system of justice in England and Wales in that there is no defendant and no accused (Levine, 1999). The system is, in theory at least, inquisitorial as distinct from adversarial (Luce, 2003; Tarling, 1999). Adversarialism is based on legal proceedings whereby one party attempts to secure a favourable verdict at the expense of the other party. In coronial proceedings there are no parties to 'take sides', the coroner directs an inquisition into the facts of the case to determine the cause/s of death. As such, there is no intention to ascribe liability or guilt on individuals. It follows that the emphasis is on fact-finding as distinct from the apportionment of blame. The reality of this process, however, is widely disputed both in England and Wales (see, for example Shaw and Coles, 2007; Davis *et al.* 2002), and in Australia (see, for example Scott Bray, 2008; Corrin and Douglas, 2008). The principal reason for this in cases of DAPC is due to the often highly contentious matter of how an individual died (see, for example Thomas *et al.* 2008)

A number of widely publicised cases since the 1990s focused attention upon the role of the coroner in socio-political and socio-legal terms. These cases include: the Hillsborough disaster in 1989 when 96 people died at a high-profile domestic English football game (Scruton *et al.* 1995); the Marchioness pleasure cruiser disaster in 1989 where 51 people died as a result of it sinking in the River Thames; and the Harold Shipman case in 2000 where a registered general practitioner was found to have murdered at least 15 patients and unlawfully killed 166 others in Greater Manchester (Luce, 2003). These cases raised significant questions about the capacity of coroners to hold organisations to account for avoidable deaths; for promoting public safety; and in attempting to avoid future fatalities by learning from failures in organisational practice, training or policy. It is no surprise therefore, that the coronial system which had been long held to be archaic and anachronistic, became subject to a number of significant public reviews in this period as the then

Labour government sought to reform and modernise the coronial system in order that it should be more representative of societal needs and expectations (see, for example Thomas *et al.* 2008; Shaw and Coles, 2007). The coincident effects on coronial practice wrought by article 2 of the ECHR from 2000 onwards ensured that the coronial system became increasingly relevant to the state and society in terms of highlighting wrong-doing, learning lessons, and holding organisations accountable.

Although coroners fulfil an important function for state and society, they are notable for being under-researched by academics. Indeed, some have speculated that such investigation is long overdue (see, for example, Baker, 2016; McLaughlin, 2007; Beckett, 1999; Scraton and Chadwick, 1987). In England and Wales, recent high-profile cases of DAPC such as Sean Rigg⁹ and Ian Tomlinson¹⁰ have highlighted the effectiveness of the coronial system in identifying errors and also suggesting how lessons might be learned to prevent future deaths. Two recent major reviews have made clear that the coronial system provides a more thorough, rigorous and independent investigation into such deaths than the IPCC, and that the IPCC could itself learn lessons from coronial practice (Casale *et al.* 2013; IPCC, 2014). These reviews also noted the fundamental importance of article 2 of the ECHR in guiding coronial process and practice to ensure a rigorous, independent and public investigation into cases of DAPC.

4.1 Organisational characteristics

The coronial system is best imagined not as a national service but as a collection of local services (Chief Coroner, 2014). There are currently 99 coronial areas in England and Wales (Ministry of Justice, 2014). This number has decreased markedly since the 1980s, largely due to a desire by local authorities to reduce costs as coroners retire from their positions (Matthews, 2014). The number of coronial areas pose a challenge in terms of learning lessons that may prevent future deaths in that the coronial system has long been noted as lacking central oversight (see, for example, Shaw and Coles, 2007; Smith, 2003). This highly regionalised demarcation can lead to coroners becoming protective of their autonomy (Davis *et al.* 2002). Coronial areas are not necessarily contiguous with the local government authority, the NHS authority, or to the area of

⁹ Died in a London police station in 2008 after being restrained by police officers. An independent review into the IPCC investigation into his death concluded that the coroner's inquest was able to uncover a number of failings that the IPCC were not, noting: 'The preventive role of the IPCC requires a more proactive and holistic approach to understanding the circumstances surrounding deaths in custody' (Casale *et al.* 2013, p.98).

¹⁰ Died as a result of being hit with a baton and pushed to the ground by a police officer during the G20 protests in London, 2009. The coroner's inquest produced markedly different findings to that of the IPCC investigation leading to a criminal case to be called against the police officer in question (see Scott Bray, 2013, Greer and McLaughlin, 2012)

police authority. The organisation of coronial districts appears to be without regard for specific requirements such as case load or capability (Luce, 2003). The place where the deceased meets their death dictates which coroner the death is reported to (Matthews, 2011). Geographical jurisdiction may also dictate the type of knowledge and expertise that the coroner possesses (Thomas *et al.* 2008).

Coroners in urban areas typically have a greater volume of cases than those in rural areas. A coroner may also have an atypical preponderance of secure facilities within their regional jurisdiction. This could result in them performing a greater proportion of inquests into deaths in these facilities than coroners whose geographical boundaries do not include such facilities (Shaw and Coles, 2007). Conversely, it may be that a coroner seldom encounters such cases and is consequently less well prepared for an inquest into a custody death. This can result in cases where the coroner is unaware of changes in statute or policy and thus needs to adjourn the inquest while s/he brings her/himself up to date with these developments (Thomas *et al.* 2008). It follows that the ability of the coroner to be able to conduct a rigorous inquest into a case of DAPC may have more to do with geographical jurisdiction and case load than experience, training or statutory requirements (see Matthews, 2014). Thus while article 2 inquests are considered to be more rigorous and wide-ranging than was previously the case, it does not necessarily mean that the coroner is adept at overseeing such an inquest. This underlines the tension between the obligations imposed by article 2 of the ECHR and their practical application in the coronial system.

4.2 Role and function: themes in coronial practice

The practitioner literature available on coroners notes that the role and function of the coroner is ambiguous. It suggests that the form and function of the coroner's inquest is either misunderstood, ill defined, ambiguous, discretionary or any combination thereof (see, for example Smith, 2003; Davis *et al.* 2002). In the most recent fundamental review of the coronial system Luce (2003) stated unequivocally that when imagining a reformed service it would be helpful to consider overtly what it *can* do in terms of aims and purpose, particularly regarding what other services and/or organisations cannot. It appears that rather than the government or legislators shaping this function it is the requirements of article 2 of the ECHR that have determined what the coronial system might do.

Discretion is a recurring theme within the key practitioner texts (see, for example Levine, 1999; Thomas *et al.* 2008; Dorries, 2004; Matthews, 2002). In Luce's (2003, p.71) review, he noted: 'The phrase we have heard more than any other during the Review is "the coroner is a law unto himself"'. There is insufficient space here to detail every example of discretion, but the following are

noted as being relevant to the issue of DAPC. At the most fundamental level, the coroner has discretion over when and where the inquest is held; over what evidence is presented; and which witnesses should attend in what order. The coroner has discretion over who has access to documents pre- and post inquest – the specific term being ‘any properly interested person.’ Perhaps unsurprisingly, those individuals who may or may not match this criterion are subject to the coroner’s discretion (Dorries, 2004).

The issue of discretion can be seen in the way in which narrative verdicts are recorded in cases of DAPC. These vary considerably depending on the discretion of the particular jury, some being recorded as questionnaires; others as free-form handwritten narrative; some being 3 lines long and others more than three pages (Baker, 2015). Thus although article 2 of the ECHR has produced a change in practice through the introduction of narrative verdicts, this has been mediated by the institutional structures present in the coronial system. As Scraton and Chadwick (1987) note, Coroners Rules reflect the discretionary nature of proceedings in that they effectively represent a set of guidelines as distinct from a ‘hard and fast’ framework. The 1971 Brodrick report (the last major report on the coronial system prior to Luce) was emphatic in stating that: ‘The law is flexible, but only because it is archaic and exiguous. The coroner can determine his own “style” and method because he is independent and largely beyond challenge’ (cited in Luce, 2003, p.100).

Smith (2003) and Davis *et al.* (2002) note that there are significant differences of interpretation by coroners at inquests with factors as diverse as family involvement, post-mortem procedure, verdict framing and jury direction all having demonstrably divergent interpretations dependent on coronial jurisdiction. Smith (2003), Davis *et al.* (2002) and Luce (2003) note that these differences are the result of structural issues as opposed to individual idiosyncrasies. Luce (2003, p.72) believes such structural issues indicate a lack of consistency in training and appointment, an ambiguous procedural framework and a general ‘lack of clear objectives’. To these, Smith (2003, p.57) adds a lack of leadership and regulation, noting that when compared to the rest of the judiciary, coroners are: ‘to a very large extent...left to their own devices’. Davis *et al.* (2002, p.78) acknowledge that there will always be differences in styles between coroners: ‘but the present level of idiosyncrasy goes beyond this, suggesting that there is not always a consensus even with regards to the purpose of an inquest’.

Structural idiosyncrasy affects how the effects of article 2 of the ECHR are mediated. Whilst article 2 inquests are more rigorous and wide-ranging than was previously the case, it must be noted that they can only occur in light of the comments made above regarding consensus over the purpose of an inquest. With 99 coroner areas, it seems unproblematic to assert that the terms ‘rigorous’ and

'wide-ranging' are relative in terms of how an article 2 inquest is undertaken. Similarly, the use of coroners' reports, which are now held to be mandatory in cases of DAPC in the coronial system need to be considered in this light.

The coronial system, then, is regionalised, has ambiguous roles and functions, and is notable for its use of discretion. These characteristics might also be viewed favourably when considering the role and function of the coroner in investigating and reporting on cases of DAPC. The regionalised nature of the system might reflect both the relative autonomy of coroners and of them being grounded in local communities, in a way that other elements of the justice system may not be. Indeed, it could be argued that the ambiguity of role and function and the large degree of discretion may enable coroners and juries to examine complex cases with greater rigour as a result of not being hidebound by statutory structures. In this sense, it might be argued that the system meets the requirements of open justice, transparency and legitimacy reflected in the obligations imposed by article 2 of the ECHR in a way that, for example, the IPCC as a more structured and rigid organisation does not, as was noted earlier in this paper (see, for example Baker, 2015; IPCC, 2014; Casale *et al.* 2013).

4.3 Reform and stasis

The most recent attempts to reform the coronial system illustrate its 'forgotten' nature. In the aftermath of the Luce report (2003, p.16) which deemed the coronial system 'unfit for purpose' there was protracted debate in government and parliament about how a new bill might re-shape the coronial system. The re-shaping was driven by numerous official reviews, but also by the demands of the HRA 1998 and its requirement to meet the obligations of the ECHR (see, for example JCHR, 2004). The debate about how the coronial system in England and Wales would look in the 21st century eventually produced the Coroners and Justice Act, initially passed in 2009 but not enacted until July 2013.

The coronial system is marked by significant gaps between reform being proposed and enacted. Ten years passed from the Luce (2003) review to the enactment in 2013 of the 2009 Coroners and Justice Act; similarly the Wright (1936) review was discarded for 17 years until it eventually formed the basis of the 1953 Coroners Rules (Levine, 1999); and the Brodrick (1971) review was largely ignored, as was noted in the summary of the Shipman review more than thirty years later (Smith, 2003). In the four years between the Coroners and Justice Act being passed and enacted, aspects of the 2009 Act were repealed, for example the right of appeal. It might also be noted that the 2009 Act created an entirely new function of death reporting which was intended to work both adjacent and complementary to the coronial system. The intention was that a National

Medical Examiner would oversee a network of Medical Examiners working as medical experts alongside but independent of coroners, who were now required to be practising lawyers (Chief Coroner's Office, 2013). This system has not yet been implemented, and there is no indication as to when this might occur (Matthews, 2014).

My point in highlighting the issue of reform and stasis is to draw attention to a number of relevant issues pertinent to the present discussion. First, a trend of governmental desire to reform a non-centralised system in which ambiguity of purpose is well established. Secondly, a similar tendency of government to seemingly discard, ignore, or significantly circumscribe recommendations produced by official reviews. Thirdly, this indicates that reform of the system in the last one hundred years has been piecemeal. Although reform of the coronial system has often been on the governmental agenda, it might be argued that precedents resulting from article 2 of the ECHR have effected more substantive change in coroners' practices. The key change that emerged, after much parliamentary debate, from the 2009 Act was the creation of the role of Chief Coroner for England and Wales, a position taken up in September 2012 by Judge Peter Thornton (Matthews, 2014).

'The role of the Chief Coroner is intended to:

- 1) Improve liaison between the government (both central and local) and the coroners operating the system;
- 2) A role in the appointment of coroners;
- 3) Provide national leadership and guidance to coroners;
- 4) Increase the efficiency of the coroner system.'

(Matthews, 2014, p.31)

The Chief Coroner's first major act was to draft a set of directions to all coroners in England and Wales about how the 2009 Coroners and Justice Act should be put into practice; this was published in late 2013 (Chief Coroner's Office, 2013). Broadly stated, it set out a series of expected standards and requirements of coroners. As such, the directions may be seen to be an updated and consolidated version of Coroners Rules. Of particular relevance is that the Chief Coroner must produce an annual report on the coronial system and send this to the Lord Chancellor (Matthews, 2014). This arguably represents the first time a national report has been compiled about the coronial system and therefore indicates an attempt at a more 'national' type of system. It is, however, notable that the Chief Coroner does not have a deputy, although the provision of one is enabled through the 2009 Coroners and Justice Act. Matthews (2014, p.22) further notes that there is no

obligation in the Act for the role of Chief Coroner to be filled, rather than the Lord Chief Justice 'may' appoint a Chief Coroner. At the time of writing it is too early to comment on how the Chief Coroner may affect the coronial system, but there might be concern over the relatively limited resources at his disposal to enforce Coroners Rules and consolidate a national coronial system.

V. Conclusion

This paper discussed changes effected by article 2 of the ECHR to coronial practice when investigating and reporting on cases of DAPC in England and Wales. The coronial system exists as a key nexus in the relationship between police accountability, open justice and legitimacy; and between state and society. The most recent evolution of these relationships is manifest in changes effected by article 2 of the ECHR on the coronial system. In England and Wales, the state meets the obligation of the ECHR through article 2 inquests in the coronial system. There is no hard and fast statutory framework that defines or determines how this should occur, rather it happens as a result of principle and precedent in the common law system, as demonstrated in the case of Middleton.

Reform and stasis in the coronial system are evident in the evolution that has occurred as a result of article 2 of the ECHR. The article established that proposed reforms have consistently been delayed, ignored, or diluted. It argued that the reform of the coronial system with regard to cases of DAPC has been most evidently effected by article 2 of the ECHR. Thus the state has principally had coronial reform imposed on it by the obligations of the ECHR. In this sense, reform has been driven by precedents which were obliged as a result of demands external to the state. Reform has been unplanned and reactive rather than planned and proactive on behalf of the state. Stasis is represented in the relatively unchanged aspects of coronial practice set out in statute, and characterised by ongoing coronial themes outlined below.

The coronial system is characterised by issues such as ambiguity of aims and purpose; of being an essentially regional rather than a national system; and of having significant discretion in terms of the processes and practices it employs. It is therefore unsurprising that changes effected by article 2 of the ECHR have been piecemeal and driven primarily by precedent. With 99 coronial areas in England and Wales, issues of autonomy, discretion and ambiguity mean that there are a variety of different approaches employed in the investigation of cases of DAPC through article 2 inquests. Similarly, narrative verdicts are notable for the variety of ways in which they are recorded, appearing to be largely determined by the specific issues the jury considers relevant, and this has produced divergent approaches in terms of their content, format and length. Finally, the coroner's report is now mandatory if the coroner believes that lessons could be learned that may prevent future deaths. Although coroners may make recommendations, they have no power to enforce them. With

99 autonomous coroners writing such reports, there is clearly scope for divergent interpretations and this might also affect the way in which a plethora of public organisations may or may not choose to react to such a report.

Thus it appears clear that the ambiguous role and function of the coroner, the regionalised nature of the coronial system, and the significant degree of discretion afforded the coroner all represent enduring themes in coronial practices and processes in England and Wales. Whilst there has been an evolution in the way in which cases of DAPC in England and Wales are investigated and reported on due to the obligations imposed by article 2 of the ECHR, this evolution has occurred within the institutional constraints inherent within the coronial system. Although changes in coronial practice have been effected by obligations imposed by article 2 of the ECHR these changes are in turn affected by pre-existing structures and issues inherent in the coronial system in England and Wales.

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