Prisons & Probation Ombudsman
Independent Investigations

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Justice Select Committee
BY EMAIL

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Dear Justice Committee

Re: Inquiry into the Coroner Service in England and Wales

Thank you for letting us know about the House of Commons Justice Committee's Inquiry into the Coroner Service in England and Wales. I am grateful for the opportunity to provide our comments for the Committee to consider.

My role

The Prisons and Probation Ombudsman (PPO) carries out independent investigations into deaths and complaints in custody. My role and responsibilities are set out in our Terms of Reference[1].

My office has two main duties:

- To investigate complaints made by prisoners, young people in detention (young offender institutions and secure training centres), offenders under probation supervision and immigration detainees.
- To investigate deaths of prisoners, young people in detention (including residents in secure children's homes), approved premises' residents and immigration detainees due to any cause, including any apparent suicides and deaths due to natural causes.

The purpose of these investigations is to understand what happened, to correct injustices and to identify learning for the organisations whose actions we oversee so that we can make a significant contribution to safer, fairer custody and offender supervision.

My submission to the inquiry

The PPO's contact with coroners

Our deaths investigations bring us into contact with coroners and their offices. When we begin an investigation into a death, we make early contact with the relevant coroner who sends us the post-mortem or cause of death when it is available. We inform the coroner of the expected dates by which we will produce our draft report (20 weeks from notification in

[1] www.ppo.gov.uk/about/vision-and-values/terms-of-reference/

the case of deaths from natural causes and 26 weeks in the case of other deaths) and our final report. Coroners use these dates to determine the date of inquests. (If we need to suspend our investigations for any reason – for example, while a police investigation takes place or while we wait for the cause of death – we inform the coroner and provide revised dates.)

When we produce our report on the death, we send a copy to the coroner (as well as to the bereaved family, the service in remit and NHS E/I) at the draft stage and when it is finalised. The final report includes an action plan provided by the service in remit and the healthcare provider in response to any recommendations we have made.

The PPO's report, together with any other evidence, is considered at the inquest. We do not publish our reports until after the inquest has taken place in order to avoid prejudicing the outcome.

Unevenness of coroners' services

In our experience there is considerable variation in the way coroners and their offices work and some are more efficient and effective than others.

For example, some coroners' offices provide information about the dates of upcoming inquests and the conclusions of completed inquests on line, making this information easily accessible to stakeholders. In other cases, this information is only available in response to emails and phone calls.

The timeliness with which coroners schedule inquests also varies widely. We recently raised our concerns about the length of time it often takes for inquests to be held in Wales with the Health, Social Care and Sport Committee of the Welsh Parliament. For example, a death occurred in a Secure Children's Home (SCH) in England and also in a SCH in Wales in the same week of February 2017. The inquest into the English death took place in July 2019; the inquest into the Welsh death has not yet been scheduled. Another example, was a death at HMP Swansea in March 2014 where the inquest took place in February 2020.

These lengthy delays are not confined to Wales; we have also seen delays of years before inquests have been held in England. We would be happy to provide some examples if that would be of interest.

Such significant delays are distressing for the bereaved families, and also reduce the value of any learning from the death. We find it very frustrating when have to wait years before we can publish the report of our investigation, because it means our recommendations for improvement are not widely promulgated at a time when they may make the most difference.

Other variations include whether or not the coroner requests toxicology tests. In some prison deaths it may be immediately apparent that there is strong likelihood that the death was drug-related. If toxicology tests are not requested, however, it will not be possible to demonstrate whether drugs played a part and the scope for learning is therefore reduced.

Ways to strengthen the Coroners' role in the prevention of avoidable future deaths

We consider that holding inquests promptly is key. The value of any learning is significantly reduced if the inquest takes place years after the death.

How the Coroners Service has dealt with Covid-19

The main impact that we have seen has been on jury inquests which have had to be postponed because of the lockdown and the social distancing restrictions. Some areas have built up significant backlogs.

Some coroners, but not all, have made effective use of video and teleconferencing facilities to continue with matters such as pre-inquest reviews.

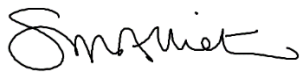
Improvements in services for the bereaved

One significant area for improvement would be to improve the timeliness of inquests since long delays are distressing for bereaved families.

We also know that bereaved families can find the inquest process very intimidating, especially if they are not able to obtain legal representation. The other parties at an inquest (such as the prison, the healthcare provider and individual members of staff) will generally each have their own legal representatives and this can give families the impression that the odds are stacked against them.

I hope that this is helpful. Please contact me if you require additional information or further examples.

Yours sincerely



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