



Refuge's Response to 'Coroner Reform: The Government's Draft Bill
Improving Death Investigation in England and Wales'
Department for Constitutional Affairs

September 2006

Refuge

Founded in 1971, Refuge has grown from a small charity, pioneering the world's first refuge, to be the country's largest single provider of specialist accommodation and support for women and children escaping domestic violence. On any given day, we support over 900 women and children in our refuges and through our community based outreach services.

Refuge runs award winning media and advertising campaigns to raise public awareness of domestic violence nationally and internationally, whilst also campaigning and lobbying for better provision for women and children experiencing domestic violence.

Introduction

1.1 Each week in England and Wales, 2 women are killed by a current or former partner¹ and almost 5 times this number of abused women commit suicide.² The children of abused women are also at risk from domestic violence perpetrators, at least 29 of whom have been killed³ over a 10 year period. The risks to children begin before birth, as domestic violence is known to either begin or escalate during pregnancy⁴ with the result that domestic violence is not only associated with maternal death,⁵ it is also the leading cause of foetal death.⁶

1.2 Refuge strongly believes that many of these deaths can be prevented if we implement suitable mechanisms for investigation and review alongside appropriate legislation, professional practice and programmes of public education. And whilst progress has been made in some of these directions, there remains a long way to go in others, with the investigation of domestic fatalities being one area where we have not really left the starting block.

1.3 Refuge believes that the processes of investigation and of review in relation to unexpected deaths or homicides within a domestic violence context are vital if we are to properly understand the circumstances and causes of those deaths and if we are to prevent future tragedies.

¹ Flood-Page & Taylor (2003) 'Crime in England and Wales 2001/2002: Supplementary Volume'

² Walby, S (2004) 'The Cost of Domestic Violence' DTI

³ Saunders, H (2004) '29 Child Homicides'

⁴ Lewis, Gwynneth, Drife, James, et al. (2001) 'Why mothers die: Report from the confidential enquiries into maternal deaths in the UK' 1997-9; RCOG

⁵ Lewis, Gwynneth, Drife, James, et al. (2001) *ibid*

⁶ Friend (1998) 'Responding to violence against women: a specialist's role' Editorial, *Hospital Medicine*, 59(9), 98-99

1.4 The work of domestic fatality reviews across North America have helped professionals to understand better the risk factors that can increase the 'dangerousness' of a perpetrator⁷ and to make recommendations for policy, systems and practice in an attempt to protect better their victims. Refuge is concerned however, that domestic fatality review teams tend to operate in private, with investigations protected from external scrutiny by confidentiality agreements and a very limited dissemination of findings. Limitations in terms of the investigative powers of the review team are also a concern. Unlike coroner's inquiries or inquests, domestic fatality review teams do not have the powers to compel witnesses to attend nor to disclose records or other evidence vital to the inquiry. Refuge is also concerned about the marginal role assigned to families within the domestic fatality review process.

1.5 Refuge is calling for the development of a system which allows for effective, independent, public investigations into domestic fatalities, where the families of victims are fully involved. Refuge believes this process is particularly important in circumstances where there are indications that a State agent has been negligent in its duty to prevent loss of life. Refuge is not confident however that the coronial system, neither as it stands nor with the benefit of reforms outlined in the Coroners Bill 2006, will be able to deliver such a system and considerable improvement is still needed.

The Coroners Bill and Allied Reform

2.1 Refuge is pleased that the government is planning reform of the coronial service and is enshrining these developments within legislation. Positive measures outlined in the bill include:

- A new structure of national leadership and accountability
- Proposals for a co-ordinated programme of training for coroners
- New rights of appeal for the bereaved
- New powers to obtain evidence for investigations
- The widening of the scope of investigations to include the circumstances of deaths when Article 2 of the European Convention of Human Rights is engaged.

A New Structure

2.2 Whilst the new coronial structure of national leadership under a chief coroner accountable to the Lord Chancellor, is preferable to the present arrangement of no national leadership or clear accountability, it appears to fall short of expectations.

2.3 The Fundamental Review of the death certification and coroner service,⁸ the Coroner's Society and the select committee charged with pre-legislative scrutiny of the bill, have recommended the need for a national service which employs both coroners and their officers. It was hoped that these reforms would create a coherent structure and help to solve the problems of fragmentation, unequal access to resources and conflicts of interest evident across the current system. Coroner's officers have traditionally been employed either by the police or the local authority. This can present problems for a coroner who must direct the daily work of an officer employed by the police and for the officer himself, who must work according to two different

⁷ Websdale, N (2000) 'Lethality Assessment Tools: A critical analysis' VAW net, Applied Research Forum

⁸ Luce (2003) 'Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review'

systems. Further conflicts can occur when Coroners find themselves having to negotiate additional funds from their local authority in order to carry out a more effective investigation into the acts or omissions of that same local authority. There is evidence that these latter conflicts can, on occasion, become untenable, with some coroners having to fund investigations using resources from the Coroner's Society.⁹

2.4 The proposed structure is for coroner's officers to remain in the employ of either the local authority or the police and for coroners to remain the employees of local authorities, but with central accountability to the chief coroner. This is likely to be a blow to coroner's officers who carry out a vital, front line role in the service and whose career structure arguably deserves the same degree of attention and reform as that of coroners.

2.5 A national service which includes both coroners and their officers would go some way to resolving issues of independence from local authorities and in promoting coherence and consistency by bringing both professions within the same funding, management and training structure.

Training and Guidance

3.1 Refuge is supportive of the proposals to develop a programme of training for both induction and continuing professional development for coroners. Refuge believes it would be crucial to include mandatory components on domestic violence within this training in order that coroners could be properly equipped to carry out effective investigations into domestic fatalities and reach appropriate judgements on the causes and circumstances surrounding these deaths.

3.2 There are questions nevertheless, about how a comprehensive system of training will be funded. If the situation remains as it is at present, then local authorities would foot the bill and there already appear to be substantial difficulties with this arrangement¹⁰ specifically, insufficient funds and/or coroners to provide cover for those on training. In addition, it seems crucial that coroner's officers have access to appropriate training and it is a pity that a programme for their continuing professional development has not been included within proposals set out in the bill. Without a substantial injection of cash and resources it is difficult to see how coroners and their officers will be able to deliver the reformed and improved service proposed under the bill.

New Rights of Appeal

4.1 Refuge is supportive of the Charter for Bereaved People who come into contact with the coronial service and of the new rights of appeal outlined in the bill.

New Powers to Obtain Evidence for Investigations

5.1 Refuge supports the new powers given to coroners to obtain evidence in investigations.

The Widening to the Scope of Investigations

6.1 Refuge is pleased to see on the face of the bill a clause which, where necessary, requires that an investigation should also include the circumstances by which the victim came by their death. The European Convention on Human Rights, Article 2 and the positive obligation which it

⁹ Victor Round Oral evidence to the select committee (26 April 2006)

¹⁰ Victor Round Select Committee oral evidence (26 April 2006)

places upon States to protect and safeguard the lives of its citizens, appears to have had a significant impact on coronial law. In addition, the House of Lords has set out minimum standards for such investigations¹¹ which include: independence, effectiveness, promptness, public scrutiny and accessibility to the family of the deceased; an investigation which does not meet these standards constitutes a violation of Article 2.

6.2 Refuge believes these developments have relevance for domestic fatalities, particularly in circumstances where there appear to have been opportunities to avert the death but systemic failings prevented this. Refuge very much hopes that appropriate, adequately resourced and enhanced investigations of this type will not only provide families with effective investigations into the circumstances of their loved one's death but also help to inform legislation, policy and practice, thereby preventing future tragedies. The creation of clear protocols which promote co-operation with domestic fatality reviews and serious case reviews seems important in order to maximise preventative efforts both locally and nationally.

Other Issues:

Involvement of Families

7.1 Refuge believes that relatives of the deceased should be involved fully in the investigative process. This means that they should have access to all documentation and evidence in connection with their relative's death, including the circumstances surrounding it. In contrast, the draft charter indicates that families *"will have a right to see reports of any post-mortems and normally of other investigations, unless the coroner decides that some material needs to remain confidential to him/her permanently or for a period of time in order to protect the rights of third parties."*¹²

7.2 In order to participate fully in the process, particularly when this includes investigation into the acts or omissions of a State agent, Refuge believes that *all* families should be provided with State funded legal representation. This would help to place them on an equal footing with those whose actions they seek to investigate. It is, therefore, a pity that changes to the legal aid rules which govern financial assistance to families engaged with inquests have not been addressed in this bill.

7.3 Refuge is pleased to see options for children and young people below 17 to give evidence via video link.

Inquests and Other Investigations

8.1 Refuge is pleased that the government intends to continue holding inquests in public, though is concerned about the proposal to prohibit publication of information in some instances, such as some suicides and child deaths believing the process should be as open and transparent as possible. Nevertheless, in cases where it is *clearly not* in the public interest to share information about the deaths, these new measures might provide welcome relief to some families.

¹¹ Jordan and Ors v. UK (2001) 37 EHRR 52

¹² The draft charter for bereaved people who come into contact with the coroner service (para 12 June 2006)

8.2 Working Together to Safeguard Children¹³ (2006) sets out proposals on how Local Safeguarding Boards should respond to the sudden and unexpected deaths of children. This includes establishing Child Death Review Panels and working according to a protocol agreed with the coronial service, which involves a designated paediatrician who would also have a role in investigating the cause of death. Refuge would recommend including on the face of the bill, clarity about the duties and responsibilities of coroners with regard to other processes of death investigation. Refuge also believes it is important for the bill to make clear the duties and responsibilities of allied medical professionals, such as paediatricians who have a duty to investigate the death. Guidance on model processes for working across and in parallel with other agencies or investigations of the same deaths would be of benefit, particularly to the coronial service which historically has been detached from local authority structures and partnerships.

Outcome of the Investigation

9.1 Refuge is pleased that the bill gives the coroner powers to make a report to any person who might have the power to prevent similar tragedies occurring in the future. Dissemination of investigative findings in this way echoes the spirit of domestic fatality reviews in that the aim of sharing information about the death is not to lay blame but to prevent future deaths in similar circumstances.

9.2 Refuge would agree with the select committee's recommendation that coroners adopt an *'enhanced role in relation to public health and safety'*, a role which is both enshrined in legislation and *'backed up with significant additional resources to produce a system which proved greater public benefit and value for money.'*¹⁴

Juries

10.1 Refuge is concerned that the government proposes to limit the number of inquests that will require juries. Inquest¹⁵ suggests that juries are extremely important for families in terms of providing legitimacy and accountability to the investigation. Juries can be particularly important during investigations where families are not represented legally and the balance of legal or institutional power seems weighted against them. Inquest state, *"...they know the jury is not part of the establishment and that their peers are judging the circumstances of the death"*¹⁶.

Resumption of Investigations

11.1 Refuge is concerned that in cases where investigations are resumed following conclusion of another investigation, such as a criminal trial or public inquiry, the coroner is prevented from reaching a conclusion which is inconsistent with the outcome of this former inquiry.

Death Certification Scheme

12.1 The select committee charged with bringing pre-legislative scrutiny to this bill, are in agreement with many experts in the field who gave evidence on the matter of death certification. They state *"death certification, investigation and registration are processes which are inextricably*

¹³ Dfes

¹⁴ Eighth Report: Reform of the coroners' system and death certification (1 August 2006)

¹⁵ Inquest's response to the Fundamental Review of Coroner Services (2002) www.inquest.org.uk

¹⁶ Inquest (ibid)

linked. The government's decision not to reform the death certification system leaves many fundamental problems unaddressed¹⁷.

12.2 It is of concern to Refuge that Tom Luce, in evidence to the committee stated *"there are all sorts of environments in which people can die and they can be certified as having died natural deaths when they might have been subject to abuse or neglect for example in nursing homes or residential homes."*¹⁸

12.3 The BMA are very clear about the need for reform of the death certification service, highlighting the insufficient training on this process given to doctors and medical students. They also highlight the crucial role of medical examiners in the process of scrutinising death certificates and recommend that a number of medical examiners are appointed by each coroner.¹⁹

12.4 Refuge would agree with these experts in calling for reform of the death certification scheme.

A Specialist Domestic Violence Service?

13.1 The value of a specialist service for responding to domestic violence has already been recognised by the criminal justice system. We now have specialist domestic violence courts, domestic violence police officers and independent domestic violence advocates who support victims as they negotiate the legal system. Refuge suggests that there might be some merit in developing a domestic violence coroner's court where effective inquiries can be held into the deaths of both adults and children who die in such circumstances.

13.2 Another option would be to train a cohort of coroners who could specialise in domestic violence investigations across several locations and there are already provisions within the bill that allow a coroner to request and the chief coroner to direct, another perhaps more specialist coroner, to carry out an investigation.

[Ends]

¹⁷ Select Committee report (2006) *ibid*

¹⁸ Tom Luce Oral evidence Q94

¹⁹ BMA response to the government's draft bill (16 August 2006)