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Briefing on coronial reform

March 2011

INQUEST welcomed the objective of the Coroners and Justice Act 2009 "to put the bereaved at the heart of the process." The Act has the potential to make real progress in remedying many of the problems in the current system. However, the new model agreed by Parliament less than two years ago would be rendered completely hollow without the driving force and national leadership of a Chief Coroner.

This briefing analyses government arguments in support of their decision not to implement the reforms to the inquest system contained in the Coroners and Justice Act 2009 and to abolish the Chief Coroner's office. It contains answers to the questions that Peers and MPs frequently ask INQUEST about proper reform of the coronial system and the government's plans. INQUEST believes the government's arguments on coronial reform do not add up – logically or financially.

Background

Why do we need a Chief Coroner and fundamental reform of the inquest system?

1. The current, antiquated system is built on a statutory framework set out in the Coroners Act 1887 with the most recent statute, the Coroners Act 1988, being largely a consolidating measure. The coroner's system operates as a fragmented, non-professional assortment of individual coroners who operate with no compulsory training and little accountability. There are a growing number of coroners who adopt an efficient, modern approach to running inquests but, overall, there is a 'postcode lottery' of service for bereaved families with good practice dependent on the approach of individual coroners rather than agreed and inspected quality standards.
2. Delays of two or three years to the inquest process are not uncommon. This causes difficulty for all concerned but particularly so for bereaved people who have described how their lives have been put on hold until they have been through the inquest process. As there is no public scrutiny of the death for such a long period, the opportunity for identifying what went wrong and to prevent other deaths is hindered. Compounding this problem, the current system has no robust mechanism to monitor inquest findings or to take any follow up action with the relevant public bodies based on any issues that arise out of inquests. Findings of inquests proceedings are not effectively and routinely recorded, shared, analysed and acted upon so that issues of systematic failure are properly addressed.
3. INQUEST has extensively documented the failings of the current inquest process and how too often it adds to families' distress rather than providing a mechanism for addressing concerns and preventing future deaths.¹ We are not lone critics. Successive governments have recognised the system is in need of fundamental reform and commissioned three extensive reviews in 1936, 1965 and 2001. The most recent review, chaired by Tom Luce, was a £1.1 million comprehensive analysis of the current system which involved evidence gathering and consultation with over 200 coroners, families, lawyers and organisations. In their final report the independent reviewers concluded that the coronial system had been seriously neglected over many decades and it *"must undergo radical change if [it is] to become fit for the purposes of a modern society and capable of meeting future challenges."*² They went on to make a number of recommendations to deal with critical defects in the current system. Central to their

¹ Including, for example, Shaw, H. and Coles, D. *Unlocking the Truth: Families' Experiences of the Investigation of Deaths in Custody*, INQUEST 2007; *How the inquest system fails bereaved people* INQUEST, 2002. Copies available on request.

² Para 1, the independent review of Coroner Services commissioned by the Home Office and chaired by Tom Luce, *Death Certification and Investigation in England, Wales and Northern Ireland*, 2003.

recommendations was the creation of the post of Chief Coroner for England and Wales. Since then there have been a number of other high-profile reviews, parliamentary reports or inquiries also calling for an overhaul of the system.³

Why did the government include the Chief Coroner in the Public Bodies Bill?

4. In his announcement to the House of Commons on 14 October 2010 the Cabinet Office Minister, Francis Maude MP, set out government plans for the reform of public bodies “to increase transparency and accountability, to cut out duplication of activity and to discontinue activities that are simply no longer needed”. On the same day the Parliamentary Under-Secretary of State for Justice, Jonathan Djanogly MP made a written ministerial statement⁴ outlining the government’s intention to abolish, through the Public Bodies Bill, the office of Chief Coroner and associated posts and to bring forward a more limited number of reforms to the coronial system.⁵
5. It is difficult to justify why the post is included in the Public Bodies Bill⁶. The Chief Coroner was intended, for the first time, to bring transparency and accountability to the coronial service by providing judicial oversight and national leadership. The judicial office holder would also carry out highly technical and specialised activities including presiding over an appeals system and conducting some inquests which involve complex concerns about individual and systemic failings by state agencies and breaches of Article 2 ECHR – both of which require independence and impartiality. The overwhelming need for the functions that a Chief Coroner has been recognised in numerous high-profile reviews, parliamentary reports or inquiries, by Parliament itself in enacting the Coroners and Justice Act 2009, and implicitly by the Coalition Government who have pledged to transfer the functions of the Chief Coroner to other bodies.
6. In December 2010, the House of Lords rejected the government’s attempt to abolish the post by voting overwhelmingly (by 277 votes to 165) in favour of an amendment tabled by Baroness Finlay of Llandaff to remove the Chief Coroner and associated offices from the Public Bodies Bill. INQUEST believes that, despite a clear message from Peers the government will press ahead and re-insert the Chief Coroner’s office into Schedule 1 of the Bill as it moves to the House of Commons.
7. The government has acknowledged that the fundamental reason for trying to abolish the Chief Coroner’s office is cost.

³ See, for example: Independent Review of Coroner Services Commissioned by the Home Office and chaired by Tom Luce *The Report of a Fundamental Review: Death Certification and Investigation in England, Wales and Northern Ireland*, 2003; Joint Committee on Human Rights *Deaths in Custody: Third Report of Session 2004-05*; Select Committee on Constitutional Affairs *Reform of the coroners’ system and death certification: Eighth Report of Session 2005-06*; Final report of the *Redfern Inquiry* into the analysis of human tissue taken from individuals who had worked in the nuclear industry, published 16 November 2010.

⁴ See the Hansard record of the Written Ministerial Statements of 14th October 2010 made by Jonathan Djanogly MP:
www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101014/wmstext/101014m0001.htm#10101430000175.

⁵ Including Deputy Chief Coroners, Medical Advisers to the Chief Coroner and Deputy Medical Advisers to the Chief Coroner

⁶ In response to queries in correspondence from INQUEST the government has side-stepped the question of whether the Chief Coroner is correctly included in the Bill by stating “as the office of Chief Coroner has not been set-up there are no activities currently being carried out under the 2009 Act”.

The government's arguments

"We can't afford it"

8. Jonathan Djanogly MP has explained to the House of Commons in October 2010 that *"the purpose of abolishing the Chief Coroner post is, first, to save the £10 million start-up costs and then the £6.5 million running costs, but also so that some of the Chief Coroner's leadership and operational functions can be transferred to an alternative body."*⁷
9. In December 2010, in response to requests from members of the House of Lords, the Ministry of Justice finally provided an estimate of costs for full implementation of the coroners provisions in the Coroners and Justice Act.⁸ The estimated £10 million set-up costs include £3,850,000 for IT, £2,233,000 for the Ministry of Justice Programme Team and a contingency of £693,000. It is not clear on exactly what basis the sums were drawn up as no supporting impact assessment or narrative accompanied the figures.
10. In January 2011, INQUEST made Freedom of Information Act requests for policy documents, civil servant's emails and other relevant materials relating to the creation of these costings. The limited material released by the Ministry of Justice makes clear that officials preparing the costings in November 2010 were unsure of the precise details included in the costings and were having to 'check' figures⁹. This raises the question: if the decision to abolish the Chief Coroner's post, as announced in October, was made primarily on the basis of cost, why were officials having to gather information on costs in November 2010?
11. INQUEST believes the figures relied on by the government are taken from an impact assessment conducted by the Ministry of Justice in December 2008.¹⁰ INQUEST believes it is inappropriate to rely on these calculations as the impact assessment was conducted on the assumption that the fundamental reforms in the Coroners and Justice Bill *would* be implemented. As a result, the 2008 impact assessment did not evaluate the costs of the current failing system including:
 - financial costs of adjourned and delayed hearings;
 - expensive judicial reviews against coroner's decisions;
 - costs to the NHS of the impact of delays in the current system on bereaved families' physical and mental health. Research conducted by INQUEST in 2002 has demonstrated this is likely to be substantial¹¹.

⁷ 19 October 2010, *HC Deb*, col 795 in response to a parliamentary question from Caroline Lucas MP

⁸ The 2 page document setting out the Ministry of Justice's estimation of costs has been deposited with Parliament and can be found via: www.parliament.uk/deposits/depositedpapers/2010/DEP2010-2203.doc.

⁹ The original freedom of information request and the response can be supplied by INQUEST on request.

¹⁰ Ministry of Justice, *Impact Assessment of the coroner sections of the Coroners and Justice Bill* (December 2008) available from: www.justice.gov.uk/publications/docs/coroners-justice-bill-ia-coroner-reform.pdf

¹¹ In 2002 INQUEST published the results of a detailed survey which indicated that the majority of bereaved families facing inquests suffer some serious adverse effect to their health and personal lives in the medium to long term¹¹. Given the number of sudden deaths each year in the UK, this translates into a finding of a major social and public health problem at a national level – which, to date, has escaped the attention of government and decision makers almost entirely. We asked respondents whether their physical health had *"improved, deteriorated or stayed the same"* since the death. Of the 130 families surveyed, almost two-thirds (64%) identified a deterioration. Asked the same question in relation to their *"state of mind"*, again two-thirds (66%) felt this had deteriorated. Of yet more serious concern was that, when asked subsequently whether they had experienced *"serious physical"* or *"serious mental health problems"* since the inquest, approximately one-third of all respondents answered positively in response to each category (30% and 31% respectively).

12. Most significantly, given the current system is failing to learn from previous fatalities, the costs of repeated and expensive investigations and inquests into similar deaths are not included in this costs assessment. The government's approach to date has been *"we can't afford"* to implement Chief Coroner's office. INQUEST argues a brief examination of the costs of the current system – in relation to failing to prevent deaths in custody alone - demonstrates that the government's approach should be *"we can't afford not to"*.
13. The government has been unable to respond to requests, through Parliamentary questions, to provide comprehensive information about the public funds currently spent on deaths in all forms of custody (police, prison and psychiatric detention)¹². The Home Office has been unable to provide figures for the costs to the public purse of IPCC investigations and legal representation at inquests following deaths in police custody. The Ministry of Justice has confirmed that in relation to deaths of prisoners in custody the costs for legal advice and representation of Ministry of Justice bodies at inquests was £2.7million in 2009/10 alone. The average cost of each Prisons and Probation Ombudsman investigation is approximately £16,000 and 179 deaths were investigated in 2009-10 at a cost of £2.8million.
14. Setting up the Chief Coroner's office and implementing the reforms in the Coroners and Justice Act would improve the ability of the coronial system to learn from deaths in custody (and other deaths that raise questions of public health and safety) and, ultimately, prevent further unnecessary deaths which saves emotional costs to families and financial costs to society. When the government's figures are analysed in the light of this, proper reform of the inquest system with a Chief Coroner and implementation of reforms in the Coroners and Justice Act offers good value for money. Failing to proceed with the appointment of a Chief Coroner is a false economy.

"We need to abolish the office of Chief Coroner"

15. The government asserts that it must abolish the Chief Coroner's post if they are to take forward even the limited amendments to the coronial system they propose. This does not follow. It is possible in law for certain functions of a judicial body or officer to be transferred to another without the need to abolish the former. A recent and important example of this happening is that certain functions of the High Court, namely part of the judicial review jurisdiction, have been transferred to the Upper Tribunal under the Tribunals, Courts and Enforcement Act 2007. This has not required the abolition of the High Court or any part of it such as the Administrative Court. We believe it would be possible for the government to amend the Coroners and Justice Act to enable a transfer of selected powers to other judicial bodies without needing to abolish the Chief Coroner's post. INQUEST has asked the government to clarify the legal basis on which they assert it is necessary to abolish the Chief Coroner's post in order to transfer the functions of the office to an alternative body. No answer has yet been received.

"The Chief Coroner's office was intended to be largely administrative and had few powers to formally govern the system"

16. The government's attempt to re-cast the Chief Coroner's office as a largely administrative post is disingenuous. In reality, the Chief Coroner was intended to spearhead reform of the system and, through the Coroners and Justice Act 2009, Parliament gave the Chief Coroner specific

¹² See the answers to parliamentary questions tabled by Jeremy Corbyn MP on Coroners and Deaths in Custody on: 11 January 2011; 18 January 2011 and 24 January 2011 via: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/csmallfiles/mps/commons_hansard_2717_wad.html

and significant powers to tackle deep-seated issues relating to the operation of the coroners system as a whole. Even the Ministry of Justice's own 'Job Description' or 'Main Activities of the Chief Coroner'¹³ make clear that the post was envisaged to be a judicial and leadership role.

17. The Chief Coroner would have powers and responsibilities to:

1. Manage coroners' courts by allocating cases in order to deal with particularly complex cases, backlogs or delays, or to cater for unexpectedly large numbers of deaths due to a major incident (s.3 of the Coroners and Justice Act 2009 and paras 5-6, Main Activities of the Chief Coroner). Crucially, this would have been a step towards tackling the unacceptable delays that plague the current system;
2. Drive up standards in the system through training (s. 37 of the Act gives the Chief Coroner powers and responsibilities to make regulations about training). It was also envisaged the Chief Coroner would issue guidance to coroners on ways of working, lay down practice directions, set national standards of service (s.42 of the Act and paras 8-9, Main Activities of the Chief Coroner);
3. Work with the Lord Chancellor and Ministry of Justice to make regulations and rules overhauling practice and procedure at inquests (s.43(2) sets out regulations may only be made if a judicial office holder, envisaged as the Chief Coroner, agrees);
4. Deal with appeals made against coroners' decisions, including on issues such as whether to investigate a death or not or any finding as to cause of death (s.40 of the Act). The new appeals system overseen by the Chief Coroner would have offered families a route to resolve poor decision-making by coroners and spared some of them from only being able to challenge decisions through expensive and time-consuming judicial reviews;
5. Develop and operate an effective scheme for ensuring that recommendations and warnings relating to public safety emerging from coroners' investigations are brought to the attention of those responsible for creating the relevant risks, regulatory bodies and the public. Critically, the Chief Coroner would be able to take steps to ensure that such recommendations and warnings are acted on (para 20 Main Activities of the Chief Coroner);
6. Monitor the performance of coronial system including through provision of an annual report to the Lord Chancellor addressing, amongst other things, levels of consistency between coroner areas, the number of investigations that have been ongoing for over a year, identification of specific resource issues and any other matters which the Chief Coroner wishes to bring to public attention (s.36 of the Act and paras 11-12 of Main Activities of the Chief Coroner). The annual report would have been published and laid before Parliament offering an opportunity for further scrutiny and debate.

"The Chief Coroner is not a judicial post"

18. INQUEST is deeply concerned that the proposal contained in the Public Bodies Bill to abolish the judicial office of the Chief Coroner through secondary legislation is unconstitutional. INQUEST has received legal advice from Rabinder Singh QC that questions the government's approach in the Public Bodies Bill and points out that *"if Parliament can authorise the abolition of the office of Chief Coroner by ministerial order, it is difficult to see why it could*

¹³ "Main Activities of the Chief Coroner" contained in *Reform of the coroner system – next stage* Ministry of Justice consultation paper CP06/10 (pages 97-101) available via <http://www.justice.gov.uk/consultations/docs/coroner-reform.pdf>

not also authorise the abolition in that way of the office of Lord Chief Justice or even the entire Supreme Court".¹⁴

19. In response, the government has argued that it is "*perfectly legitimate*" to abolish the Chief Coroner's office through the Public Bodies Bill because the "*the role of the Chief Coroner was never to be entirely judicial*". However, it is clear from the Coroners and Justice Act that the Chief Coroner is a judicial office. The post holder, who must be a High Court or Circuit Court judge, is appointed by the Lord Chief Justice for a term decided by the Lord Chief Justice. Section 35 and Schedule 8 of the Coroners and Justice Act 2009 set out the main provisions governing this new office and were brought into force on 1 February 2010. A senior Circuit judge, HHJ Peter Thornton QC was appointed to the office by the Lord Chief Justice shortly afterwards but has not taken up his position.
20. Following concerns expressed by Peers, the government agreed to remove 18 offices (including the Judicial Appointments Commission, Surveillance Commissioners and the Parole Board) from the Public Bodies Bill¹⁵ reportedly because the Cabinet Office Minister, Francis Maude, said they performed some kind of judicial function, and he wanted to protect their independence. INQUEST does not understand the logic as to why, if they are rightly concerned to protect judicial independence, the government seems intent on including the office of the Chief Coroner in the list of bodies to be abolished in the Bill.

"The functions of the Chief Coroner can be transferred to alternative bodies"

21. INQUEST is also concerned about the constitutional implications of a planned transfer of functions from the independent, judicial office holder of Chief Coroner to alternative bodies. In particular Lord McNally has told Members of the House of Lords "*we are going to take much of what was in the legislation in-house in the Ministry of Justice and do the tasks ourselves*"¹⁶.
22. INQUEST has written to Ministers on several occasions to request clarification but there is still, six months after the announcement of the government's intention to abolish the Chief Coroner, no answer as to which of these functions would be transferred to whom. It would clearly be inappropriate for the Lord Chancellor to have oversight of the coronial system in circumstances where he is also responsible for HM Prison Services who are often forcefully represented in inquests following a death in custody (particularly with an eye to protecting the Ministry of Justice from civil liability), and is statutorily responsible for final decisions regarding the provision of Exceptional Public Funding to families bereaved by a death in custody. Similar objections arise to the transfer of some of the Chief Coroner's functions to the Attorney General given his role as chief legal adviser to the Crown with responsibility for the Treasury Solicitor's Department and Government Legal Services.

¹⁴ INQUEST instructed Bindmans LLP to seek leading counsel's opinion on the constitutional implications of the government's proposals. Rabinder Singh QC's Opinion on the Proposed Abolition of the Chief Coroner, Appeals System and Medical Adviser was written in January 2011. INQUEST wrote to both the Cabinet Office Minister and the Parliamentary Under-Secretary of State to raise our concerns and ask for their response to leading counsel's opinion. The government responded in March 2011 making clear they "fundamentally disagree" that there are constitutional difficulties in using secondary legislation to abolish the office of Chief Coroner. Copies of Rabinder Singh's Opinion, INQUEST's letter to Ministers and their response can be provided on request.

¹⁵ See coverage of the decision via <http://www.bbc.co.uk/news/uk-politics-12271426>

¹⁶ Hansard, HL Deb, 3 November 2010, col 1661

“It is possible to make substantial improvements to the coroners system without implementing the office of Chief Coroner” and “a new national charter will improve people’s experiences of the current inquest system”

23. The government’s proposals for coronial reform are no more than tweaks of a system that is in need of fundamental root and branch reform. According to the announcement made on 14 October 2010, the government intended to: commence some operational provisions around transfer of inquests between coroner’s jurisdictions; review and update the Coroners Rules; issue guidance including a national charter for families; encourage the further establishment of support services provided by the voluntary sector to those attending inquests and improve training for coroners and their officers¹⁷.
24. In response to concerns expressed by Peers about their approach to coronial reform the government urged parliamentarians to *“judge us by what we do”*¹⁸. In light of that, it is worrying that the only concrete proposal for reform that the Ministry of Justice has taken forward so far, a discussion paper on a revised Charter, is completely inadequate.
25. The written ministerial statements of October 2010 announced plans to take forward *“a national charter for bereaved families”*. This would build on the two previous consultations on a Charter for bereaved people conducted in 2006 and 2008. However, in December 2010, the Ministry of Justice circulated a discussion paper on a Charter for *all* interested persons who come into contact with the inquest system. This is an entirely different proposition. Attempting to sweep up all properly interested persons in a single Charter is inappropriate. The lack of considered thought that has gone into this new version of the Charter is illustrated by a reference in the discussion paper that *“wherever possible, the coroner’s office will provide properly interested persons with an appropriate private waiting room when they attend an inquest”*. This proposal originated from bereaved families’ observations that their distress was exacerbated when inadequate facilities in coroners courts meant they were forced to wait with those who had been involved with their relative immediately before their death. The current provision in the draft Charter, encompassing all properly interested persons, is pointless as bereaved families would be in no better position: they may have access to a waiting room but in no way would it be private as the other properly interested parties such as prison officers, insurance companies and so on would also be entitled to use the facilities.
26. The 2008 version of the Charter was developed in tandem with the Coroners and Justice Act and sets out the levels of service bereaved people could expect to receive from coroners in a reformed system and, if they did not, set out the ways in which they could rectify that.¹⁹ Central to this Charter was the Chief Coroner’s role in resolving complaints. The Chief Coroner was to have overall responsibility for establishing and overseeing a system for responding to, investigating, resolving and acting on complaints about the service provided by coroners. In the absence of a Chief Coroner, the Charter is toothless. It is telling that the December 2010 discussion paper did not set out any effective, alternative proposals for monitoring and enforcement to ensure that the new document has any impact in improving the service offered to bereaved people who come into contact with the coroners courts.
27. INQUEST, and other bereavement organisations, were disappointed that what had originally intended to be a robust set of standards putting bereaved people at the heart of a reformed

¹⁷ (though note the reply from the Parliamentary Under-Secretary to Rob Ffello MP in the House of Commons on 27 October 2010:

www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101027/text/101027w0002.htm#10102766001587).

¹⁸ Lord McNally, HL Deb, 3 November 2010, col 1662

¹⁹ Available via: www.justice.gov.uk/publications/docs/charter-bereaved-reformed-coroner-system.pdf

system has been watered down to a generic document with no enforceable provisions. We urged the Ministry of Justice to take proper account of previous, detailed consultations and revise their proposals before a new version of the Charter is put out for full consultation later this year²⁰.

“Those who oppose abolition are frustrating any reform of the system”

28. It has been implied that opposing government plans to scrap the Chief Coroner’s office frustrates reform of the coronial system because it means that the limited amendments to the system proposed by government could not go ahead. Over thirty years, INQUEST has worked to ensure bereaved families are better treated in a fundamentally reformed coronial system and we remain committed to that aim. INQUEST firmly believes that abolishing the Chief Coroner’s office and losing all the benefits it would bring in overhauling the system is a disproportionate way to achieve a small gain.

29. Having been fully engaged in the governmental and legislative processes to reform the coronial system, INQUEST was dismayed at the inclusion of the Chief Coroner in the Public Bodies Bill. Other organisations have condemned the government’s decision: in December 2010 a coalition of 13 charities supporting bereaved people wrote to The Editor of *The Times* to express their concerns.²¹ As well as INQUEST, the signatories included:

- The Royal British Legion
- CRUSE Bereavement Care
- Victim Support
- Action against Medical Accidents (AvMA)
- Cardiac Risk in the Young
- Child Bereavement Charity
- Disaster Action
- Support after Murder and Manslaughter (SAMM National)
- Survivors of Bereavement by Suicide
- The Compassionate Friends
- RoadPeace
- BRAKE

30. INQUEST remains concerned that if the Chief Coroner’s office is abolished, the opportunity to create an inquest system fit for the 21st Century which saves lives will be wasted. This is a false economy if there ever was one and we urge Parliamentarians to help us persuade the government to reconsider.

²⁰ INQUEST’s detailed response to the December 2010 Discussion Paper is available on request

²¹ The letter can be found via: www.thetimes.co.uk/tto/opinion/letters/article2841682.ece

About INQUEST

INQUEST is the only organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. It has a proven track record in delivering an award-winning free in depth complex casework service on deaths in state detention or involving state agents. It works on other cases that also engage article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability. It monitors public interest inquests and inquiries into contentious deaths to ensure the issues arising inform our strategic policy and legal work.

INQUEST undertakes research and develops policy proposals to campaign for changes to the inquest and investigation process. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; holds those responsible to account and disseminates the lessons learned from the investigation process in order to prevent further deaths occurring. INQUEST is represented on the Ministerial Council on Deaths in Custody and the Ministry of Justice Coroner Service Stakeholder Forum.

INQUEST publications include: briefings on individual cases and on thematic issues arising; *Inquest Law*, the journal of the INQUEST Lawyers Group; specialist leaflets on deaths in prison and in police custody; a regular e-newsletter; and three groundbreaking books: *In the Care of the State? Child Deaths in Penal Custody in England and Wales* (2005); *Unlocking the Truth – Families' Experience of the Investigation of Deaths in Custody* (2007) and *Dying on the Inside – Examining Women's Deaths in Prison* (2008).

INQUEST was the Winner of the Longford Prize in 2009; Joint Winner of the Liberty/JUSTICE Human Rights Award in 2007 and Winner of a Campaign for Freedom of Information Award in 1999.

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