Independent Advisory Panel on Deaths in Custody report on delays to inquests into deaths in custody

Introduction

1.1 Concerns about delays to inquests into deaths in custody have been expressed by Parliamentarians, NGO's, and Independent Monitoring Boards among others. The Joint Committee on Human Rights[1] in its report on deaths in custody noted the importance of timely inquests to satisfy the requirements of Article 2 and to ensure reports can be made to prevent future deaths and its concerns that delays may in some instances lead to breaches of Article 2. A draft version of this paper was circulated to a range of stakeholders[2] for their views in order to produce this final version.

Context of Coronial Reform

1.2 There have been several attempts to introduce coronial reform that would reduce delays and improve public confidence in the system, particularly Dame Janet Smith's Inquiry into Shipman the Independent Review of Death Certification and Investigation in England, Wales and Northern Ireland chaired by Tom Luce, both of which reported in 2003 and led to Home Office commitments to improve resources and accommodation for inquests, and a service to be overseen by a Chief Coroner – which led ultimately to the provisions in the Coroners and Justice Act 2009.

1.3 The government announced its intention to abolish the role of Chief Coroner as part of the Public Bodies Bill (due to the cost of establishing the office), but has recently published a consultation[3] on the proposals in the Bill, setting out plans not to implement the role of Chief Coroner but to transfer some functions to the Lord Chief Justice and Lord Chancellor. The Panel has already corresponded with the Ministry of Justice on

[1] Joint Committee on Human Rights Third Report Session 2004-05
http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1513.htm#a64
[2] Discussion paper sent to Coroners' Society, MoJ, PPO, IPCC, CQC, NOMS, Department of Health, Home Office, YJB, and lawyers who are members of the Ministerial Council stakeholder & practitioner group
[3] http://www.justice.gov.uk/consultations/reform-public-bodies.htm

the government's alternative model for discharging the functions of the Chief Coroner, and we have expressed our concern that the proposed Ministerial Board would not have the same impact on problems of resources and performance in relation to death in custody inquests. We are disappointed that the suggested transfer of functions does not include the reference to addressing delay that was contained in the job description for the Chief Coroner. The IAP has also responded formally to the consultation, which closed on 11 October.

1.4 This paper sets out information the Panel has collected from coroners on the scale and reasons for delays into death in custody inquests.

Background on delays to death in custody inquests

1.5 The IAP recognises that delays to inquests have an enormous impact on the family, the staff involved, and frustrate the opportunity to learn lessons from deaths in custody. The IAP has heard directly from bereaved families[4] about the difficulties caused by unexplained delays to inquests, which places great emotional stress on them. An early IAP meeting with a small group of coroners highlighted a number of reasons for delays to inquests into deaths in custody. These include the disproportionate number of custodial settings in some coroner districts; waiting for investigations undertaken by other bodies; difficulties with securing dates for witnesses to attend and finding appropriate accommodation in which to hear the inquest, including accommodation for a jury.

1.6 A lack of timely scrutiny undermines the preventative potential of the coronial process, and the ability of the coroner to report matters of concern to the relevant authorities and play a key role in looking at standards of custodial care.

1.7 The secretariat for the IAP developed a questionnaire in conjunction with the Coroners' Society, to obtain more accurate data from coroners on the reasons for delay, and the results are presented below. This information is not intended to criticise individual coroner practices, but to provide an evidence base to develop recommendations that might alleviate delays for inquests into death in custody cases

[4] http://iapdeathsincustody.independent.gov.uk/news/iap-holds-family-listening-day/

and promote a system in which learning from deaths is timely and embedded in emerging good practice in all the custody sectors.

1.8 Historically it has been difficult to establish information on delay as the Ministry of Justice (MoJ) does not currently collect specific data on death in custody inquests. However, they will be doing so in future with the first report due in 2012. In the absence of such statistics it is not possible to refer to an average time for completion of these inquests. MoJ data for all types of inquest show the average time to complete an inquest from time of notification of death was 27 weeks[5] in 2010. [6]Although some death in custody cases fall inside this average duration, the IAP does not consider this to be a reasonable comparator. Death in custody inquests require the use of juries and often follow in-depth independent investigation by other bodies. For example, Prisons and Probation Ombudsman (PPO) investigations have targets between 20-26 weeks for investigating deaths, and the inquest will quite correctly, rarely be heard until these reports are complete. The PPO recognises that this target is not met in the majority of its investigations.

1.9 Nevertheless, data gathered from coroners, and presented in this report, shows there are a substantial proportion – approximately 25% - of death in custody inquests taking more than two years to complete. We recognise, and support, the importance of quality investigations into deaths in custody. We also recognise that some cases are particularly complex, where there will be an inevitable delay in order to conduct thorough investigations. But these cases should be the exception. The IAP also notes that the delays are concentrated in particular areas where coroners are disproportionately burdened with complex cases by virtue of the number of prisons or other institutions within their geographical district.

Article 2-compliant investigations

1.10 The IAP workstream on Article 2-compliant investigations, led by Professor Philip Leach, is closely linked to the work on cross-sector learning. Professor Leach is working

[5] http://www.justice.gov.uk/downloads/publications/statistics-and-data/mojstats/coroners-bulletin-2010.pdf
[6] The question asked is about any inquest outstanding for more than twelve months. This means that an inquest concluded 13 months after the death is recorded alongside those concluding two, three or more years after the death.

with the PPO and Offender Health on concerns about delays to investigation reports caused, principally, by problems with obtaining timely clinical reviews. These difficulties compound delays into inquests. Professor Leach's recommendation that the future model for coronial standard-setting, guidance and oversight should focus on deaths in custody to ensure improvement on delays (as well as other problems such as public funding for family legal representation and disclosure of documents), is also due for discussion at the next Ministerial Board in October. Article 2 requires investigations (including inquests) to be reasonably prompt.[7] For some deaths in custody (e.g. deaths of detained patients) there are no independent investigations other than an inquest. This places even greater importance on focusing coroners' resources on custody cases.

Methodology

2.1 The IAP secretariat issued a questionnaire (see **Annex A**) in August 2010, in conjunction with the Coroners' Society, to Coroners' offices in England and Wales in order to collect information on the number and length of outstanding inquests into deaths in custody[8] as well as the factors contributing to delays. A total of 104 responses were received over a few months until January 2011. Coroners were invited to explain the reasons for delays in their own words. We should point out that this data has not been collected to facilitate a statistical analysis of performance in individual jurisdictions, but it shows the scale of delays in death in custody cases across districts as well as the range of reasons cited for delay. We acknowledge that as the data was a snapshot of outstanding cases it is already out of date but it does for the first time provide an analysis of delays and some of the multi-factorial reasons for them.

2.2 This report draws out the common themes and the prevalence of delay by custodial sectors. The responses are based on feedback from coroners about their caseloads at a single point in time. They have provided a range of reasons for delays to death in custody cases, which do not necessarily link to the specific cases that they report as outstanding.

[7] Jordan v UK, 4 May 2011

[8] Custodial sectors covered - Prisons & Young Offender Institutions (YOIs); Secure Training Centres (STCs); Police custody; Immigration Removal Centres and other UKBA detention and patients detained under the Mental Health Act.

Results

3.1 The Secretariat collated results from coroners. This shows, for each coroner, the number of custodial settings in their jurisdiction and the total outstanding caseload reported by the coroner. It also breaks down the number of outstanding cases by sector and length of delay, as well as the reasons given for delay by each Coroner.

3.2 The full data set has been analysed, and shows that Coroners listed a total of 451 outstanding cases. Approximately half (49.2%) of the outstanding cases were less than one year after date of death, as set out in **Chart 1** below.

Chart 1 - Outstanding Death in Custody Inquest Caseloads by Duration (Aug 2010 - Jan 2011)

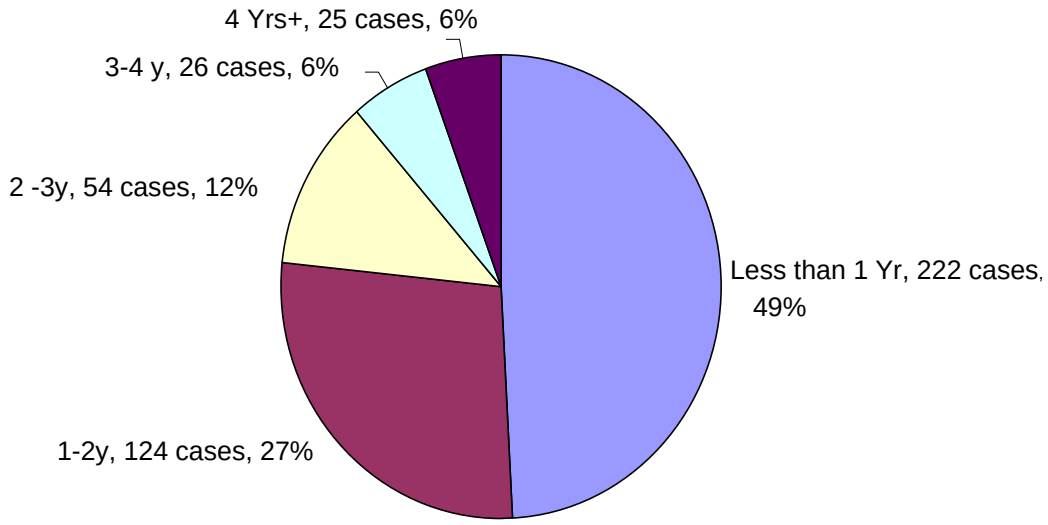

Chart 2 - Number of custodial settings by custodial sector

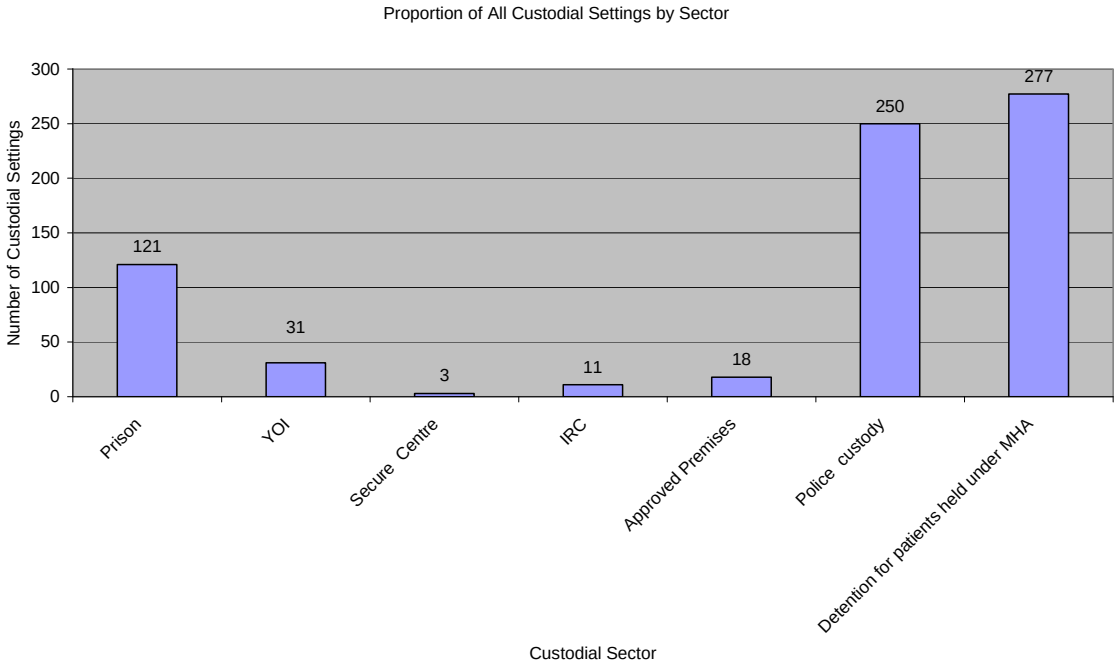

Chart 3 - Outstanding deaths in custody inquests by custodial sector (at Jan 2011)

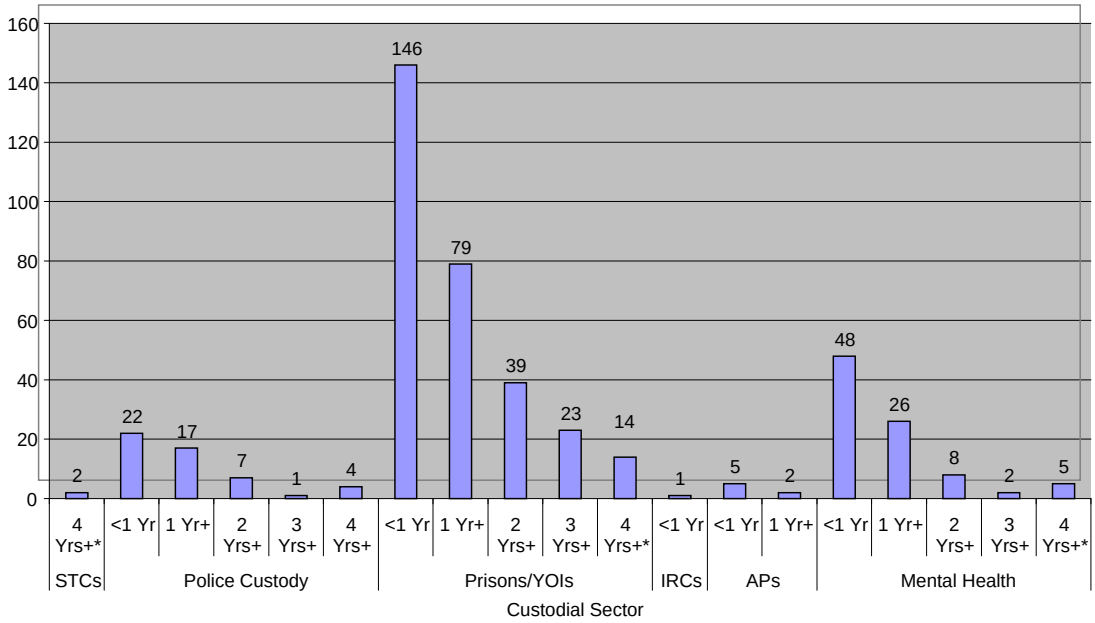

Chart 4 - Outstanding death in police custody inquests by length of delay

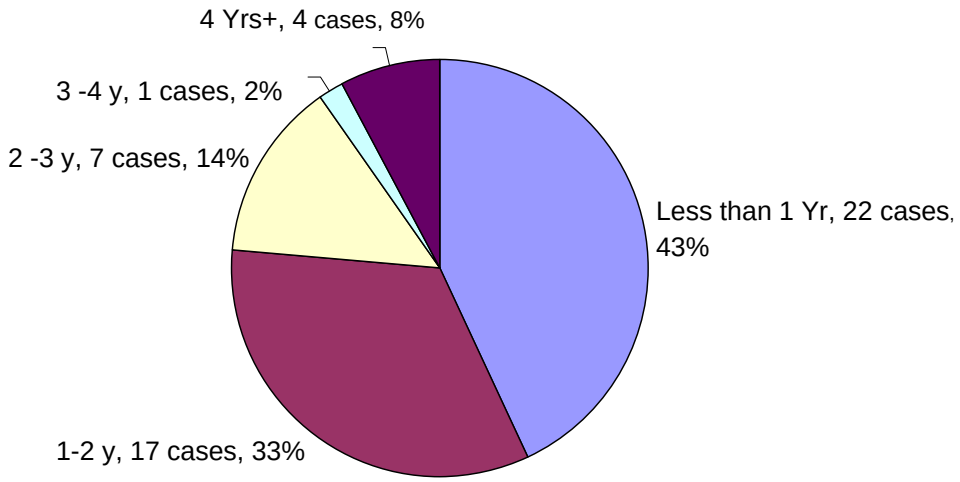

Chart 5 - Outstanding death in prison / YOI inquests by length of delay

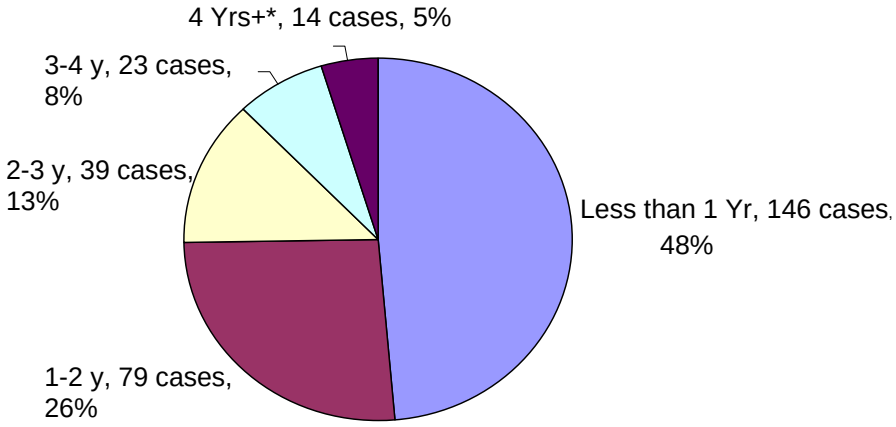

Chart 6-Outstanding inquests into deaths of detained patients by length of delay

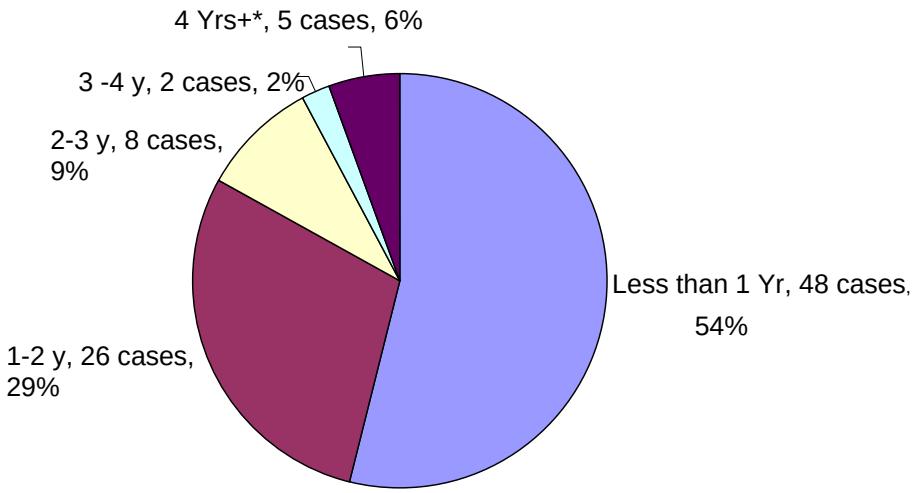

Table 1 - to show proportion of death in custody inquests over 2 years old by sector

Years/sector	**Police**		**Prison**		**Detained patients**	
2-3 years old	14%	7 cases	13%	39 cases	9%	8 cases
3-4 years old	2%	1 case	8%	23 cases	2%	2 cases
> 4years old	8%	4 cases	5%	14 cases	6%	5 cases
Total	**24%**	**12**	**26%**	**76**	**17%**	**15**

Analysis

3.3 **Chart 3** shows that prison deaths (301) make up the largest proportion of outstanding cases followed by mental health (89) and police deaths (51).

3.3 **Chart 2** and **Chart 3** show that by sector, mental health settings and police custody contributed the largest number of settings (277 (39%) and 252 (35%) respectively). However, they contribute just 89 (20%) and 51 (11%) of the outstanding inquests. This is in line with expectations, as the population in prisons is much greater than those in police and mental health settings. The length of stay in prison is much greater than for police settings. Prisons & young offender institutions (YOIs) totalled 152 (21%) settings and over 301 (67%) outstanding inquests. 32% of the total caseload was new prison/YOI cases less than 12 months old.

3.4 **Table 2**, below, shows the total number of recorded deaths by custody sector over a twelve year period.

Table 2 - Excerpt from IAP Statistics Bulletin on Deaths in Custody

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Prison[1]	146	142	164	182	207	174	153	185	165	169	196	**1883**
Police[2]	30	29	32	34	39	28	26	23	18	16	19	**294**
In-Patient Mental Health Setting (detained patients)	406	346	307	331	310	337	363	325	326	294	283	**3628**
Approved Premises	24	22	21	12	20	17	10	17	15	9	12	**179**
STC / SCH[3]	0	0	0	0	2	0	0	0	0	0	0	**2**
Immigration detention[4]	1	0	0	2	4	2	1	0	0	0	2	**12**
Total Deaths in State Custody for England and Wales	**607**	**539**	**524**	**561**	**582**	**558**	**553**	**550**	**524**	**488**	**512**	**5998**

1. Includes deaths of individuals 18 and over in custody or released on licence for medical reasons. These also include deaths of 15 - 17 year olds held in YOIs. These figures exclude two deaths that occurred in Haslar Immigration Removal Centre, which is run by HM Prison Service in 2003 and 2004. These are included in the immigration detention figures.

2. Deaths in or following police custody as defined in category A of the PACE Act 1984.

3. These figures include deaths of young people in Secure Training Centres (STCs) and Secure Children's Homes (SCHs)

4. These figures include the three prison service run IRCs at Haslar, Dover and Lindholme.

3.5 **Chart 1** shows the proportion of outstanding death in custody inquests by duration. 49% (222) of all cases were less than one year old, and 27% (124 cases) between 1-2 years. However, 12% (54 cases) were 2-3 years old. 6% (26 cases] of cases were 3-4 years old and 6% (rounded – 5 cases) were 4 years or older.

3.6 **Charts 4, 5 and 6** show that the proportions of delay by duration were broadly similar for mental health, police and prison/YOI deaths. Charts are not provided for Immigration Removal Centres (IRCs), approved premises and secure training centres (STCs) data as the numbers are too small to show informative proportions.

3.7 **Charts 4, 5 and 6** show that most of the cases were concentrated under one year, and approximately 25-30% of cases were 1-2 years old. **Table 1** compares the proportion of cases older than two years emanating from prison, police and mental health setting deaths. This shows that between 9-14% of cases were 2-3 years old – police and prison deaths were similar (13% and 14%). The distribution of older cases is more uneven – for example, 8% (23 cases) of prison cases were 3-4 years old compared to 2% (2 cases) of mental health and 1% (1 case) of police cases. However, 8% (4) of police cases and 6% of mental health cases were older than four years, compared to 4% (14).

3.8 Although we recognise that many cases are complex, it is our view there should not be such a high proportion of cases taking more than two years to complete. Delays of more than two years are unacceptable and interfere with the requirement for prompt investigation, and potential learning to prevent future deaths.

Inquests into deaths of patients detained under the Mental Health Act

3.9 Deaths of detained patients who die of natural causes are not routinely reported to coroners. Although guidance suggests that coroners should treat all deaths in state detention as deaths in custody, there is no legal requirement for coroners to treat such cases in the same way as a death in prison or police custody.

3.10 The data shows that delays are less prevalent for death of detained patient cases. These cases are less likely to be delayed by other investigations, unlike prison and police cases. But it is important to note that the number of outstanding cases involving deaths of detained patients do not represent the total number of such deaths. **Table 2**, an excerpt from IAP statistics on deaths in all custody sectors, shows that there were 283 deaths of detained patients in 2010, but there are only 89 inquest cases reported by coroners.

3.11 Providers are required to report all deaths of detained patients to the Care Quality Commission (CQC). Although it is suggested as good practice to refer deaths in all state detention to coroners, this is open to interpretation by coroners. There is no legal requirement for mental health providers to refer deaths of detained patients to Coroners unless they meet the existing criteria for reporting deaths – that is, the death was violent or unnatural, that it was sudden of unknown cause or it occurred in prison. In practice, some providers do refer such cases to Coroners, but the data received on outstanding cases show that this is a small proportion of deaths of detained patients. These inquests need not be heard with a jury and there is anecdotal evidence that there are fewer applications for legal representations by families – factors that can lead to delays in other death in custody cases. These issues are currently being addressed jointly by the IAP working groups on Article 2-compliant investigations and deaths of detained patients. However if the reforms in the Coroners and Justice Act 2009 go ahead regardless of changes to leadership and governance structure, then there will be a requirement for jury inquests in these cases which without additional guidance/resources may result in an increase in delays to these inquests being heard,

Detail on outstanding death in custody inquests by district

3.12 The IAP used data from districts to exemplify areas where there are particular pressures on coroners arising from death in custody cases. The average number of outstanding cases was six. However, cases in seven districts account for 33% of the total number of outstanding cases, although this can generally be attributed to the greater number or the nature of the custodial settings in such districts. These districts also have high numbers of all reported deaths[9] (i.e. not just in custody) and are set out in **Table 3** below:

Table 3 showing districts with highest number of outstanding death in custody inquests

District	No. death in custody inquests	2010 total reported deaths	Information

[9] Table 9 from http://www.justice.gov.uk/downloads/publications/statistics-and-data/mojstats/coroners-bulletin-2010.pdf

		in district	
Inner S. London	26	3399	This is a particularly busy district, including HMP Belmarsh and HMP Brixton. The previous coroner was absent due to ill health for a long period prior to his death. The newly appointed coroner is prioritising the backlog of cases. 4 prison cases were between 2-3 years old and four were 3-4 years old.
W. Yorkshire Eastern	26	3757	MoJ statistics do not show any performance problems with this district. There are four large prisons in this district (Wakefield, Leeds, New Hall and Wealstun) known to generate a higher than average number of deaths in custody. Most of the outstanding cases are prison deaths – 12 cases were less than one year old, but 6 were 1-2 year, 5 were 3-4 years and 2 were older than four years.
Preston & W. Lancashire	21	2743	MoJ statistics do not show any performance problems with this district. There are a large number of custodial settings (including five prisons – Garth, Kirkham, Preston, Wymott and Lancaster and one YOI – Lancaster Farms). All the outstanding cases were prison deaths, 9 of which were under one year. 5 were 1-2 years old, 2 were 2-3 years, 1 was 3-4 years and 4 were older than four years.
Birmingham & Solihull	20	4624	MoJ report a large caseload for this district, and there are 28 custodial settings, including HMP Birmingham and a large number of hospitals detaining patients under MHA. However, 14 cases were prison deaths under 1 year old, with just one between 2-3 years. There was 1 MHA case over 4 years old.
North & South Durham & Darlington	19	2420	There are three prisons in this district including large establishments such as Durham, and Frankland, as well as the women's prison, Low Newton. However, 10 of the outstanding cases were prison deaths under one year old, and 5 were 1-2 years old. 2 STC cases were older than 4 years, as these were particularly complex.
Essex & Thurrock	18	4992	MoJ report a large caseload for this district and a large number of custodial settings (particularly mental health, and one prison). There has been a cluster of deaths at HMP Chelmsford. There were 3 prison death cases over 4 years old in this district. Most outstanding cases (14) were deaths of detained patients – 2 were 2-3 years old, 1 was 3-4 years old and 2 were older than 4 years.

3.13 The Panel recognises that the number of deaths in each establishment cannot be predicted reliably, and so pressures on individual districts may change from year to year. However, we have attempted to look at the association between the number of custodial

settings in a jurisdiction and the number of outstanding inquests. Coroners have previously reported that their caseload becomes complex very quickly once they are required to investigate a number of deaths in custody and this can have a disproportionate impact on capacity/efficiency. The data we collected shows a medium degree of correlation (0.7) between the number of custodial settings in each Coroner's district and the number of outstanding inquests. This means in general, and in line with expectations, the larger the number of custodial settings – and indeed, the size and complexity of particular prisons, the larger the outstanding caseload. It would be reasonable to expect coroners to be resourced in line with the demands of a large number of complex inquests.

3.14 However, the districts in **Table 4** below stand out as having caseloads (reported between August 2010-January 2011) exceeding their 'size', showing that the number of deaths per district can create unpredictable pressure on existing resources and case management:

Table 4 showing districts with high numbers of outstanding death in custody inquests despite relatively small number of custodial settings

District	**No. death in custody inquests**	**2010 total reported deaths in district**	**Information**
West Yorkshire (E)	26	3757	Although there are fewer settings in total, there are four large prisons in this district (Wakefield, Leeds, New Hall and Wealstun) and most of the outstanding cases are prison deaths – 12 cases were less than one year old, but 6 cases were 1-2 years old, 5 were 2-3 years old and 2 were 3-4 years old.
South Yorkshire (E)	17	2537	MoJ statistics show that there has been an increase in the time to complete cases in this district but no particular issues have been reported. There is a large local prison (Doncaster). Again, most delays arise from prison deaths – 4 cases were 2-3 years, 3 cases were 3-4 years and 1 was over 4 years old.
Leicester & S Leicestershire	14	3502	MoJ statistics show an improvement in timescales for completing inquests in general in this district. There are 4 relatively large prisons (Glen Parva, Gartree, Leicester & Stocken), which account for most of the older cases. 6 cases were 1-2 years old, and 4 were 2-4 years old.

Peterborough	13	1103	MoJ statistics show that this area performs well with an average time for completion of all inquests at 26 weeks. There is only one prison (Peterborough), and two police custody settings. There are 3 outstanding police inquests (between 1-3 years) and 4 prison cases under one year. 2 prison cases were between 2-3 years old, 1 was 3- 4 years old and 2 were 4 years or older.

Reasons for delays

3.15 Coroners were asked to provide reasons for delays in their own words. With hindsight, this has not generated sufficiently robust data to show how the reasons relate to length of delay, as well as to each custodial sector. Notwithstanding these flaws in the methodology, we have obtained an overall impression from Coroners about why there are backlogs in completing death in custody inquests to help inform the recommendations in this paper. The reasons are detailed in **Table 5** below.

Table 5 – Coroner reasons for inquest backlogs: Aug-Jan 2010

Delay type	**Reason for delay**	**Nos. of coroners citing this reason**	**% of responses**
Outstanding investigations by other bodies (39%)	IPCC reports	13	13%
	PPO reports	16	15%
	MHA/SUI reports	6	6%
	CPS decisions	6	6%
Complications (24%)	Complexity of cases	9	9%
	Arising further enquiries	5	5%
	Existing backlog	5	5%
	MHA case – complex due to number of organisations	4	4%
	NHS trust has not provided information	1	1%
	Coroner suspended	1	1%
Procedural (21%)	Family engagement and legal representations	8	8%
	Slow pace of enquiries	2	2%

	Securing dates and witness attendance	8	8%
	Adjournments	4	4%
Resources (13%)	Workload due to large number of settings	3	3%
	Staff shortage	5	5%
	Limited/unsuitable jury accommodation	6	6%
Total (*figures do not add up to totals)		104	100%

Note: The numbers are not mutually exclusive. Proportions do not add up to 100%.

3.16 Coroners report a wide range of reasons for delays although there are commonalities in terms of delays in outstanding investigations by other bodies and the delays created by complexity of having a number of deaths in custody cases to deal with at one time.

3.17 The most common reason was waiting to receive Prisons and Probation Ombudsman (PPO) reports (mentioned in 15% of responses) and Independent Police Complaints Commission (IPCC) reports (mentioned in 13% of responses). Although this applies to many of the cases less than 12-months old, some examples relate to cases delayed by over two years. However, delays to IPCC and PPO investigation reports may be caused by other factors, such as awaiting clinical reviews and other expert reports such as toxicology, and CPS decisions on prosecution. Coroners referred to IPCC and PPO investigations interchangeably in their returns, so it is difficult to specify the number of cases that are affected by delays emanating from IPCC and PPO investigations. Both bodies are making efforts to reduce delays to their investigations and the IAP would like to work closely with them to understand the progress they are making and the reasons for ongoing delays.

3.19 Professor Leach, who leads on the Panel's workstream, looking at Article 2-compliant investigations, is undertaking work with the Prisons and Probation Ombudsman (PPO) to examine the impact of recent efforts to reduce delays to their investigations into fatal incidents, which is principally due to delays in receiving clinical reviews. The Panel notes the complexities in improving performance in this area, and

will report to in due course to the Ministerial Board on its view on the progress being made by PPO in conjunction with Department of Health.

3.20 The complexity of cases was cited in 9% of responses. Family engagement and waiting for legal representation was cited 8% of responses. Securing dates and witness attendance was also cited in 8% of responses. Accommodation problems, awaiting mental health reports and CPS decisions were each cited in 6% of responses.

3.21 In summary, the main reason for delay is a high number of custody cases in one district, which can quickly create a complex caseload where there is a sudden increase in deaths. These delays are exacerbated by the factors set out in **Table 5**– particularly waiting for investigation reports from other bodies; families arranging legal representation; and other practical and resource difficulties. Some coroners also struggle to obtain sufficient funding from local authorities to run efficient accommodation and offices.

Conclusion and Recommendations

4.1 The Panel has presented, for the first time, a report on the extent of the delays of death in custody inquests and we have used this data to develop recommendations to tackle and reduce delay.

4.2 In summary, the data shows that approximately 25% of death in custody inquests are taking over two years to complete – with 6% taking three to four years and 6% taking over four years. The proportions of delay are broadly similar across all the custodial sectors, although delays of three to four years are greatest for prison cases, and very long delays of over four years are greatest for police and mental health cases.

4.3 It is difficult for the Panel to make actionable recommendations in the absence of a confirmed governance structure for coroners. We also recognise that coroners have very little power over their resource allocation and there is no statutory timetable for completing inquests. However, we have responded to the consultation on reforms

proposed in the Public Bodies Bill, and have made recommendations here that could be driven by whichever governance structure the MoJ decide to implement in future.

Recommendations

1. PPO/IPCC investigations (and production of other reports that these bodies rely on such as clinical reviews, expert reports and toxicology tests) can hold up inquests into police and prison cases and the coroner has no authority to insist that an investigation is completed within a specific time frame. The current situation also means there are no clear lines of responsibility if there are delays.

   The IAP will require more detailed information about delays in CPS decisions and their impact as well as delays to IPCC investigations. The Panel will continue to receive data from the PPO on the reasons for delay to investigations.

2. The MoJ Coroners and Burials Unit should carry out an annual audit and identify districts where delays are greatest and discuss the reasons with the coroner to formulate an improvement plan in conjunction with the local authority, including the allocation of additional resources. This could include supporting coroners to make submissions to the relevant local authorities where funding is an issue.

3. From 2012 Ministry of Justice (MoJ) statistics on inquests will report specifically on performance on death in custody cases and should require Coroners to report on delays of over one year, two years, for death in custody cases and the reasons for these. The figures should be reported to the new MoJ Ministerial Board (if the Chief Coroner role is not implemented) and the Lord Chancellor, and placed in the public domain through Parliament.

4. The relevant senior representatives of local authorities should be accountable to the proposed Ministerial Board structure to respond to concerns about lack of funding for particular districts and to ensure there is an understanding at local authority level of the impact of delays on bereaved families and the scope for learning from deaths in custody.

5. A robust casework management approach to inquests into deaths in custody should be adopted by all coroners, including appropriate use of pre inquest hearings. This should be reflected in upcoming MoJ training events for coroners. These allow for agreement and communication of a timetable that can be regularly reviewed, and calling the investigation bodies to account for delays as well as anticipating complexities that may lead to delay and to manage expectations of the family by communicating the reasons for any delays.

6. The MoJ should ensure that training for coroners includes information on managing expectations of families and ensuring they set up a mechanism for providing clear, early information to families about where to go for independent advice and support and the obtaining of legal advice and or representations (including how to apply for funding) so this does not create unforeseen delays further into the case.

7. The MoJ should amend the draft Charter for the coroner service to ensure that coroners' offices review cases more frequently and assess whether they need resources or help from another district to complete death in custody cases more quickly.

8. Investigation bodies' family liaison protocols and Coroners courts should provide information to bereaved people on how to get advice and support about the inquest process.

Deborah Coles