His Honour Judge Thomas Teague KC, Chief Coroner of England and Wales

Response to the Right Reverend James Jones KBE - Report on the Experiences of the Hillsborough Families

Introduction

1. I am grateful for the opportunity to respond formally to the Report by the Right Reverend James Jones KBE about the experiences of the Hillsborough Families, published by the Home Secretary on 1 November 2017.

2. The post of Chief Coroner of England and Wales was created by section 35 and Schedule 8 of the Coroners and Justice Act 2009. The Chief Coroner provides judicial leadership to all Senior Coroners, Area Coroners and Assistant Coroners in England and Wales. With the Judicial College, he devises and supervises training for all coroners and leads the coroner service of England and Wales. As well as his statutory functions, which are set out in the Coroners and Justice Act 2009, he oversees, with the Ministry of Justice, the implementation and development of statutory and other coroner reforms. More information can be found about the Chief Coroner on Judiciary.uk.

3. The Report is an important document and I welcome the fact that Bishop James Jones, with his unique perspective on the Hillsborough investigation and the experiences of the families, was asked to produce it. As Chief Coroner I am committed to continuing to work with Government, charities, bereaved families and others to address the issues it highlights and ensure that the experiences of the Hillsborough families in the immediate aftermath of the disaster, and in the first inquests, are never repeated.

4. The purpose of this response is to address the parts of the Report that relate to coroners and to respond to the recommendations that are associated with the coroner service.

Point of learning 2 – Reappraisal of the treatment of families following a major incident

5. I would like to reassure the Hillsborough families and Bishop James Jones, that the coroner service and associated professions and organisations have reflected deeply since 1989 and we have made significant positive changes to how we respond to mass fatality events and other serious incidents. There are also new projects underway to improve families' experiences in these tragic

cases; for example, the government has committed to introducing an Independent Public Advocate via primary legislation, which will provide practical support to those bereaved in large-scale disasters.

6. Coroners are a key component of any immediate response to a serious public incident involving significant loss of life. They work closely with the Chief Coroner and local and national partners to ensure they remain prepared to provide an effective operational response.

7. The main pillars of the modern coroner response to a mass fatality and Disaster Victim Identification (DVI) incident are:

   - Adherence to the Clarke principles and Interpol DVI standards;
   - A continuous focus on operational preparedness, including working with local and national partners, and effective collaborative working with UK National Disaster Victim Identification Unit[1] (UK DVI) and other emergency services;
   - Improved governance via the Chief Coroner and the cadre of DVI coroners, who have wider experience of mass fatality incidents; and
   - High-quality DVI training, which is refreshed on a regular basis.

Adherence to the Clarke principles

8. Following the *Marchioness* disaster in 1993, Lord Justice Clarke produced a report and recommendations, including four principles:

   Honest and, as far as possible, accurate information at every stage;
   Respect for the deceased and bereaved persons;
   A sympathetic and caring approach;
   The avoidance of mistaken identification.

9. These principles underpin the training provided to coroners and are reflected in Chief Coroner guidance (for example, see paragraph 7 of Guidance 32[2], which discusses post-mortem examination approaches in DVI incidents based on 'respect for the deceased and the bereaved').

10. Coroner and police methodology following a mass fatality event involves adherence to Interpol DVI techniques, in which the UK is now a world leader. These principles are essential in the accurate identification of the deceased, which in some situations can be very complex.

A continuous focus on operational preparedness

[1] National Policing Units (npcc.police.uk)
[2] https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-32-post-mortem-examinations-including-second-post-mortem-examinations1/

11. Despite the severe resourcing difficulties that I described in a recent lecture[3], we have witnessed the development since the Hillsborough disaster of an effective mass fatality response structure in which coroners play a central role, alongside local partners. Coroners participate in Local Resilience Forums (which are multi-agency partnerships comprising representatives from local public services), where they work with others to develop and review post-mortem examination and body storage plans, including arrangements for a designated disaster mortuary in the event of a major incident.

12. In the immediate aftermath of an incident the coroner chairs the Mass Fatalities Coordination Group, ensuring all participants work together to provide an effective identification, emergency mortuary and forensic strategy.

13. Coroners also work closely with UK DVI, the role of which is to coordinate and enhance the national capability of the police service to respond to mass fatality incidents in the UK. To achieve this, it engages with police services, government departments, local authorities and others (including coroners) and organises/contributes to training. Collaboration between UK DVI, the police and coroners has led to a national 'on call' 24/7 rota being set up when DVI incidents occur, under the joint management of the police and senior coroners.

14. In every operational response, there is an active focus on the needs of the bereaved, including facilitating the viewing of loved ones where this is possible, and ensuring that the process is explained in a way that is sensitive and clear.

15. As part of the significant recent modernisation of the coroner service there is now far more widespread use of less-invasive post-mortem scanning technology, which can replace the invasive autopsy in some situations. Post-mortem scanning technology is increasingly used in mass fatality and DVI incidents, where it can have particular advantages alongside other techniques.

Improved governance via the Chief Coroner and the cadre of DVI coroners and wider experience of mass fatality incidents

16. To maintain a body of DVI knowledge within the coroner service, there is now a cadre of specialist DVI senior coroners chaired by two experienced members under the overall supervision of the Chief Coroner. The coroners within the cadre undertake regular mass fatality training, including an annual training conference with UKDVI. Their role is to provide support, advice and leadership to other coroners on DVI incidents. They can also be used as a resource for dealing with the most difficult cases, as the Chief Coroner's global case management powers allow the nomination of an 'incident coroner' whose role is to manage all coroner investigations arising out of an individual event giving rise to mass fatalities.

[3] Death and Taxes – the past, present and future of the coronial service https://www.judiciary.uk/speech-by-the-chief-coroner-death-and-taxes-the-past-present-and-future-of-the-coronial-service/

17. The ability to allocate an incident coroner can also be of considerable assistance when dealing with the repatriation of bodies from abroad; the coordinated approach taken to those who lost their lives in the MH17 disaster provides a good example.

18. During the past decade, senior coroners and their staff have, sadly, gained extensive experience from tragic and complex mass fatality incidents, including the Grenfell tower disaster, the Manchester Arena bombing, the downing of Flight MH17 and the Shoreham air crash. The coroner responses to those events involved significant and sensitive engagement with bereaved families in a way which was the complete antithesis of the approach taken in the immediate aftermath of the Hillsborough disaster. The Covid-19 pandemic has also given coroners valuable recent experience in cooperating with local government resilience functions.

Training for mass fatality and DVI incidents

19. In 2017–2018, for the first time, all coroners in England and Wales underwent training in mass fatality preparedness during their obligatory two-day Judicial College continuation course. This training, which included the Clarke principles set out above, was prepared in collaboration with UKDVI and, in suitably modified form, was subsequently delivered to coroners' officers during the 2018-2019 training cycle.

20. My office is currently preparing refresher training for coroners on mass fatality and DVI incidents. This will take place during the course of 2024 and will cover current approaches to such incidents, including best practice in facilitating viewing for families.

Point of learning 5 – 'Property of the coroner'

21. Coroners, coroners' officers and staff should never refer to the deceased as being the 'property' of the coroner. My predecessors and I have taken steps to ensure that the language used to explain the coroner's legal control over a body is sensitive, respectful and legally accurate. For example, in September 2019 my predecessor issued Guidance 32 on post-mortem examinations[4], which contains the following direction:

    (ii) Explanation by the coroner to the family of legal control over the body

    11. Coroners, their officers and staff must explain to the family of the deceased that the coroner has legal control over the body. This is a statutory power which gives the coroner the ability to carry out his functions to investigate the death and ensures the preservation of the best evidence. It is an important independent safeguard for the integrity of the investigation.

    12. At no point should the coroner, his officers and staff refer to the body of a

[4] Chief Coroner's Guidance No. 32 Post-Mortem Examinations Including Second Post-Mortem Examinations[1] - Courts and Tribunals Judiciary

deceased as the 'property' of the coroner, nor should they use other forms of insensitive or 'off-hand' language when explaining the coroner's legal duties. This is one of the issues which was rightly highlighted by Bishop James Jones in his Review of the Hillsborough families' experiences and which can cause great and unnecessary distress to bereaved people. Coroners and their officers should also keep the bereaved family advised of the likely timescales for release of the body and any reasons for retaining the body. If a body cannot be released within 28 days of the death being notified to the coroner, there is a duty to notify the next of kin of the reasons.

13. Similarly, police officers and police staff who come in to contact with bereaved people must also be careful not to misrepresent the coroner's position by describing the body of a deceased as the 'property' of the coroner. Senior coroners should make efforts to ensure their local police force understands this issue and should provide training on it as necessary.

14. At all times, coroners, their officers and staff must explain the legal position to families carefully and sensitively. This should be by telephone or in person, rather than solely by correspondence or email.

22. More recently, revised Guidance 26 on Organ Donation, published in May 2023, took care to set out the law about lawful control over a body.

23. I have today written to the College of Policing and the National Police Chief's Council to ensure that the guidance is re-circulated to police officers who may, in the course of their work, find themselves being asked to explain to a bereaved person why and how a coroner is involved in the investigation of a death. It is important that police officers do not inadvertently misrepresent the role of the coroner.

24. I am grateful to the Lord Chancellor for writing to me on 7 June 2023 to ask that I reiterate the importance of this principle to all coroners. I have done so today, and will take the opportunity to remind them again when Guidance 32 is updated in due course.

25. I have carefully read Bishop Jones's powerful points about viewing and visiting deceased loved ones. This requires sensitive handling on a case-by-case basis in accordance with the modern approach to mass fatality and DVI incidents that I have outlined above. On rare occasions, where the bodies of deceased persons have undergone significant disruption, it may be very difficult, or even impossible, to facilitate. Whatever the circumstances, however, it is important that the coroner listens carefully to the wishes of the bereaved persons. A family-focused approach, enabling the viewing and touching of deceased loved ones wherever possible, has been consistently applied by coroners dealing with mass fatality events since the publication of the Report in 2017. This approach will be reinforced in the forthcoming round of DVI refresher training.

Point of learning 9 (iii) – 'Proper participation': cultural change and point of learning 9 (iv) – 'Proper participation': inquest processes

26. I am especially grateful to Bishop Jones for the helpful insights contained in this section of his Report.

Pen Portraits

27. I published Guidance on 5 July 2021 which sets out a comprehensive framework for the use of pen portraits in inquests.[5] Providing a pen portrait allows families to let the court know something of their loved one in life – what he or she did, their interests and hobbies, and details of their wider circle of family and friends.

28. The practice of admitting pen portrait material is one I personally encourage. In my recent lecture[6] marking the tenth anniversary of the implementation of the reforms introduced by the Coroners and Justice Act 2009, I cited the use of pen portraits as a practical illustration of the principle that since an inquest touches not a body but the death of a person, it is the deceased, and by necessary extension the bereaved, who should always be at the heart of the inquest process.

Position Statements

29. One of my priorities as Chief Coroner is to uphold the inquisitorial nature of the inquest process. An inquest is a fact-finding process conducted by a coroner, with the aim of answering four specific questions, namely: who the deceased was and how, when and where the deceased came by his or her death[7], without appearing to determine any question of civil liability or any question of criminal liability on the part of a named person. Unlike civil or criminal proceedings, there are no 'parties' to a coroner's inquest, which represents the culmination of an investigative process rather than the formal resolution of a dispute. Instead, those particularly affected by an investigation have the status of 'interested persons' with the right to participate in the proceedings. That inquests are inquisitorial is of real benefit to the bereaved and to the administration of justice, as I discussed in detail last year in my lecture entitled: 'The Coroner's Inquest'[8].

30. The adoption of 'position statements', (a procedural innovation originating in the adversarial context of family proceedings) would in my view imperil the inquisitorial ethos of a coroner's inquest, so I do not support their introduction. As I have explained, it is not a coroner's function to adjudicate between the competing positions of disputants. Indeed, the Coroners and Justice Act 2009 specifically prohibits a coroner from expressing any opinion on any matter other than the four statutory questions to which I have referred[9].

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[5] Chief Coroner's Guidance No. 41 Use of 'Pen Portrait' Material[1] - Courts and Tribunals Judiciary
[6] Death and Taxes – the past, present and future of the coronial service https://www.judiciary.uk/speech-by-the-chief-coroner-death-and-taxes-the-past-present-and-future-of-the-coronial-service/
[7] Section 5(1) Coroners and Justice Act 2009
[8] https://www.judiciary.uk/chief-coroner-leeming-lecture-2022/
[9] Section 5(3) Coroners and Justice Act 2009.

31. The promulgation of new rules or regulations governing the conduct of inquest proceedings is a matter for the Lord Chancellor and the Lord Chief Justice and is a process in which the Chief Coroner has no statutory role.

Training and recruitment

32. I recognise the need to provide and refresh training for coroners in judgecraft, including handling representatives appropriately and ensuring that all vulnerable persons – whether they attend as interested persons, witnesses or in any other capacity – receive appropriate support. In the years since the publication of Bishop Jones's report, these learning points have consistently informed the development of annual coroner training.

33. On 2 March 2018 the annual training day for all senior and area coroners in England and Wales focused on the needs of vulnerable people during the coroner investigation and in the inquest hearing. Vulnerability is a state we can all occupy at different times in our lives, and bereavement can place someone in the most vulnerable of positions. It is important that coroners are trained to recognise and understand this. I should particularly like to thank Bishop Jones for speaking to all senior and area coroners during the morning session of that event.

34. Mandatory continuation training for all coroners delivered in 2019/20 addressed the vulnerability of bereaved people and witnesses, communication with families, the behaviour of counsel and general control of the court room. Alongside this, the training for coroners' officers – who engage more frequently with families during the inquest process – focused on language and dealing with vulnerable people.

35. Coroner training was substantially disrupted by the Covid-19 pandemic, but in-person training resumed in April 2022 and included judgecraft and DVI elements. The focus in the current round of training (2023-24) is on access to justice, including learning from inquests. A substantial portion of the training concerns Prevention of Future Death Reports, and Deborah Coles, Executive Director of INQUEST, is one of our guest speakers.

36. Coroners are appointed to their posts by Local Authorities. Since 2013, all coroner appointments have been subject to the consent of the Chief Coroner and the Lord Chancellor, enabling central oversight of recruitment procedures. I am currently considering the revision and updating of Guidance[10] for Local Authorities on the appointment of coroners to improve the robustness of the process.

Guidance on Disclosure

37. Guidance on Disclosure[11] was issued in September 2022, reminding coroners of their obligation to provide prompt information and documentation to

[10] Chief Coroner's Guidance No.6 The appointment of coroners - Courts and Tribunals Judiciary
[11] GUIDANCE No 44 DISCLOSURE final (judiciary.uk)

interested persons, including the bereaved.

Legal Regulators Toolkit and Competences

38. My team and I played a leading role with the Ministry of Justice, INQUEST, and others in supporting the creation by the Bar Standards Board, the Solicitors Regulation Authority and the Chartered Institute of Legal Executives of a 'toolkit' to guide lawyers who appear at inquests.

39. The toolkit provides legal professionals with a clear framework and list of competencies for practising in coroners' courts. It explains the purpose of the coroner's inquest and the standards to which advocates and others are expected to adhere. It also includes guidance on adapting communication style and engagement with participants in an inquest, and underlines their potential vulnerability. Lawyers can use the toolkit as a resource for addressing learning and development needs, and to ensure that they understand the unique and sensitive challenges involved in undertaking inquest work.

40. The regulators published the toolkit and competences in September 2021, accompanied by several video presentations, including videos on 'understanding the unique nature of inquests' and 'the importance of practising competently in inquests', which I produced.[12] My office is working with the regulators on monitoring and reviewing the practical impact of the toolkit.

Point of learning 10 – Evaluating coroners' performance

41. I have carefully considered the proposal that I should explore mechanisms for allowing coroners' performance to be evaluated and for performance data to be made public. However, Coroners are judges and it is not constitutionally appropriate to carry out public evaluation of judicial decision-making. The principle of judicial independence rightly operates to preclude any judge from commenting publicly on the judicial decision of another. Judicial decision-making is properly supervised by the higher courts (for example, through the judicial review process) and standards of personal conduct are upheld through the Judicial Conduct Investigations Office. It is not for me as Chief Coroner (other than when sitting as a member of the Divisional Court), or for anyone else, to pass judgment on coroners' decisions. It would also be inconsistent with the rule of law if the prospect of public feedback influenced the outcome of inquests. To enable coroners (or any judge) to make decisions based solely on the facts before them, they cannot be subject to that kind of external influence.

42. Although I do not consider public evaluation to be constitutionally appropriate, my predecessors and I have worked hard to ensure that coroners are trained to a consistently high standard on all aspects of their judicial practice. As with the training for all branches of the judiciary, coroner training is designed to encourage consistency of approach and continuous professional development

[12] Resources for those practising in the Coroners' Courts (barstandardsboard.org.uk)

on legal and judicial skills. The regular training offer for coroners includes multi-day induction training, which all coroners are required to attend when first taking office, and annual continuation training, which is a mandatory two-day residential course. Coroners also attend ad hoc training when needed, together with a range of specialist courses and events each year.

43. As coroners' officers provide much of the public-facing work of the coroner service, I also oversee the provision of an annual residential training course aimed at increasing consistency of practice and developing their skills. I have made significant progress over the past two years in refining coroners' officer training and have encouraged the development of relevant professional qualifications for those who might wish to pursue them.

Point of learning 11 – Learning the lessons from an inquest

44. Prevention of Future Death (PFD) Reports are an important ancillary part of the coroner's judicial role.

45. Coroners have a statutory duty to issue a PFD report when an investigation gives rise to a concern that future deaths will occur and the coroner considers that action should be taken to reduce the risk.

46. In 2020, my predecessor published revised guidance to assist coroners with the detail of the law and encourage consistency of approach in the use of PFD reports.[13] The recent judgments of the Administrative Court in the cases of *Gorani*[14] and *Dillon*[15] have provided further clarification on the legal parameters relating to PFD reports.

47. Since 2013, PFD reports and responses have been published on the Chief Coroner's webpages[16], providing additional transparency within the coronial system. In 2021 I issued a PFD publication policy, which explains how publication decisions are made and how they can be reviewed. The publication of PFD reports enables public scrutiny, making them a vital tool in ensuring lessons are learned and steps are taken to reduce the risk of future harm.

48. Since January 2023, I have ensured that PFD reports are published directly onto www.judiciary.uk webpages, which makes them fully searchable (previously, searches could only be run on the metadata associated with reports). Whilst this may appear to be a small technical change, it has considerably increased the ease with which reports can be analysed and themes identified, benefitting public learning (including for those using assistive technology). I also have been working closely with researchers at Oxford University to ensure that the relevant public and academic bodies are aware of their Preventable Death Tracker project, which uses sophisticated web-scraping techniques to aggregate data from PFD reports and produce

[13] Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths[i] - Courts and Tribunals Judiciary
[14] https://www.bailii.org/ew/cases/EWHC/QB/2022/1593.html
[15] High Court Judgment Template (bailii.org)
[16] Coroners' courts - Courts and Tribunals Judiciary

academic analysis.

49. My office continues to work with others (for example, the Ministerial Board on Deaths in Custody and the Independent Advisory Panel on Deaths in Custody[17]) to explore how the impact of PFD Reports can be enhanced.

Point of learning 18: Coroners should ensure that the decisions they make on toxicology – especially in respect of children – are made in a sensitive way, driven by necessity. Special care should be given to the way in which toxicology results are made public.

50. I accept the force of this recommendation and I am confident it is accepted by coroners throughout the service. As I hope I have set out earlier in this document, the approach to dealing with mass fatality incidents has undergone a transformation since the Hillsborough disaster.

51. Toxicology is an important component of the toolkit available to coroners in conducting a death investigation and whether it is needed in a particular case will depend on the facts. It is therefore not possible to provide guidance to coroners stipulating when it should or should not be ordered. However, the importance of taking a sensitive approach to toxicology decisions is a matter that my predecessors and I have sought to reinforce. For example, in 2017, my predecessor drew coroners' attention to the publication of Bishop Jones's report, including the toxicology remarks.

52. The use of toxicology in a mass fatality incident, with specific reference to the experience of the families in the Hillsborough disaster, will be part of the refresher training for coroners on mass fatalities and DVI incidents that is now under preparation.

Point of learning 19 - All bereaved families should be given clear information immediately following death concerning the coronial processes and their associated rights.

53. The deceased, and by extension their families, must always be at the heart of the inquest process. It follows that the bereaved should be given accurate and timely information as an investigation progresses. This applies not just in the context of a mass fatality event, but to all death investigations.

54. I have ensured that this requirement is explicitly set out in Chief Coroner guidance. Firstly, Guidance 32 on post-mortem examinations confirms that bereaved persons should always be informed of their statutory rights in relation to a post-mortem examination. Secondly, and more broadly, in Guidance 44[18] on disclosure, I have reinforced the need for the bereaved to be given the right information at the right time. As paragraph 10 of the Guidance says:

[17] *More Than a Paper Exercise – September 2023*
[18] GUIDANCE No 44 DISCLOSURE final (judiciary.uk)

It is imperative that, subject to the restrictions on disclosure…, Interested Persons are given sufficient information at an early enough stage for them to participate fully in the investigation process. Where Interested Persons are unrepresented, this includes ensuring that they understand how disclosure works. Coroners are advised to provide unrepresented Interested Persons with guidance on disclosure, both orally and in writing, as early as possible in the investigation process. As the Justice Select Committee report dated 27 May 2021 stated:

'Bereaved people are at a disadvantage when they do not have access to the evidence. It is important that the process for obtaining evidence is explained clearly to them as this is important for the fairness of the Inquest.'

55. I have also worked with others to improve the information provided to bereaved families. For example, in 2018, my office worked closely with the Home Office, Ministry of Justice and INQUEST to develop and published a simple leaflet for families whose loved ones died in police custody[19] And in 2020, my office collaborated with the Ministry of Justice on the major revision to the *Guide to Coroner Services*[20]*.*

Conclusion

56. I would like to reiterate my gratitude to Bishop Jones for the work he did to expose the truth of the Hillsborough disaster, culminating in the completion of the fresh inquests conducted by Sir John Goldring in 2016. His report was not only hugely significant to the Hillsborough families but has helped to transform the approach to subsequent DVI incidents.

57. Tom Luce, who led the 2001–3 Fundamental Review of Death Certification in England and Wales, described the coroner system in England and Wales as a "forgotten service". As I saw for myself during my recent national tour, that remains an accurate description. That coroners have managed to develop today's sophisticated mass fatality response structure in the face of the wider challenges of inadequate staffing, accommodation and funding is a tribute to their extraordinary dedication and hard work, as well as that of their equally overworked officers and staff. If we are to sustain and improve the service, eliminate backlogs and reduce delays, urgent action will be necessary in many coroner areas to simplify the governance structure and restore realistic staff, accommodation and funding levels.

58. I would like to commend the description of the modern purpose of the coroner system formulated in 2006 by the Commons Select Committee on Constitutional Affairs:

> *"The death certification and investigation systems have essential roles, providing each person who dies with a last, posthumous service from the State; they serve families and friends by clarifying the causes and circumstances of the death; and they contribute to the health and*

[19] https://www.gov.uk/government/publications/deaths-in-police-custody-leaflet-for-families
[20] Guide to coroner services - GOV.UK (www.gov.uk)

safety of the public as a whole by providing information on mortality and preventable risks to life."

59. That summary underlines a profound truth about the proper focus of death investigation. In this response I have reiterated the well-known principle that coroners have a duty to place the bereaved at the heart of the inquest process. But such a duty cannot exist in a vacuum. It presupposes the existence of a prior duty to the deceased. The ultimate reason for the centrality of bereaved families is that the coroner's inquest exists to discharge a posthumous duty to the dead whom they represent. That is why I prefer to say that it is the deceased, and by extension the bereaved, who should be at the heart of the process.

60. To recognise the ultimate priority of the deceased is to remember that each coroner's inquest touches not a body, but the death of an individual person. That, as I have already pointed out, is why recent guidance encourages coroners to admit pen portrait material at inquests. In the end, it is only by upholding and defending the centrality of the deceased that we can protect their families against the risk of being marginalised.

61. If placing the bereaved at the heart of every investigation is to be a reality, and not just a hollow slogan, we must ensure that coroners provide families with the information, explanations and above all respect to which they are entitled in a timely and sensitive fashion. By bringing home the terrible impact of a failure to observe these fundamental principles, Bishop Jones's report serves both to remind us of the work that remains to be done and to spur us to the necessary action.

6 December 2023