JUSTICE Student Human Rights Network Conference 2015

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Workshop 2: Exploring human rights issues in inquests and public inquiries[1]

a) Background

The theme of today's conference is using human rights law and advocacy beyond the civil and criminal courts. As illustrated by both of our keynote speakers, one of the most high profile roles played by human rights law in the UK, beyond ordinary civil and criminal litigation, is in the responsibility of the State to effectively investigate when someone dies and public authorities may bear some responsibility. In the UK, this responsibility is substantially discharged through inquests in the Coroners' Court and the conduct of public inquiries.

This short workshop is designed to provide a brief introduction to the legal framework for the operation of inquests and public inquiries and to initiate a discussion about the key human rights issues which regularly arise during the investigation of high-profile deaths.

b) What are inquests and public inquiries?

An **inquest** is a public investigation into a sudden, unnatural or unexplained death. It is conducted by a coroner, an independent judicial office holder acting on behalf of the Crown. The primary purpose of holding an inquest is to enable the coroner to establish who has died and how, when and where they died. Recent examples include the inquest considering the deaths of Mark Duggan and Jimmy Mubenga. Mark Duggan was killed by firearms officers during a police investigation. Reports of his death were believed to have given rise to protests and subsequently were linked to the outbreak of riots in London. His inquest recorded a verdict of lawful killing. Jimmy Mubenga died while being deported in the custody of G4S, a private security company contracted by the Home Office to conduct deportations. The jury returned a verdict of unlawful killing.

A **public inquiry** is a public investigation into issues of serious public concern, conducted on behalf of the Crown. It is conducted by an Inquiry Panel, which may consist solely of a

[1] JUSTICE thanks intern Ciar McAndrew for her assistance in the preparation of materials for this workshop.

chairman or a chairman assisted by additional members of the inquiry team. There are two types of inquiry:

Non-statutory inquiries are those which are not established on the basis of any enabling statute. They do not have any powers to compel witnesses or take evidence on oath, and are therefore mainly used to investigate the actions of public officials, who can be expected to co-operate without the need for coercive powers.[2] For example, the *Chilcot* Inquiry examining the UK's involvement in the Iraq war (report pending).

Statutory inquiries are inquiries established pursuant to statute, most commonly the Inquiries Act 2005, which provides a general legislative framework for statutory inquiries. A statutory inquiry under the Act has full powers to call for witnesses and evidence. Examples include the *Leveson* Inquiry on press standards and the *Baha Mousa* Inquiry on the treatment of Iraqi civilians by UK armed forces in Iraq.

A non-statutory inquiry can be turned into a statutory one. For example, the Home Secretary has recently announced that the *Independent Panel Inquiry into Child Sexual Abuse,* initially established as a non-statutory investigation, will be reconstituted under the Inquiries Act 2005.

c) Domestic law, inquiries and inquests

Inquests are governed by the **Coroners and Justice Act 2009 (CJA 2009)**:

- **Duty to investigate:** The coroner must investigate a death within his jurisdiction as soon as is practicable if he has reason to suspect that the deceased died a violent or unnatural death, the cause of death is unknown, or that the deceased died in custody or otherwise in state detention (Section 1, CJA 2009).

- **Inquests:** If, after a post-mortem, the cause of death is still unclear, or the coroner has reason to suspect that the death might have been violent or unnatural, an inquest must be held to determine the circumstances of the death (Section 6, CJA 2009).

    - **Juries:** A Coroner must sit with a jury, which will make decisions on matters of fact, if he has reason to suspect that:
        - The deceased died while in custody or otherwise in state detention and that either i) the death was violent and unnatural or ii) the cause of death is unknown; or
        - The death resulted from the actions of a police officer / a member of a service police force in the purported execution of his duties; or
        - The death was caused by accident, poisoning or disease (Section 7, CJA 2009).

[2] Cabinet Secretary advice on the establishment of a judicial inquiry to explore the findings of the Culture, Media and Sport Select Committee into Press Standards: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60808/cabinet-secretary-advice-judicial.pdf

- **Conclusions and determinations, findings and verdicts:** At the end of an inquest, the Coroner or the Jury must give their conclusions and a verdict (Section 10, CJA 2009). These are in two forms:

    - **Short form** findings or verdicts are in one of a range of terms which describe the manner of death. These include: 'accident or misadventure', 'lawful' or 'unlawful killing', 'natural causes' and 'open' (where there is insufficient evidence for any other outcome).

    - **Narrative** findings or verdicts are provided alternatively, or in addition to a short form verdict, where the coroner will set out the facts and circumstances surrounding the death in more detail, explaining the reasons for the decision.

- **Preventing future deaths (Schedule 5, CJA 2009):** If the evidence heard during the course of an inquest gives rise to a concern that circumstances creating a risk of other deaths will occur or continue to exist, the corner can produce a Preventing Future Deaths[3] report (PFR report) under Schedule 5 of the Act. This report is sent to the organisation responsible for those circumstances, and is intended to address the issues which gave rise to the death being investigated at the inquest, and help avoid future such deaths. For example, the Mark Duggan PFD highlighted a number of concerns that circumstances creating a risk of death existed, including the fact that the scene of the fatal police shooting was not video recorded.

Public inquiries are generally governed by the **Inquiries Act 2005**.

- **Initiating an inquiry:** A Minister may cause an inquiry to be held in relation to a case where it appears to him that either: a) events have caused or are capable of causing public concern, or b) there is public concern that particular events may have occurred (Section 1, IA 2005).

  The Minister will appoint a Chair and other necessary inquiry panel members (Section 4 IA, 2005)[4] and set the terms of reference (Section 5, IA 2005). He must inform Parliament of his intention to hold an inquiry as soon as 'reasonably practical' (Section 6, IA 2005).

- **Inquiry powers:** The Chair has the power to require the production of evidence and the attendance of witnesses (Section 21, IA 2005), as well as taking evidence on oath (Section 17(2), IA 2005).

  The Chair must deliver the Inquiry Report to the Minister, who then must arrange for publication and the laying of the report before Parliament (Sections 24-25, IA 2005).

[3] Formerly known as a Rule 43 report (under Rule 43 of the Coroners Rules 1984)

[4] If the Minister wants to appoint a judge as chairman, he must first consult the senior Lord of Appeal in Ordinary, the President of the Supreme Court or the Lord Chief Justice (depending on the level of the judge) under S10 Inquiries Act 2010.

The Minister must make provision for the costs of the Inquiry, including in respect of legal representation (Section 39, IA 2005). Both the Chair and the Minister have the power to restrict public access to the inquiry (Section 19, IA 2005).

Neither an inquest nor a public inquiry has the power to determine any person's civil or criminal liability.[5] However, findings in an inquest or a public inquiry may lead to further investigations, prosecutions or civil claims. So, further inquiries by the Police Service of Northern Ireland followed the report of the *Saville* Inquiry and a prosecution was brought against the shooting officer after the conclusion of the *Azelle Rodney* inquiry.

Although there are many parallels in the powers afforded to an inquest and a public inquiry, some key differences exist. First, while a jury must be convened in connection with some inquests, nothing in the Inquiries Act makes provision for the involvement of a jury. Second, while the Coroners Act broadly specifies the nature and purpose of any inquest, the terms of reference of any public inquiry will vary, being set by the Minister in consultation with the Chair. Thirdly, the powers of a Chair in a public inquiry are, at least in broad statutory terms, shared with Ministers.

Decisions of a Coroner and the findings of an inquest, and decisions in connection with a public inquiry, may be challenged by way of judicial review.

d) Procedural obligations, the right to life and Article 2 ECHR

Article 2(1) provides that:*"Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence in a court following his conviction of a crime for which this penalty is provided by law.*[6]The case law of the European Court of Human Rights ("ECtHR") clarifies that, like most ECHR rights, Article 2 confers both negative and positive obligations.So*, "the first sentence of Article 2(1) enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction"*[7]

The positive obligations of the State, include a **generalprocedural obligation** which applies in connection with all deaths.This creates a duty on the state to facilitative an independent judicial system to determine the cause of any death, and if necessary, to hold accountable those responsible for it.[8] In practice, in the UK, both the role of the police and the CPS in investigating and prosecuting unlawful killing and the inquest system help discharge this function.

An **enhanced procedural obligation** applies in cases involving the state. The Court explained in *Edwards v UK:*

[5] Section 10(2) Coroners and Justice Act 2009; Section 2(1) Inquiries Act 2005
[6] The limitation carved out for the death penalty in this paragraph no longer applies to the UK since it ratified Protocol 6 ECHR.
[7] *Osman v United Kingdom* [1998] ECHR 101
[8] See for example, *Dodov v Bulgaria* [2008] ECHR 43.

> *"[T]he effective implementation of domestic laws which protect the right to life, and in those cases involving state agents or bodies, to ensure their accountability for deaths occurring under their responsibility."*[9]

The House of Lords in *Amin* further explained:

> *"the purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light, that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."*(Lord Bingham)[10]

In *Jordan v UK*[11]and subsequent case-law, the ECtHR has identified a number of accepted criteria which must be satisfied:

- ***Initiated by the State*****:** *"[W]hatever mode [of investigation] is employed, the authorities must act of their own motion, once the matter has come to their attention. They cannot leave it to the initiative of the next of kin either to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures."*

- ***Effective:*** *"capable of leading to a determination…and to the identification and punishment of those responsible"*.

- ***Independence:*** *"not only a lack of hierarchical or institutional connection but also a practical independence"*.

- ***Transparency and public scrutiny***: Rule 11(3) of the Coroners (Inquests) Rules 2013 requires inquest hearings to be held in public. However under Rule 11(4), the Coroner may exclude the public from an inquest in the interests of national security.Under Schedule 1, Part 1 CJA 2009 (s3(1)), a senior coroner must suspend an inquest if the Lord Chancellor requests him to do so on the ground that the cause of death is likely to be adequately investigated by a public inquiry under IA 2005.[12] Section 18, IA 2005 contains a presumption that hearings will be held in public[13], the Chair can restrict attendance by relatives, journalists and legal representatives, and the final report of an inquiry can be redacted or not made public at all.[14]

- ***Family Participation*****:** *"In all cases, however, the next-of-kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests".* The impact of this finding for the involvement of families in inquests and

[9] *Edwards v UK* [2002] 35 EHRR 19
[10] *R v Secretary of State for the Home Department, ex parte Amin* [2003] UKHL 51
[11] *Jordan v UK* [2003] 37 EHRR 52
[12] In order to exercise this power, the Lord Chancellor must appoint a senior judge, whose appointment has been approved by the Lord Chief Justice, as the chairman of the inquiry. Note that under s3(2), the coroner can continue their investigation if there are exceptional reasons for doing so.
[13] The presumption of a public hearing does not apply to non-statutory inquiries, such as the recent inquiry into self-afflicted deaths of young adults in custody between 18-24 years old, or the *Morecambe Bay* inquiry
[14] Section 25(4) Inquiries Act 2005, as was the case with the interim report of the *Gibson* Inquiry.

public inquiries has been particularly important. In some case, but not all, this will require the State to provide an individual with legal aid.[15]

- ***Prompt:****"[A] prompt response by the authorities in investigating ... may generally be regarded as essential in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts."*

- ***Capable of identifying systemic failings*****:** In *Oneryildiz v Turkey,* the ECtHR stressed that inquiries must be able to address systemic failings, being "*capable of… ascertaining the circumstances in which the incident took place and any shortcomings in the operation of the regulatory system."*[16]

  Thus, inquests which satisfy this standard will have a narrative verdict.[17]A full report by a public inquiry or a substantive PFD Report may also help meet the standards of an Article 2 ECHR inquiry in practice.

e) Some human rights questions for discussion

This workshop will focus on some of the key human rights questions which domestic courts and the European Court of Human Rights have considered in the past decade.

- **Family participation:** *What do you think are the barriers to family participation in practice?*

- **Disclosure and "secret evidence":** *Can the duty to investigate under Article 2 ECHR be satisfied in all cases, including those involving evidence potentially damaging to national security?*

- **The rights of witnesses:** *Are the steps taken to protect the rights of witnesses to inquests and public inquiries proportionate?*

- **Independence:** *Can an inquiry governed by the Inquiries Act satisfy Article 2 ECHR? What about alternative forms of public inquiry?*

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[15] *R (on the application of Mohammed Farooq Kahn) v Secretary of State for Health*, [2003] EWCA Civ 1129; *Letts, R (on the application of) v The Lord Chancellor &Ors* [2015] EWHC 402 (Admin) (20 February 2015)
[16] *Oneryildiz v Turkey* [2004] 41 EHRR 20
[17] *R (Middleton) v West Somerset Coroner* [2004] UKHL 10