Lord Chancellor's Exceptional Funding Guidance (Inquests)

1. This guidance is issued by the Lord Chancellor to the Director of Legal Aid Casework under section 4(3) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 ('the Act'). The Director must have regard to this guidance in determining whether civil legal services in relation to an inquest are to be made available under section 10 of the Act. As, in practice, applications will be considered by caseworkers on the Director's behalf, this guidance is addressed to caseworkers.

2. This guidance sets out some of the factors that caseworkers should take into account in deciding exceptional funding applications in relation to inquests. It is not intended to be an exhaustive account of those factors. In particular, it is not intended to replace the need for consideration of representations in individual cases and any applicable case law. Applications should be considered on a case by case basis.

3. The Government has retained Legal Help, the advice and assistance level of legal aid, for inquests into the death of a member of the individual's family. Legal Help can cover all of the preparatory work associated with the inquest, which may include preparing written submissions to the coroner. Legal Help can also fund someone to attend the inquest as a 'Mackenzie Friend', to offer informal advice in Court, provided that the coroner gives permission.

4. Funding for representation at an inquest is not generally available because an inquest is a relatively informal inquisitorial process, rather than an adversarial one. The role of the coroner is to question witnesses and to actively elicit explanations as to how the deceased came by his death. An inquest is not a trial. There are no defendants, only interested persons, and witnesses are not expected to present legal arguments. An inquest cannot determine civil rights or obligations or criminal liability, so Article 6 ECHR is not engaged.

5. There are two grounds for granting legal aid for representation at an inquest. The first is that it is required by Article 2 ECHR. The second is where the Director makes a "wider public interest determination" in relation to the individual and the inquest. These are dealt with in turn below.

Article 2 ECHR

Funding Criterion

6. Pursuant to section 10(3) of the Act, Article 2 ECHR may require legal aid to be granted for representation before the Coroners' Court. Funding will be granted where:

The procedural obligation under Article 2 ECHR arises and, in the particular circumstances of the case, representation for the family of the deceased is required to discharge it.

7. In effect this is a two stage test. Caseworkers should first be satisfied that the procedural obligation under Article 2 ECHR arises. Where the caseworker is satisfied, he or she will then decide whether funded representation is required to discharge the procedural obligation.

Article 2 – Background and caselaw concerning inquests

8. Article 2 ECHR confers a “right to life”. It imposes on States “substantive obligations” both not to take life without justification and to do all that could be reasonably expected to avoid a “real and immediate” risk to life where the State knows or ought to know of the risk of a breach of Article 2 (the “operational duty”), and also to establish a framework of laws, systems, precautions, and means of enforcement which will, to the greatest extent reasonably practicable, protect life (the “systemic duty”).

9. Article 2 also imposes a “procedural obligation” on the State. The “procedural” obligation arises where there are “circumstances that give ground for suspicion that the State may have breached a substantive obligation imposed by Article 2”[1].

When is the Article 2 procedural obligation triggered?

10. There are some categories of case in which the mere fact of death gives rise to a possibility of State responsibility and this suffices to trigger the Article 2 procedural duty. In these categories, the procedural duty is **automatically** triggered, whether or not the evidence in the case discloses an arguable breach of any of the substantive obligations imposed by Article 2.

11. The case law in this area is complex and developing but indicates that the categories in which the Article 2 procedural duty will be automatically triggered include at least:

    - all intentional killings by state agents (e.g. a police shooting)[2];
    - all violent deaths and suicides of persons detained in police or prison custody or during the course of arrest or search[3]; and
    - all violent deaths and suicides of persons detained in mental hospitals[4].

[1] R (Smith) v Oxfordshire Assistant Deputy Coroner [2010] UKSC 29 at §84
[2] see e.g. McCann v UK 21 EHRR 97, at §161; Jordan v UK (2003) 37 EHRR 2
[3] Salman v Turkey (2000) 34 EHRR 425; R (L) v Secretary of State for Justice [2009] 1 AC 588

12. In *Letts* it was said that the suicide of a voluntary psychiatric patient is also capable (depending on the facts) of automatically triggering the Article 2 procedural duty[5]. However, the precise circumstances in which the suicide of a voluntary psychiatric patient will automatically trigger the procedural duty is presently unclear, so caseworkers should have regard to any relevant case law that emerges.

13. If caseworkers consider that the case falls within one of the categories in which the Article 2 procedural obligation is automatically triggered, or that it arguably does, they should proceed to the second stage of the test: is funded representation for the family of the deceased required to discharge the procedural obligation?[6]

14. Even outside the categories where the Article 2 procedural obligation is automatically triggered, that duty may arise if – on the facts of the case – it can be shown that the State was arguably in breach of one of its substantive duties (i.e. the operational duty or the systemic duty).

15. It is *unlikely* that there will be an arguable breach of the substantive obligations where there is no State involvement in the death, for example, the fatal shooting of one private individual by another private individual (where the authorities had no forewarning or other knowledge prior to the death). Another example is a death in State detention through natural causes.

16. In the context of allegations against hospital authorities (outside of the categories of case where the procedural duty is automatically triggered) *R (Humberstone) v Legal Services Commission*[7] makes clear that there will **not** be a breach of the substantive obligation where a case involves only allegations of ordinary medical negligence, as opposed to where the allegations of negligence are of a systemic nature. The judgment also emphasises the necessity for care to be taken to ensure that allegations of individual negligence are not dressed up as systemic failures.

17. Coroners may express a view as to whether they consider that the procedural obligation automatically arises, or that there has been an arguable breach of the substantive obligation and whether they intend to conduct a '*Middleton* inquiry'. It should be noted that, should the coroner choose to express their views, they are material and not determinative. There is no expectation that the coroner's views should be actively sought.

If the procedural obligation is triggered, is funded representation for the family of the deceased required to discharge the procedural obligation?

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[4] R (Smith) v Oxfordshire Assistant Deputy Coroner (above) at §210(iv)
[5] R (Letts) v Lord Chancellor [2015] EWHC 402 (Admin) at §92, see also §101
[6] ibid at §103
[7] [2011] 1 WLR 1460

18. In cases where a caseworker has decided that the procedural obligation arises, he or she must then consider the second stage of the test for funding under Article 2 ECHR.

19. Where the "procedural obligation" does arise, *Middleton*[8] makes clear that a *Jordan* compliant inquest is necessary. *Jordan* is a reference to the case of *Jordan v UK*[9]. This case concerned the shooting by police in Belfast of a young, unarmed man in 1992. The court established in *Jordan* that in order to satisfy the requirements of Article 2, any investigation had to satisfy the following five criteria to be effective:

    - The inquiry must be on the initiative of the State, and it must be independent;
    - It must be capable of leading to a determination of whether any force used was justified, and to the identification and punishment of those responsible for the death;
    - It must be prompt and proceed with reasonable expedition;
    - It must be open to public scrutiny to a degree sufficient to ensure accountability; and
    - The next-of-kin of the deceased must be involved in the inquiry to the extent necessary to safeguard their legitimate interests.

20. In most cases the coroner can conduct an effective investigation, with the family's participation, without the family of the deceased needing to be legally represented[10].

21. In considering whether funded representation may be necessary to discharge the procedural obligation, all the individual facts and circumstances of the case must be taken into account by caseworkers, including: i) the nature and seriousness of the allegations against State agents; ii) previous investigations into the death; and iii) the particular circumstances of the family.

i) The nature and seriousness of any allegations which are likely to be raised at the inquest against public authorities or other agencies of the State

22. Particular regard will be given to allegations based on evidence of gross negligence or systemic failures, for example, closely related multiple and avoidable deaths from the same cause within the same institution; criminal conduct; and attempts to conceal information or otherwise interfere with an investigation into the circumstances surrounding the death.

ii) The particular circumstances of the family

[8] R(Middleton) v HM Coroner for Western Somerset [2004] 2 AC 182
[9] (2003) 37 EHRR 2
[10] R (Humberstone) v Legal Services Commission (above) at §78; R (Letts) v Lord Chancellor (above) at §§120-122

23. Relevant factors may include whether the applicant is suffering from severe mental health problems (potentially arising from the circumstances of the death), or has a learning disability. As previously noted, Legal Help can be used to prepare a family for the inquest; to prepare submissions to the coroner setting out the family's concerns and any particular questions they may wish the coroner to raise with witnesses.

iii) Whether previous investigations into the death have taken place, and whether the family has been involved in such investigations

24. In some cases, separate investigations are carried out by authorities such as NHS Trusts, the Independent Police Complaints Commission and the Crown Prosecution Service prior to the inquest. Where there has not been a previous investigation, or the family has not played an active role in a previous investigation, the inquest may be the only investigation the State conducts into the death where the family is involved to the extent necessary to safeguard their legitimate interests.

25. Having considered the factors above, alongside all the circumstances of the case, caseworkers should make a decision on whether the second limb of the Article 2 test is met; and therefore whether to authorise funding for the family of the deceased.

Wider Public Interest

26. Section 10(4) of the Act sets out that the Director can grant legal aid for excluded services for inquests (i.e. advocacy) where the applicant qualifies for legal aid, and the Director makes a "wider public interest determination" in relation to the applicant and the inquest.

27. A "wider public interest determination" is a determination that, in the particular circumstances of the case, the provision of advocacy for the individual for the purposes of the inquest is likely to produce significant benefits for a class of person, other than the applicant and members of the applicant's family.

28. In the context of an inquest, the most likely wider public benefits are the identification of dangerous practices, systematic failings or other findings that identify significant risks to the life, health or safety of other persons.

29. For a wider public interest determination to be made the wider public interest must be 'significant'. Whether wider public interest is significant will depend on a number of factors: what the benefits are; whether the benefits are more or less tangible; whether they will definitely flow to other persons or whether this is just a possibility; and the numbers of people who will benefit (it will be unusual for significant wider public interest to apply to something that benefits fewer than around 100 people, for example).

30. It should be noted that, in relation to inquests, it is not sufficient that there is significant wider public interest in the inquest itself. There must be significant wider public interest *in the client being represented* at the inquest for the case to qualify for a wider public interest determination. This means that an applicant must be able to demonstrate that representation is necessary to obtain any benefits that may arise, not just that the inquest itself may provide benefits.

31. In deciding whether to make a wider public interest determination, caseworkers should consider whether there is a suggestion of large-scale systemic failure. If, for example, someone dies because a procedure is inappropriate or risky, then the caseworker will need to consider whether there are credible allegations that inadequate systems were in place. If the systems in place are adequate, but they were not followed, the reasons for this need to be considered. If the procedures were not followed because of the actions of a reckless individual, then caseworkers should consider whether the recklessness was a result of poor training or monitoring or otherwise reveals some systemic failing. If not, the case may not satisfy the 'wider public interest' test. If the procedures were not followed because no one knew about them, or there had been inadequate training or monitoring, then this may reveal systemic failure.

32. Caseworkers will also need to consider whether there are likely to be improvements to systems as a result of the inquest. Where there were poor systems but these were followed correctly, or where there were good systems which were not followed correctly, the questions will be: are these failings so significant that reforming them (by improving systems or staff training) would bring significant benefits to a significant number of people (100 or more other persons) – and – how likely is it that such improvements will follow from the inquest? If the poor systems were in place, and these were not followed correctly, then there may be a need for a radical overhaul of the systems and improvements to staff training and management. If it seems that benefits of these kinds will flow from representation at the inquest (perhaps through rule 43 recommendations; see below), then this will add weight to a case to fund on wider public interest grounds.

33. Under rule 43 of the Coroners Rules 1984, the coroner may announce at the inquest that he is reporting the case to the authorities with recommendations for action to prevent the recurrence of similar deaths. The authorities are not legally bound to accept or act on these recommendations, although they must respond to such a letter. Where no corrective action has been taken to prevent further deaths of the same kind, and the coroner says he is minded to make rule 43 recommendations, this may add weight to the case to grant funding, if the applicant's legal representation is likely to enable him to uncover these systemic failings.

34. Where there have already been other investigations (by the ombudsman, Health & Safety Executive, hospital, etc) and these have made recommendations for improvements to systems or training, then this will reduce the potential for benefits to flow from the inquest, unless these investigations have failed to consider important evidence or additional significant errors.

35. Where the hospital or the body in question has accepted responsibility for failings leading to the death and has agreed to change systems or improve training to ensure that a similar death does not reoccur, then this will also reduce the likelihood that benefits will flow from the inquests, as these benefits have already been secured, so it is less likely that the case will be considered to be of wider public interest.

Eligibility Limits

36. In general applicants must satisfy the eligibility limits as set out in regulations. However, there is a discretion to waive the financial eligibility limits relating to inquests if, in all the circumstances, it would not be reasonable to expect the family to bear the full costs of legal assistance at the inquest. Whether this is reasonable will depend in particular on the history of the case and the nature of the allegations to be raised against State agents, the applicant's assessed disposable income and capital, other financial resources of the family, and the estimated costs of providing representation.

37. Where funding is granted to provide Legal Representation at an inquest, contributions may be waived in whole or in part. Where it is appropriate for a contribution to be payable this may be based upon the applicant's disposable income and disposable capital in the usual way ignoring upper eligibility limits. As funding will cover only one-off advocacy services at the inquest, an appropriate total contribution will normally consist of one month's assessed income contribution. Capital contributions will not take into account the client's home, or any award of damages received by the family in compensation for the deceased's death. Contributions should always be based on what can reasonably be afforded by the applicant and his or her family in all the circumstances of the case.