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GOVERNMENT WHIP FOR DCMS, FCDO AND HO

15 November 2021

Dear Lord Paddick,

POLICE, CRIME, SENTENCING AND COURTS BILL: OFFENSIVE WEAPONS HOMICIDE REVIEWS – LORDS COMMITTEE STAGE AMENDMENTS

During the Lords Committee debate on the 27th October (Official Report, columns 839-847), I committed to writing to you to provide further information on how Offensive Weapons Homicide Reviews (OWHRs) will work in practice alongside coroners' investigations. I would like to thank you for your close scrutiny and contribution to the debate of these important provisions, which we believe will help prevent future deaths. I have also taken this opportunity to touch upon other issues that were raised during the debate.

Coroners' inquests

The issue at the heart of your amendment relates to whether an OWHR is needed in cases that are subject to a coroner's inquest, and that an OWHR would be duplicative. As I noted during the debate, inquests are legal inquiries into the cause and circumstances of a death, and are limited to the four statutory questions of who, where, when and how or by what means they came about their death. However, in many homicides where an offensive weapon is used, there will not be an inquest because the criminal prosecution will answer the four statutory questions and therefore an inquest will not need to take place. The legislation supports this practice; when there is a prosecution, the coroner is required to suspend any inquest proceeding (see paragraph 7 of Schedule 1 to the Coroners and Justice Act 2009) and at the conclusion of the prosecution, the coroner's investigation may not be resumed unless the senior coroner thinks that there is sufficient reason for resuming it. This reflects the principle that there should not be duplication of inquiry within the judicial system unless it is necessary. As such, homicides involving an offensive weapon that meet the threshold for an OWHR are unlikely to also be subject to an inquest given the majority also involve criminal trial.

In the debate you cited the example of the Manchester Arena bombing inquest which took place following a criminal prosecution. Resumption of a coroner's inquest does

occur in cases where there is some wider or precursor issue in respect of the death which the coroner needs to consider or where Article 2 of the European Court of Human Rights (ECHR) is engaged in terms of the death investigation. In the case of Manchester Arena, there were issues around what was known by the authorities about the perpetrators which was relevant to the inquest process. But these are not the sort of issues an inquest following a homicide is required to consider in most circumstances.

For clarity, the inquests arising from the deaths in the Manchester Arena terror attack were converted into a public inquiry, set up under the Inquiries Act 2005, following a request from the coroner in September 2019.

Prevention of future death reports

Whilst there are legal requirements for reviews to take place following certain types of death, being those reviews set out in clause 25, there is currently no legal requirement for an equivalent review in the majority of adult homicides involving an offensive weapon. In the debate you pointed to the prevention of future death (PFD) reports prepared by coroners, as an example of the duplication an inquest could have with an OWHR. As you stated during the debate; coroners' powers are set out under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 Act, as well as Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. This includes where an investigation gives rise to concern that future deaths will occur, and the investigating coroner is of the opinion that action should be taken to reduce the risk of death, the coroner must make a report to the person that s/he believes may have the power to take such action. Such a report will be produced after the conclusion of an inquest.

There are however some fundamental differences between the PFD and OWHR and as such there would not be a duplication of effort or process:

(1) Recommendations

In a PFD report the coroner can draw attention to an area of concern, highlighting that in their opinion action should be taken to prevent future deaths. They should not recommend what that action should be, and they must allow the person/organisation to provide the remedy.

OWHRs in contrast are designed to play an important role in driving forward multi-agency solutions to tackle serious violence and homicide by identifying lessons to be learned and opportunities to take action in respect of those lessons, as set out in clause 27 of the Bill. Making clear recommendations to an organisation when needed, are consequently a key part of the review process.

(2) Timing

PFDs are produced following a coroner's investigation, and as set out above this would be after the conclusion of any criminal trial, if at all. In contrast we are working with local agencies to co-design OWHRs that can be completed and published quickly, where possible, to ensure that recommendations to safeguard and tackle homicide can be acted on quickly and lives can be saved.

(3) Oversight

As highlighted in the point above, coroners' powers are set out in legislation, and this does not provide for an oversight function. There is a duty in law placed on to those to whom a PFD report is directed, which requires them to respond within 56 days however no further follow-up on the completion of an action is taken by a coroner. In contrast, for OWHRs the Home Office Oversight Board will be established to oversee the process, monitor implementation of any findings/recommendations and support dissemination of learning and best practice locally and nationally. This scrutiny would be lost if homicides were not subject to an OWHR, because an inquest was being held.

In addition to the Oversight board, OWHRs also include a notification process to the Secretary of State, providing a clear line of accountability and transparency over which review partners are subject to the duty to arrange and conduct a review. Furthermore, clause 23 of the Bill and regulations made under clause 23(1)(c) will set out clear criteria as to when a review partner is under a duty to arrange a review. In contrast PFDs only need to be carried out where a coroner is of the opinion that actions should be taken. The Report of the Chief Coroner to the Lord Chancellor set out that in 2019 30,000 coroners inquests were opened while between July 2018 – June 2019 only 505 PFDs were carried out, which is in less than two percent of inquests.

Review Partners

In response to your queries regarding relevant review partners and the decision to carry out an OWHR; there are four conditions that must be met before a review is required, as set out in clause 23(1)(a) to (d). Under clause 24 regulations made by the Secretary of State will provide clear criteria for identifying the relevant review partners in respect of a homicide and statutory guidance issued under clause 31 will also assist partners with this process. If, on a rare occasion agreement is not reached, it would be expected that review partners work together to come to an agreement on whether the criteria had been met. If they are unable to reach an agreement, the Secretary of State and Home Office Oversight Board will be made aware of this disagreement through the notification process and could seek to discuss the differences of opinion with the review partners to understand the issues and seek a resolution. A review of partners' decision as to whether the conditions are met could also be subject to challenge in judicial review proceedings.

As I outlined during the debate, to ensure that there will be no cases where there are no relevant review partners, clause 24(5)(c) of the Bill also allows for regulations under that clause to give the Secretary of State power to direct which review partners are the relevant review partners in respect of a death. Should the regulations under clause 24 include this direction power, we would not expect that it would be used regularly, because we intend for the regulations to identify which partners are the relevant review partners in the great majority of cases.

Numbers of OWHRs

In response to your query regarding the number of OWHRs which will be carried out each year; this is set out in the impact assessment published with the Bill. In

2019/20, using the Homicide Index, it was estimated that 526 of the cases that are still recorded as homicide would not meet the criteria for an existing review. Almost half of these homicides (251) involved an offensive weapon and would not be subject to a homicide review under existing criteria and so could be subject to an OWHR depending on whether they meet the conditions that will be set out in regulations, and if a decision is made to roll OWHRs out across England and Wales.

I have copied this letter to Lord Ponsonby of Shulbrede and Lord Beith. I am also placing a copy in the library of the House.

Sharpe of Epsom

LORD SHARPE OF EPSOM OBE

The Lord Paddick
House of Lords