



Ministry of  
**JUSTICE**

# **Reform of the Coroner System**

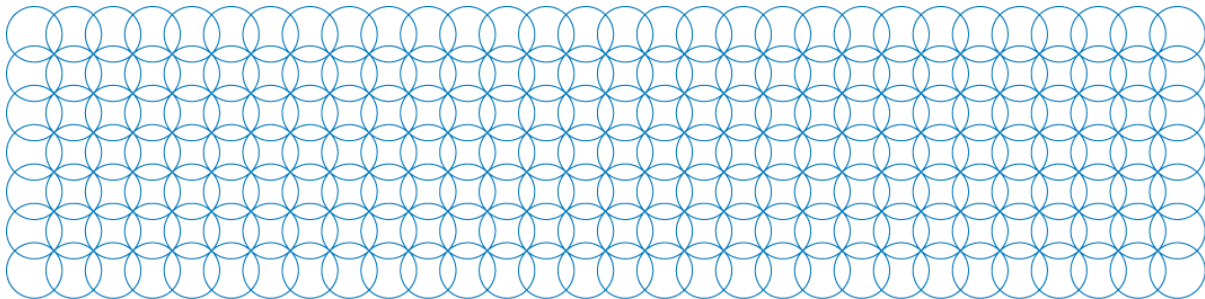
## **Next Stage**

### Preparing for implementation

**Consultation paper CP06/10**

Published on 11 March 2010

This consultation will end on 1 July 2010







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**JUSTICE**

## **Reform of the Coroner System – Next Stage**

Preparing for implementation

**A consultation produced by the Ministry of Justice.**

**This information is also available on the Ministry of Justice website:  
[www.justice.gov.uk](http://www.justice.gov.uk)**

## About this consultation

**To:** Coroners and those who work within and who fund the system, voluntary sector stakeholders, general public

**Duration:** From 11 March 2010 to 1 July 2010

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**Response paper:** There will be a response to this paper in autumn 2010, which will pave the way for a further consultation document, setting out the draft secondary legislation, in early 2011. Both documents will be published at: [www.justice.gov.uk](http://www.justice.gov.uk)

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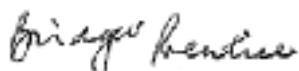
## Ministerial foreword

The reform of the coroners' system in England and Wales has been one of my most important priorities over the last three years. Working with the Lord Chancellor, and the Health Secretary in respect of the parallel changes to death certification, we have devised a framework which we believe will deliver benefits for many families when they unexpectedly, and in unhappy circumstances, come into contact with the coroners' system.

During the three years, I have met with several of those families, and they have given contrasting accounts of their experiences. For me, this inconsistency in the provision of good quality service, together with providing families with the opportunity to participate more extensively in coroners' investigations, is at the heart of the reform programme.

In Part One of the Coroners and Justice Act, we now have the first significant Parliamentary legislation on coroners in more than a century. The Act creates a Chief Coroner and a national framework more generally, but enables us also to build on, and spread, the good practices which already take place at a local level.

Although, as many of you know, I am leaving Parliament while this consultation is taking place, and it will be for new Ministers to take forward its outcome, I shall be watching closely over the next two years to ensure there is no slippage in the April 2012 implementation target, and no dilution of the policy which Parliament has agreed and which I wholeheartedly support.



**Bridget Prentice**

**Parliamentary Under Secretary for Justice**

## Executive summary

The aims of coroner reform are:

- To deliver an improved service for bereaved people.
- To introduce national operational leadership for the first time but ensure the system is embedded better locally.
- To ensure more effective investigations and inquests.

This consultation paper represents the latest step in the Government's work to reform the coroner system in England and Wales. As at all the previous stages, and following Parliamentary endorsement of the framework and many of the key features of the new system contained in Part One of the Coroners and Justice Act 2009, we are keen to hear views, from all those with an interest, on several important areas of detail as we take forward the implementation programme over the next two years.

The Government's work to reform the death certification system will be subject to separate consultation later this year. While there will be overlap, in the immediate aftermath of a death, between the roles of the coroner and the new medical examiners responsible for independent scrutiny of what are believed to be non-suspicious deaths, our approach is to seek views on these new arrangements through a separate consultation paper.

This is the first stage in a two stage public consultation process. This year, we are inviting your views on the policy which will inform the drafting of the secondary legislation and the guidance which flows from it. We have selected areas where we know many of those with an interest have ideas they would like to share. These areas are:

- **The specific deaths which should be reported to coroners.**
- **The criteria, and administrative and financial arrangements, for transferring cases from one coroner to another.**
- **Post-mortem examinations.**
- **Search, entry and seizure powers.**
- **Policy and practice on the disclosure of documents.**
- **The conduct of inquests.**
- **The new appeals & complaints systems.**
- **Training.**
- **Short Death Certificates.**



As annexes, we attach a glossary of some commonly used terms, and a first draft of a Chief Coroner job description. The latter will almost certainly develop further when the first Chief Coroner is appointed, probably on a part-time basis initially, in the next few months.

As a result of the feedback we receive, and also taking full account of the Government commitments given during extensive debate on policy during Parliamentary passage of the Bill in 2009, and with the assistance of experienced practitioners and others with a close interest, we will prepare a second consultation paper in early 2011 which will include the actual draft rules and regulations.

This will enable us to finalise the secondary legislation during the second half of 2011, so that we have sufficient time to ensure that all those within the coroner system, and those professionals who interact with it, have training and guidance on the new ways of working in advance of the planned implementation date of April 2012. We are also aware of the need for the public to be aware of the changes to the system and will be arranging to produce relevant guidance, including a final version of the Charter for Bereaved People – on which there is also likely to be further consultation, probably in 2011 – to coincide with the implementation date.

### **Summary of the main policy in the Act**

To assist you in seeing how the matters on which we are consulting fit in with the policy agreed by Parliament, we set out here a summary of the main policy in Part One of the Act:

- **Introduction of a Chief Coroner.** The Lord Chief Justice will appoint a High Court or Circuit Judge after consultation with the Lord Chancellor. There will also be Deputy Chief Coroners who may be either High Court or Circuit Judges, or senior coroners. They will be supported by a team of administrators. It has not yet been decided where the office will be based.
- **Purpose and outcome of coroners' investigations, including inquests.** The Act clarifies the purpose of investigations, including inquests, and defines which deaths should be investigated, which cases should be held with juries (likely to increase slightly to about or just over 2% of all inquests), and that coroners may not determine any matters of criminal or civil liability.
- **Requirement for doctors to refer specified deaths to coroners.** This will ensure doctors report appropriate deaths to coroners but without overloading the system – there is considerable over-reporting of deaths at present, which causes unnecessary anxiety to families. All deaths which do not go to the coroner will be considered instead by the new medical examiners, so if they take a different view from the certifying doctor there is the safety net of a referral to the coroner at a later stage.

- **Improved medical support for coroners.** One of the functions of medical examiners will be to provide general advice to coroners on a case by case basis. This may mean, for example, that there is no need for coroners to commission post-mortems in respect of some deaths. At a national level, a Medical Adviser to the Chief Coroner will be appointed, one of whose roles is likely to be to issue guidance, and contribute to training, on medical matters.
- **Relaxation of boundary restrictions.** Although the system of coroner areas remains geographically based, there will no longer be rigid restrictions on where post mortem examinations or inquests may be held (but both may be subject to any guidance issued by the Chief Coroner). There will also be power for investigations to be transferred from one coroner to another by the Chief Coroner, or by agreement between the coroners concerned. For deaths of military personnel where the bereaved family live in Scotland or Northern Ireland, there is the opportunity for the investigation to be transferred to those countries.
- **New coroner areas and appointment system.** The current coroner districts vary in size, and the aim is to move towards areas over which one full time coroner will preside, with support from other, possibly part-time, coroners where required (in large geographical areas, for example). Coroner appointments can currently seem opaque, particularly for deputy and assistant deputy coroners, who are appointed directly by coroners. The new nationally monitored appointment system will lead to greater consistency and transparency in the recruitment process across England and Wales.
- **Independent inspection and accountability.** There are no current inspection arrangements. HM Inspectors of Courts Administration (HMICA) were to be the appointed inspectors but it was announced in December 2009 that there are plans to abolish the organisation before the reforms take effect. Alternative arrangements are under active consideration. Coroners continue to be answerable for judicial conduct to the Lord Chancellor and Lord Chief Justice, and will be accountable to the Chief Coroner for the operation of the Charter for Bereaved People and for the other national standards which he or she establishes.
- **Power to make reports to prevent future deaths.** At present, this power is contained in coroners Rules (rule 43, as amended in July 2008). This has now been moved to the primary legislation – in paragraph 7 of Schedule 5 to the Act – with the intention that guidance to coroners will lead to greater consistency in its use across England and Wales.
- **Appeals system.** Challenges to coroner decisions at present are via Judicial Review, or by Attorney General agreement that the decision should be reconsidered by the High Court. This provides very restricted access for bereaved families. In the new system, the Chief Coroner (or a deputy Chief Coroner) will consider appeals about decisions set out in Section 40 of the Act. The matters to be subject to appeal have been

carefully considered – following consultation while the Bill was being developed - to ensure a proportionate balance between the rights of families (and other interested persons) and to avoid the appeal system being overwhelmed.

- **Power to secure information, to enter and search premises and to seize material.** Coroners currently have limited powers to compel evidence to be provided. These provisions will enable search and entry to premises (permission being provided by the Chief Coroner) and give wider powers to compel evidence to be given, produced or provided with offences for non-compliance.
- **Lord Chancellor to issue Charter for Bereaved People.** The Charter lists a number of services which should be delivered to bereaved people, to enable them to better participate in coroner investigations. As mentioned above, we will probably be consulting for the final time on the Charter during 2011.
- **Power to appoint Judges to complex cases.** Judges currently have to be appointed, by a coroner, as deputy assistant coroners in an area to hold an inquest. The process can be cumbersome. The Act will enable the Chief Coroner and Lord Chief Justice to agree appointments quickly in appropriate cases, although it remains the intention to use the power sparingly.
- **Coroner for Treasure.** At a local level, coroners' duties to investigate treasure finds have been removed and jurisdiction given instead to a single Coroner for Treasure. This will enable coroners to focus on death investigations, and enable the Coroner for Treasure to become a national expert and a source of advice to the very distinct groups interested in treasure investigations. We are not seeking views on the treasure system, as it relates to coroners, as part of this consultation although it may be referred to from time to time within the paper. There will be opportunity for those with an interest to provide views on treasure at a later stage of the implementation process.

We hope you find this background information helpful, and look forward to receiving your comments, where you have an interest, on the specific matters requested within the paper. However, please feel free to comment on any other issue relating to reform of the system where we have not invited specific comments.

Finally, and needless to say, we are working within tight financial constraints. The overall resources allocated to coroner reform are set out in the Impact Assessment included as one of the annexes to this paper. Most of these resources are already committed to support the policy in the Act approved by Parliament. Comments and suggestions, however attractive, therefore need to take account of this fact.

## Introduction

This consultation is being conducted in line with the Code of Practice on Consultation issued by the Cabinet Office and falls within the scope of the Code. The consultation criteria, which are set out on page 169 have been followed.

An Impact Assessment, including an Equality Impact Assessment, has been completed and indicates that no specific groups are likely to be particularly affected.

Comments on the Impact Assessment are particularly welcome.

The consultation is aimed at all those with an interest in the coroner system in England and Wales.

In particular this includes:

- The Coroners' Society of England and Wales
- The Coroners Officers Association
- The Local Government Association and local authorities
- Association of Chief Police Officers
- Other investigating authorities
- Royal College of Pathologists and other medical groups

All voluntary sector groups which have identified themselves as having an interest during previous consultations, or during the passage of the Coroners and Justice Bill through Parliament.

## **Introduction to policy**

This consultation is an important part of our work to develop the detail of how a reformed coroner system will work in practice. Under reform, and with the arrival of medical examiners under the new death certification arrangements, there will be some significant changes in the way the system operates and in how services are delivered. For those familiar with the Coroners Act 1988, some of the terminology used in the new Act is also significantly different.

Before seeking your views on specific issues in the pages ahead, and building on the summary of the main policy in the new Act in the previous section, we set out here some of the new concepts. You might also find useful the glossary of frequently used terms or abbreviations on page 102.

### **Coroner areas**

This is the new term for what are currently known as coroner districts. Over time, in a reformed system, it is likely that there will be fewer areas than there are districts

### **Senior coroners**

As well as creating the first ever Chief Coroner for England and Wales, at a local level the Act replaces the terms ‘coroner’, ‘deputy coroner’ and ‘assistant deputy coroner’ with ‘senior coroner’, ‘area coroner’ and ‘assistant coroner’.

Although much of the Act expresses duties in terms of the senior coroner, it also makes clear that an area or assistant coroner conducting an investigation may perform the functions of a senior coroner.

All new areas will have a senior coroner and a pool of assistant coroners to be drawn on as the workload demands. Several areas will also have area coroners, possibly on a full-time basis. This is most likely to be in areas which are geographically large, or where there are other relevant demographic features, such as the presence of a number of prisons or hospitals (including psychiatric hospitals).

### **Deaths reported to coroners**

The policy in the Act is intended to lead, over time, to a significant reduction in the number of deaths reported to coroners. In Parliament, this was estimated at between 80,000 and 100,000 deaths annually. However, it is important to stress that although it is anticipated the number of deaths reported to coroners will decrease, the workload across the system will remain at about the same level as at present because of other new practices introduced by the Act and the Charter for Bereaved People.

## **Coroner investigations**

The Act sets out that coroners conduct “investigations”.

It recognises that there are four main stages in an investigation, and that particular cases may be discontinued after any of these stages:

- i. A coroner decides whether the death is one which he or she should investigate.
- ii. If so, a coroner decides whether a post-mortem examination is required or, if not, that the death may be registered on the basis of medical or other information that has been received.
- iii. If a post-mortem examination has taken place, the coroner decides whether the death can be registered and the case discontinued, or whether the case should go on to inquest.
- iv. An inquest is held.

In some cases, the Chief Coroner’s powers to transfer cases from one coroner to another, and the new rights to appeal particular coroner decisions, will introduce significant new stages.

Coroners will continue to rely on reports, in relation to many deaths, from other investigating authorities before they are able to list them for inquest. Coroners do not, and will not in the future, direct, manage, or supervise such investigations but they may sometimes ask for particular lines of inquiry to be pursued.

## **Inquests**

When an inquest is held, coroners (or juries when relevant) will return “determinations” rather than “verdicts” about the factual matters they are required to decide. The short form determinations available to coroners are subject to consultation in this paper.

Coroners ancillary, but important, role to prevent future deaths through bringing causes of death to the attention of public authorities – either through reports arising from individual cases, or through information provided to enable statistical findings to be made - will be encouraged.

## **Post-mortem examinations**

Post-mortem examinations need not necessarily be by invasive procedures. This allows for scientific and technological developments which may enable examinations to take place in a less invasive way in the future.

## **Improved liaison with funding authorities**

Where they do not presently exist, there need to be closer working relationships between coroners and their funding authorities to ensure that the work of the coroner is understood and valued.

## Chapter 1: Deaths to be reported to a senior coroner

### Purpose

1. This policy is designed to ensure that coroners have reported to them the deaths that should be reported to them; and that there is clarity between the role of the coroner and the new medical examiner which the Act creates.
2. The introduction of medical examiners will have the benefit of tackling the over-reporting of deaths to coroners which takes place within the current system, while at the same time ensuring that all deaths are scrutinised independently. At present, some 45% of deaths are reported to coroners each year – this is 15-20% higher than in any other country which has coroners whose responsibilities are broadly similar.

### What the current law provides for

3. There is currently no statutory duty on doctors to refer deaths to a coroner. At present the only specific duty falls on registrars<sup>1</sup>; on prison governors, to report the death of an inmate; and on the commanding officer or commandant, to report the death of a person in the UK in naval quarters or in an army or air force establishment.
4. In practice, the majority of deaths are referred to coroners by attending doctors or directly by the police. There is some national guidance on this for doctors<sup>2</sup> but it is quite broad brush. Some coroners have developed more detailed protocols to help doctors decide whether or not to refer a death. However, these are local arrangements and such protocols - and therefore the cases being referred – vary from district to district.

### What policy on reporting deaths to coroners is contained within the Coroners and Justice Act 2009 and how will the new procedures work?

5. When the Coroners and Justice Act 2009 comes into force it will introduce a new death certification system in England and Wales to run parallel with the coroner system.
6. When someone dies the default position will be for an attending practitioner (“the registered medical practitioner who attended the deceased before his or her death”) to review the information provided by the person who verified the death, together with the deceased’s medical

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<sup>1</sup> The duty for registrars to refer deaths to the coroner is prescribed in the Birth and Death Regulations 1987.

<sup>2</sup> For example, the ONS/GRO guidance for doctors certifying the cause of death.

records etc, and to complete a medical certificate of cause of death (MCCD).

7. A medical examiner (a new post) will scrutinise the MCCD. This will entail a proportionate review of medical records, as well as consideration of the circumstances leading to the death and any concerns raised by the family. The medical examiner will also have access to existing clinical governance data. If they are content, the medical examiner will confirm the cause of death on the MCCD and the death can be registered.
8. In certain cases and circumstances, however, deaths will be reported to a senior coroner, rather than being dealt with by an attending practitioner and medical examiner. This is likely to happen in one of the following ways:
  - The attending practitioner reports the death to a senior coroner (often in discussion with a medical examiner).
  - The attending practitioner completes an MCCD but, after scrutiny, the medical examiner refers the death to a senior coroner.
  - There is no attending practitioner, or the doctor(s) who was attending the deceased before s/he died is not available within a specific period of time, and so another medical practitioner refers the death to a senior coroner.
  - The police (or someone else) report the death directly to a senior coroner.
9. The senior coroner will carry out an initial assessment based on the information provided by the medical practitioner or police. If the coroner decides that there is no need for a coroner investigation, s/he will refer the case to a medical examiner<sup>3</sup>. If the coroner retains the case, s/he will open an investigation into the death and will certify the cause of death based on information obtained by a post-mortem and, possibly, an inquest.

**Cases and circumstance in which a registered medical practitioner should notify a senior coroner of a death**

10. Section 1 of the Coroners and Justice Act 2009, says that senior coroners must investigate a death if he/she has reason to suspect that:
  - The deceased died a violent or unnatural death;
  - The cause of death is unknown; or
  - The deceased died while in custody or otherwise in state detention.

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<sup>3</sup> If there is an attending doctor who fulfils the legal requirements, s/he will complete the MCCD. If not, then the medical examiner will prepare an MCCD.



11. It follows that if it is reasonable to believe that one (or more) of these categories applies, then the death should be referred to a senior coroner for him or her to assess whether an investigation is necessary.
12. Section 18 of the 2009 Act gives the Lord Chancellor a power to “*make regulations requiring a registered medical practitioner, in prescribed cases or circumstances, to notify a senior coroner of a death of which the practitioner is aware.*” The purpose of these new regulations – and associated guidance to be produced – is to specify the cases or circumstances in which a death must be referred to a senior coroner and to ensure consistency across England and Wales.
13. It is proposed that registered medical practitioners will be required to refer deaths to a senior coroner in the cases or circumstances below. These are based on feedback gathered during a previous consultation process (in 2007) and more recent input from a small working group made up of coroners, doctors and pathologists. The cases and circumstances are:
  - Where there is no attending practitioner or the attending practitioner(s) is unavailable within a prescribed period.
  - The death may have been caused by violence, trauma or physical injury, whether intentional or otherwise.
  - The death may have been caused by poisoning.
  - The death may be a result of intentional self-harm.
  - The death may be a result of neglect or failure of care.
  - The death may be related to a medical procedure or treatment.
  - The death may be due to an injury or disease received in the course of employment, or industrial poisoning.
  - The death occurred whilst the deceased was in custody or state detention, whatever the cause of death.
  - The cause of death is unknown.
14. It is recognised that there may inevitably be an overlap between some of these categories.
15. Rather than trying to give a single definition of the term “unnatural death” – a complex and evolving concept – the categories set out in the second to the seventh bullet points are all examples of unnatural deaths.
16. In relation to the first bullet point, please note that the 2009 Act defines an attending medical practitioner as a “registered medical practitioner who attended the deceased before his or her death”. Before the Act comes into force the Department of Health will consider whether any practitioner who

fills these criteria should be able to complete an MCCD, or whether the criteria should be narrowed for death certification purposes. They will also be considering the time period in which an attending practitioner can complete the MCCD, before the death must be referred to a senior coroner. Please note that the definitions in the table below are based on current guidance and may be changed.

17. Under current legislation<sup>4</sup> a death – even an apparently natural death – can only be certified without reference to the coroner if the attending doctor has seen the deceased after death or within 14 days before the death. Otherwise the registrar must refer the death to the coroner. In previous consultation exercises both the Ministry of Justice and the Department of Health have sought views on whether the 14 day rule was necessary and should continue to apply. Reactions were mixed. Some respondents felt that the time period was irrelevant and that the quality of information available to the doctor (for example, medical history and information about the circumstances of the death) was far more important. Others felt it was helpful to have a clear cut off point at which deaths should be referred to a coroner – although some suggested an extension to 21 or 28 days.
18. We would again appreciate comments on this. With the medical examiner system to act as a safety net, we believe that a 14 day time limit is too short. With developments in the delivery of palliative care in particular, we believe that either the limit should be higher – 21 or 28 days – or there should be no limit at all, and it should be left to the discretion of the attending practitioner, in discussion with the medical examiner where necessary, to determine whether the death should be reported to a coroner under one of the other categories for referral.
19. These categories are each described in more detail in the ‘Cases and circumstances in which a registered medical practitioner should notify a senior coroner of a death’ section below. This will form the basis of guidance for medical practitioners.

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<sup>4</sup> The Registration of Births and Deaths Regulations 1987

## Cases and circumstances in which a registered medical practitioner should notify a senior coroner of a death<sup>5</sup>

### 1. Case/circumstance: There is no attending practitioner, or the attending practitioner(s) is unavailable within a prescribed period.

#### Draft guidance for registered medical practitioners

Only an attending practitioner – a registered medical practitioner who attended the deceased before his or her death – can complete a medical certificate of cause of death (MCCD), without reference to a senior coroner.

“Attending practitioner” is generally accepted to mean a doctor who has cared for the patient during the illness that led to death and so is familiar with the patient’s medical history, investigations and treatment. He or she should also have access to relevant medical records and the results of investigations.

In hospitals there may be several doctors in a team caring for the patient. It is ultimately the responsibility of the consultant in charge of the patient’s care to ensure that the death is properly certified. In general practice, more than one GP may have been involved in the patient’s care and so be able to certify the death.

If there is **no attending practitioner** then the death must be referred to a senior coroner. You will need to provide the senior coroner with the relevant medical and supporting information.

Similarly, if the **attending practitioner(s) is unavailable** on either the day the person died (or the day the body was discovered) or the following working day then the death must be referred to a senior coroner. Again, you will need to provide the senior coroner with the relevant medical and supporting information.

If the **identity of the deceased is not known**, then it follows that there will be no attending doctor and/or the deceased’s medical history is unknown, precluding the completion of an MCCD. In this scenario the death must be referred to the senior coroner.

A coroner investigation may not be necessary in all these cases. If the senior coroner is satisfied that he/she does not need to open an investigation then he/she will refer the case to a medical examiner, who, after carrying out a light scrutiny, can issue a medical certificate of cause of death. For example, this might happen if the deceased was receiving palliative care at home, and this was well documented in the GP notes, but the GP is unavailable.

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<sup>5</sup> This is based on current ONS/GRO guidance. The Department of Health will be considering this definition as part of its death certification programme.

**2. Case/circumstance: The deceased died as a result of violence, trauma or physical injury whether intentional or otherwise**

**Draft guidance for registered medical practitioners**

A violent death involves some sort of trauma or physical injury. For example, if the deceased:

- Died as the result of trauma or injuries inflicted by someone else or by him/herself.
- Died as the result of trauma or injuries sustained in an accident, such as a fall or a road collision.

**3. Case/circumstance: The death was caused by poisoning**

**Draft guidance for registered medical practitioners**

This applies to deaths caused by the deliberate or accidental intake of poison, including:

- Illicit drugs.
- Medical drugs (e.g. a self administered overdose or an excessive dose given in error or deliberately).
- Toxic chemicals.

**4. Case/circumstance: The death may be a result of intentional self-harm**

**Draft guidance for registered medical practitioners**

This may apply if it is reasonable to suspect that the deceased died as the result of poisoning, trauma or injuries inflicted by his/herself, as per categories (2) and (3) above.

Or the death may be a result of gross failure by the deceased to preserve their own life. This may include, for example, a failure to:

- Take adequate nourishment or liquid.
- Obtain basic medical attention.
- Obtain adequate shelter or warmth.

It does not extend to deaths where the lifestyle choices of the deceased – for example, to smoke, drink or to eat excessively – may have resulted in their death.

**5. Case/circumstance: The death may be a result of neglect or failure of care.**

**Draft guidance for registered medical practitioners**

This applies if the deceased was in a dependent or vulnerable position (e.g. a minor, an elderly person, a person with a registered disability) and it is reasonable to suspect that there was a gross failure to provide them with – or to procure for them – certain basic requirements. This would include, for example, a failure to provide:

- Adequate nourishment or liquid.
- Adequate shelter or warmth.
- Proper medical care.

It also includes wholly unexpected deaths, albeit from natural causes, where it is reasonable to suspect that the death results from some culpable human failure.

**6. Case/circumstance: The death may be related to a medical procedure or treatment**

This applies if the death may be related to surgical, diagnostic or therapeutic procedures and investigations, anaesthetics, nursing or any other kind of medical care. It includes scenarios such as:

- Deaths that occur unexpectedly given the clinical condition of the deceased prior to receiving medical care.
- Mistake(s) was made in the medical procedure or treatment e.g. the deceased was given an incorrect dosage of a drug.
- Medical procedure or treatment may have either caused or contributed to death (as opposed to the injury/disease for which the deceased was being treated).
- Deaths that are clinically unexplained.
- The original diagnosis of a disease or condition was inappropriately delayed or erroneous, leading to the death.

**7. Case/circumstance: The death may be due to an injury or disease received in the course of employment, or industrial poisoning.**

**Draft guidance for registered medical practitioners**

This includes injuries sustained in the course of employment, for example if the death was due to a fall from scaffolding, or being crushed in machinery.

It also includes deaths that may be due to diseases received in the course of employment. For example, if the deceased was:

- A current or former coal miner who died of pneumoconiosis.
- A current or former furniture worker who died of cancer of the nasal sinuses.
- A current or former construction worker who died of asbestos-related lung-disease e.g. asbestosis or mesothelioma.

This extends to scenarios in which the deceased may have contracted a disease as a result of the employment of another - for example, someone who died of asbestosis as a result of washing their partner's overalls which were covered in asbestos.

#### **8. Case/circumstance: The death occurred whilst the deceased was in custody or state detention, whatever the cause of death**

##### **Draft guidance for registered medical practitioners**

A death must be reported to the coroner if it occurred while the deceased was in custody or state detention - i.e. if he/she was compulsorily detained by a public authority - whatever the cause of the death. This includes:

- Prisons.
- Young Offender Institutions.
- Secure accommodation for young offenders.
- Any form of police custody e.g. the deceased was under arrest (anywhere) or detained in police cells.
- Immigration detention centres.
- Hospitals, where the deceased was detained under mental health legislation.
- Court cells.
- Cells at a tribunal hearing centre.
- Military detention.
- When the deceased was a detainee who was being transported between two institutions.

#### **9. Case/circumstance: The cause of death is unknown**

##### **Draft guidance for registered medical practitioners**

If you are an attending practitioner i.e. if you attended the deceased before his or her death – you are expected to prepare an MCCD stating the cause of death to the best of your knowledge and belief based upon a conscientious appraisal of the deceased's medical history and any other information available. As with a clinical diagnosis, this means a reasonable tolerance of uncertainty is acceptable.

If you have questions about the cause of death, or about completing the MCCD, you should discuss these with a medical examiner.

If you are unable to identify the cause of death (and therefore unable to complete an MCCD) then you should refer the death to a senior coroner.

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### **Duty to notify a senior coroner of a death**

20. Subject to the outcome of this consultation, regulations will create a duty for registered medical practitioners to notify a senior coroner of a death in the cases and circumstances above.
21. It is anticipated that, in practice, one of the following would be responsible for referring a death to the coroner:
  - The attending practitioner, including a hospital consultant, who would otherwise complete the MCCD.
  - The registered medical practitioner, including a hospital consultant, who attends the deceased shortly after the time of death.
  - The medical examiner.
22. The regulations could stipulate that once one attending practitioner or registered medical practitioner has notified a coroner of a death, there is no duty on others to do so.
23. To support medical practitioners and to enable them to in carrying out this duty it will be necessary to provide training and guidance on what is expected of them. Written guidance will be available for medical practitioners alongside the books of MCCDs. We need to consider what other forms of training and guidance should be provided. Training for medical examiners on this issue will be included in the e-learning package being developed by the Department of Health. One option would be for this to be made available more widely.

### **Failure to comply with regulations**

24. We want to ensure that deaths are reported to the coroner appropriately and consistently in future i.e. that registered medical practitioners comply with the new regulations and guidance. There are two scenarios in which non-compliance on behalf of the medical practitioner may arise:
  - Poor practice due to a lack of knowledge or understanding.
  - Deliberate and wilful failure to report a death or deaths.

25. Coroners and medical examiners will be expected to work closely together in future. They will be jointly in a position to identify those registered medical practitioners who routinely fail to report deaths to the coroner or, equally, who report deaths to the coroner unnecessarily. One option would be for medical examiners to offer or arrange further training for the practitioner to address the problem.
26. If the registered medical practitioner in question continued to fail to report deaths to the coroner, it is proposed that the medical examiner or the coroner should report the matter to the relevant primary care trust (for GPs) or medical director (for hospital doctors). If it cannot be resolved locally it should be reported to the General Medical Council who would conduct a full investigation and assess the appropriate action to take, if any, depending on the circumstances.
27. Deliberate or wilful failure to report a death(s) should also be reported to the relevant primary care trust or medical director who will involve the GMC and/or the police as necessary – or reported directly to the GMC and/or the police if that is more appropriate. If there is found to be criminal activity then existing criminal sanctions will apply. It is not thought to be necessary to create a new, separate offence.

#### **Summary of Issues on which we would welcome your views in this chapter**

- **Q1: Do you agree with the suggested cases and circumstances in which a registered medical practitioner must notify a senior coroner of a death? If not, what alternative or additional cases and circumstances would you suggest (bearing in mind the coroner's remit to investigate deaths as defined in section 1 of the 2009 Act)? (Paragraph 19)**
- **Q2: We would welcome comments on the draft guidance for registered medical practitioners which explains the cases and circumstances in which a senior coroner should be notified of a death. In particular, short illustrative examples that could be included in the guidance. (Paragraph 19)**
- **Q3: Given new ways of delivering Health services, particularly to the terminally ill, should the time period for a death to be automatically reported to a coroner be extended to 21 or 28 days, from 14 days, of a doctor not having attended their patient? Or should there be no time limit at all? (Paragraphs 17 and 18)**
- **Q4: What channels should be used to provide training and guidance for medical practitioners on the cases and circumstances in which a senior coroner should be notified of a death? (Paragraph 23)**



- **Q5: Do you agree with the proposed arrangements for dealing with registered medical practitioners who consistently or deliberately fail to notify a senior coroner of a death(s)? If not, what alternative arrangements – short of creating a new offence – would you suggest? (Paragraphs 24 to 27)**

## Chapter 2: Transferring cases from one coroner area to another

### Purpose

1. These measures will bring flexibility into the coroner system, and take account of the needs of a bereaved family to have a prompt investigation and inquest, conducted in accordance with national standards and, wherever possible, and in relation to the inquest, held at a geographically convenient location.
2. We anticipate that the measures could be used in the following circumstances:
  - a) When the death requiring investigation occurred overseas.
  - b) When the death occurred in England and Wales – when someone was on holiday or on business – but the immediate family lives in a different part of the country.
  - c) When the death occurred near the boundaries of two coroner areas but the bereaved family live on the side of the boundary where the death would not normally be investigated.
  - d) If there is a major incident, or there is a major outbreak of disease, where there are many casualties.
  - e) Where there are unexpected surges in reported deaths to particular coroners.
  - f) Where the coroner believes he or she has a conflict of interest in conducting the investigation, perhaps through knowing the deceased well.
  - g) Where the coroner is subject to a formal complaint, which has been accepted for investigation, by a party to the case.
3. In terms of Chief Coroner directed transfers, systems will need to be in place to enable him or her to be made aware of all the circumstances set out above. In most cases, he or she will be alerted by the coroner concerned, but there will also need to be arrangements for bereaved families, and other interested persons, to make application to the Chief Coroner for a particular death to be transferred.

**What detailed policy on transferring investigations is contained within the Coroners and Justice Act 2009 (including regulation making powers)?**

4. Under section 2 one coroner (coroner A) may request another coroner (coroner B) to conduct an investigation. If coroner B agrees to conduct the investigation he or she must then carry out that investigation as soon as possible; and no other coroner can conduct the investigation. Coroner B will then have powers to move the body in order to ensure a more efficient inquiry.
5. Coroner A must give the Chief Coroner notice in writing of any request made by him or her to coroner B, stating whether or not coroner B agreed to it.
6. Under section 3 the Chief Coroner may transfer an investigation from coroner A, in whose area the body of the deceased lies, to coroner B, who will conduct the investigation. Coroner B must then carry out the investigation as soon as possible, and no other coroner can do so. Coroner B will then have powers to move the body, in order to ensure a more efficient inquiry. In making a decision to direct a transfer we anticipate that the Chief Coroner will consider the convenience and cost of a transfer to everyone involved in the investigation. While this will mostly focus on the bereaved family, it will also include the police, pathologist, and any experts and lay witnesses.
7. Regulations made under section 43 will set out the process for notification of transferred investigations.
8. Local authorities will continue to be responsible for the funding of a reformed coroner system. We propose that regulations, under Schedule 7 of the Act, will set out where the responsibility for meeting expenses will lie for transferred investigations; and the process for incurring and meeting expenses.
9. Details of each of these elements are below:

**Responsibility for meeting expenses**

10. Our proposals for three possible options for local authorities' responsibility for meeting expenses – a general principle and two exceptions to that general principle - were debated by Parliament when sections 2 and 3 of the Act were being considered. We would be grateful for views on these proposals.

*The general principle for meeting expenses*

11. The general principle will be that coroner A's local authority will retain responsibility for meeting expenses, even after transfer of an investigation to coroner B. The following examples would apply this general principle:
- a) A bereaved family lives far from where their loved one died, and the Chief Coroner directs coroner B, who is more local to the family, to carry out that investigation.
  - b) Coroner A reports to the Chief Coroner that he or she has a conflict of interest in carrying out the investigation, and coroner B then investigates the death.
  - c) A sudden high number of local deaths is referred to coroner A, due to, for example, a TB outbreak or during a pandemic. This takes up a great deal of coroner A's time, so the Chief Coroner either directs coroner B to take on some of these cases or to take on some of coroner A's normal day to day work, provided in both instances that no families are seriously inconvenienced.
  - d) A family complains to the Chief Coroner about a coroner's handling of an investigation and, if relations between family and coroner 'irretrievably break down', the Chief Coroner may direct coroner B to carry out the investigation.
12. Keeping responsibility for meeting expenses with coroner A's local authority will guard against offering a financial incentive for coroner A's area to conduct its business less efficiently in order to create a backlog of cases with the aim of prompting a transfer of a case to another authority.

*The first exception to the general principle*

13. The first exception will be where coroner B's area would pay the expenses of an investigation. This would apply to most deaths abroad or deaths where the body is near the boundary of two areas and the bereaved family live in the area of the coroner who would not normally have responsibility for the investigation. Examples of these exceptions could be:
- a) Someone dies in an accident abroad, and is flown back to an airport in coroner A's area. However the bereaved family lives in coroner B's area in another part of the country.
  - b) A soldier is killed in action abroad, with their body then repatriated to coroner A's area. However the bereaved family lives in coroner B's area in another part of England, to where the investigation is transferred.

- c) Someone dies in a hospital which is near to the boundary between Hampshire and Surrey. The hospital is actually in Hampshire, but the bereaved family live in Surrey.

14. We propose that coroner B's area should meet the expenses incurred in such investigations as coroner A's area will have no connection with the deceased or bereaved family, other than being the location to either where the body is repatriated initially or to where the place of death is situated. This will minimise the unnecessary burden on areas with, for instance, ports or airports, or with hospitals with catchment areas which cross coroner boundaries.

*The second exception to the general principle*

15. The second exception is where the circumstances of the case or cases mean that responsibility should be shared between two or more local authorities. Examples could be:
- a) Two or more people are ultimately killed in one incident, such as a car accident or food poisoning incident, in coroner A's area. While still alive, one person is moved to coroner B's area, where they later die. Under the Act investigations would usually happen in the two areas where the bodies were lying. However, the Chief Coroner may decide that both deaths should be investigated jointly by coroner A in whose area the incident occurred.
  - b) Two or more fatal incidents (for instance several linked suicide terrorist incidents) occur in different coroner areas. The Chief Coroner may direct a transfer of an investigation from one coroner to another, so that all the deaths can be investigated as one comprehensive investigation.

**Process of incurring and paying expenses**

16. We propose that regulations set out the following for transferred investigations:

- a) That the local authority A schedule of fees under paragraph 7(1) of Schedule 7 will apply to the coroner B who has agreed or been directed to conduct the investigation in the same way it normally applies to coroner A.
- b) That, under the general principle, coroner B will be accountable to coroner A's relevant authority for expenses incurred in a case transferred to them, as they would normally be accountable to their own authority.

- c) That coroner B should provide accounts and evidence to relevant authority A, where that authority is meeting his or her expenses.
- d) That, when expenses incurred by a senior coroner will be shared by authorities, they are apportioned according to the number of deaths for which each authority would normally have responsibility - between the relevant authorities and then paid in such manner as has been agreed. If necessary, the Chief Coroner could issue advice on a case by case basis as to how costs should be apportioned.
- e) That if the relevant authorities concerned cannot agree as to how the expenses should be apportioned, regulations (made under paragraph 9(2) (c) of Schedule 7) would allow them to make representation to the Chief Coroner.

### Process for notification of transferred investigations

17. As set out above, under section 2 (5) coroner A must notify the Chief Coroner of any request he or she makes for coroner B to investigate a case, and coroner B's response. Under section 3 (4) the Chief Coroner must notify Coroner A of his/her decision to transfer a case to coroner B. We suggest that regulations about all section 2 and 3 transfers should say that (*italics denote points on which we are seeking views*):

- The Chief Coroner should also set out to coroner B (the receiving coroner) and coroner A (the coroner from who the case is transferred) in writing the reason for the transfer.
- *Coroners A and B must agree at the time of transfer which of them will confirm in writing, to any identified interested persons, that the transfer has taken place, and write to those interested persons **within 5 working days**.*
- *Coroner A must give coroner B the relevant paperwork **within 5 working days of receiving the direction from the Chief Coroner**.*

### Resource implications

18. We do not believe these measures will create a new burden on coroners or local authorities.
19. Under the Act local authorities will continue to be responsible for the funding of a reformed coroner system, and for meeting expenses incurred in an investigation. 'Meeting expenses' means paying or reimbursing expenses incurred by coroners when conducting their statutory duty to investigate a death.

They would include:

- a) Allowances payable, under Schedule 7, to jurors and witnesses.
  - b) Fees and expenses payable to people conducting post mortems (which might include costs relating to medical reports, mortuaries and body storage, removal of the body to the mortuary from the place of death, histology, bacteriology and forensic toxicology).
  - c) These costs when incurred by the Chief Coroner or the Coroner for Treasure, a judge, former judge or former coroner acting as a coroner.
  - d) Indemnifying those carrying out coroner investigations.
20. The general principle of leaving responsibility for expenses with coroner A's relevant local authority, even after an investigation is transferred to coroner B, means that in the vast majority of cases there will be no extra resource burden on coroner B's local authority for taking on additional work.
21. Where coroner B's relevant authority meets the costs of a transferred investigation, the expenses of the coroner would be met or reimbursed by his or her own relevant authority in the usual way.
22. Coroners will not receive an additional fee for carrying out a transferred investigation, unless the coroner to whom the case is transferred holds office on an "hours worked" or similar basis.

**Summary of issues in this chapter on which we would welcome your views**

- **Q6: Whether there are other main circumstances when consideration should be given to cases being transferred (paragraph 2).**
- **Q7: "Who pays" in circumstances where an investigation is transferred whether on the direction of the Chief Coroner or by agreement between the coroners concerned (paragraphs 10 to 15).**
- **Q8: On the process for notification of transferred investigations (paragraph 17), that:**
  - **Coroners A and B must agree at the time of transfer which of them will confirm in writing, to any identified interested persons, that the transfer has taken place, and write to those interested persons within 5 working days.**
  - **Coroner A must give coroner B the relevant paperwork within 5 working days of receiving the direction from the Chief Coroner.**

## **Chapter 3: Post-mortem examinations and retention of bodies**

### **Purpose**

1. The main purposes of the changes in relation to post-mortem examinations are:
  - That examinations are to be carried out only when required.
  - That there is greater consistency between coroners in the circumstances when they commission a post-mortem examination.
  - That examinations are completed to the agreed degree of certainty to establish the cause of death.
  - That the bereaved family, wherever possible, are provided with better opportunities to be informed about the purpose and outcome of examinations.
  - To remove geographical restrictions on where examinations may be carried out.
  - To enable less invasive examinations to be conducted when they can establish the cause of death to the agreed degree of accuracy.
  - To enable the bodies of those who have died to be returned as promptly as possible to their loved ones.
  - To provide, in occasional circumstances, for examinations to be carried out other than by medically qualified practitioners.

### **What the 1988 Coroners Act provides for**

2. The current law on coroners' post-mortem examinations and the retention and release of bodies (including body parts) is largely contained within the Coroners Act 1988, the Coroners Rules 1984 and the Human Tissue Act 2004, together with related secondary legislation and codes of practice. There are, however, some references within other pieces of legislation, as well as statutory guidance and case law, which are relevant.
3. Separate arrangements apply to post-mortem examinations in deaths where criminality is known or suspected (although it is important to underline the coroner's responsibility in relation to custody of the body) and, apart from seeking views on the time limit when the body may be released to the family for the funeral, we are not otherwise seeking views on the procedures followed where this is the case. However, if



respondents do wish to provide views on matters relating to forensic post-mortem examinations we should be happy to receive them.

**What policy on post-mortem examinations and release / retention of bodies is contained in the 2009 Act?**

4. Section 14 allows a coroner to request a 'suitable practitioner' to make a post-mortem examination of a body. Under section 14(1) the coroner may do this either if the coroner is responsible for conducting an investigation into the death in question or, in occasional circumstances, to decide whether the duty to conduct an investigation has arisen.
5. Section 14(2) makes clear that the coroner's request may specify the kind of examination to be made. The examination ordered could therefore be a fully invasive post-mortem examination, but it could also be a post-mortem examination carried out by another method (including less invasive methods such as Magnetic Resonance Imaging scans) or a specific test on a particular part of the body. This effectively removes the need for separate mention of what used to be referred to as 'special examinations' – all such examinations will now be collectively referred to simply as 'post-mortem examinations'. Unlike now, it will be possible in future for a specific test to be commissioned irrespective of whether the coroner has decided to hold an inquest.
6. Section 14(3) defines a 'suitable practitioner' as either a registered medical practitioner or a practitioner of a description designated by the Chief Coroner. The process for designating such persons, who are expected to be few and from a scientific background, will be outlined in regulations. The Medical Adviser to the Chief Coroner, enabled by section 38 of the Act, is likely to play a leading role in the designation process.
7. Section 14(4) establishes that where there is suspicion that a death was wholly or partly caused by improper or negligent treatment on the part of a registered medical practitioner or other person, that person must not conduct or assist at the post-mortem examination, although they are entitled to be represented at such an examination.
8. Section 14(5) places a responsibility on the person who conducted the post-mortem examination to report the results of the examination to the coroner as soon as is practicable and in whatever form the coroner requires.
9. Section 15 allows the body to be moved for the purpose of an examination. The body may be removed to any suitable place for this purpose, and importantly, section 15(2) provides that this may be within the coroner's area of jurisdiction or elsewhere. The coroner is therefore no longer restricted to moving the body within his or her own or an adjoining area.

This is significant as it allows coroners far greater scope to access specialist forms of post-mortem examination.

10. Schedule 5 paragraph 1 contains powers enabling the coroner to summon witnesses and require evidence to be produced. Whilst not explicitly stated this includes medical witnesses, including pathologists, and evidence such as post-mortem examination reports.

### **The purpose of a coroner commissioned post-mortem in non-criminal cases and the way forward**

11. Consideration of the purpose of a coroner's post-mortem is both a practical and a theoretical point that has given rise to considerable debate not least in Parliament, particularly in the House of Lords, during the passage of the Act. This chapter gives effect to the undertakings given in debate that the Government would provide further opportunities for those with an interest to give their views as we develop secondary legislation and guidance.
12. At its most fundamental level, we believe that the purpose of the coroner's post-mortem examination is to provide the coroner with sufficient information to carry out his or her legal duty of establishing the cause of death, when it is unknown or uncertain, so a decision may be made as to whether an inquest is required or the death can be registered without an inquest. If an inquest is required, the post-mortem examination report is likely to be introduced as evidence at the hearing, and the person who conducted the examination and prepared the report will often be called as a witness.
13. However, some believe that coroners' post-mortem examinations should have additional purposes. In particular it is argued that – if carried out to a greater degree of accuracy - they can play a key role in preventing future deaths, particularly in identifying whether there is a specific underlying cause such as an inherited genetic defect that was responsible for the death and may be present in other family members, or may be passed on to future generations. They may also contend that this will help to inform the development of public health policy more generally.
14. As far as bereaved families are concerned, there are other factors to take into account. On the one hand, there might be a desire to know whether other family members may be at risk of a similar illness, so that treatment may be provided to prevent it. On the other hand, families' views may be governed by their religious beliefs. A number of faiths share similar views about interference with the body of someone who has died (and indeed some people of no religious faith have strong views on this subject too). Whether a person is a member of a particular faith or of none, however, a key factor for the Government remains that the views of the bereaved family should, as far as possible, be taken into account throughout a

coroner's investigation process, and this applies also to post-mortem examinations.

15. As well as the purpose of the post-mortem examination itself, there is also the question of the process for dealing with any tissue samples or organs removed during the course of the examination.
16. Following public inquiries into the practices at the Bristol and Alder Hey Hospitals in recent years (both reports were published in 2001) – and the Government is currently awaiting the report of a related inquiry into the way deaths of those who worked in the nuclear industry were dealt with - Parliament has made its position on this clear in the Human Tissue Act 2004. The policy in the Act is that if tissue is not held for the purposes of the coroner, or held as evidence under related legislation, then it may not be retained without the consent of the next of kin. If such consent has not been received within 3 months – and our view is that it should be within 3 months of the end of the conclusion of the coroner commissioned post-mortem examination being carried out - then any retained material, unless it is required for evidential purposes in related proceedings, should be destroyed.
17. However, the Government is also committed to ensuring that arrangements are made so that bereaved families are in a position to make an informed decision. As the draft Charter for Bereaved People, which was published in January 2009 when the Coroners and Justice Bill was presented to Parliament, sets out at paragraph 37:

“Sometimes, organs or tissues are retained for additional examination. In this instance, the coroner should reach advance agreement with the appropriate next of kin as to what should happen when they are no longer required for coroners' purposes. The coroner should convey the wishes of the next of kin to the relevant pathologist.”
18. Matters of cost are also relevant. The more detailed and complex the post-mortem examination procedure is, and the more information is expected from it, the more expensive it is likely to be.
19. These costs will usually have to be met by the local authority responsible for that particular coroner area.
20. Policy developments therefore need to strike a balance between the differing needs of different families, the coroner's statutory duty, and what is possible within existing funding.

**Matters currently dealt with in rules or case law – and what the Government intends to take forward, or not take forward, in the new secondary legislation**

21. There are a number of issues relating to post-mortem examinations that are currently dealt with in the Coroners Rules 1984. We include our initial thoughts on those issues here to allow respondents to have the fullest picture of our proposals on post-mortem examinations as a whole.
22. We propose that Rule 5 (on delay) is explicit within section 1(1) of the new Act, and is no longer required.
23. Matters dealt with at present under Rule 6 (the matters the coroner must consider before commissioning a post-mortem examination) are now partially dealt with in section 14 of the new Act. However, we propose to introduce regulations outlining the process by which the Chief Coroner may designate certain types of practitioner (who are not registered medical practitioners) as suitable for carrying out.
24. Rule 7 (on who should be notified about a post-mortem examination and who will have the right to attend or be represented) will be covered by a new regulation which, in turn, will be reflected in the final version of the Charter for Bereaved People. In addition, we envisage a regulation to be necessary to set out who may attend a post-mortem examination for training purposes.
25. Rule 8 (those who attend a post-mortem examination should not interfere with its conduct) is now partly covered under the Human Tissue Authority's (HTA) code of practice on post-mortem examinations with regard to issues of confidentiality (paragraph 40 of HTA Code of practice 3 on post-mortem examinations), but for the sake of completeness we propose it will be reflected in the new regulations.
26. Rules 9 and 9A (about the preservation of material removed during the course of a coroner post-mortem examination) sets out the respective duties of coroners and pathologists during the course of a coroner's investigation. We have set out elsewhere in this chapter how we intend to deal with this, and sought your views on it.
27. We consider that Rule 10 (on the format and contents of post-mortem examination reports) will need to be restated in the new regulations. At present it is not our intention to change the format of these reports and the information they contain. However, we would welcome views as to whether the present system works well or whether there could be improvements to the format and contents of these reports. It would remain our intention that the person conducting a post-mortem examination will not provide a copy

of his or her report to any person other than the coroner without the express authorisation of the coroner, as currently specified in rule 10(2).

28. Rule 11 (on the venue of a post-mortem examination) is now dealt with under Section 16 and Schedule 3 of the Human Tissue Act. Paragraphs 149 – 166 of the HTA's code of practice set out what the HTA expects in terms of compliance with its standards on Premises, Facilities and Equipment. We propose that the new regulations will make the appropriate cross reference for the sake of completeness.
29. Rules 12, 12A and 13 on 'special examinations' are no longer relevant as in the new system we will not be distinguishing between 'post-mortem examinations' and 'special examinations'. These rules will therefore not need to be replicated.

#### **The Human Tissue Act 2004**

30. Measures contained within the Human Tissue Act 2004 (and its underpinning codes of practice) are not affected by the new system except to the extent we have set out.
31. The exception to this, within the Act, was a minor amendment to section 43 of the Human Tissue Act to prevent any action being taken on a body in respect of preparation for organ donation – when there is reason to believe that it is a death which may be reported to a coroner - without the coroner's express consent. The HTA's code of practice on "Donation of solid organs for transplantation" provides good practice guidelines in these circumstances, and where local agreements between transplant teams and coroners do not exist, we would encourage them to be established.

#### **Release of the body of the person who has died**

32. Matters relating to jurisdiction over, and release of, the body will be clarified in the new regulations. At present there is no time limit within which the coroner must release the body to the family for burial or cremation. In the vast majority of cases this is not an issue, and the body will be released after a matter of days once initial investigations regarding the identification of the deceased and a post-mortem examination have been conducted.
33. However, there have been rare cases where the body has been retained for a very lengthy period – often in instances where criminal proceedings have been initiated, or are being considered, and where the defence legal team request additional post-mortem examinations as part of the construction of their defence. In one particular instance, we are aware that the body of a young child was not released for a funeral for approximately two years. Such delays in releasing the body can cause added grief to the

bereaved family and should be avoided wherever and whenever possible. To address this issue, it is our intention that in future regulations should state that, unless it is the family who request further examinations, the body should be released to them for a funeral after a maximum of 30 days from the date where the coroner assumed jurisdiction over the body (although, in practice, most bodies will be released far more quickly than this) unless the Chief Coroner rules otherwise.

**What new subjects will be contained in the new regulations? What would we like your views on?**

34. The following subjects are likely to be included in the new regulations, and we would appreciate the views of respondents as to what should be contained on these matters:

- Do respondents have any views as to the process for designating ‘practitioners of another description’ (i.e. those who are not registered medical practitioners) for the purposes of carrying out post-mortem examinations? Should such designations be done on an individual basis or by reference to the type of skill or qualification required? Should such designations have a time limit attached to them?
- Do respondents have any views as to what the format and contents of the post-mortem request and report forms should be, in future?
- It is the Government’s stated intention that bodies should be released to the family for burial / cremation after no more than 30 days, unless otherwise ordered by the Chief Coroner. In reality, the vast majority of bodies will be released more quickly than this and we are referring here to a small number of criminal cases where the body may provide important evidence about the offence, and the identity of the offender.
  - Do you agree that 30 days is a suitable timescale within which bodies must be released?
  - Will this timescale give enough time for any legitimate requests for second post-mortems to be commissioned?
  - Do you have any comments as to what would be the most effective way for the Chief Coroner’s agreement to the body being retained for a longer period to be obtained?
  - Should the Chief Coroner’s agreement be available only on application from the coroner?
  - Should other interested parties have the right to go directly to the Chief Coroner to apply for such an extension, or should all requests be made via the coroner?

**What will be contained in guidance issued by the Chief Coroner? What would we like your views on?**

35. We anticipate that the Chief Coroner will issue guidance on certain key issues relating to post mortem examinations. These may be consulted on in due course by the Chief Coroner, but we would welcome comments on the issues below to help to start the process.

- **When a post-mortem examination is required.** Even allowing for current inconsistencies in the recording of deaths reported to coroners, it is apparent that there are significant differences of approach between coroners on when a post-mortem examination is commissioned. The Government's view is that there are too many coroner post-mortems carried out – on about 22% of all deaths each year – but the challenge is to ensure that examinations are commissioned for the appropriate deaths. Do respondents have suggestions as to how this may be achieved?
- **The degree of accuracy required by a coroner's post-mortem examination.** Is the purpose to establish an approximate cause of death or should greater precision be required? Or should greater precision be required in certain types of death only, and if so, which types? Does it have a wider function in establishing trends in particular types of death and establishing, for example, genetic causes and links that may be of direct benefit to the deceased person's family (even to the extent of preventing future deaths) or the wider public? How far should the views of the family be taken into account or influence the decision?
- **Consultation with next of kin.** At present, coroners' post-mortem examinations do not require consent from the next of kin. This is enshrined in legislation by way of section 11 of the Human Tissue Act 2004, and will remain the case under the new system. However, we would contend that it would be matter of best practice to consult the next of kin wherever possible. However, at present the way coroners go about this consultation is not covered in any rules, regulations or guidance. This raises a number of questions. Should the procedure by which coroners consult be formalised in most circumstances? If so, and at the same time, should the next of kin be invited to consent to approving the retention of tissues, samples etc for medical research or other ancillary purposes? Who is best placed to do this? The coroner? The coroner's officer? An attending police officer or doctor?
- **When might a coroner wish to consider authorising a post-mortem examination to be carried out by a less invasive method?** This would include when to consider requesting a post-mortem examination conducted by a less invasive method such as an MRI or CT scan. Are there particular types of assumed deaths which are better suited to a less invasive examination? To what extent should the views of the bereaved family and their religious / cultural concerns be taken into account when deciding on the method of post-mortem examination to be commissioned?

**Summary of issues in this chapter on which we would welcome your views**

- **Q9: What do respondents consider to be the purpose of a coroner commissioned post-mortem examination? (paragraphs 11 to 20 and 35 bullet point 2)**
- **Q10: In addition to ensuring greater consistency in the commissioning of post-mortem examinations, how may the number of post-mortem examinations be reduced? (paragraph 35 bullet point 1)**
- **Q11: Should consultation with the relevant next of kin about the examination occur, as a matter of best practice, before the examination takes place (except in cases of suspected homicide)? (paragraph 35 bullet point 3)**
- **Q12: Where it has not been possible, for whatever reason, to consult with the next of kin prior to the examination, how should matters relating to tissue retention be dealt with? Does the current ‘3-month rule’ work in practice? Should the 3 months begin from the date of the conclusion of the examination? (paragraphs 16 to 17)**
- **Q13: When might a coroner wish to consider authorising a post-mortem examination to be carried out by a less invasive method? (paragraph 35 bullet point 4)**
- **Q14: Who might be designated as suitable to conduct post-mortem or related examinations if they are not registered medical practitioners? (paragraphs 6, 23 and 34 bullet point 1).**
- **Q15: Do respondents agree that, providing a body has been identified, 30 days should be the maximum time by which the body of someone who has died should be released for a funeral? (paragraphs 32, 33 and 34 bullet point 3).**
- **Q16: Do respondents have any views as to what the format and contents of the post-mortem request and report forms should be, in future? (paragraph 34 bullet point 2)**



## **Chapter 4: Coroner investigations – Entry, Search and Seizure**

### **Purpose**

1. This change will provide coroners with powers to access all relevant information to carry out their functions fully but proportionately in every case.
2. These powers are primarily intended for two purposes:
  - a) Deaths which are reported to coroners where they themselves conduct an investigation – for example hospital deaths where the cause of death is unnatural or unknown, or deaths from mesothelioma where the death is regarded as unnatural (because of exposure to asbestos).
  - b) Deaths which have been, or are being, investigated by another organisation – the police, the Health and Safety Executive, a transport investigation branch, the Prisons and Probation Ombudsman, the Independent Police Commission etc – and where, either on receipt of interim information from the organisation, or of the organisation’s final report, the coroner decides he or she wishes to secure further information to assist his or her own responsibilities.

### **What the current law provides**

3. Under the Coroners Act 1988, coroners do not have any power to enter and search premises or to seize evidence. Similarly, the Coroners Rules 1984 do not provide the coroner with these powers. In practice and in most circumstances, once police are present at the scene of a death – irrespective of whether they have had to make forcible entry to the premises – they have a responsibility to make their own assessment, which may involve the collection of evidence to enable them to determine whether a death is suspicious or unnatural.

### **What new policy is contained in the Act?**

4. The Act gives coroners new statutory powers to enter and search land or property and seize items which are relevant to their investigations. This is not intended to extend the number of cases which coroners are responsible directly for investigating or to cut across the roles of other investigators. Other than in the most exceptional circumstances, the powers are unlikely to be discharged by the coroner personally in the immediate aftermath of the death being discovered. They are primarily intended for situations either where the police have immediately eliminated the possibility of the death being suspicious but where the information they

have provided to the coroner leads him or her to request the police to seize specific items (or to direct a coroner's officer to do so) if the owner of the material is unable or unwilling to consent to the material being removed; or where a coroner has already received an investigator's report, and the coroner decides that further evidence is required in relation to the case. This could be in premises either where the death occurred, or where the body was discovered, or premises where the coroner believes there is material relevant to the death.

### **Interaction between coroners' investigations and other investigations**

5. It has never been intended to set up alternative and parallel coroners' investigations when other organisations already have a duty to investigate a death, and nor is it intended that coroners should manage such investigations or be able to intervene directly in how such investigations are conducted. As such, protocols will need to be established between coroners and these organisations so that coroners, with appropriate permission from the Chief Coroner, secure the material they need for their own purposes, particularly to ensure that, where appropriate, a subsequent inquest is Article 2 compliant. Such protocols will also need to be developed, or confirmed where they already exist, for other scenarios where investigatory responsibilities could overlap.
6. Much of the Parliamentary debate focused on whether these new powers could be used to seize material from the scene of a death in its immediate aftermath and, if so, whose responsibility this would be and how they would be authorised. In our view, it is most likely that the police are the first persons in authority to attend an unexpected or suspicious death in the community – whether it is as a result of, for example, a road traffic incident, a fire, an apparent suicide or the misuse of drugs - for the purposes of establishing whether a criminal offence has taken place. In the event of a sudden death in the home or in the community from non-suspicious physical causes, where the ambulance service may be first on the scene, the ambulance service may ask the police to attend if they make an assessment that they cannot be certain that there are no suspicions attached to the death, or if the police are needed for public order reasons.
7. However, there may be some circumstances when the police or the ambulance service attend a death "at home" and more or less immediately establish that it is not suspicious. After consulting the deceased person's GP, they may then contact the coroner because they believe the case may come within his or her jurisdiction because the cause of death cannot be certified. In those circumstances, we believe that, providing there are other occupiers of the premises, and that they are available to give consent, it is likely that consent to the removal of items by the police, on the coroner's

behalf, would be given. However, if consent was not given or was not available, then the coroner could be alerted and authorisation could be arranged quickly either from the Chief Coroner or from a nominated senior coroner.

8. However, in a situation where (i) a warrant is not needed because the occupier agrees to hand over items, but (ii) attending police are reluctant to take items on the coroner's behalf and (iii) the coroner considers evidence might be compromised unless taken immediately, the coroner or his/her officer would have the option to attend the premises themselves. This is the type of scenario that could be included in protocols between police, coroners and others so that investigative resources are used effectively.
9. In parallel to these powers, there are also new powers in paragraph 1 of Schedule 5 to the Act which enable a senior coroner to issue a notice requiring a person to produce documents or to produce any *thing* for examination. A person who fails to comply can be fined up to £1000 by the coroner. It is an offence to distort or alter evidence or documents, or to prevent it being given or produced for the purposes of an inquest. It is also an offence to suppress or conceal a document that a person knows is relevant or to intentionally alter or destroy such a document. These powers and the related sanctions are not currently available to coroners and will assist them in obtaining relevant evidence.

### **New regulations**

10. We propose that the new procedure for search and entry will mirror, where possible and appropriate, ***sections 15 and 16 of the Police and Criminal Evidence Act 1984, regarding safeguards and execution***. This is permitted under section 43 (3)(h) of the Act and will ensure that entry and search are carried out in a manner which is subject to protections similar to those contained in PACE. Within this overarching principle, the possible subject matter of the regulations for '**Entry and Search**' could include the following:
  - **Procedure and prescribed format for approaching the Chief Coroner for permission to conduct an entry and search of relevant premises (including permission to seize items)**. We anticipate that in normal circumstances the coroner would have to set out in writing on a prescribed form (which may be produced and transmitted electronically), to be sent to the Chief Coroner (or a nominated delegate), an application outlining the premises he or she wishes to gain entry to, the identity of the person in occupation, the investigation it relates to, the reason for requiring the power to force entry to premises for the purposes of search and seizure, the identity, so far as possible, of the articles or persons to be sought, and the

timescale within which a response is required. In non-urgent cases we would anticipate a turn round time for such requests of between 48 hours and 5 days would be appropriate. However, in cases of real urgency, and as agreed by Parliament, we propose that the coroner may request permission over the telephone.

- **Procedure and prescribed format for the Chief Coroner (or a nominated delegate) to make his or her decision known.** The outcome of the decision (including any reasons why a request had been declined) would have to be set out in writing on a prescribed form (which may be produced and transmitted electronically), to be sent to the coroner who made the application. This would be the case even when authority to use these powers was sought and granted over the telephone. In those circumstances, a hard copy record would need to be completed for audit trail purposes. There will be an additional requirement that the Chief Coroner (or his or her nominee) must maintain a record of why they agreed the authorisation, with the details of all such authorisations to be summarised in the Chief Coroner's annual report. Where a written authorisation is provided, a copy should be shown to the householder or landowner when entry is being effected.
- **Procedure for the Chief Coroner to nominate a senior coroner to authorise entry, search, and seizure.** We would anticipate that, to ensure a 24 hour service, 365 days a year, the Chief Coroner would give written authorisation to a small number of experienced senior coroners - following an "expressions of interest" process to take on the responsibility - delegating them to carry out this function on his or her behalf when he or she is unavailable to discharge it. The intention is that they would receive a small additional fee for carrying out this work. As we propose that urgent applications may be made over the telephone, we do not consider it necessary to allocate a number of delegated coroners to cover certain geographical areas. However, given that certain sensitive documents may need to be transmitted electronically as part of this process, as part of new IT arrangements all coroners should be attached to a secure network to enable safe transmission.
- **The period of notice that needs to be given to the property owner before search and entry can take place – if any.** We would anticipate that in normal circumstances (i.e. when entry and search are not being conducted at the scene of death at the time the death has occurred or is discovered) a reasonable period of notice could be given to landowners and occupiers before the coroner carries out entry and search of premises and seizure of items. We would suggest a period of 48 hours notice would be sufficient. However, in situations where the Chief Coroner has given approval for the power to be exercised without notice due to the very strong risk of concealment, loss, damage, alteration or destruction of evidence (as outlined in paragraph 3(3) of Schedule 5), no notice will be required. This exemption might also apply to scene of death entry and search so as to ensure the appropriate use of police or other resources.

- **Delegation of the powers of entry, search and seizure.** It is not anticipated that coroners will carry out the actual physical activity of entry, search and seizure personally in the majority of cases. Instead, coroners will be able to delegate these functions under provisions to be made under the regulation making powers contained at section 43(3)(c). We would anticipate that on the whole these functions would be delegated to coroners' officers or police officers.
- **The process for carrying out entry, search and seizure.** We propose that the procedures for carrying out the entry to and search of premises and the seizure of items should be equivalent, wherever possible, to those processes and procedures contained in sections 15, 16 and 21 of the Police and Criminal Evidence Act 1984. This would mean, for example, that the Chief Coroner's permission to conduct an entry and search would only permit a single entry and search (i.e. not repeated entries and searches); that entry and search must be conducted at a reasonable time of the day unless it appears that the purpose of the search would be frustrated by delaying the search; and that the search may only be conducted to the extent required for the purposes of the coroner's investigation. We also propose that regulations will clarify that other persons may accompany the coroner (or his or her delegate) to enable them to carry out their lawful entry, search and seizure unhindered and to the best of their ability.

11. We propose that the new procedure for seizure will mirror, where possible and appropriate **section 21 of the Police and Criminal Evidence Act 1984 regarding seizure**. This is permitted under section 43 (3)(i) and will ensure that seizure is carried out in a manner which is subject to protections similar to those contained in PACE. Within this overarching principle, the possible subject matter of the regulations for '**Seizure**' could include the following:

- **Procedures as to how seizure of items should take place, including a period of notice that seizure is to take place (if any).** We would anticipate that seizure could take place at any time of the day, without notice or consent, and if necessary without the owner being present. We propose that the regulations will include, as detailed above, references to the notice periods that need to be given before entry can take place, how that notice is to be given, the forms that should be used, the process by which notice is served, who notice needs to be served upon, and so on. It is anticipated, however, that once entry has been effected, no further period of notice should need to be given before seizure can take place – the coroner (or his or her delegate) would merely have to inform the owner of the goods that they have been seized, and the reason for that seizure. In the case of documents or computer files, however, the owner will be given opportunity to make copies before the items are removed from the premises.

- **Who the coroner may take with him or her onto the premises to assist with the removal of goods seized.** We would anticipate that the coroner (or, more usually, his or her delegate) should be empowered to take onto the premises any person they think necessary to ensure the goods are seized and removed promptly and effectively. This may include, for example, locksmiths and removal people, but may also require certain specialists if the items are valuable, fragile, or are for example computer records that require downloading or documentary records that require photocopying. We would certainly not expect coroners or their officers to carry out such specialist tasks without assistance – we accept that neither coroners nor their officers will necessarily be experts in forcing locks, removing fragile goods or downloading files from complex computer systems.
- **Prescribed format of an inventory of goods seized to be left with the owner of the goods/property concerned.** The inventory should be contained on a prescribed form, and should be signed either by the coroner or his or her delegate – if the owner of the goods seized is present, then ideally they should sign it too – although refusal to sign should not be allowed to prevent the removal. If the owner is not present or refuses to sign, the inventory should be left in a prominent position within the property in a sealed envelope.
- **Procedures for taking copies of documents.** We would anticipate that procedures should exist not only for taking copies of documents on site, but also for the temporary removal of documents for copying and subsequent return if necessary. Once a seized or copied document has been put before the inquest as an exhibit it will become subject to provisions on making documents available to interested persons, and copies can therefore be provided to interested persons, as outlined in Chapter 5 on disclosure.
- **Procedures for downloading or removing information held in an electronic format.** We would anticipate that all such activity would be performed in a way that does not corrupt the information or cause damage to hardware or software. Similarly, owners should be allowed to download files onto disks to enable them to be used on another computer if it is the computer hardware itself that needs to be seized.
- **Procedures for returning seized items.** This would include not only the processes for returning seized items that have been used as evidence to their original owner, but also procedures for disposing of items the ownership of which is unknown, the ownership of which is illegal or which the owners do not wish to have returned to them for whatever reason. Disputes as to the ownership of an item seized as evidence are not for the coroner to decide upon and should be resolved via other legal channels

### **What are the estimated resource implications?**

12. This depends on how often these powers are used and whether they are carried out by, or in conjunction with, police or other law enforcement officers or removal specialists. It is not anticipated they will be widely used (we estimate no more than 10 to 15 applications per area per year), and therefore we do not think that there will be significant resource implications for coroners and those who fund the coroner system.
13. It is expected that this function will in the main be conducted by coroners' officers when coroners themselves are responsible directly for conducting an investigation. Many coroners' officers are retired or serving police officers and would have received suitable training to enable them to carry out such work, and this is likely to continue under the Act. Those who are not retired or serving police officers may require some training, however.
14. If coroners' officers do this work, it will form part of their regular duties, although there may be cost implications if the use of specialists such as locksmiths or specialist removal and storage companies is required for certain large, delicate or perishable objects. We propose that regulations will allow coroners to delegate this function to other persons also. This is to allow for the fact that, in certain cases, computer experts or other forensic specialists may be required to help seize evidence of a digital and IT nature. We would therefore appreciate views as to whether it would be appropriate for coroners to delegate to coroners' officers, the police or other officials the power to carry out this function on their behalf.

### **Summary of issues in this chapter on which we would welcome your views**

- **Q17: Who do coroners envisage carrying out these functions on their behalf? Do coroners envisage delegating this task to coroners' officers, the police, or someone else entirely? Who do other consultees feel should carry out this task on behalf of the coroner? Who do you think would be suitable qualified to carry out this task on behalf of coroners? (paragraph 14)**
- **Q18: Should the person entering, searching and seizing have in their possession, in every circumstance, some form of documentation stating their authority to be on the land or premises and to remove items and documents? (paragraph 10 bullet point 6)**
- **Q19: We propose that the procedure for obtaining permission to carry out a search, and the process for carrying out search and seizure, should, where possible, mirror the process used by the police in accordance with the Police and Criminal Evidence Act 1984. This could be achieved by way of a code of practice, as was**

**proposed during Parliamentary debates on this issue. Do you consider this approach is appropriate? (paragraphs 10 and 11)**

- **Q20: Do you have views on the other aspects of the proposed procedure for entry search and seizure set out in Chapter 4?**
- **Q21: In normal circumstances, should some form of notice be given to the landowner / occupier that entry, search and seizure is to be undertaken? Is 48 hours a suitable period of notice? (paragraph 10)**



## Chapter 5: Disclosure of information by coroners

### Purpose

1. One of the Government's reforms' key aims is to improve the standing and involvement of bereaved families in investigations. A significant way of achieving this is to ensure they have the opportunity to access the material which the coroner will be taking into account in coming to his or her decisions. When we were preparing the Bill for Parliament, we often heard complaints from families that they would turn up for an inquest with few or no papers for them to consider in advance, whereas official bodies would have files of material which appeared to be relevant to the matters being discussed. It is this perceived imbalance which we seek to address in a reformed system.
2. The main principles of a disclosure regime for the coroner system are set out in the draft Charter for Bereaved People. Paragraph 19 states that family members will, "Have a right, on request, to see reports of any post-mortem examinations carried out." Paragraph 25 says that, "Disclosure of all relevant documents to be used in an inquest will take place, on request, free of charge and in advance of an inquest, to those family members whom the coroner has determined have an interest in the investigation." However paragraph 26 qualifies this: "It is possible, for legal reasons, that not all documents that the coroner intends to use at an inquest will be able to be disclosed, or disclosed in full." The draft Charter's approach was endorsed by Parliament.
3. It is important to stress that such an approach is not intended to change the inquisitorial nature of a coroner's function, or to increase the need for families to be represented by lawyers. Under the Act, coroner investigations remain non-adversarial. Unlike criminal trials, they are fact-finding inquiries which can attribute responsibility but cannot apportion blame. This was emphasised by the Government during the passage of the Act through Parliament. Subject to the slight increase in the number of cases where legal aid will be considered automatically as a result of Section 51 of the Act, we expect the vast majority of inquests to continue to take place without lawyers present. Where lawyers are involved, they will have the same rights of access as interested persons to material that the coroner determines is relevant, and is not subject to privilege.
4. Additionally, although the Charter mentions only family members who are interested persons to an investigation, we need to ensure that in attempting to provide them with greater opportunities for disclosure, we are

not setting up a system which overlooks the rights of other interested persons.

5. The purpose of this chapter, therefore, is to gather respondents' views on the new disclosure regime to help us decide what should be contained in secondary legislation and what should be contained in guidance.
6. In our view, secondary legislation or guidance needs to cover the following matters:
  - Clarity about what may or may not be disclosed and when.
  - Ensuring consistency of approach in disclosure practices between coroners.
  - Ensuring that all interested persons, whether family members or not, have a right to request information.
  - Factoring in all relevant legislation and case law as it applies to organisations whose reports may be considered for disclosure by a coroner.
  - The resources needed to disclose information.
7. Increased disclosure must be matched against the coroner's need to:
  - Ensure that an investigation is not prejudiced by disclosure of information that is too early or too widespread.
  - Ensure that an investigation does not prejudice other proceedings.
  - Ensure that material subject to legal privilege, a public interest immunity certificate or any other legal restriction –such as copyright or data protection - is not disclosed.
  - Ensure that information which could endanger third parties is not disclosed.
  - Give careful consideration to the sensitivities of a bereaved family by warning them that they may find certain information distressing.
  - Ensure that other interested persons to a particular investigation have the opportunity for material to be disclosed to them if a family requests disclosure.
  - Ensure that only information which is relevant to the investigation is disclosed.
8. 'Information' in this chapter refers to items such as post mortem reports, witness statements, investigation reports and other documents relevant to an inquest.

9. Disclosure regarding those rare investigations to be held alternatively as an inquiry under the Inquiries Act 2005 will be dealt with under the terms of that Act, and is therefore not covered in this consultation.

#### **What the current law provides for**

10. Rule 57 of the Coroners Rules 1984 requires a coroner, on the application of a properly interested person and on payment of a prescribed fee, to supply to them a copy of any report of a post-mortem examination, a related special examination, certain notifications, any notes of evidence, or of any document put in evidence at an inquest. A coroner may also, on application and without charge, permit any properly interested person to inspect such documents.
11. Regarding deaths where the state is implicated, including deaths in state custody, the European Court of Human Rights (ECtHR) has criticised coroners' current lack of advance disclosure of witness statements as failing to comply with the procedural obligation under Article 2 (the right to life). In 2001 an ECtHR judge said that this obligation should also extend to non Article 2 cases<sup>6</sup>.
12. In order to address more general legal issues such as document ownership and copyright, coroners may obtain written consents to disclosure where they believe an investigation would be aided by making statements and reports available. They may also issue conditions or restrictions when supplying documents to ensure that disclosure will not, for instance, lead to intimidation of a witness, or a media or other campaign that may prejudice an investigation.
13. We believe that it is clear that there is an increasing move towards disclosure of documents wherever possible, and our secondary legislation and guidance will aim to be consistent with, and build on, that in a fair and proportionate way.
14. In terms of payments which coroners may charge, the Coroners' Records (Fees for Copies) Rules 2002<sup>7</sup> provide for a charge of £1.10 for each photocopied page they provide; and, for other types of documents, £6.20 for a copy of up to 360 words, £13.10 for between 361 and 1440 words, and for larger documents, £13.10 for the first 1440 words and thereafter 70p for each 72 words or part thereof.

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<sup>6</sup> Jervis on Coroners (2002), section 10-46

<sup>7</sup> [www.opsi.gov.uk/SI/si2002/20022401.htm](http://www.opsi.gov.uk/SI/si2002/20022401.htm)

**Policy on disclosure that is contained within the Coroners and Justice Act 2009 (including regulation and rule-making powers)**

15. The Coroners and Justice Act 2009 provides for regulations and rules to be made regarding disclosure of information to and by coroners, during the course of an investigation.
16. Section 43(3)(d) provides that regulations concerning investigations, other than in relation to inquests may make provision allowing information to be disclosed or requiring information to be given. Section 45(2)(g) provides that rules concerning the practice and procedure of inquests and appeals may make provision with respect to the disclosure of information.
17. Fees payable to coroners for supplying copies of documents in their custody relating to investigations or inquests that they are conducting or have conducted may also continue to be prescribed (Schedule 7, paragraph 8).

General principle for disclosure to interested persons

18. An interested person may request disclosure of a document at any time. We anticipate that requests are most likely following a post mortem examination, following a coroner's decision to conduct an inquest, and following the conclusion of an investigation. In addition, the draft Charter for Bereaved People sets out that a coroner's office should normally update bereaved people on the progress of an investigation at least every three months. It is possible that such contact may prompt a request for documents to be disclosed. This chapter seeks views on the timescale in which coroners' offices should respond to a request, and whether there should be a deadline for requests to be made.
19. Our general principle is that coroners should disclose information, on request, to interested persons. This would be consistent with:
  - The draft Charter for Bereaved People (provided for in section 42 of the Act). This says that usually all relevant documents for an inquest should be disclosed on request in advance of an inquest to those family members whom the coroner has determined have an interest in the investigation.
  - The new appeals system (section 40), under which interested persons may appeal against certain coroner decisions. If coroners disclose information this will help to ensure that any interested person has the material they need in order to consider whether to appeal a coroner decision at the relevant point in the investigation.
  - Investigations into deaths where Article 2 of the European Convention on Human Rights (ECHR) is engaged. A general principle of disclosure will be consistent with the procedural obligation under Article 2 of the ECHR.

20. This general principle would also meet recommendation 42 of the Macpherson Report on the Stephen Lawrence Inquiry (1999), which stated:

*42. That there should be advance disclosure of evidence and documents as of right to parties who have leave from a coroner to appear at an inquest.*

### **Exceptions to the general principle**

21. There will be exceptions to the general principle of disclosure. The draft Charter says that it is possible, for legal reasons, that not all documents that the coroner intends to use at an inquest will be able to be disclosed, or disclosed in full. In such cases, on request, the coroner will explain the reasons why he or she has not disclosed a particular document, or part of a document. This could relate to information that is subject to legal privilege or public interest immunity.
22. We also do not propose that interested persons should have all disclosable material provided to them automatically, or that if one interested person requests disclosure it should be automatically sent to all others. The key point is that they should be made aware that they are entitled to request the information. It will be a matter for them as to whether they make the request, including in relation to assisting with an appeal application.
23. In addition we need to recognise that a substantial amount of material that may be subject to disclosure is provided to the coroner from other organisations, such as (but not exclusively):
- The police.
  - The Independent Police Complaints Commission.
  - Health and Safety Executive.
  - Prison and Probation Ombudsman.
  - Ministry of Defence Service Inquiries.
  - Marine, Air and Rail Accident Investigation Branches.
24. These organisations have their own disclosure policy and practice which coroners will need to take account of when providing disclosure to interested persons to their own investigations. While ideally practice would be consistent across these organisations, in reality it may not be consistent and we ask respondents to this consultation to take this into account. We also request respondents to recognise that it is beyond the scope of the coroner reform process to change the disclosure practice of other organisations.

### **Coroners charging for disclosure of information to interested persons**

25. Secondary legislation should be consistent with the draft Charter for Bereaved People which states at paragraph 25 that:

*Disclosure of all relevant documents to be used in an inquest will take place, on request, free of charge and in advance of an inquest, to those family members whom the coroner has determined have an interest in the investigation.*

26. However regulations may give the coroner the power to charge other interested persons for disclosure of documents, before and after an inquest.

**Bearing these principles in mind we should be grateful for your views on the questions set out at the end of this chapter.**

### **Resource implications**

27. We are conscious that that there will be extra costs to coroners and their officers and other staff, both in terms of time taken to copy documents and distribute them, and in terms of physical resources such as copiers, paper and postage.
28. In order to quantify this we should be grateful for respondents' views on the questions below.
29. However we believe that the Chief Coroner's likely dissemination of best practice and national standards, on matters such as record-keeping, will identify opportunities for efficiencies. In addition efficiencies throughout the system will allow resources to be re-directed to this area. Alternatively, if the fee for disclosure is set at a suitable level, it may enable the system to be self funding.

Summary of issues in this chapter on which we would welcome your views

#### General principles

- **Q22: Do you agree that we have captured the right principles and struck a proper balance between those which compete?**
- **Q23: Should we permit requests to be made at any stage in a coroner's investigation? If so how long should coroners be given to respond to requests, in order to not delay investigations, but to provide them with workable timescales?**

#### Impact of free disclosure of information to bereaved people

- **Q24: What do you expect the level of take-up to be of the Charter for Bereaved People's provision for information to be disclosed to bereaved people, free of charge? How would it compare to current requests?**
- **Q25: Are there any circumstances where bereaved people should pay for disclosure of material?**
- **Q26: What would the impact be on coroners and their staff of disclosing information free of charge, to bereaved people and possibly to other interested persons? What would the costs be and how would those costs be comprised?**

#### Disclosure to other interested persons

- **Q27: We do not propose that interested persons should have all disclosable material provided to them automatically, or that if one interested person requests disclosure it should be automatically sent to all others. We propose instead that they should be made aware firstly that they are entitled to request the information, and secondly that they are made aware of requests for disclosure made by other interested persons to the case. Do you agree with this approach? If not, please suggest an alternative.**
- **Q28: What level of requests for information from other interested persons would you expect to see, and why?**
- **Q29: How common is charging for disclosure in practice at present? Should we specify the circumstances in which a coroner can charge?**
- **Q30: What levels of fees should be payable?**
- **Q31: To whom should the fee be paid? If paid to a coroner's office, should the fee be passed on to the relevant local authority?**

- **Q32: Once an investigation is completed, should we specify a time limit for obligation for requests to a coroner to disclose information – e.g. 6 months/a year after the conclusion of the investigation – so that, after a certain period, a coroner will have discretion to refuse a request for information?**



## Chapter 6: The conduct of the inquest

### Purpose

1. In this chapter we seek respondents' views on some of the policy which will inform the secondary legislation in relation to the most public aspect of the coroner's role – the conduct of an inquest.
2. The main purposes of the changes we are proposing are:
  - To ensure that inquests are carried out where necessary and ascertain the facts required about the death in question.
  - To ensure that inquests are carried out without avoidable delay so that families can grieve for their loss in private knowing that there are no further public proceedings for them to face.
  - To ensure that coroners have access to all necessary evidence and witnesses to enable them to fulfil the purposes of the inquest and answer, as fully as possible, the questions which families have.
  - For those inquests that require a jury or a number of witnesses, to ensure that mechanisms exist to enable a jury to be summoned and sworn in; and that witnesses are summoned and attend at an appropriate time and place, and are able to give the best evidence possible.
  - To ensure that coroners make reports to prevent future deaths whenever appropriate.
  - To ensure that the determinations (formerly known as verdicts) available to coroners (or juries) are the correct ones.
3. Policy relating to the disclosure of reports or other documents relating to inquests is dealt with in the previous chapter on disclosure.

### Where the current law is to be found

4. The current law on the conduct of inquests is largely contained within the Coroners Act 1988 and the Coroners Rules 1984.

### *Policy on the conduct of inquests that is contained within the Act 2009*

5. Section 6 of the 2009 Act places a duty upon the coroner to hold an inquest into a death as part of the investigation into any death he or she is investigating. This duty is qualified, however, by section 4(3)(a), which states that in cases where the investigation is discontinued as a result of the cause of death being adequately revealed by way of a post-mortem examination, no inquest is to take place.

6. The matters that the coroner (or jury in cases where a jury is sitting) must ascertain are at section 5. Under section 5(1), the coroner or jury should ascertain the identity of the deceased; how, where and when the deceased person came about their death; and any other particulars required to enable the death to be registered in accordance with the requirements of the Births and Deaths Registration Act 1953. Section 5(2) further clarifies that in cases that engage Article 2 ECHR, ‘how’ a person came about their death includes the circumstances leading up to and surrounding their death. The determinations and findings that are to be made as the outcome of any investigation, including those investigations where an inquest is required, are outlined in section 10.
7. As we have set out earlier, neither the coroner nor the jury may express any opinion on any other matter apart from those they are required to establish. Additionally, section 10(2) makes clear that the inquest’s conclusions must not be framed in such a way as to appear to determine any question of civil or criminal legal liability. While this is sometimes a fine line to tread when determining “how” someone died, many coroners are adept at keeping on the right side of such a line. This is likely to be a matter which is included in training for new coroners, as set out in chapter 8.
8. An inquest into a death must be held without a jury unless the coroner thinks there is sufficient reason for doing so or section 7(2) of the Act applies. Under section 7(2), an inquest must be held with a jury if the death occurred whilst the deceased person was in custody or some other form of state detention, and was a violent or unnatural death or a death of unknown cause; if the death resulted from the act or omission of a police officer or service police officer in the purported execution of their duty; or if the death was caused by a notifiable accident, poisoning or disease. The coroner’s discretionary power to call a jury when he or she thinks there is sufficient reason for doing so is contained at section 7(3). The number of jurors required to make up a jury is 7-11 persons (section 8(1)). A senior coroner has power to summon persons to attend as jurors (section 8(2)) and to punish jurors for non-appearance or misconduct (Part 1 of Schedule 6).
9. A coroner’s powers to summon and examine witnesses and to require evidence to be produced for the inquest are contained in paragraph 1 of Schedule 5; and the offences in relation to persons who fail to attend as witnesses or produce evidence are contained in part 2 of Schedule 6.
10. Persons who are to be regarded as ‘interested persons’ in any investigation, and therefore also for any inquest that forms part of that investigation, are listed at section 47 of the Act.

11. Senior coroners must make reports to organisations which have the power to prevent future deaths (paragraph 7 of Schedule 5). Section 36(4)(d) requires the Chief Coroner to provide a summary of these reports, and responses to them, in his or her annual report to the Lord Chancellor. We consulted extensively on this power when revising Rule 43 of the Coroners Rules 1984 in 2008, and we are not therefore inviting further comments at this stage.
12. In addition, there is power in the Act to make rules regulating the practice and procedure at or in connection with inquests (section 45). These may include rules on the provision of evidence at inquests (section 45(2)(a)); the power to make rules relating to the adjournment or resumption of inquests (section 45(2)(d)); directions by the coroner that a name or other matter is not to be disclosed at the inquest other than to those persons specified in the direction (section 45(2)(e)); directions by the coroner excluding specified persons from all or part of an inquest in the interests of national security (section 45(3)(a)); and directions by the coroner to excluding specified persons from an inquest when a child is giving evidence if the coroner is of the opinion that doing so will improve the quality of the witness's evidence (section 45(3)(b)).
13. Regulations prescribing the allowances, fees and expenses that may be paid to witnesses and jurors will be made under powers contained within Schedule 7.

#### **What might the new Rules in relation to inquests contain?**

##### ***Items currently contained within the rules that we wish to amend or expand and on which we would like your views are as follows:***

14. Rule 16 of the Coroners Rules 1984 currently provides for the formal **opening**, adjournment and closing of an inquest. We would argue that this is now largely an anomaly as coroners will, in a reformed system, be opening investigations rather than inquests, and will not have a requirement to open investigations in court.
15. Matters relating to the identification of the person who has died and to certification of the death can be dealt with at that stage and in an appropriate environment. However, when coroners have decided that a death needs to go on to inquest – in some cases because of the already known circumstances of the death, in others because of the outcome of a post-mortem examination – there may be grounds for an inquest to be opened formally, even if the inquest is then immediately adjourned and the full hearing does not take place until some time in the future. We would welcome respondents' comments as to whether such a provision should be retained within the rules.

16. With regard to **evidence**, we propose that there should be provision similar to rules 37 and 37A on the admissibility of documentary evidence and public inquiry findings. Under the current rule 37, the coroner may admit as evidence at the inquest documentary evidence which he or she considers relevant and which in his or her opinion is unlikely to be disputed, unless a person from a defined group (broadly equating to ‘interested persons’ in the new Act) objects to it being admitted. The coroner may also accept such documentary evidence, even if it is objected to, if in his or her opinion the maker of the document would be unable to give oral evidence within a reasonable timescale. Documents made by persons who are now deceased may be admitted if the coroner thinks they are relevant. Documentary evidence is to be read aloud as part of the inquest proceedings unless the coroner directs otherwise. Rule 37A provides for public inquiry findings to be admitted as documentary evidence in instances where an inquest has been resumed following an adjournment due to the establishment of an inquiry under the Inquiries Act 2005 into matters relating to the death in question.
17. We are aware, however, that there have been critical comments from members of the senior judiciary, with experience of conducting inquests, that rule 37 is unduly complicated, and although intended to make the admission of documentary evidence more flexible it has in fact had the opposite effect. We would therefore be interested in views as to whether these rules should be extended or clarified, and if so, what would be the best way to achieve this.
18. In relation to the **retention and return of exhibits**, documents and personal effects of the deceased at the conclusion of the inquest, the current position is that an exhibit may be retained by the coroner until he or she is satisfied that it is not required for the purposes of any other legal proceeding (rule 55). Once the coroner is satisfied that the item may be released, it may be returned either to the owner or, in the case of exhibits that previously belonged to the deceased, the next of kin. If the next of kin has indicated that they do not wish items to be returned, the coroner may arrange for the items to be destroyed or disposed of. Any documents, other than exhibits, are to be retained by the coroner for a minimum of 15 years, unless the court directs otherwise (rule 56). The coroner may choose to keep copies of documents that are exhibits and return the original document to its proper owner if he or she feels it is appropriate to do so.
19. The position with regard to retention of exhibits and documents in particular is worth comparing with the position regarding such evidence in criminal trials. At present, codes of practice are issued under the Criminal Procedure and Investigations Act 1996 with regard to the retention of evidence after criminal trials (for example, for the purposes of appeals).

This would include any medical records, post-mortem reports, samples, etc that formed part of the evidence at a trial. Under the current national code of practice, such evidence is to be retained for a period of at least six months from the date of conviction (although we are aware that some police forces adopt local practices which recommend longer retention periods – in some cases up to 3 years or more), although if an appeal is in progress when the six month period expires, all material is to be retained until the appeal is determined.

20. We would welcome comments as to whether there is an argument for retaining, increasing or reducing the requirement for documents to be kept for 15 years as is the case at present, particularly in view of the new appeal arrangements against coroners' decisions which the Act establishes.

***New items we intend will be contained in the new rules and on which we would like your views are as follows:***

*“Short form verdicts” and “narrative verdicts”*

21. At present, the “verdict” is that part of the “inquisition” (the “inquisition” is the formal record of the inquest) that contains the conclusions of the coroner or jury as to the death in question. The 2009 Act abolishes references to “inquisitions” and “verdicts” largely because these terms are considered more appropriate to adversarial proceedings and can lead to misconceptions about what an inquest may achieve. Instead, under the Act, the coroner will make a “determination” in respect of questions about the identity of the deceased and how, when and where they came by their death; and “findings” in respect of matters that need to be ascertained to enable a death to be registered (section 10 of the Act). We ask below further questions about the current form of verdicts, including what are currently known as “short form verdicts” and “narrative verdicts”, available to coroners and juries and what might be appropriate for the new system of “determinations” and “findings”<sup>8</sup>.

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<sup>8</sup> “Short form verdicts” are those verdicts which fit into one of a series of established categories as laid out on the inquisition form – Form 22 – contained within schedule 4 of the Coroners Rules 1984. “Narrative verdicts” are those which do not rely upon or fit into the categories laid down in Form 22 but where the coroner or jury rely on a written ‘narrative’ to express their conclusions as to the cause of death.

22. The most widely used common ‘short form verdicts’ of those currently available to coroners and juries are as follows:

- Natural causes.
- Accidental death.
- Misadventure.
- Suicide.
- Industrial disease.
- Dependence on drugs.
- Non-dependent abuse of drugs.

23. Other, less common ‘short form verdicts’ currently available to coroners and juries include:

- Stillbirth.
- Want of attention at birth.
- Lawful killing.
- Unlawful killing.

24. In addition, the options of ‘open verdicts’ and ‘narrative verdicts’ are also currently available.

25. This can lead to misunderstanding and inconsistencies. It can also make it difficult for statisticians to keep accurate records of the different types of death coroners are dealing with over a period of time, making it harder to identify trends in mortality statistics than would otherwise be the case. Such data can be important in identifying requirements regarding, for example, health care, social care, and the need for measures to tackle certain areas of deprivation.

26. The Coroner for Surrey and for the Queen’s Household, Michael Burgess OBE, has suggested a number of other short form verdicts which coroners may consider using. They are:

- Died from an unforeseen complication of a necessary therapeutic procedure.
- Died from an overdose of drugs either self administered or administered by another.
- Died from injuries received in the course of a road traffic collision.
- Died from trauma following an unwitnessed fall.
- Died from trauma consistent with or following a fall whilst suffering from severe natural disease.

- Died from self-inflicted injuries but the intention of the deceased was unclear.
27. Respondents are therefore asked for their views as to whether a pro-forma for determinations should be included in the new rules, including a list of categories of causes of death; and if so, what those categories should be.
28. Should coroners be required to return a narrative determination in any case where they are unable to attribute one of these determinations? This would mean an end to “open” verdicts, currently returned in about 7 % of inquests each year, and which most families regard as profoundly unsatisfactory in reflecting the cause of their loved one’s death.

### **Narrative determinations**

29. The problems inherent in the ‘short form verdict’ system have led, in recent years, to a move towards the greater use of ‘narrative verdicts’. It is estimated that ‘narrative verdicts’ are now returned in approximately 10% of cases. As the law stands, there is no reason why the coroner or jury could not continue to use a narrative determination whenever they feel the situation merits it.
30. In cases which engage Article 2 ECHR, in light of the ruling in *Middleton*<sup>9</sup>, coroners are more aware of the options open to them, including the option of a narrative determination if that would enable them to better describe the circumstances of the death. It is anticipated that the Chief Coroner may consider issuing guidance on the circumstances in which a narrative determination would be considered appropriate.
31. We are also concerned that mortality statistics are not skewed as a result of narrative determinations being made. One option, and for statistical purposes only, is for the coroner (including in jury cases) to complete a related form which provides the nearest equivalent short form determination.
32. We would welcome comments from respondents as to whether, in addition to likely Chief Coroner guidance, there should be a requirement in the rules in relation to the recording of narrative determinations; and if so, what.

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<sup>9</sup> R vs. HM Coroner for the Western District of Somerset and Another ex parte Middleton [2004] UKHL10

### **Inquest to be held promptly**

33. Although there is no requirement in the existing rules that the inquest should be held as soon as possible after death, European case law<sup>10</sup> does provide, in cases where Article 2 ECHR is engaged, that the inquest must commence promptly and be pursued with reasonable expedition. In addition, section 1 of the 2009 Act places a duty on a senior coroner to conduct an investigation “as soon as practicable.”
34. However, there would be no purpose in proceeding to inquest where the coroner (or the jury, if one is sitting) does not have the information he or she needs to make the determinations required by section 5 of the Act. As was stated often during the course of Parliamentary debate on the Bill, delays in holding inquests are often not the responsibility of the coroner – rather they rest with one of the many organisations which conduct investigations into particular deaths, some of which may be complex and/or require extensive enquiries.
35. While reducing avoidable delays will be a major driver of a reformed system – and the Chief Coroner will have an important role to play in this respect under the monitoring arrangements to be established under section 16 - we would welcome views as to whether a requirement in the rules that an inquest be held promptly would have any value, or whether it is considered that the provisions in section 1 of the 2009 Act and the existing requirements derived from European case law are sufficient for this purpose.

### **Procedure for summoning witnesses**

36. At present, the procedure for summoning witnesses is largely informal, although there does exist a formal summons document that may be completed and issued by the coroner to the witness should the coroner feel it to be necessary to issue this (the document is currently contained in the Coroners Rules 1984 at Schedule 4 Form 8 App. 2).
37. In the 2009 Act, the power for coroners to summon witnesses is contained in paragraphs 1 and 2 of Schedule 5. However, the schedule does not set out the practical mechanisms to be used to summon witnesses to attend an inquest. We believe that this could usefully be dealt with in rules. We would welcome your comments on this approach.

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<sup>10</sup> Jordan vs. UK (2001) ECtHR



### **Unsworn evidence**

38. There is currently no provision for a coroner to accept unsworn oral evidence. However, section 45(2)(a) of the Act allows for rules to make provision about evidence, including provision requiring evidence to be given on oath other than in prescribed circumstances. This therefore opens the way for oral evidence to be accepted in certain limited circumstances unsworn.
39. It had previously been proposed – at clause 48 of the 2006 draft Bill - that all witnesses at an inquest must give evidence under oath, unless they are under the age of 14, or if the coroner is otherwise unable to be satisfied that the witness has sufficient understanding of the responsibility involved in taking an oath, in which case the coroner may permit the witness concerned to give unsworn oral evidence to the inquest hearing. This remains the preferred option of the Ministry of Justice. We would be grateful for views.

### **Provision of better evidence**

40. We would welcome comments from respondents as to whether the circumstances in which vulnerable and potentially vulnerable witnesses should be granted protection in giving evidence by way of anonymity, screening, by clearing the courtroom and, where the facilities exist, via live video link, should be set out in the rules, as in clauses 44 to 47 of the 2006 draft Bill. As the draft Bill set out, in clause 45, if these provisions are used, the coroner, a jury (where relevant) and all interested persons or their representatives, must be able to see and hear the witness.

### **Power to withhold name or other matter from disclosure, including UK Special Forces**

41. A new provision under the reformed system is the scope contained at section 45(2)(e) allowing for rules to make provision for a coroner to make a direction allowing or requiring a name or other matter not to be disclosed except to persons specified in the direction.
42. The main aim of this new provision is to enable coroners to give a direction allowing the name or other details of UK Special Forces personnel who die not to be disclosed. If such a direction is given by the coroner, the coroner will be able to make an order under section 11 of the Contempt of Court Act 1981 prohibiting the publication of that name in connection with the investigation.

43. This will allow deceased UK Special Forces personnel and their families to retain their anonymity (should the family so wish), and means that the duty of confidentiality imposed on UK Special Forces personnel and their families during the deceased person's life is reciprocated in the reporting of their inquests.
44. Although it is anticipated that this power will be used almost entirely for this purpose, there may be other rare circumstances in which it will be used, for example for a witness whose life is in danger.
45. It is anticipated that the circumstances in which names are required or allowed to be withheld will be set out in rules, and we would welcome comments from respondents as to what should be the principles coroners apply to justify the use of this power – other than the circumstances set out above. (N.B. This is not intended to re-open the very full debate which has already taken place about the reporting of inquests. The general presumption will remain that, in all but the most exceptional circumstances, inquests will be open to public scrutiny.)

**Items currently contained within the rules that we wish to alter or expand**

46. With regard to the geographical **location of the inquest**, currently section 5(2) of the Coroners Act 1988 specifies that (subject to certain minor exceptions) the inquest must be held within the coroner's area of jurisdiction only. While a rule implementing a similar provision will not be required in the new system – because the 2009 Act offers flexibility for any inquest to be held anywhere in England and Wales – the coroner's local authority (or the lead authority when the coroner's area relates to a group of local authorities) will need to be fully consulted, if they are not involved directly or jointly in making the arrangements, before coroners schedule inquests out of their areas where additional costs will arise.
47. At present, procedures regarding the **adjournment** of inquests are largely contained within the rules (rules 23, 25 to 29 inclusive, 32 and 35). These provisions require inquests to be adjourned in circumstances where an inspector or representative of the relevant enforcing authority is not present; where a person whose conduct has been called into question is not present; when requested by the chief officer of police; when requested by the Director of Public Prosecutions; in circumstances where it appears to the coroner that the death is likely to be due to an offence under the Road Traffic Act 1972 or the Suicide Act 1961, and a person might be charged with such an offence; or where the deceased had a relevant association with visiting armed forces.
48. The 2009 Act introduces the concept of suspending investigations, which will include adjourning any inquest that may have been opened as part of

that investigation. The Act already contains provision requiring the suspension of an investigation (including any related inquest) in situations where certain criminal charges may be brought (Schedule 1 paragraph 1); where certain criminal proceedings have been brought (Schedule 1 paragraph 2); where the cause of death will be adequately investigated by way of an inquiry under the Inquiries Act 2005 (Schedule 1 paragraph 3); or in any case where it appears reasonable for the coroner to do so (Schedule 1 paragraph 5). In all these instances there is a statutory requirement upon the coroner to adjourn any inquest that is currently ongoing as part of the investigation, including discharging any jury (Schedule 1 paragraph 6). There is therefore no need to repeat these provisions in the new rules.

49. It is proposed, however, that the new rules will, make provision for adjourning inquests in situations where an inspector or representative of an enforcing authority is not present, as currently provided for in rule 23, or where a person whose conduct has been called into question is not present, as currently provided for in rule 25.
50. Rule 31 provides for the coroner to produce a **certificate** stating the result of any relevant criminal proceedings to the registrar of deaths within 28 days of being informed of the result of the proceedings concerned. It is anticipated that this requirement will be substantively replicated. It is proposed the provision will also be extended to cover the notification of the registrar of any changes or additions to the particulars to be registered as a result either of the coroner proceedings or parallel proceedings. Where the Chief Coroner amends a determination, for example as the result of an appeal, he or she will notify the registrar of the amended particulars.

**Items currently contained within the 1984 Coroners Rules that are likely, in substance, to be replicated in a reformed system**

51. There are a number of items currently contained in the rules – mostly procedural in nature – to which we do not intend to make substantive changes in the new system, mainly because they are uncontentious and, as far as we are aware, operate effectively at present.
52. These items are outlined below to allow consultees to see the full picture on how we foresee inquests operating under the new system.
53. The **days on which an inquest should not be held** are currently Good Friday, Christmas Day, or on a bank holiday (unless the coroner thinks it to be necessary on the grounds of extreme urgency). In addition, no inquest shall be held on a Sunday - current rule 18.
54. The **procedures for notifying next of kin** and other interested persons – current rules 19 and 33 - about inquest arrangements.

55. The **procedures for examining witnesses** – currently in rules 20(1) and 21.
56. No witness shall be obliged to answer any question that may lead to **self-incrimination** – current rule 22.
57. Any **person whose conduct is likely in the opinion of the coroner to be called into question** at an inquest shall, if not already duly summoned, be given reasonable notice of the date, time and place at which the inquest will be held – current rule 24.
58. The provision that where any witness or juror who has been bound over to attend at an adjourned inquest is notified by the coroner that their attendance at the adjourned inquest is not required or that the inquest will not be resumed for any reason, any **recognizance** entered into by said witness or juror is thereby voided – current rule 34.
59. That all **exhibits** produced in evidence at an inquest will be marked with an allocated consecutive number – each number to be preceded by the letter ‘C – current rule 38’.
60. The requirement for coroners to take **notes of evidence** at inquests - current rule 39.
61. That **no person shall address the coroner** (or the jury) as to the facts of the case – current rule 40.
62. That when the coroner is sitting with a jury, he or she shall **sum up the evidence** to the jury at the end of the inquest prior to sending them to consider their determination – current rule 41.
63. Current rules 44 to 52 all relate to summoning **jurors**, and it is proposed that their substance will be replicated in the new rules.

We would welcome comments from respondents on any of these issues.

#### **Guidance to be issued by the Chief Coroner**

64. As well as secondary legislation, it is also anticipated that the Chief Coroner will issue guidance on certain key issues. These will be consulted on in due course by the Chief Coroner.
65. On the general subject of the conduct of inquests, it is anticipated that the Chief Coroner may wish to issue guidance on the following subjects:

- When coroners may wish to use their discretionary powers and decide to hold an inquest with a jury. This was an issue that was subject to considerable Parliamentary debate during the passage of the Bill through Parliament.
- The types of deaths which engage Article 2 of the ECHR.
- The circumstances in which a narrative determination would be considered appropriate.
- The circumstances in which the coroner may wish to exercise his or her discretion under Schedule 1 paragraph 5 to suspend an investigation. For example, there are cases involving deaths abroad where the coroner establishes that an investigation is being carried out, and where court proceedings will take place which will consider and establish the particulars relating to the death.

**Are there other areas where respondents suggest the Chief Coroner may consider issuing guidance in relation to the administration and conduct of inquests?**

**Summary of issues in this chapter on which we would welcome your views**

**Practicalities:**

- **Q33: Should a formal requirement for the opening of an inquest be retained? (paragraphs 14 to 15)**
- **Q34: Should there be a formal requirement for an inquest, when relevant, to be held as soon as possible after the death? (paragraphs 33 to 35)**

**Witnesses:**

- **Q35: Should the procedures for summoning witnesses be put on a more formal footing, in similar terms to those regarding the summoning of jurors, for example? (paragraphs 36 to 37)**
- **Q36: Should the circumstances when vulnerable or potentially vulnerable witnesses may be granted special measures while giving evidence be put on a formal basis? (paragraph 40)**
- **Q37: In what circumstances do respondents think coroners should exercise powers to withhold names or other matters? (paragraphs 41 to 45)**

**Evidence and exhibits:**

- **Q38: Should there be a formal basis for coroners to accept unsworn evidence at inquests? (paragraphs 38 to 39)**
- **Q39: Should the position on admissibility of documentary evidence be extended or clarified? (paragraphs 16 to 17)**
- **Q40: Is there an argument for retaining, increasing or reducing the requirement for documents to be kept for 15 years as is the case at present - particularly in view of the new appeal arrangements against coroners' decisions which the Act establishes? (paragraphs 18 to 20)**

**Short form and narrative determinations:**

- **Q41: Should a new list of short form determinations be established; and if so, what should the categories be? (paragraph 27)**
- **Q42: Should coroners be required to return a narrative determination in any case where they are unable to attribute one of these determinations? (paragraph 28)**
- **Q43: Should the rules contain something on the availability and use of narrative determinations, and if so, what? (paragraph 32)**

**General:**

- **Q44: We would welcome comments from respondents on any of the issues contained within the Coroners Rules 1984 that are likely, in substance, to be replicated in the new rules (paragraphs 46 to 63)**
- **Q45: Are there any other areas where respondents suggest the Chief Coroner may consider issuing guidance in relation to the administration and conduct of inquests? (paragraphs 64 to 65)**

## Chapter 7: Appeals and complaints

### Purpose

1. One of the most important measures to increase the standing of bereaved families in coroners' investigations is the creation of a new system enabling appeals against particular decisions taken by coroners. This will be the first national system of its kind anywhere in the world.
2. While this is a source of considerable pride, it does mean we have to tread particularly carefully to establish the right procedures to govern the new system. As part of this, once the system is designed and the rest of the policy in Part 1 of the Act is implemented, we intend to pilot the new procedures to ensure they work as intended. This is likely to happen between April 2012 and March 2013, with the aim of the system being introduced nationally from April 2013.
3. The purpose of this section of the consultation paper is to gather your feedback on how we envisage the appeals system will work, and at the same time provide information about the parallel new way of dealing with complaints. This will help us to decide what needs to be included in secondary legislation and what is best left to guidance.
4. It is also the Government's view that the appeal system should not be the first recourse if an interested person is dissatisfied with a coroner's decision. We believe that some dissatisfaction can be resolved through an explanation of the reason for a decision, and we would expect to see this built into the process.

### Current position

5. At present, if bereaved people and other interested persons in relation to a coroner's investigation are dissatisfied with a particular decision, they have few means of redress. The only recourse is judicial review, or by asking the Attorney General to refer the case to the High Court for an order to be made for a new inquest to be held - or for an inquest to be held at all if the reason for the representations is that no inquest was held. In most years, there are no more than 15 or 20, combined, of such judicial reviews and applications to the Attorney General.
6. And, on complaints about standards of service, at present while some coroners have published arrangements in place, others do not and, in any event, these arrangements – and the services which coroners offer - vary from area to area. It is almost impossible to gauge, therefore, what the

level of dissatisfaction is within the current system. A qualitative snapshot survey, conducted by Ipsos-MORI in 2006, indicated that almost 1 in 5 of those surveyed were dissatisfied with their overall experience<sup>11</sup>.

7. The new legislation ensures that bereaved people and other interested persons will be able, easily and without charge, to take action if they are dissatisfied with a coroner decision, the standard of service they have received, or if they have concerns about a coroner's conduct. It introduces the following measures:

#### Appeals

8. Section 40 of the Act provides a right for interested persons to appeal, to the Chief Coroner, against coroner decisions. For the first time bereaved people and other interested persons in relation to a coroner's investigation will have a free and accessible way to challenge a range of decisions made by the coroner.
9. However, we believe that if an interested person is not happy with a coroner decision, they and the coroner's office should wherever possible try to resolve the issue without a formal appeal. It could be that an interested person is not content with a coroner decision simply because they do not understand it, or the issue they have is actually a service delivery complaint and not a decision attracting appeal rights. In such a case a brief discussion with the coroner's office may resolve the issue and render a formal appeal unnecessary. We therefore propose that this informal resolution should be standard practice before the formal route begins.
10. We are seeking views as to how this initial informal process would work in practice, in the 'What will be contained in the new rules about the appeals process?' section below.

#### Complaints about standards of service

11. The draft Charter for Bereaved People, which it is proposed will be made under section 42 of the Act, sets out that bereaved people will be able to complain to the Chief Coroner if they feel that they have not received the services set out in the Charter and they are dissatisfied by the coroner's response after they have brought the matter to his or her attention. The Chief Coroner will then take any action he or she decides is appropriate and will inform the complainant of that action. Other interested persons will also be able to give feedback to the Chief Coroner about the standards of service that coroners give, including complimentary feedback.

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<sup>11</sup> DCA Research Series No. 6/06, "Users' experiences of the coroners' courts"



### Complaints about coroner conduct

12. Schedule 3 of the Act provides for complaints about a coroner's conduct to be made to the Office of Judicial Complaints, as is currently the case. Any subsequent disciplinary proceedings will be dealt with by the Lord Chief Justice in conjunction with the Lord Chancellor. The Lord Chancellor may, with the Lord Chief Justice's agreement, remove a coroner from office for incapacity or misbehaviour.
13. It will be important to be clear about the distinction between complaints about a failure to deliver a particular service in a particular case - which would not normally be regarded as misbehaviour unless, and without reasonable justification, it was repeated in other cases - and complaints about a coroner's personal misconduct.

### ***What policy on appeals is contained within the Coroners and Justice Act 2009?***

14. An interested person may appeal to the Chief Coroner against any of the following decisions of a coroner (section 40(1) and (2) of the Act):
  - A decision whether to conduct an investigation into a person's death.
  - A decision whether to discontinue an investigation after a post mortem.
  - A decision whether to resume an investigation which has been suspended.
  - A decision not to request a post mortem examination.
  - A decision to request a second post mortem unless the decision is to request an examination of a different kind from the one already carried out.
  - A decision to give a notice about witnesses or evidence for an investigation.
  - A decision whether there should be a jury at an inquest.
  - A decision whether to exercise a power to give a direction excluding certain persons from all or part of the inquest, if the coroner is of the opinion that the interests of national security require this.
  - A decision contained in a determination as to the answer to certain questions (who the deceased person was; how, when and where the deceased came by his or her death; and, where relevant, including in what circumstances the deceased came by his or her death).
  - A decision contained in a finding as to the particulars required by the Births and Deaths Registration Act 1953 to be registered concerning a death.
  - A failure to make any of the decisions that fall within the above list.

15. Section 40 (5) also allows a person who the coroner has decided is not an interested person in his or her investigation to appeal against that decision.
16. The Chief Coroner can consider any evidence which he or she thinks is relevant to the substance of the decision, determination or finding against which an appeal has been brought.
17. If the appeal relates to a coroner's determination or finding (such as their decision on what the cause of death was), then under section 40(8)(a) the Chief Coroner can either:
  - Change the determination or finding within a coroner's decision; or
  - Quash the determination or finding and order a fresh investigation.
18. Where the appeal relates to other decisions (such as whether to use a jury at the inquest), under section 40(8)(b) the Chief Coroner can:
  - Substitute any other decision that could have been made; or
  - Quash the decision and remit the matter for a fresh decision.
19. In the case where the appeal relates to a failure to make a decision, under section 40(8)(c) the Chief Coroner can either:
  - Make any decision that could have been made; or
  - Return the matter to the coroner for a decision to be made.
20. The Chief Coroner can also make any order he or she thinks appropriate, including an order as to costs, under section 40(8)(d).
21. If the coroner's investigation is being undertaken by a (serving or retired) High Court Judge, (including the Chief Coroner if he or she is a High Court Judge), or a Circuit Judge, different appeal arrangements apply. In such cases, the Court of Appeal or a High Court judge respectively will hear the appeal (Schedule 10, paragraph 4(1)).
22. A party to an appeal under section 40 of the Act may appeal from a decision of the Chief Coroner on a question of law to the Court of Appeal. In such cases the Court of Appeal may decide to do one of the following:
  - Confirm the decision;
  - Substitute any decision that could have been made for the decision; or
  - Quash the decision and remit the matter for a fresh investigation or decision.

23. The rules to be made under section 45 of the Act may include provision as to the way in which, and the time within which, appeals are brought; and to regulate appeals practice and procedure.

**What will be contained in the new rules and regulations about the appeals process?**

24. We anticipate that the practice and procedure for appeals will include the following:
- That an appeal against the opening of an investigation (under section 40(2)(a)) may not be used for the purpose of preventing a post mortem. Subject to this exception, an investigation or an inquest should be adjourned pending the outcome of an appeal.
  - That the following appeals must be made and heard before the start of an associated inquest, so that the inquest can then proceed as efficiently as possible:
    - A decision whether to conduct an investigation into a person's death.
    - A decision whether to discontinue an investigation after a post mortem.
    - A decision not to request a post mortem examination.
    - A decision to request a second post mortem unless the decision is to request an examination of a different kind from the one already carried out.
    - A decision whether there should be a jury at an inquest.
25. So, for example, if an interested person is unhappy with the determination of an inquest, they will not be able to appeal about the failure to summon a jury on the basis that they believe, in retrospect, that they would have had an outcome they would have preferred if a jury had been summoned.
26. There may be rare circumstances when an inquest, which has already begun, has to be adjourned pending the outcome of an appeal. This is most likely to be when the coroner is hearing evidence and determines that the courtroom needs to be cleared in the interests of national security. Often, it will be possible to make and announce this determination before an inquest has begun, but on occasions the oral evidence may not necessarily tally with a written statement. In these circumstances, and as with appeals about post-mortem examinations, the Chief Coroner is likely to hear the appeal quickly to ensure that the inquest can proceed quickly.
27. More generally, two or more related appeals may be heard together. This is necessary in order to support efficient and convenient listing of cases for the parties involved and making the best use of the Chief Coroner's time.

For instance two or more interested persons may appeal about two or more different issues regarding one investigation, or about separate but linked investigations. This might include, for example, deaths directly or indirectly connected to the same event or incident, but not necessarily being investigated by the same coroner.

28. We propose, and should be grateful for views on the following proposals:

- That the person who wishes to appeal must complete a notice of appeal in order for the Chief Coroner<sup>12</sup> to consider the appeal.
- That the notice of appeal should include a declaration that an attempt has been made to resolve the matter informally directly with the coroner or his office. If so, should this also apply where an appeal is about a post-mortem examination and therefore must be made within a very short timescale?
- That the Chief Coroner may disregard an appeal if he or she decides the appeal is vexatious or frivolous, and must document his or her reasons for doing so.
- That the Chief Coroner will determine the method of considering the appeal – i.e. whether there should be a paper or oral hearing. Notices of appeal will offer the appellant the option of making an argument as to why the appeal should be subject to an oral hearing. However the intention is that the majority of appeals will be considered on the papers as it is felt that they can be dealt with just as thoroughly, and certainly more quickly, that way. In particular the necessarily quick timescales for dealing with post mortem appeals mean that these will usually be heard on the papers. There may however be a very small number of cases where, due to the complexity of fact, circumstances and evidence, the Chief Coroner may agree that an oral hearing may be appropriate.
- That the Chief Coroner should inform other interested persons that an appeal has been lodged and the nature of the appeal, and their opportunities for making representations to the Chief Coroner about the appeal.
- That there should be timescales, as proposed below, for lodging appeals and for the Chief Coroner to rule on appeals. In particular, we would welcome views on whether the time limit for making an appeal against the decision to discontinue an investigation before an inquest, and against the decision given at the end of an inquest, could be 15 days rather than 60 days, like the time limit for most other cases. It would also be helpful to have your views as to whether there are any barriers to the time limit for post mortem appeals working in practice.

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<sup>12</sup> Reference to the Chief Coroner should also include reference to a Deputy Chief Coroner. It is highly unlikely that the Chief Coroner will be able to consider all appeals personally.

### Timescales for appeals

29. We intend to introduce time limits for making and ruling on appeals, so that the system is as efficient as possible. Following consultation in 2008 the Draft Charter for Bereaved People suggests the following time limits, on which we should be grateful for views:

- Appeals against the decision not to hold a post-mortem examination or against a second post-mortem examination being held, should be made within one working day, so that valuable evidence is not lost.
- There should be a maximum of 15 working days to appeal for most cases – such as an appeal against a decision whether to investigate; or against a decision not to resume an investigation. This will include cases where a medical examiner issues a certificate stating the cause of death and the case is not referred back to the coroner.
- There will be a limit of 60 working days to make an appeal against the decision to discontinue an investigation before an inquest; and against the decision given at the end of an inquest.

30. In addition our current policy intention is that rules will specify that:

- The Chief Coroner will decide whether to consider an appeal that is lodged out of time – i.e. consider the mitigating circumstances – providing that a decision the Chief Coroner can make remains relevant. For example, the Chief Coroner cannot consider an appeal against matters which have to be resolved before an inquest, if the inquest is already under way. To facilitate this additional process, the notice of appeal will need to provide for an interested person to indicate that they are appealing out of time and the reasons for doing so.
- An appeal will be heard as promptly as possible according to the nature of the matter being appealed. (We anticipate that guidance will say that for a paper appeal on one of the matters of urgency, it is likely to be determined within 3 to 5 working days. For a paper appeal on non-time critical matters, it is likely that the deadline will be 4 to 6 weeks from the time the appeal is lodged. We would expect appeals requiring an oral hearing to be held within 3 months of the appeal being made.)

### Forms and notices

31. We will draw up forms, and associated guidance for appeals. We will factor in consultation responses when drawing these up. We envisage that forms will include:

- Notice of Appeal – which the appellant will complete and send to the Chief Coroner's office; and associated guidance.
- Notices from the Chief Coroner's Office – for instance acknowledging receipt of an appeal; giving reasons why an appeal is not accepted;

confirming that an appeal is considered to be out of time; notifying an oral hearing date and venue; giving written reasons for a decision.

- Notices about Chief Coroner cost orders – for instance applications to the Chief Coroner for a cost order to be made; and notices containing the Chief Coroner’s final decision.
- Onward appeals – for instance an application notice for permission to appeal to the Court of Appeal (via the Chief Coroner’s Office) and notice of permission to appeal to the Court of Appeal.

### **Resource implications**

32. We have identified that as the appeals system is entirely new, it is likely to involve new work for coroners in responding to requests for case information and opinions when an appeal is made. However we anticipate that any additional work for coroners will be countered by ensuring that there are improvements in general case management and recording, and the design of a standard form on which their explanation of the reason for their decision can be easily entered. There will also be advice and support from the appeals administration team in the Chief Coroner’s office while the system beds in.
33. However, we have undertaken to work with the Local Government Association, local authorities and coroners to assess the impact on coroner workloads. The proposed pilots in 2012-13 are expected to assist with this work.

### **Issues in this chapter on which we would welcome your views (paragraph 28)**

- **Q46: Do you agree that the person who wishes to appeal must complete a notice of appeal in order for the Chief Coroner to consider the appeal?**
- **Q47: Do you agree that the notice of appeal should include a declaration that an attempt has been made to resolve the matter informally directly with the coroner or his office? If so, should this also apply where an appeal is about a post-mortem and therefore must be made within a very short timescale?**
- **Q48: Do you agree that the Chief Coroner may disregard an appeal if he or she decides the appeal is vexatious or frivolous, and must document his or her reasons for doing so?**
- **Q49: Do you agree that the Chief Coroner will determine the method of considering the appeal – i.e. whether there should be a paper or oral hearing?**

- **Q50: Do you agree the proposed timescales set out for lodging appeals and for the Chief Coroner to rule on appeals?**

## Chapter 8: Training of coroners, their officers and staff

### Purpose

1. The purpose of this section of the consultation paper is to gather respondents' views on what training should be given to coroners, coroners' officers and support staff in a reformed coroner system. There is no provision for this in current legislation.
2. Section 37 of the Coroners and Justice Act 2009 makes provision about training for the first time. Its aims are:
  - To promote the value of training for those working in the coroner service in England and Wales.
  - To ensure that training is tailored to meet the needs of coroners, coroners' officers and support staff given their respective roles in a reformed coroner system.
  - To ensure that all those working within the coroner system are aware of and apply up to date relevant law, best practice, guidance and standards.
3. There will be separate training on new procedures, probably in late 2011 and early 2012, for those who will be working in the reformed system. As this will be largely before reform takes effect in April 2012 – and therefore will not be subject to regulations to be made under Section 37 - this training is not subject to consultation. However, for information, we set out here the planned broad headings for this training:
  - Overview of the reformed system.
  - Interaction with the medical examiner system.
  - New forms.
  - Charter for Bereaved People, including investigations into specific types of deaths.
  - Practical skills and procedures on those Act provisions which will have a direct effect on working practices.

### What the current law provides for

4. No current or previous legislation on the coroner system has made reference to the training of those who work within it. The Act's measures therefore demonstrate the importance which the Government attaches to training of coroners and those who work with them. This will build on the



training already provided, largely as a result of the considerable efforts of the Coroners' Society and the Coroners Officers Association.

### **Resource implications**

5. Currently the Ministry of Justice administers and pays for some training for coroners and their officers – namely induction training; continuing professional development training for coroners; and training on particular issues.
6. We envisage that the cost of delivering training which is set out in the regulations will be met centrally by the Chief Coroner's office. Travel and accommodation costs, and deputising cover costs would continue to be met locally by employers. As such we anticipate no new burden on employers. General employee training – such as on Health and Safety, or Human Resources issues - will also continue to be provided by employers.
7. The central and local budgets for training will continue to be limited and as such it is important to consider how to obtain best value for money for the training.

### **What policy on training is contained within the Coroners and Justice Act 2009?**

8. Section 37 of the Act gives the Chief Coroner a power (but does not impose an obligation), with the Lord Chancellor's agreement, to make regulations about training (in particular, the kind of training, amount of training and frequency of training), in a reformed coroner system, of:
  - Senior coroners, area coroners and assistant coroners.
  - The Coroner for Treasure and Assistant Coroners for Treasure (who will be drawn from the pool of assistant coroners able to conduct death investigations).
  - Coroners' officers and other staff assisting coroners (including assisting the Coroner for Treasure).
9. This chapter seeks views solely on the training of coroners, coroners' officers and other support staff on matters related to the investigation of deaths. It does not address issues regarding specific training on 'treasure' related matters for the Coroner for Treasure and his or her assistants, which will be dealt with in advance of the postholders taking up their duties, with further ongoing training a matter for further consideration in the future.

## Five issues on which we would welcome your views

### A) Content of training

10. We should be grateful for views on the following tables, which suggest training for coroners and their officers and staff. Do you agree with the content of the tables? Is there anything missing?

**Table 1: Coroners – suggested training**

#### **Induction for all new coroner appointees (training courses of about 2 days each) excluding the Coroner for Treasure**

##### Level 1

- Reviewing and developing skills in dealing with all parts of an investigation. Could include :
  - Whether coroner has jurisdiction to investigate a death/which deaths should be reported.
  - First decisions and initial matters to be considered.
  - Evidence gathering and pre-inquest preparation.
  - Adjourning and resuming the investigation.
  - Post-mortem examinations – when to commission, what to commission, understanding post-mortem reports, Human Tissue Act issues, communicating with families.
  - Best approaches to dealing with difficult witnesses.
  - Conducting an inquest, including an appropriate courtroom manner.
  - Determinations.
  - Forms.
  - Understanding the appeals system.
  - Making reports to prevent future deaths.
  
- Understanding national standards and guidance, including the Charter for Bereaved People.
  
- Understanding the roles of, and working with:
  - Medical examiners.
  - The Chief Coroner.
  - National Medical Adviser to the Chief Coroner.
  - Coroners' officers.
  - Bereaved families.
  - Other organisations who conduct investigations into violent and unnatural deaths (e.g. police, Health and Safety Executive, Prisons and Probation Ombudsman).

Level 2

- Improving understanding of the detailed procedure involved in presiding at an inquest, including an inquest which engages Article 2 of the European Convention on Human Rights.
- Handling unexpected difficulties which can arise in the course of an inquest.
- Increasing understanding of the cultural and social diversity of the many people who pass through the coroner's court, whether as a bereaved person or as a witness.
- Learning from skilled and experienced coroners about the nature and responsibilities of coronial work including best practices.
- Procedures for information subject to legal privilege or public interest immunity.
- The application of the Freedom of Information and Data Protection legislation in the coroner service context.
- Conducting an inquest with a jury.

**Continuing professional development training for senior coroners (modules marked \* would also be suitable for area and assistant coroners – currently known as Deputy and Assistant Deputy Coroners)**

We suggest there would be benefit in the Chief Coroner conducting a training needs analysis for continuing professional development training. Your responses will help to inform the Chief Coroner's view.

Our view of what continuing professional development could comprise is:

- Understanding bereaved families. \*
- Understanding particular medical conditions/types of death. \*
- Case Management/keeping delays to a minimum. \*
- Negotiating and influencing skills. \*
- Reports to prevent future deaths - sharing good practice. \*
- Post-mortem examinations – sharing good practice. \*
- Office/staff management and leadership skills. \*
- Record-keeping - to ensure consistently good record-keeping practices across the country, so that information may be provided quickly and efficiently to the Chief Coroner for statistics and appeals.
- Working effectively with your local authority and local police authority (where relevant).
- Other issues on which a training need arises.

**Periodic updates on developments / changes (training by email/website; and the Chief Coroner may convene a training event)**

Could include:

- Appeals system when it goes live/when pilot concludes.
- Any changes to legislation that may impact on coroner investigations.
- Any changes to rules and regulations after go-live date.
- Significant case law.
- Changes to procedures, forms, record keeping.

**Table 2: Coroners’ officers and administrative support staff – suggested training**

<b>Type of training</b>
<p><b>Induction (training course of around 2 days)</b></p> <ul style="list-style-type: none"> <li>• Aims and ethos of the system.</li> <li>• The role of the coroner.</li> <li>• The role of the coroner’s officer / staff, and knowledge and skills needed.</li> <li>• Reportable deaths and the role of the medical examiner.</li> <li>• Initial procedure when a death is reported to coroner.</li> <li>• Post-mortem examinations.</li> <li>• Pre-inquest procedures.</li> <li>• Procedures around inquests.</li> <li>• Procedures following an inquest.</li> <li>• Communicating with families.</li> <li>• Liaising with others – police, medical practitioners, lawyers, other interested persons.</li> <li>• Difficulties which arise, and how to handle them.</li> <li>• The cultural and social diversity of the people who interact with the coroner system, whether as a bereaved person or as a witness.</li> <li>• Learning from skilled coroners and officers about the nature and responsibilities of coroner officer / staff work.</li> </ul>
<p><b>Refresher training (training course of around 1 day)</b></p> <p>This could cover:</p> <ul style="list-style-type: none"> <li>• Changes in processes.</li> <li>• Training on medical conditions/specific types of death.</li> </ul>
<p><b>Periodic updates on developments / changes (training by email/website; and the Chief Coroner may convene a training event)</b></p> <p>To include:</p> <ul style="list-style-type: none"> <li>• Appeals system when it goes live/when pilot concludes.</li> <li>• Any changes to legislation that may impact on coroner investigations.</li> <li>• Any changes to rules and regulations after go-live date.</li> <li>• Significant case law.</li> <li>• Changes to jurisdictions - process, forms, record keeping.</li> </ul>

## **B) Whether training should be voluntary or compulsory**

11. We anticipate that the Chief Coroner will expect coroners, officers and other staff to have a minimum amount of training each year. We should be grateful for views on the following questions:

- Should only some training be compulsory – if so what – e.g. induction training? Why?
- If compulsory, or part compulsory, should training have to happen before a coroner / officer / staff can operate, or within a certain period of their beginning – say 3 or 6 months? Or should only particular duties be exempt until training is received?
- Should trainees have to complete a certain number of training days per year, or certain modules? What should the requirement be?
- If training is compulsory, what might be effective sanctions to ensure completion?
- What should happen if training is compulsory and someone cannot complete it – because of work commitments, illness, or lack of authorisation from managers?
- Assuming full induction has been received, should the minimum number of training days be the same for each category of person to be trained?

## **C) Who should deliver training?**

12. The Chief Coroner's office will have responsibility for oversight of training strategy, and for managing the budget for training which is specified in regulations.

13. Training could then be provided by:

- The Chief Coroner's office, either directly or through contractors.
  - Some coroners and officers who are trained to provide training- either nationally or regionally.
  - Training specialists.
  - Other bodies such as academic institutions, local authorities, the Coroners Officers Association, bereavement charities.
- Who do you think would be best placed to deliver training and why?

- Should the Chief Coroner approve a provider before they can train coroners, coroners' officers and support staff?
  - Should there be a mix of providers, depending on the event?
  - Should training provide Continuing Professional Development (CPD) credit for coroners?
14. In addition we appreciate that, at a local level, additional independent training may continue to be provided for coroners / their staff (for example by a university, the Coroners Officers Association or a bereavement charity). On the job and 1:1 training is also likely to remain important.

**D) Format, accessibility and value for money of training**

15. It is important that training is as accessible as possible and represents the best value for money.
16. There is a variety of different media via which training can be provided. It may be appropriate for a particular training topic to be addressed via one medium, or a combination of media. In addition the Chief Coroner will need to consider not only the effectiveness of different types of training, but also balancing this with the cost of each medium and the training's accessibility (in terms of location, necessary resource commitment of trainee, and possible leave from office). Key factors for the main ways of delivering training are set out below.
17. Training courses have advantages and disadvantages. Advantages could be that the training would be away from the workplace and its distractions; and there would be the opportunity to share experiences, and network with other attendees. However this must be weighed against the disruption to work, and perhaps difficulty of attending; and the disruption to work life balance that long training days and / or travel distances, and overnight stays away from home would bring. This could perhaps be mitigated by regional training events.
18. Whilst training courses may be funded centrally, associated expenses, such as trainee travel and accommodation costs, as well as local training, will continue to be met locally by the employer – i.e. the local authority or police authority as appropriate. These authorities will also be responsible for paying for deputising cover should it be required.
19. On-site locally delivered training – where a trainer visits a coroner office and trains the coroner and / or officers and staff - could be a cheaper, and perhaps more accessible option. However it may be difficult to 'close' an office while training is occurring. It could also mean one or more trainers

travelling the country delivering training, so training could be infrequently available.

20. E-learning / website training packages in workplaces would offer fewer resource implications, and more flexibility, than attending training courses. Whilst initial outlay is required to set up a package, maintenance and user costs tend to be low. However the necessary IT must be in place; and trainees may find it difficult to take time out from their job whilst still in the workplace. E-learning may be more or less appropriate for different learning topics.
21. Other ways of delivering training - In addition to these 3 main delivery models, other formats of training are possible – such as seminars on particular subjects; meetings with / events held by voluntary groups or other interest groups; and one to one coaching and mentoring.

#### **E) Other practical issues**

22. Should some types of training event be open to a mixed audience – e.g. coroners, their officers and other staff, medical examiners, medical examiner officers, local authority staff? If so, which?
23. Should coroners be expected to devise an initial induction package locally for new area and assistant coroners, and / or for coroners' officers and staff, based on a central template provided by the Chief Coroner's office? Or do coroners believe this is not part of their role given that they do not have direct management responsibility for any of these groups?
24. Are there any other issues the Chief Coroner should consider if drawing up training regulations?



Issues in this chapter on which we would welcome your views

25. We would welcome your views on the 5 broad areas, which we have set out above:

**A) Content of training – paragraph 10**

- **Q51: We should be grateful for views on the tables at paragraph 10, which suggests training for coroners and their officers and staff. Do you agree with the content of the tables? Is there anything missing?**

**B) Whether training should be voluntary or compulsory – paragraph 11**

We anticipate that the Chief Coroner will expect coroners, officers and other staff to have a minimum amount of training each year, and we should be grateful for views on the following questions:

- **Q52: Should only some training be compulsory – if so what – e.g. induction training? Why?**
- **Q53: If compulsory, or part compulsory, should training have to happen before a coroner / officer / staff can operate, or within a certain period of their beginning – say 3 or 6 months? Or should only particular duties be exempt until training is received?**
- **Q54: Should trainees have to complete a certain number of training days per year, or certain modules? What should the requirement be?**
- **Q55: If training is compulsory, what might be effective sanctions to ensure completion?**
- **Q56: What should happen if training is compulsory and someone cannot complete it – because of work commitments, illness, or lack of authorisation from managers?**
- **Q57: Assuming full induction has been received, should the minimum number of training days be the same for each category of person to be trained?**

**C) Who should deliver training – paragraphs 12 to 14**

- **Q58: Who do you think would be best placed to deliver training and why?**
- **Q59: Should the Chief Coroner approve a provider before they can train coroners, coroners' officers and support staff?**
- **Q60: Should there be a mix of providers, depending on the event?**
- **Q61: Should training provide Continuing Professional Development (CPD) credit for coroners?**

**D) Format, accessibility and value for money of training – paragraph 15 to 21**

We would suggest, and be grateful for views on, the following suggestions for delivery of training:

- **Q62: Training courses – possibly residential – for induction courses for coroners and officers; and continuing professional development training.**
- **Q63: On site locally delivered training – for local issues**
- **Q64: E-learning – for refresher training; updates on developments / changes; and information which it is useful to have permanently available to refer to**

**E) Other practical issues – Chapter 8, paragraph 22 to 24**

- **Q65: Should some types of training event be open to a mixed audience – e.g. coroners, their officers and other staff, medical examiners, medical examiner officers, local authority staff? If so, which?**
- **Q66: Should coroners be expected to devise an initial induction package locally for new area and assistant coroners, and / or for coroners' officers and staff, based on a central template provided by the Chief Coroner's office? Or do coroners believe this is not part of their role given that they do not have direct management responsibility for any of these groups?**

- **Q67: Are there any other issues the Chief Coroner should consider if drawing up training regulations?**

## Chapter 9: Death registration procedures

### Purpose

1. To improve death registration arrangements by providing for bereaved families to have the option of a short certificate of death to use for administrative or other purposes where the cause of death does not need to be disclosed. This may be because an organisation, such as a bank or utility company, only requires confirmation of the **fact** of death.

### What the current law provides for

2. At present, there is scope only for full death certificates, which include the cause of death, to be issued.

### What policy is contained within the Act?

3. Under Schedule 21, paragraph 19, which amends the Births and Deaths Registration Act 1953, the Registrar General may prescribe a new form of short death certificate with the specific intention of providing a certificate that omits the cause of death. By paragraph 19 of Schedule 21 of the Act, the Births and Deaths Registration Act 1953 is therefore amended.
4. The new provision includes a power to prescribe a fee for the certificate. The Registrar General is seeking views on charging fees in this context and on the content of the short death certificate. It will still be possible to buy a full certificate that includes all the information recorded in an entry in the register of deaths.

### Charges

5. The fees for certificates issued by the registration service are reviewed with Her Majesty's Treasury and set out in Orders made by Ministers. Different fees are payable depending on whether a certificate is bought from the registrar who registers the birth, marriage or death, or later from a superintendent registrar or from the General Register Office. We would expect fees for death certificates to be set as part of this process. In terms of the parallel system for the registration of births, there is provision for one free short certificate to be issued at the time a birth is registered.
6. Should an equivalent short death certificate be issued by a registrar of births and deaths free of charge for each death registered in England and Wales? Please include the reasons for your views.

### **Content of short death certificate**

7. An entry in a current death register and any full death certificate includes the following information:
  - I. The local authority area within which the death took place.
  - II. Date and place of death.
  - III. Names of the deceased.
  - IV. Date and place of birth of the deceased.
  - V. Occupation and address of the deceased and the name of their spouse or civil partner.**
  - VI. The name, address and signature of the person who gave information for the death registration (N.B. this is the coroner where there was an inquest).**
  - VII. The cause of death and the name of the doctor or coroner who certified the cause of death.
  - VIII. The date of registration and the signature of the registrar who registered the death.**
8. Should a short certificate omit any of the information shown in **bold** above, as well as the information about cause of death? It is important that those organisations which are most likely to receive the new short certificate (such as banks, building societies and utility companies) have sufficient information for their purposes.

### **For information: Other changes to death registration provided for in the Act**

9. The new coroner and death certification provisions in the Act have other effects on the requirements for death registration. The consequential amendments to the Births and Deaths Registration Act 1953 will include further detail about these consequential changes as follows:
  - I. The Registrar General will no longer have responsibility for death certification. The Secretary of State for Health is given the duty to provide medical certificate of cause of death (MCCD) forms for doctors, together with instructions for their completion. The MCCD will continue to be prescribed by regulations after consultations with the Registrar General for England and Wales, the Statistics Board and Welsh Ministers.
  - II. Registrars will register deaths where they receive either:

- A medical certificate of cause of death completed by an appropriate licensed medical practitioner and confirmed by a medical examiner; or
- A notification from a senior coroner of the outcome of a post-mortem examination, or a certificate of the particulars to be registered following an investigation or discontinued or suspended investigation.

III. Registrars will issue the certificate for burial or cremation where a cause of death is certified by a licensed medical practitioner and confirmed by a medical examiner. Where a death is investigated by a senior coroner the authority for burial or cremation will be issued by him or her.

IV. Where a senior coroner has suspended an investigation there is new provision for him or her to notify the registrar of any changes or additions to the particulars to be registered. The registrar is required to register the death afresh to record the new information.

V. Where the Chief Coroner amends a finding, he or she will notify the registrar of the amended particulars. The registrar is required to register the death afresh to record the amended particulars.

VI. With the introduction of further scrutiny of all deaths, the requirement for the registration of a death after more than 12 months to be authorised by the Registrar General is removed.

VII. The list of those people who may give information to a registrar for the registration of a death is extended to include a personal representative of the deceased and the partner of the deceased (defined as living as partners (same or different sexes) in an enduring relationship at the time of the death).

#### **Summary of issues on which we would welcome your views**

- **Q68: Should an equivalent short death certificate be issued by a registrar of births and deaths free of charge for each death registered in England and Wales? Please include the reasons for your views.**
- **Q69: Should a short certificate omit any information about the occupation and other details of the person who has died, and the person who has authorised registration of the death?**

## List of questions asked

We would welcome responses to the following questions set out in this consultation paper.

### Chapter 1 – Deaths to be reported to a senior coroner

Q.1: Do you agree with cases and circumstances in which a registered medical practitioner must notify a senior coroner of a death? If not, what alternative or additional cases and circumstances would you suggest (bearing in mind the coroner's remit to investigate deaths as defined in section 1 of the 2009 Act)?

Q.2: We would welcome comments on the draft guidance for registered medical practitioners which explains the cases and circumstances in which a senior coroner should be notified of a death. In particular, short illustrative examples that could be included in the guidance.

Q.3: Given new ways of delivering Health services, particularly to the terminally ill, should the time period for a death to be automatically reported to a coroner be extended to 28 days, from 14 days, of a doctor not having attended their patient? Or should there be no time limit at all?

Q.4: What channels should be used to provide training and guidance for medical practitioners on the cases and circumstances in which a senior coroner should be notified of a death?

Q.5: Do you agree with the proposed arrangements for dealing with registered medical practitioners who consistently or deliberately fail to notify a senior coroner of a death(s)? If not, what alternative arrangements – short of creating a new offence - would you suggest?

### Chapter 2 – Transferring cases from one coroner area to another

Q.6: Whether there are other main circumstances when consideration should be given to cases being transferred.

Q.7: "Who pays" in circumstances where an investigation is transferred whether on the direction of the Chief Coroner or by agreement between the coroners concerned.

Q.8: On the process for notification of transferred investigations, that:

- Coroners A and B must agree at the time of transfer which if they will confirm in writing, to any identified interested persons, that the transfer had taken place, and write to those interested persons within 5 working days.

- Coroner A must give coroner B the relevant paperwork within 5 working days of receiving the direction from the Chief Coroner.

### **Chapter 3 – Post-mortem examinations and retention of bodies**

Q.9: What do respondents consider to be the purpose of a coroner commissioned post-mortem examination?

Q.10: In addition to ensuring greater consistency in the commissioning of post-mortem examinations, how may the number of post-mortem examinations be reduced?

Q.11: Should consultation with the relevant next of kin about the examination occur, as a matter of best practice, before the examination takes place (except in cases of suspected homicide)?

Q.12: Where it has not been possible, for whatever reason, to obtain such consent, how should matters relating to tissue retention be dealt with? Does the current '3-month rule' work in practice? Should the 3 months begin from the date of the conclusion of the examination?

Q.13: When might a coroner wish to consider authorising a post-mortem examination to be carried out by a less invasive method?

Q.14: Who might be designated as suitable to conduct post-mortem or related examinations if they are not registered medical practitioners?

Q.15: Do respondents agree that, providing a body has been identified, 30 days should be the maximum time by which the body of someone who has died should be released for a funeral?

Q.16: Do respondents have any views as to what the format and contents of the post-mortem request and report forms should be, in future?

### **Chapter 4 – Coroner investigations – Entry, Search and Seizure**

Q.17: Who do coroners envisage carrying out these functions on their behalf? Do coroners envisage delegating this task to coroners' officers, the police, or someone else entirely? Who do other consultees feel should carry out this task on behalf of the coroner? Who do you think would be suitably qualified to carry out this task on behalf of coroners?

Q.18: Should the person entering, searching and seizing have in their possession, in every circumstance, some form of documentation stating their authority to be on the land or premises and to remove items and documents?

Q.19: We propose that the procedure for obtaining permission to carry out a search, and the process for carrying out search and seizure, should where possible, mirror the process used by the police in accordance with the Police and Criminal Evidence Act 1984. This could be achieved by way of a code of



practice, as was proposed during Parliamentary debates on this issue. Do you consider this approach is appropriate?

Q.20: Do you have views on the other aspects of the proposed procedure for entry search and seizure set out in Chapter 4?

Q.21: In normal circumstances, should some form of notice be given to the landowner/occupier that entry, search and seizure is to be undertaken? Is 48 hours a suitable period of notice?

### **Chapter 5 – Disclosure of information by coroners**

Q.22: Do you agree that we have captured the right principles and struck a proper balance between those which compete?

Q.23: Should we permit requests to be made at any stage in a coroner's investigation? If so how long should coroners be given to respond to requests, in order to not delay investigations, but to provide them with workable timescales?

Q.24: What do you expect the level of take-up to be of the Charter for Bereaved People's provision for information to be disclosed to bereaved people, free of charge? How would it compare to current requests?

Q.25: Are there any circumstances where bereaved people should pay for disclosure of material?

Q.26: What would the impact be on coroners and their staff of disclosing information free of charge, to bereaved people and possibly to other interested persons? What would the costs be and how would those costs be comprised?

Q.27: We do not propose that interested persons should have all disclosable material provided to them automatically, or that if one interested person requests disclosure it should be automatically sent to all others. We propose instead that they should be made aware that they are entitled to request the information. It will be a matter for them as to whether they make the request, including in relation to assisting with an appeal application. Do you agree with this approach? If not, please suggest an alternative.

Q.28: What level of requests for information from other interested persons would you expect to see, and why?

Q.29: How common is charging for disclosure in practice at present? Should we specify the circumstances in which a coroner can charge?

Q.30: What levels of fees should be payable?

Q.31: To whom should the fee be paid? If paid to a coroner's office, should the fee be passed on to the relevant local authority?

Q.32: Once an investigation is completed, should we specify a time limit for obligation for requests to a coroner to disclose information – e.g. 6 months/a year after the conclusion of the investigation – so that, after a certain period, a coroner will have discretion to refuse a request for information?

## **Chapter 6 – The conduct of the inquest**

Q.33: Should a formal requirement for the opening of an inquest be retained?

Q.34: Should there be a formal requirement for an inquest, when relevant, to be held as soon as possible after the death?

Q.35: Should the procedures for summoning witnesses be put on a more formal footing, in similar terms to those regarding the summoning of jurors, for example?

Q.36: Should the circumstances when vulnerable or potentially vulnerable witnesses are to be granted special measures while giving evidence be put on a formal basis?

Q.37: In what circumstances do consultees think coroners should exercise powers to withhold names or other matters?

Q.38: Should there be a formal basis for coroners to accept unsworn evidence at inquests?

Q.39: Should the position on admissibility of documentary evidence be extended or clarified?

Q.40: Is there an argument for retaining or reducing the requirement for documents to be kept for 15 years as is the case at present – particularly in view of the new appeal arrangements against coroners' decisions which the Act establishes?

Q.41: Should a new list of short form determinations be established; and if so, what should the categories be?

Q.42: Should coroners be required to return a narrative determination in any case where they are unable to attribute one of these determinations?

Q.43: Should the rules contain something on the availability and use of narrative determinations, and if so, what?

Q.44: We would welcome comments from respondents on any of the issues contained within the Coroners Rules 1984 that are likely, in substance, to be replicated in the new rules.

Q.45: Are there any other areas where respondents suggest the Chief Coroner may consider issuing guidance in relation to the administration and conduct of inquests?

## **Chapter 7 – Appeals and complaints**

Q.46: Do you agree that the person who wishes to appeal must complete a notice of appeal in order for the Chief Coroner to consider the appeal?

Q.47: Do you agree that the notice of appeal should include a declaration that an attempt has been made to resolve the matter informally directly with the coroner or his office? If so, should this also apply where an appeal is about a post-mortem and therefore must be made within a very short timescale?

Q.48: Do you agree that the Chief Coroner may disregard an appeal if he or she decides the appeal is vexatious or frivolous, and must document his or her reasons for doing so?

Q.49: Do you agree that the Chief Coroner will determine the method of considering the appeal – i.e. whether there should be a paper or oral hearing?

Q.50: Do you agree the proposed timescales set out for lodging appeals and for the Chief Coroner to rule on appeals?

### **Chapter 8 – Training of coroners, their officers and staff**

Q.51: Do you agree with the content of the tables for training of coroners, their officers and staff? Is there anything missing?

Q.52: Should only some training be compulsory – and if so, what – e.g. induction training? Why?

Q.53: If compulsory, or part compulsory, should training have to happen before a coroner / officer / staff can operate, or within a certain period of their beginning – say 3 or 6 months? Or should only particular duties be exempt until training is received?

Q.54: Should trainees have to complete a certain number of training days per year, or certain modules? What should the requirement be?

Q.55: If training is compulsory, what might be effective sanctions to ensure completion?

Q.56: What should happen if training is compulsory and someone cannot complete it – because of work commitments, illness, or lack of authorisation from managers?

Q.57: Assuming full induction has been received, should the minimum number of training days be the same for each category of person to be trained?

Q.58: Who do you think would be best placed to deliver training and why?

Q.59: Should the Chief Coroner approve a provider before they can train coroners, coroners' officers and support staff?

Q.60: Should there be a mix of providers, depending on the event?

Q.61: Should training provide Continuing Professional Development (CPD) credit for coroners?

Q.62: Should there be training courses – possibly residential – for induction courses for coroners and officers; and continuing professional development training?

Q.63: Should there be on site locally delivered training – for local issues?

Q.64: Should there be E-learning – for refresher training; updates on developments / changes; and information which it is useful to have permanently available to refer to?

Q.65: Should some types of training event be open to a mixed audience – e.g. coroners, their officers and other staff, medical examiners, medical examiner officers, local authority staff? If so, which?

Q.66: Should coroners be expected to devise an initial induction package locally for new area and assistant coroners, and / or for coroners' officers and staff, based on a central template provided by the Chief Coroner's office? Or do coroners believe this is not part of their role given that they do not have direct management responsibility for any of these groups?

Q.67: Are there any other issues the Chief Coroner should consider if drawing up training regulations?

## **Chapter 9 - Death registration procedures**

Q.68: Should an equivalent short death certificate be issued by a registrar of births and deaths free of charge for each death registered in England and Wales? Please include the reasons for your views.

Q.69: Should a short certificate omit any information about the occupation and other details of the person who has died, and the person who has authorised registration of the death?

**Thank you for participating in this consultation exercise.**

## Main activities of Chief Coroner

1. From 2012 the main activities of the Chief Coroner will be:

### JUDICIAL ROLE

#### Conducting an investigation

2. The Chief Coroner may conduct an investigation into a person's death. The circumstances in which the Chief Coroner will sit will be determined by the Chief Coroner.

#### Appeals

3. The Chief Coroner – or a deputy - will deal with appeals made by an interested person against a decision made by a coroner. The decisions that can be appealed are set out in the 2009 Act, and include:
  - Whether to conduct an investigation into a person's death.
  - Whether to discontinue an investigation.
  - Whether to resume a suspended investigation into a person's death.
  - The coroner's final determination and finding.

The Chief Coroner may also issue guidance or practice directions to coroners arising from appeal decisions.

#### Applications for search and entry

4. The Chief Coroner - or a nominee - will authorise (or otherwise) all applications by coroners to search and enter land or premises for the purposes of an investigation.

#### Managing coroner business

5. The Chief Coroner may allocate coroner business in order to deal with particularly complex cases, backlogs or delays, or to cater for unexpectedly large numbers of deaths due to a major incident. He/She may:

- Direct a coroner to conduct an investigation (which, but for the direction, would otherwise fall to a different coroner).
  - Request the Lord Chief Justice to nominate a High Court or Circuit judge to conduct an investigation.
6. Additionally, the Chief Coroner may notify the Lord Advocate if he or she believes that an investigation should be carried out in Scotland under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 – rather than by a coroner’s investigation. This applies in circumstances when someone is killed abroad on active military service, or involved in the training of those on active service. There are reciprocal arrangements for the Lord Advocate to notify the Chief Coroner if the investigation should be conducted by a coroner.

#### Applications where no body exists

7. Where a coroner believes that a death has occurred in or near his or her area (including in adjoining territorial waters) in circumstances that would normally require an investigation, but the body is lost, destroyed or absent, the coroner should report the matter to the Chief Coroner, rather than to the Secretary of State as at present. The Chief Coroner will decide whether an investigation into the death should be carried out, and by whom.

### **LEADERSHIP ROLE**

#### National guidance and standards

8. The Chief Coroner will be responsible for:
- Issuing guidance to coroners on ways of working.
  - Giving practice directions.
  - Developing protocols between coroners and other organisations.
  - Setting national standards of service.
  - Monitoring performance, particularly in relation to delayed investigations.
9. The sort of topics on which the Chief Coroner could issue guidance, practice directions and standards may include:
- Procedures for conducting investigations into the deaths of service personnel.
  - Circumstances in which a coroner may hold an inquest with a jury.

- When a coroner may consider holding an inquest (or part of an inquest) in camera on the grounds of national security.
  - The timeliness of coroner investigations.
  - The conduct of post-mortem examinations, including matters such as the timely release of bodies to bereaved relatives, and matters pertaining to the use and retention of human tissue.
10. A draft *Charter for Bereaved People* was published alongside the draft Bill. It will be for the Chief Coroner to develop the Charter, through consultation with interested groups, so that it is ready to be introduced in 2012. The Chief Coroner will be responsible for monitoring the Charter once it is introduced.

#### Training

11. The Chief Coroner will be responsible for ensuring that appropriate arrangements exist for the training and continuing professional development of coroners, coroners' officers and other staff who assist coroners in carrying out their duties.
12. The training framework will be developed through regulations made by the Chief Coroner, with the agreement of the Lord Chancellor, before April 2012.

#### Working with interested groups

13. The Chief Coroner will need to forge constructive working relationships with leaders of key organisations and interested groups including the Ministry of Justice and other government departments, the Coroners' Society, voluntary sector organisations, and with other coronial (or equivalent) jurisdictions in the UK and elsewhere.

#### Liaison with the media

14. The Chief Coroner is likely to have a high media profile and will be required to brief and respond to enquiries from the press and media.

#### Investigation of complaints

15. The Chief Coroner will have overall responsibility for establishing and overseeing a system for responding to, investigating, resolving and/or acting on complaints about the service provided by coroners. For example, complaints about a failure to deliver a service or services set out in the Charter for Bereaved People.

16. Complaints about coroner conduct will continue to be dealt with by the Office of Judicial Complaints, as per the Constitutional Reform Act 2005.

#### Supporting coroners in negotiations with local authorities and police authorities

17. If the Chief Coroner believes that particular coroners do not have sufficient resources to discharge their statutory functions, then he or she might support the coroner in negotiations with the local authority with funding responsibility.
18. The Chief Coroner may also benchmark existing resource provision; issue guidance on resources; and oversee discussions between coroners, local authorities, and the police to agree new coroner area boundaries, generally to support a full-time coroner caseload.

#### Chief Coroner's Annual Report

19. The Chief Coroner must provide an annual report to the Lord Chancellor, covering issues such as:
  - Best practice, particularly in relation to services to bereaved families.
  - The number of complaints and appeals dealt with over the year.
  - Identification of any specific resource issues and action taken to address them.
  - Any other matters the Chief Coroner wishes to bring to public attention.

The report will be published and laid before Parliament.

#### Coroner reports to prevent future deaths

20. The Chief Coroner will develop and operate an effective scheme for ensuring that recommendations and warnings relating to public safety which emerge out of coroners' investigations are brought to the attention of those responsible for creating the relevant risks and/or of the relevant regulatory and other bodies and/or of the public and for taking steps to ensure so far as possible that such recommendations and warnings are acted upon.



## ADMINISTRATIVE ROLE

### Coroner appointments

21. Local authorities are responsible for appointing coroners, but the Lord Chancellor and the Chief Coroner must consent to their appointment. The Chief Coroner will have some input as to the job description and selection criteria for these appointments, so as to ensure the quality of the candidates, and may be represented on the selection panel which chooses the successful candidate.

### Designation of medical practitioners

22. Where a particular kind of post-mortem examination is required (i.e. one carried out by a forensic archaeologist ), only non-medically registered practitioners designated by the Chief Coroner – with advice from his/her Medical Adviser - may conduct the examination.

### Emergency planning

23. The Chief Coroner will be the point of contact for national emergency planning exercises, and lead (for coroners) on matters relating to national guidance on emergency planning.

## Glossary of terms

**(Including definitions, interpretations, abbreviations and acronyms)**

### *Adjournments, discontinuance, suspensions and resumptions*

An adjournment is a temporary break in the conduct of an inquest, either for a fixed period which may be laid down in rules or for a period such as the coroner sees fit (which may be an indefinite period), for a particular purpose. This may be, for example, to enable a particular witness or interested person to be able to attend, or to allow for a particular piece of evidence to be produced at the inquest.

Discontinuance of an investigation occurs in situations where the coroner believes that the cause of death has been revealed to his or her satisfaction prior to the need for calling an inquest into the death in question arising. This is most likely to be because the cause of death has been revealed by a post-mortem examination when the cause was previously unknown. Provision for such discontinuance is made at section 4 of the 2009 Act.

Suspension of an investigation will occur when it becomes clear that the cause of death may well be established by way of a legal forum other than a coroner's investigation, or when some other form of investigation is taking place that may be unduly prejudiced by the continuation of the coroner's investigation. This would be, for example, when certain criminal charges may be brought or are brought, or when the cause of death is subject to investigation by way of an inquiry established under the Inquiries Act 2005, but may also occur in other circumstances where the coroner feels it to be appropriate.

Suspended investigations may be resumed as and where appropriate if the coroner is of the opinion that there is sufficient reason for doing so. This may occur, for example, in cases where criminal charges have been brought, but the accused pleads guilty before the actual cause of death has been fully established. Provision for suspension and resumption of investigations is made at Schedule 1 of the 2009 Act.

### *Appeals, complaints and disciplinary hearings*

An appeal is the method by which an interested person will be able to challenge a coroner's decision. Such appeals will ordinarily be made to the Chief Coroner, and can be made on a number of grounds as laid out in section 40 of the 2009 Act.

Complaints about standards of service received by bereaved people from a coroner or coroner's office can also be made to the Chief Coroner. The standards of service bereaved persons can expect to receive will be set out in the Charter for Bereaved People. If the complaint is upheld, the Chief Coroner will then take any action he or she decides is appropriate in order to improve the standard of service provided. He or she will also inform the complainant of that action. Other interested persons will also be able to give feedback to the Chief Coroner about the standards of service that coroners give.

With regard to disciplinary hearings about a coroner's personal conduct (rather than about decisions they've made or the service they have provided), the Act provides for complaints about a coroner's conduct to be made to the Office of Judicial Complaints, as is currently the case. Any subsequent disciplinary proceedings will be dealt with by the Lord Chief Justice in conjunction with the Lord Chancellor. The Lord Chancellor may, with the Lord Chief Justice's agreement, remove a coroner from office for incapacity or misbehaviour.

#### *Areas and coroner areas*

An 'area', in relation to a senior coroner, area coroner or assistant coroner, means the 'coroner area' for which that coroner is appointed.

England and Wales is to be divided into a number of 'coroner areas' – each 'coroner area' is to consist of the area of a local authority or the combined areas of two or more local authorities.

#### *Body*

References to 'body' in the Act includes 'body parts'.

#### *Coroners - senior coroners, area coroners and assistant coroners*

The relevant authority for each coroner area must appoint a coroner, to be known as the 'senior coroner', for that area. This appointment must be approved by both the Lord Chancellor and the Chief Coroner.

The Lord Chancellor may also require the appointment of a specified number of 'area coroners' and a minimum number of 'assistant coroners' for each area. Again, such 'area coroners' and 'assistant coroners' as have been ordered are to be appointed by the relevant authority, although again the approval of both the Lord Chancellor and the Chief Coroner is required for each appointment. Area coroners and assistant coroners may perform any functions of a senior coroner during a period when the senior coroner is absent or unavailable, or at any other time with the consent of the senior coroner.

Senior coroners and area coroners are entitled to salaries and pensions, to be agreed with and provided for by the relevant authority – assistant coroners are

entitled only to fees, again to be agreed with and provided for by the relevant authority.

*Determinations, findings and matters to be ascertained*

The ‘matters to be ascertained’ reflect the purpose of the coroner’s investigation, as laid down in section 5 of the 2009 Act. The matters to be ascertained by an investigation are who the deceased was; how, when and where the deceased died; and any further particulars necessary to enable the requirements of the Registration Act 1953 to be complied with. In addition, in cases that engage Article 2 of the European Convention on Human Rights (usually those where an arm of the state is implicated in the death in question), the circumstances in which the deceased came by his or her death are also to be ascertained.

‘Determinations’ are the outcomes of the investigation, to be made by the coroner (or a jury, where one is sitting), after the inquest as to the identity of the deceased and how, when and where they died.

‘Findings’ are the outcomes of the investigation, to be made by the coroner (or a jury, where one is sitting), after the inquest with regard to allowing the requirements of the Registration Act 1953 to be complied with.

*Document*

References to ‘document’ in the Act includes information stored in an electronic format.

*Enforcing authorities, prosecuting authorities and relevant authorities*

‘Enforcing authorities’ are bodies such as the Health and Safety Executive who are charged with investigating incidents such as workplace accidents under the Health and Safety at Work etc. Act 1974.

‘Prosecuting authorities’ are bodies such as the Director of Public Prosecutions, who consider whether criminal charges should be brought with regard to any particular case.

‘Relevant authorities’ are, in instances where a coroners area consists of one local authority, that local authority; and in instances where a coroner area consists of more than one local authority, the authority nominated to take lead responsibility for coroner matters on behalf of all the local authorities concerned.

### *Interested person*

Any person specified in section 47(2) of the 2009 Act is to be regarded as an 'interested person' for the purposes of an investigation. This includes family members and people such as personal representatives, medical examiners, beneficiaries and insurers, those whose acts or omissions may have caused or contributed towards the death in question and trade union representatives if the death occurred at work or as the result of an industrial disease. The coroner also has a power to designate anyone he or she feels has sufficient interest in the case as an 'interested person'. Any person who the coroner decides is not an 'interested person' in the case may appeal that decision to the Chief Coroner.

### *Investigations and inquests*

Under the 2009 Act, there is recognition that the coroner's role extends beyond sitting in court presiding over 'inquests'. It refers instead to coroners conducting 'investigations', of which, in some cases, the 'inquest' may be a part (usually the final part). Many cases which are currently reported to coroners and where at least some preliminary 'investigation' takes place, do not proceed to an 'inquest'. (In 2008, about 235,000 deaths were reported to coroners whilst only 31,000 inquests were held.)

Under the new system, once a coroner has established jurisdiction for a case, sometimes following preliminary inquiries, he or she will formally open an 'investigation'. This will be required for all deaths where a post-mortem is to be held – or has been held – and in any other case where it is clear that more than cursory involvement will be required. The coroner's decision to open an 'investigation' will be subject to appeal. This will be a largely administrative procedure which can be conducted on the papers rather than in open court (although it could take place in open court if it seemed more appropriate given the nature of the case).

The 'inquest' will remain as the final part of an investigation which proceeds for its full length, and will be the formal hearing that takes place in court.

### *Notifiable accident, poisoning or disease*

An accident, poisoning or disease is to be regarded as 'notifiable' if it is required by any Act of Parliament to be reported to a government department, an inspector or other officer of a Government department, or to an inspector appointed under health and safety legislation. The relevance of this is that the inquest into any death so caused must be held with a jury.

### *Post-mortem examination*

Any examination of the body that takes place after death is known as a post-mortem examination. With specific regard to coroner's post-mortem examinations, these are any examinations ordered by the coroner under his or her powers at section 14 of the 2009 Act. As was made clear during Parliamentary debates on this section, 'post-mortem examinations' are not restricted to invasive methods such as a full autopsy carried out by a pathologist – they may also include other less invasive methods of examination, such as by way of MRI scan, or an examination of specific organs, samples or body parts. A coroner's post-mortem examination need not be carried out by a medical practitioner (although in reality the vast majority of them will be), but could also be carried out by other designated persons, such as forensic scientists

### *Regulations and rules*

Regulations are to be made under powers contained within section 43 of the 2009 Act. They will regulate the practice and procedures of investigations (other than those in connection with the conduct of inquests), post-mortem examinations and exhumations. They will be made by the Lord Chancellor, but are subject to the agreement of the Lord Chief Justice (or another judicial office holder nominated by the Lord Chief Justice for that purpose)

Rules are to be made under powers contained within section 45 of the 2009 Act. They regulate the practices and procedures at or in connection with inquests and appeals. They therefore regulate the formal, court based parts of the investigation process rather than the whole investigation itself. These rules are referred to collectively as "Coroners rules". They are made by the Lord Chief Justice (or another judicial office holder nominated by the LCJ for that purpose), although they do require the agreement of the Lord Chancellor.

### *State detention*

A person is regarded as being in 'state detention' if they are being compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1988. It is anticipated that the Chief Coroner will issue guidance to coroners as to which bodies and institutions this definition covers (although this definition is broadly intended to include institutions such as prisons, police custody, young offenders institutions, immigration resettlement centres and secure mental health units).

*Statutory guidance*

Any guidance issued by the Lord Chancellor under section 42 of the 2009 Act about the way in which the coroners system is supposed to operate in relation to interested persons will be regarded as having the status of 'statutory guidance'. Such status will reflect the importance that is placed on adherence to the contents of such guidance.

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DMACC – Deputy Medical Adviser to the Chief Coroner

DPP – Director of Public Prosecutions

HTA – Human Tissue Authority

HSE – Health and Safety Executive

IPCC – Independent Police Complaints Commission

LCJ – Lord Chief Justice

LHBs – Local Health Boards (Wales only)

MACC – Medical Adviser to the Chief Coroner

MCCDs – Medical Certificates of Cause of Death

MEs – Medical Examiners

MoJ – Ministry of Justice

MRI – Magnetic Resonance Imaging

NME – National Medical Examiner

OJC – Office of Judicial Complaints

PCTs – Primary Care Trusts (England only)

## About you

Please use this section to tell us about yourself

<b>Full name</b>	
<b>Job title</b> or capacity in which you are responding to this consultation exercise (e.g. member of the public etc.)	
<b>Date</b>	
<b>Company name/organisation</b> (if applicable):	
<b>Address</b>	
<b>Postcode</b>	
If you would like us to acknowledge receipt of your response, please tick this box	<input type="checkbox"/> (please tick box)
Address to which the acknowledgement should be sent, if different from above	

**If you are a representative of a group**, please tell us the name of the group and give a summary of the people or organisations that you represent.

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## How to respond

Please send your response by 1 July 2010 to:

**Olga Kostiw**  
**Ministry of Justice**  
**Coroners and Burials Division**  
**4<sup>th</sup> Floor (post point 4.38)**  
**102 Petty France**  
**London**  
**SW1H 9AJ**

**Tel: 0203 334 6400**

**Email: [coroners@justice.gsi.gov.uk](mailto:coroners@justice.gsi.gov.uk)**

### Extra copies

Further paper copies of this consultation can be obtained from this address and it is also available online at [www.justice.gov.uk](http://www.justice.gov.uk).

Alternative format versions of this publication can be requested from Olga Kostiw at the address above.

### Publication of response

A paper summarising the responses to this consultation will be published in autumn 2010. The response paper will be available online at [www.justice.gov.uk](http://www.justice.gov.uk)

### Representative groups

Representative groups are asked to give a summary of the people and organisations they represent when they respond.

### Confidentiality

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other

things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Ministry.

The Ministry will process your personal data in accordance with the DPA and in the majority of circumstances this will mean that your personal data will not be disclosed to third parties.

## Summary: Intervention & Options

<b>Department /Agency:</b> <b>Ministry of Justice</b>		<b>Title:</b> <b>Impact Assessment for coroner provisions of the Coroners and Justice Act 2009</b>	
<b>Stage:</b> Consultation	<b>Version:</b> 3	<b>Date:</b> 23 February 2010	
<b>Related Publications:</b> N/A			

Available to view or download at: [www.justice.gov.uk/publications/coroners-justice-bill.htm](http://www.justice.gov.uk/publications/coroners-justice-bill.htm)  
[www.opsi.gov.uk/acts/acts2009/ukpga\\_20090025\\_en\\_1](http://www.opsi.gov.uk/acts/acts2009/ukpga_20090025_en_1)

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### What is the problem under consideration? Why is government intervention necessary?

The Coroners and Justice Act received Royal Assent in November 2009. The Act provides for rules and regulations, and associated guidance, to be made on the practice and procedure governing coroner investigations and inquests. The Act was intended to address the problems with the current system identified by The Shipman Inquiry and the Fundamental Review of Death Certification and Investigation. These include: an inconsistent level of service provided to bereaved people, lack of involvement of family and friends in coroner investigations, a lack of leadership and training for coroners and a lack of medical knowledge in the system as a whole. The Act requires secondary legislation in order to become effective. This impact assessment examines nine proposed options for the secondary legislation.

**What are the policy objectives and the intended effects?** Part 1 of the Coroners and Justice Act, which includes the nine proposals on which we are consulting, will modernise and improve the coroner system in England and Wales. A new Chief Coroner will be appointed who will provide leadership to coroners and set national standards that coroners should meet in relation to the reforms. This will improve the experience of bereaved people and other interested persons coming into contact with the coroner system. The quality, efficiency, flexibility and outcomes of coroner investigations and inquests will be improved through stronger powers and improved training and guidance for coroners.

**What policy options have been considered?** The policy consultation seeks views on nine of the main provisions of Part 1 of the Coroners and Justice Act, on which the Government will make secondary legislation. Consultation responses will inform the subsequent drafting of this secondary legislation. There are 9 proposals on which we are seeking views, and on which we set out what we believe the impacts will be:

(0) do nothing; (1) the deaths which should be reported to coroners; (2) post mortems; (3) inquests; (4) entry, search and seizure; (5) disclosure of information; (6) training; (7) appeals and complaints; (8) transferring cases between coroners; (9) short death certificates; and (10) to implement all the 9 options.

**Our preferred option is Option 10, to implement all of the proposed reforms, because we believe all of the proposals to be beneficial to the coroner system in England & Wales.**

**When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?** Projected costs and benefits will be reviewed following the policy consultation. An updated impact assessment will be published alongside the Act's draft secondary legislation, likely to be published in early 2011.

### **Ministerial Sign-off** For Consultation stage Impact Assessments:

*I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.*

Signed by the responsible Minister:

.....*Bridget Prentice*..... Date: 11 March 2010

Summary: Analysis & Evidence					
Policy Option: 1		Description: Clarifying the circumstances under which a death should be reported to a coroner			
<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups'		
	<b>One-off</b> (Transition)	<b>Yrs</b>			
	£				
	<b>Average Annual Cost</b> (excluding one-off)				
	£	10	<b>Total Cost (PV)</b>	£	
<p><b>Other key non-monetised costs</b> by 'main affected groups'</p> <p>There would be a cost for Ministry of Justice of training coroners and their staff on the new regulations. The Department of Health would also incur some costs for training as part of the new Death Certification programme on which it leads.</p>					
<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'		
	<b>One-off</b>	<b>Yrs</b>			
	£				
	<b>Average Annual Benefit</b> (excluding one-off)				
	£	10	<b>Total Benefit (PV)</b>	£	
<p><b>Other key non-monetised benefits</b> by 'main affected groups'</p> <p>Fewer cases being referred to coroners resulting in reduced caseloads; medical practitioners benefit from greater clarity on which cases should be referred to a coroner or medical practitioner; and bereaved people benefit from a quicker and more responsive service from coroner and/or medical examiner.</p>					
<p><b>Key Assumptions/Sensitivities/Risks</b> It is assumed that overall annual costs will not change as a result of this option. Although coroners' caseloads will decrease, their overall workload, as a result of other proposals we are consulting on, will not.</p>					
Price Base Year	Time Period Years	<b>Net Benefit Range (NPV)</b> £	<b>NET BENEFIT (NPV Best estimate)</b> £		
What is the geographic coverage of the policy/option?			England & Wales		
On what date will the policy be implemented?			2012-2013		
Which organisation(s) will enforce the policy?			MoJ		
What is the total annual cost of enforcement for these organisations?			£ Negligible		
Does enforcement comply with Hampton principles?			Yes		
Will implementation go beyond minimum EU requirements?			No		
What is the value of the proposed offsetting measure per year?			£ Negligible		
What is the value of changes in greenhouse gas emissions?			£ Negligible		
Will the proposal have a significant impact on competition?			No		
Annual cost (£-£) per organisation (excluding one-off)		Micro	Small	Medium	Large
Are any of these organisations exempt?		No	No	N/A	N/A
<b>Impact on Admin Burdens Baseline</b> (2005 Prices)				(Increase - Decrease)	
Increase of	£	Decrease of	£	<b>Net Impact</b>	£

## Summary: Analysis & Evidence

<b>Policy Option: 2</b>	<b>Description: Transferring cases from one coroner to another</b>
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<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups'
	<b>One-off</b> (Transition)	<b>Yrs</b>	
	£		
	<b>Average Annual Cost</b> (excluding one-off)		
	£	10	<b>Total Cost (PV)</b> £
<p><b>Other key non-monetised costs</b> by 'main affected groups'</p> <p>There would be a cost for Ministry of Justice of training coroners and their staff on the new regulations. The costs of meeting expenses during an investigation will still be met by local authorities; this may be a different local authority to that in the base case.</p>			

<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'
	<b>One-off</b>	<b>Yrs</b>	
	£		
	<b>Average Annual Benefit</b> (excluding one-off)		
	£	10	<b>Total Benefit (PV)</b> £
<p><b>Other key non-monetised benefits</b> by 'main affected groups'</p> <p>Coroner offices will benefit from a quick and simple transfer of cases, and from the increased transparency within the system. Bereaved people will benefit from more involvement in the coroner system, fewer delays and will be able to request a transfer from one coroner to another.</p>			

**Key Assumptions/Sensitivities/Risks** It is assumed that national annual costs of paying for the coroner system will not change although some local authorities may pay slightly more while others may pay slightly less, depending on what is decided on policy for transfer of cases.

Price Base Year	Time Period Years	<b>Net Benefit Range (NPV)</b> £	<b>NET BENEFIT (NPV Best estimate)</b> £
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What is the geographic coverage of the policy/option?	England & Wales			
On what date will the policy be implemented?	2012-2013			
Which organisation(s) will enforce the policy?	MoJ			
What is the total annual cost of enforcement for these organisations?	£ Negligible			
Does enforcement comply with Hampton principles?	Yes			
Will implementation go beyond minimum EU requirements?	No			
What is the value of the proposed offsetting measure per year?	£ Negligible			
What is the value of changes in greenhouse gas emissions?	£ Negligible			
Will the proposal have a significant impact on competition?	No			
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	No	No	N/A	N/A

<b>Impact on Admin Burdens Baseline</b> (2005 Prices)			(Increase - Decrease)
Increase of	£	Decrease of	£
<b>Net Impact</b>			£

Summary: Analysis & Evidence					
Policy Option: 3		Description: Improve procedure for post mortem investigations			
<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups'		
	<b>One-off</b> (Transition)	<b>Yrs</b>			
	£				
	<b>Average Annual Cost</b> (excluding one-off)				
£	10	<b>Total Cost (PV)</b>	£		
<p><b>Other key non-monetised costs</b> by 'main affected groups' There would be a cost for the Ministry of Justice of training coroners and their staff on the new regulations. Local authorities may incur greater costs from requests for more detailed types of examination and/or transportation of bodies to specialist facilities. On the other hand, the policy objective is for there to be fewer post-mortem examinations nationally, which will offset these. Because of different current practices across England and Wales at present, the impact on particular local authorities may differ. Pathologists may see a reduction in the number of full invasive post-mortem examinations that they carry out.</p>					
<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'		
	<b>One-off</b>	<b>Yrs</b>			
	£				
	<b>Average Annual Benefit</b> (excluding one-off)				
£	10	<b>Total Benefit (PV)</b>	£		
<p><b>Other key non-monetised benefits</b> by 'main affected groups' This option would give greater control to coroners and would enable them to tailor their requests to suit their functions. Bereaved people will benefit from having a more tailored service that takes into account any religious/cultural requirements.</p>					
<p><b>Key Assumptions/Sensitivities/Risks</b> It is assumed that the overall annual amount spent by local authorities on post-mortem examinations will not change, although as set out above, the impact on particular authorities may be different.</p>					
Price Base Year	Time Period Years	<b>Net Benefit Range (NPV)</b> £	<b>NET BENEFIT (NPV Best estimate)</b> £		
What is the geographic coverage of the policy/option?			England & Wales		
On what date will the policy be implemented?			2012-2013		
Which organisation(s) will enforce the policy?			MoJ		
What is the total annual cost of enforcement for these organisations?			£ Negligible		
Does enforcement comply with Hampton principles?			Yes		
Will implementation go beyond minimum EU requirements?			No		
What is the value of the proposed offsetting measure per year?			£ Negligible		
What is the value of changes in greenhouse gas emissions?			£ Negligible		
Will the proposal have a significant impact on competition?			No		
Annual cost (£-£) per organisation (excluding one-off)		Micro	Small	Medium	Large
Are any of these organisations exempt?		No	No	N/A	N/A
<b>Impact on Admin Burdens Baseline</b> (2005 Prices)				(Increase - Decrease)	
Increase of	£	Decrease of	£	<b>Net Impact</b>	£

## Summary: Analysis & Evidence

**Policy Option: 4**
**Description: Implement coroner entry, search and seizure powers**

<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups'
	<b>One-off</b> (Transition)	<b>Yrs</b>	
	£		
	<b>Average Annual Cost</b> (excluding one-off)		
	£	10	<b>Total Cost (PV)</b> £
Other <b>key non-monetised costs</b> by 'main affected groups' There would be a cost for Ministry of Justice of training coroners and their officers and staff on the new regulations. Other small costs may incur if coroners delegate this power to either their officers or the police.			

<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'
	<b>One-off</b>	<b>Yrs</b>	
	£		
	<b>Average Annual Benefit</b> (excluding one-off)		
	£	10	<b>Total Benefit (PV)</b> £
Other <b>key non-monetised benefits</b> by 'main affected groups' Coroners will be better able to ascertain evidence they require to investigate a death. Bereaved people will benefit from being more certain that coroners have had access to all relevant evidence to conduct their investigation.			

**Key Assumptions/Sensitivities/Risks** It is assumed that annual costs will be negligible.

Price Base Year	Time Period Years	<b>Net Benefit Range (NPV)</b> £	<b>NET BENEFIT (NPV Best estimate)</b> £
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What is the geographic coverage of the policy/option?		England & Wales			
On what date will the policy be implemented?		2012-2013			
Which organisation(s) will enforce the policy?		MoJ			
What is the total annual cost of enforcement for these organisations?		£ Negligible			
Does enforcement comply with Hampton principles?		Yes			
Will implementation go beyond minimum EU requirements?		No			
What is the value of the proposed offsetting measure per year?		£ Negligible			
What is the value of changes in greenhouse gas emissions?		£ Negligible			
Will the proposal have a significant impact on competition?		No			
Annual cost (£-£) per organisation (excluding one-off)		Micro	Small	Medium	Large
Are any of these organisations exempt?		No	No	N/A	N/A

<b>Impact on Admin Burdens Baseline</b> (2005 Prices)				(Increase - Decrease)
Increase of	£	Decrease of	£	<b>Net Impact</b> £

Summary: Analysis & Evidence					
Policy Option: 5		Description: Disclosure of information by coroners			
<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups'		
	<b>One-off</b> (Transition)	<b>Yrs</b>			
	£				
	<b>Average Annual Cost</b> (excluding one-off)				
£	10	<b>Total Cost (PV)</b>	£		
<p><b>Other key non-monetised costs</b> by 'main affected groups'</p> <p>There would be a cost for the Ministry of Justice of training coroners and their staff on the new secondary legislation. There is a likely cost impact on coroners' officers for copying and distributing documents, in terms of both time and physical resources.</p>					
<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'		
	<b>One-off</b>	<b>Yrs</b>			
	£				
	<b>Average Annual Benefit</b> (excluding one-off)				
£	10	<b>Total Benefit (PV)</b>	£		
<p><b>Other key non-monetised benefits</b> by 'main affected groups'</p> <p>Coroners' offices would benefit from the standardisation of disclosure making requests easier to deal with. Bereaved people will benefit from this as they will receive more information. Other interested persons will benefit from greater clarity and consistency of disclosure, with a right to request documents.</p>					
<p><b>Key Assumptions/Sensitivities/Risks</b> It is assumed that the costs incurred can be met from within existing resources.</p>					
Price Base Year	Time Period Years	<b>Net Benefit Range (NPV)</b> £	<b>NET BENEFIT (NPV Best estimate)</b> £		
What is the geographic coverage of the policy/option?			England & Wales		
On what date will the policy be implemented?			2012-2013		
Which organisation(s) will enforce the policy?			MoJ		
What is the total annual cost of enforcement for these organisations?			£ Negligible		
Does enforcement comply with Hampton principles?			Yes		
Will implementation go beyond minimum EU requirements?			No		
What is the value of the proposed offsetting measure per year?			£ Negligible		
What is the value of changes in greenhouse gas emissions?			£ Negligible		
Will the proposal have a significant impact on competition?			No		
Annual cost (£-£) per organisation (excluding one-off)		Micro	Small	Medium	Large
Are any of these organisations exempt?		No	No	N/A	N/A
<b>Impact on Admin Burdens Baseline</b> (2005 Prices)				(Increase - Decrease)	
Increase of	£	Decrease of	£	<b>Net Impact</b>	£



Summary: Analysis & Evidence					
Policy Option: 6		Description: Inquests			
<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups'		
	<b>One-off</b> (Transition)	<b>Yrs</b>			
	£				
	<b>Average Annual Cost</b> (excluding one-off)				
	£	10	<b>Total Cost (PV)</b>	£	
<p><b>Other key non-monetised costs</b> by 'main affected groups' There would be a cost for the Ministry of Justice of training coroners and their staff on the new secondary legislation. There may be increased costs for witness expenses and costs of storage of evidence and exhibits.</p>					
<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'		
	<b>One-off</b>	<b>Yrs</b>			
	£				
	<b>Average Annual Benefit</b> (excluding one-off)				
	£	10	<b>Total Benefit (PV)</b>	£	
<p><b>Other key non-monetised benefits</b> by 'main affected groups' Coroners will be able to carry out their functions in an effective and efficient manner as they will have clearer guidance to carry them out.. Bereaved people will benefit from reduced delays for inquests and have more confidence in conclusions reached. The improved method by which witnesses are summoned would enable the inquest to take place promptly and allow them to give evidence in the best possible way.</p>					
<p><b>Key Assumptions/Sensitivities/Risks</b> It is assumed that annual costs will be negligible.</p>					
Price Base Year	Time Period Years	<b>Net Benefit Range (NPV)</b> £	<b>NET BENEFIT (NPV Best estimate)</b> £		
What is the geographic coverage of the policy/option?			England & Wales		
On what date will the policy be implemented?		2012-2013			
Which organisation(s) will enforce the policy?			MoJ		
What is the total annual cost of enforcement for these organisations?			£ Negligible		
Does enforcement comply with Hampton principles?			Yes		
Will implementation go beyond minimum EU requirements?			No		
What is the value of the proposed offsetting measure per year?			£ Negligible		
What is the value of changes in greenhouse gas emissions?			£ Negligible		
Will the proposal have a significant impact on competition?			No		
Annual cost (£-£) per organisation (excluding one-off)		Micro	Small	Medium	Large
Are any of these organisations exempt?		No	No	N/A	N/A
<b>Impact on Admin Burdens Baseline</b> (2005 Prices)				(Increase - Decrease)	
Increase of	£	Decrease of	£	<b>Net Impact</b>	£

Summary: Analysis & Evidence					
Policy Option: 7		Description: Implement new systems for appeals and complaints			
<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups' The new appeals system would impose a cost on coroners' offices of up to £1.8m, including legal aid costs, and a burden (administrative costs) on local authorities of up to £0.4m.		
	<b>One-off</b> (Transition)	<b>Yrs</b>			
	£				
	<b>Average Annual Cost</b> (excluding one-off)		10	<b>Total Cost (PV)</b> £	
£					
Other <b>key non-monetised costs</b> by 'main affected groups' There would be a cost for the Ministry of Justice of training coroners and their staff on the new regulations. There would also be legal aid costs for the Legal Services Commission from the new appeals system.					
<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'		
	<b>One-off</b>	<b>Yrs</b>			
	£				
	<b>Average Annual Benefit</b> (excluding one-off)		10	<b>Total Benefit (PV)</b> £	
£					
Other <b>key non-monetised benefits</b> by 'main affected groups' Bereaved people and other interested persons will now have a free and accessible way to challenge decisions made by the coroner, and any service they regard as unacceptable during a coroner's investigation.					
<p><b>Key Assumptions/Sensitivities/Risks</b> Appeals system costs are based on the system used in New South Wales, Australia. Three key assumptions are: (i) oral hearings occur in 2% of appeals; (ii) a pre-appeal stage will facilitate the filtering out of some cases; (iii) appeals submitted relating to post mortems will be dealt with on the papers as a matter of course. A pilot exercise will help determine more accurate costings. The costings for the legal aid budget are based on the Legal Aid Scheme and include £100,000 for exceptional funding by the Legal Aid Strategy Directorate. Exceptional funding is available for Article 2 or Article 2 type inquests.</p>					
<b>Price Base</b> Year	<b>Time Period</b> Years	<b>Net Benefit Range (NPV)</b> £	<b>NET BENEFIT (NPV Best estimate)</b> £		
What is the geographic coverage of the policy/option?			England & Wales		
On what date will the policy be implemented?			2012-2013		
Which organisation(s) will enforce the policy?			MoJ		
What is the total annual cost of enforcement for these organisations?			£ Negligible		
Does enforcement comply with Hampton principles?			Yes		
Will implementation go beyond minimum EU requirements?			No		
What is the value of the proposed offsetting measure per year?			£ Negligible		
What is the value of changes in greenhouse gas emissions?			£ Negligible		
Will the proposal have a significant impact on competition?			No		
Annual cost (£-£) per organisation (excluding one-off)		Micro	Small	Medium	Large
Are any of these organisations exempt?		No	No	N/A	N/A
<b>Impact on Admin Burdens Baseline</b> (2005 Prices)				(Increase - Decrease)	
Increase of	£	Decrease of	£	<b>Net Impact</b>	£

## Summary: Analysis & Evidence

**Policy Option: 8**
**Description: Training of coroners, their officers and staff**

<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups'
	<b>One-off</b> (Transition)	<b>Yrs</b>	
	£		
	<b>Average Annual Cost</b> (excluding one-off)		
	£ 800k	10	<b>Total Cost (PV)</b> £
Other <b>key non-monetised costs</b> by 'main affected groups' There would be a cost to the Ministry of Justice and Chief Coroner for delivering ongoing training.			

<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'
	<b>One-off</b>	<b>Yrs</b>	
	£		
	<b>Average Annual Benefit</b> (excluding one-off)		
	£	10	<b>Total Benefit (PV)</b> £
Other <b>key non-monetised benefits</b> by 'main affected groups' Coroners' offices benefit from the consistency in the training that they receive, thus better equipping them to provide a better service. Bereaved people would receive a better and improved service relative to the base case as a result of the training.			

### Key Assumptions/Sensitivities/Risks

Price Base Year	Time Period Years	<b>Net Benefit Range (NPV)</b> £	<b>NET BENEFIT (NPV Best estimate)</b> £
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What is the geographic coverage of the policy/option?	England & Wales			
On what date will the policy be implemented?	2012-2013			
Which organisation(s) will enforce the policy?	MoJ			
What is the total annual cost of enforcement for these organisations?	£ Negligible			
Does enforcement comply with Hampton principles?	Yes			
Will implementation go beyond minimum EU requirements?	No			
What is the value of the proposed offsetting measure per year?	£ Negligible			
What is the value of changes in greenhouse gas emissions?	£ Negligible			
Will the proposal have a significant impact on competition?	No			
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	No	No	N/A	N/A

<b>Impact on Admin Burdens Baseline</b> (2005 Prices)			(Increase - Decrease)
Increase of	£	Decrease of	£
<b>Net Impact</b>			£

Summary: Analysis & Evidence					
Policy Option: 9		Description: Short death certificates			
<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups'		
	<b>One-off</b> (Transition)	<b>Yrs</b>			
	£				
	<b>Average Annual Cost</b> (excluding one-off)				
	£	10	<b>Total Cost (PV)</b>	£	
Other <b>key non-monetised costs</b> by 'main affected groups' The cost of new procedures/equipment for providing a short death certificate will be funded by the General Register Office. As part of the consultation the GRO is seeking views on whether families should be charged fees for the provision of a short certificate.					
<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'		
	<b>One-off</b>	<b>Yrs</b>			
	£				
	<b>Average Annual Benefit</b> (excluding one-off)				
	£	10	<b>Total Benefit (PV)</b>	£	
Other <b>key non-monetised benefits</b> by 'main affected groups' The main benefit is to bereaved people as they will no longer need to disclose the cause of death to organisation that only require confirmation of death and not reasons as to cause of death.					
Key Assumptions/Sensitivities/Risks					
Price Base Year	Time Period Years	<b>Net Benefit Range (NPV)</b> £	<b>NET BENEFIT (NPV Best estimate)</b> £		
What is the geographic coverage of the policy/option?			England & Wales		
On what date will the policy be implemented?			2012-2013		
Which organisation(s) will enforce the policy?			MoJ		
What is the total annual cost of enforcement for these organisations?			£ Negligible		
Does enforcement comply with Hampton principles?			Yes		
Will implementation go beyond minimum EU requirements?			No		
What is the value of the proposed offsetting measure per year?			£ Negligible		
What is the value of changes in greenhouse gas emissions?			£ Negligible		
Will the proposal have a significant impact on competition?			No		
Annual cost (£-£) per organisation (excluding one-off)		Micro	Small	Medium	Large
Are any of these organisations exempt?		No	No	N/A	N/A
<b>Impact on Admin Burdens Baseline</b> (2005 Prices)				(Increase - Decrease)	
Increase of	£	Decrease of	£	<b>Net Impact</b>	£

## Summary: Analysis & Evidence

**Policy Option: 10**
**Description: Implement all 9 of the proposals**

<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups' Estimated transition costs of up to £0.6m have been provided for advance training on new procedures for those who work within the coroner system. Estimated annual costs provided for the new Appeals system are £2.2m. Ongoing training when the new system is implemented have been estimated at up to £0.8m. See options 1-9.
	<b>One-off</b> (Transition)	<b>Yrs</b>	
	<b>£ 0.6m</b>		
	<b>Average Annual Cost</b> (excluding one-off)		
	<b>£ 3m</b>		<b>Total Cost (PV)</b> <b>£</b>
Other <b>key non-monetised costs</b> by 'main affected groups' Coroners, coroners' officers, local authorities, police, pathologists, funeral industry and voluntary groups will need to adapt to the new legislative framework, and the new appeals system. Ministry of Justice to provide information and/or training.			

<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'
	<b>One-off</b>	<b>Yrs</b>	
	<b>£ n/a</b>		
	<b>Average Annual Benefit</b> (excluding one-off)		
	<b>£ n/a</b>	<b>10</b>	<b>Total Benefit (PV)</b> <b>£ n/a</b>
Other <b>key non-monetised benefits</b> by 'main affected groups' A more consistent service that better meets the requirements and expectations of bereaved people and that serves the public interest by preventing future deaths. Coroners, in conjunction with their local authorities, will be better able to reassign existing resources within the system, as the nature of coroners' caseload changes.			

**Key Assumptions/Sensitivities/Risks** The costs of implementation have been approximated and will be refined as our plans are developed in more detail. A key risk is the operation of the appeals system. The volume of cases likely to be appealed has been estimated using a model based on a workload assumption and also the system used in New South Wales in Australia. If the volume of appeals were to change, then this would affect the magnitude of costs and benefits of the appeals system. The appeals pilot should help inform the estimates.

Price Base Year 2009	Time Period Years 10	<b>Net Benefit Range (NPV)</b> £	<b>NET BENEFIT (NPV Best estimate)</b> £	
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What is the geographic coverage of the policy/option?		England & Wales		
On what date will the policy be implemented?		2012-2013		
Which organisation(s) will enforce the policy?		MoJ		
What is the total annual cost of enforcement for these organisations?		£ Negligible		
Does enforcement comply with Hampton principles?		Yes		
Will implementation go beyond minimum EU requirements?		No		
What is the value of the proposed offsetting measure per year?		£ Negligible		
What is the value of changes in greenhouse gas emissions?		£ Negligible		
Will the proposal have a significant impact on competition?		No		
Annual cost (£-£) per organisation (excluding one-off)	Micro 0	Small 0	Medium 0	Large 0
Are any of these organisations exempt?	No	No	N/A	N/A

**Impact on Admin Burdens Baseline** (2005 Prices)

(Increase - Decrease)

Increase of £ 0

Decrease of £ 0

**Net Impact**

£ 0

## Evidence Base (for summary sheets)

### 1. Introduction and Background

1. 1 This Impact Assessment (IA) updates the IA which was published in January 2009 to accompany the introduction of Part 1 of the Coroners and Justice Bill into Parliament.<sup>1</sup> Part 1 of the Act made provision to reform the coroner system in England and Wales. This IA accompanies our policy consultation document on the secondary legislation we propose to make under Part 1 of the Act.

### 2. Scope of the Impact Assessment

2. 1 This IA is a consultation stage IA and considers the costs and benefits of implementing options that address the problems with the current system that have been identified by the Shipman Inquiry and the Fundamental Review of Death Certification and Investigation. The Act requires secondary legislation to enable reform to become effective and we now wish to consult on 9 key policy areas on which stakeholder views will be influential.
2. 2 This IA examines nine proposed options for the secondary legislation:
- *Proposal 1:* Deaths which should be reported to coroners
  - *Proposal 2:* Transfers of cases from one coroner to another
  - *Proposal 3:* Post-mortem examinations
  - *Proposal 4:* Search, entry and seizure powers
  - *Proposal 5:* Disclosure
  - *Proposal 6:* Inquests
  - *Proposal 7:* Appeals & Complaints
  - *Proposal 8:* Training
  - *Proposal 9:* Short Death Certificates
2. 3 A tenth option has also been considered that implements all nine of the above proposals. It is believed that all of the proposals would address the problems with the current system that have been identified by the Shipman Inquiry and the Fundamental Review of Death Certification and Investigation. All nine of the above proposals would modernise and improve the coroner system in England and Wales.

#### Objectives of Proposals

2. 4 The Coroners and Justice Act received Royal Assent on 12 November 2009.<sup>2</sup> The Act contains measures to:
- Introduce national leadership through the appointment of a Chief Coroner and Medical Adviser to the Chief Coroner;
  - Deliver an improved service for bereaved people, including the introduction of a Charter for Bereaved People, and a system of appeals against coroners' decisions;
  - Introduce national standards that coroners should meet, supported by training and guidance for all coroners, their officers and staff; and
  - Make investigations and inquests more effective.

#### Affected Stakeholder groups, Organisations and Sectors

2. 5 The Act, and our consultation proposals, will have an impact on the following groups in England and Wales:
- Bereaved people;
  - Coroners and coroners' officers;

<sup>1</sup> [www.opsi.gov.uk/acts/acts2009/ukpga\\_20090025\\_en\\_1](http://www.opsi.gov.uk/acts/acts2009/ukpga_20090025_en_1)

<sup>2</sup> For more information please refer to: [www.justice.gov.uk/publications/coroners-justice-bill.htm](http://www.justice.gov.uk/publications/coroners-justice-bill.htm)



- Local authorities;
- Police authorities;
- Other investigating authorities;
- Voluntary organisations working with bereaved people;
- Pathologists; and
- Professionals involved in death certification

### 3. Problem under Consideration

3.1 The reasons for modernising and improving the coroner system in England and Wales are split by each proposal and are addressed below.<sup>3</sup>

- **Proposal 1 - Deaths which should be reported to coroners:**

Currently the guidance that states when a doctor should report a death to the coroner is unclear and not concise, leading to a disproportionately high number of cases being reported. This causes delays and leads to coroner resources not being utilised in the best possible way.

- **Proposal 2 - Transfers of cases from one coroner to another:**

Currently the only way a coroner can request another coroner to carry out an investigation, if all parties involved do not mutually agree on this, is to ask the Secretary of State to decide. If a backlog develops in one coroner area, cases are not easily transferred to an area that is less congested, therefore causing unnecessary delays.

- **Proposal 3 - Post-mortem examinations:**

Currently post-mortem examinations may be carried out in situations when they are not required, or with the most useful and appropriate method of examination not being utilised. This is due to the procedures lacking clarity, efficiency, or flexibility, and is therefore making post mortems less responsive to coroners' requirements and bereaved people's needs.

- **Proposal 4 - Search, entry and seizure powers:**

Currently coroners have to conduct their investigations without the power to enter and search premises, and seize the evidence that is relevant to the death that they are investigating. This means that coroners may not have access to all the relevant information they require in order to reach a decision.

- **Proposal 5 - Disclosure:**

There is little provision currently in relation to access to documents and information used in coroners' investigations by bereaved people and other interested persons. These people do not have clarity or consistency when they seek the disclosure of documents during a coroner's investigation.

- **Proposal 6 - Inquests:**

The problems identified in the way in which inquests are currently carried out are mainly to do with consistency across all inquests and the processes by which jurors and witnesses are summoned. The inconsistencies include what happens to the exhibit after the inquest has been completed and the application of 'short form' and 'narrative' verdicts. There is also currently no power to compel witnesses to attend and give evidence at an inquest.<sup>4</sup>

<sup>3</sup> Detailed questions on each of the policy areas are contained within the consultation paper. Responses to the consultation and comments on this section of this IA will inform further policy development, on which the Act's rules and regulations will be based, and an associated revised IA.

<sup>4</sup> The problem is given in greater detail in the base case situation for Proposal 6

- **Proposal 7 - Appeals & Complaints:**

There are currently very few means of redress for bereaved people and other interested persons who are dissatisfied with the level of service received during an investigation. The current process is lengthy as well as costly and there is an inconsistency in the way in which each coroner deals with complaints.

- **Proposal 8 - Training:**

There is not consistent training provided for coroners, their officers and other support staff. This has resulted in staff currently not being as well equipped as they could be to provide a consistently good service.

- **Proposal 9 - Short Death Certificates:**

Currently there is not an option for a short death certificate. The death certificate states the cause of death of the individual which may cause unnecessary distress to bereaved family members. A short death certificate would be used for example, when organisations require confirmation only of a death.

## 4. Cost Benefit Analysis

### Analytical Principles

- 4.1 The IA process aims to identify as far as possible the impacts of Government proposals on society. A critical part of the process is to undertake a cost benefit analysis (CBA) of the proposals. The CBA assesses whether the Government's proposals would deliver a positive net impact to society, accounting for economic, social, distributional and environmental considerations amongst others.
- 4.2 The CBA underpinning this IA rests on answering three basic questions:
  - What is the problem that government is seeking to address?
  - What options are available to government to correct this problem?
  - Are the recommended options likely to have the desired impact and are the benefits likely to justify the costs?

### Cost Benefit Analysis of our proposals

- 4.3 This section sets out the potential costs and benefits of the nine policy areas on which we are seeking views in our consultation, which this IA accompanies. We should be grateful for views on the impacts of these proposals. In addition we should be grateful for views on the equality and diversity impacts of our proposals that are specific to Race, Disability & Gender (including gender identity), Religion & Belief, Age or Sexual Orientation.
- 4.4 Each of the above proposals has been looked at individually and has been compared with the base case, which for this IA has been assumed to be "do nothing".

## PROPOSAL 0 – Do Nothing (also the Base Case)

### Description

- 4.5 HM Treasury's Green Book Guidance<sup>5</sup> requires that all options are assessed relative to a common "base case". The base case for this IA has been assumed to be "do nothing". As the base case effectively compares against itself, its net present value is therefore zero.

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<sup>5</sup> [www.hm-treasury.gov.uk/data\\_greenbook\\_index.htm](http://www.hm-treasury.gov.uk/data_greenbook_index.htm)



## PROPOSAL 1: Reporting deaths to a coroner

### Description

4. 6 We intend to clarify the cases and circumstances of death in which a registered medical practitioner should notify a senior coroner of a death. This would ensure that coroners have reported to them only those deaths that need to be reported to them, and that there is clarity about the roles of the coroner and the new medical examiner which the Act creates.

### Economic Rationale

4. 7 Currently coroners spend an unnecessary amount of time investigating deaths which are outside their jurisdiction. This has led to inefficient allocation of coroner resources. Our proposed regulations should lead to fewer cases being unnecessarily referred to the coroner, therefore enabling them to spend more time on appropriate cases and improve the efficiency of coroners.

### Current Position

4. 8 Currently, if a death occurs in any of the following circumstances, a doctor may report it to the coroner:

- after an accident or injury;
- following an industrial disease;
- during a surgical operation;
- before recovery from an anaesthetic;
- if the cause of death is unknown;
- if the death was violent or unnatural - for example, suicide, accident or drug or alcohol overdose;
- if the death was sudden and unexplained - for instance, a sudden infant death (cot death).

4. 9 In addition to this, if the deceased was not seen by the doctor issuing the medical certificate after he or she died, or during the 14 days before the death, the death must be reported to the coroner. Anyone who is concerned about the cause of a death can inform a coroner about it, but in most cases a death will be reported to the coroner by a doctor or the police.

4. 10 The generality of this guidance has meant that a disproportionately high number of cases are reported to coroners, especially following the murders by Harold Shipman. At present, 45% of deaths in England and Wales are reported to coroners each year which is some 15 to 20% higher than in any other country which has coroners whose responsibilities are broadly similar.

### Proposal - Clarifying the circumstances under which a death should be reported to a coroner

4. 11 The proposed regulations will specify the cases and circumstances of death in which a registered medical practitioner should notify a senior coroner of a death. These provisions will run in parallel with a new death certification system to be introduced under sections 19 and 20 of the Act, under which medical examiners (appointed by Primary Care Trusts in England and Local Health Boards in Wales) will scrutinise all deaths not referred to a coroner to ensure an independent check on the cause of every death in England and Wales.

4. 12 Our proposed regulations would specify that a registered medical practitioner should notify the coroner of a death where:
- there is no attending practitioner, or the attending practitioner is unavailable within a prescribed period;
  - the deceased died as a result of violence, trauma or physical injury, whether intentional or otherwise;
  - the death was caused by poisoning;
  - the death may be the result of intentional self-harm;
  - the death may be as a result of neglect or failure of care;
  - the death may be related to a medical procedure or treatment;
  - the death may be due to an injury or disease received in the course of employment or industrial poisoning;
  - the death occurred whilst the deceased was in custody or state detention (whatever the cause of death);
  - the cause of death is unknown.
4. 13 In addition, we are consulting on whether the current requirement, for a death to be referred to a coroner before it can be certified, even if the death is apparently of wholly natural causes and if the attending doctor had not seen the deceased within the previous 14 days, can be extended to 21 or 28 days.
4. 14 Local authorities would continue to be responsible for the local funding of a reformed coroner system and for meeting expenses incurred in an investigation.

## Costs of Proposal 1

### *Coroners' offices*

4. 15 Coroners and their officers and staff will require training on the new regulations in the first year. The Ministry of Justice has set aside £600k in total for training on the reformed system.

### *Medical practitioners*

4. 16 Medical practitioners will require training on the new system in the first year. The Department of Health would meet these costs.

## Benefits of Proposal 1

### *Coroners' offices*

4. 17 We anticipate that this proposal will reduce the number of cases being referred to coroners. This will enable coroners to deal more thoroughly and more quickly with their core caseloads.

### *Medical practitioners*

4. 18 Medical practitioners will benefit from greater clarity about which cases they should refer to a coroner, and which to a medical examiner.

### *Bereaved people*

4. 19 Bereaved people will benefit from a quicker and more detailed service from the coroner or medical examiner. The latter will be able to refer a death to a coroner if they believe the circumstance of the death requires it.

## **Net Impact**

4. 20 There are likely to be some transitional costs associated with training for the new secondary legislation. We do not expect any changes to annual costs in the long run. Implementation will create greater transparency with the introduction of medical examiners leading to fewer cases being referred to coroners. This does not imply that the workload of coroners will fall, but will mean that coroners should in future be able to concentrate their resources on cases that require their attention.

## **PROPOSAL 2: Transfer of cases from one coroner to another**

### **Description**

4. 21 This proposal will allow one coroner to request another coroner to conduct an investigation and allow the Chief Coroner to transfer responsibility for an investigation from one coroner to another.
4. 22 Local authorities will continue to be responsible for the funding of a reformed coroner system. Regulations will set out where the responsibility for meeting expenses will lie for transferred investigations; and the process for incurring and meeting expenses.

### **Economic Rationale**

4. 23 The current system is inefficient. It can be difficult and time consuming to transfer cases between coroner areas. The current system does not always allow for moving cases to reduce delays and backlogs and to allow for specific expertise to be matched to cases. Implementing this proposal will increase productive efficiency.

### **Current Position**

4. 24 If we do nothing, and the Coroners Act 1988 remains in force in this respect, so one coroner will continue to be able to request another coroner in a different area to carry out an investigation; and if the coroners do not agree, the requesting coroner may ask the Secretary of State to decide which coroner should conduct the investigation and make a direction accordingly.
4. 25 The Secretary of State is currently able to make a direction only after a coroner requests it. The Chief Coroner will have no powers in this respect.
4. 26 There is a continuing risk of delay, for example if a backlog of investigations develops in one coroner area – perhaps because of a pandemic, or if there are mass fatalities from one incident in this country or abroad. The system will not become more flexible and responsive to the needs of bereaved people, which is one of the key aims of reform.

### **Proposal - Provide for transferring cases from one coroner to another**

4. 27 This proposal allows investigations to be transferred quickly and simply from one coroner to another, to minimise delays for bereaved families and other interested persons. When considering a transfer, the coroners concerned or the Chief Coroner (as appropriate) will have regard to both the convenience and cost to everyone involved in the investigation, such as the police, pathologist, and any experts and lay witnesses, as well as bereaved family members. The expectation is that more cases will be transferred as a result of these proposals.

## Costs of Proposal 2

### *Coroners' offices*

4. 28 Coroners and their officers and staff will require training on the new proposals. The Ministry of Justice has set aside £600k in total for training on the reformed system.
4. 29 We do not believe these measures would create a significant new burden on coroners, local authorities, or any other group that interacts with the coroner system.

### *Local authorities*

4. 30 Local authorities will continue to be responsible for the funding of a reformed coroner system, and for meeting expenses incurred in an investigation. 'Meeting expenses' means paying / reimbursing expenses incurred by coroners when conducting their statutory duty to investigate a death. It may mean that, in some circumstances, a different local authority would meet the costs than would be the situation under the current system. We are keen to ensure fairness in "who pays" and this is one of the matters on which we are seeking views in this consultation.

### *Witnesses*

4. 31 Some witnesses may have to travel further if a case has been transferred.

## Benefits of Proposal 2

### *Coroners' offices*

4. 32 Coroners' offices will benefit from a quick and simple transfer process. They will also benefit from increased transparency as the regulations and associated guidance will set out the circumstances in which cases should transfer and the process for meeting expenses incurred in those cases. Costs per transfer should be lower.

### *Bereaved people*

4. 33 Bereaved people will benefit from more involvement in the coroner system. They will be able to request a transfer from one coroner to another. They will also benefit from fewer delays in investigations in the event of a pandemic or other incident in a coroner's jurisdiction.

## Net Impact

4. 34 Implementation will enable investigations to be transferred quickly and simply from one coroner to another, to minimise delays for bereaved families and other interested persons. It has not been possible to quantify all the impacts outlined above.

## PROPOSAL 3: Post-mortem investigations

### Description

4. 35 This proposal would provide clarification of the secondary legislation, and related guidance, regarding post-mortem examinations.

## Economic Rationale

4. 36 The current situation is inefficient. Post-mortem examinations are sometimes carried out in situations when they are not required, or where the most useful and appropriate method of examination is not being utilised. These proposed reforms will ensure that post-mortem examinations are more accurately targeted towards those cases that genuinely need them, and that the most appropriate form of examination is used in each particular case.
4. 37 Our proposals for ensuring that bodies are released to the bereaved family for burial or cremation within strict deadlines will provide an improved service to the bereaved family with greater certainty as to when they will be able to conduct a funeral.

## Current Position

4. 38 If we do nothing the existing problems within the system will remain. Firstly post-mortem rates (as a percentage of cases referred to coroners for investigation) within England and Wales will remain high when compared to other similar jurisdictions – 46% of cases in 2008, compared to 40% in Northern Ireland and averages of between 25 to 30% in Australia, Canada and New Zealand. This would indicate that a considerable number of post-mortem examinations are carried out unnecessarily in England and Wales when compared to these other similar jurisdictions.
4. 39 Secondly, there may also continue to be a great variation in the post mortem rates within England and Wales, where referral rates between jurisdictions range from 26% to 69%.
4. 40 Thirdly, unnecessary distinctions and confusion around ‘post-mortem examinations’ and ‘special examinations’ will continue, as well as a lack of clarity over who may conduct such examinations, what their purpose is and what happens to any samples taken during the course of such an examination. This could in turn lead to situations continuing where inadvertent breaches of the Human Tissue Act 2004 and its underpinning guidance on retention and storage of tissue after a post-mortem examination has been completed occur.
4. 41 Fourthly, the problems associated with the current prohibitions on moving bodies across jurisdictional boundaries will remain, thereby denying certain jurisdictions access to specialist facilities that are only available in a limited number of locations.
4. 42 Finally, the lack of clarity as to when a deceased person’s body should be released from the coroner’s custody to the family, to enable a funeral to take place, would also continue.

## Proposal – Improve procedure for post mortem investigations

4. 43 Our proposals will:
- ensure that coroners have access to all relevant medical information as to the medical cause of death in every case where they have commissioned a post-mortem examination;
  - remove geographical restrictions on where examinations may be carried out;
  - enable less invasive examinations to be conducted when they are scientifically proved to provide the required information;
  - ensure that examinations, at whatever level of invasiveness, are carried out only when required;
  - enable the bodies of those who have died to be returned as promptly as possible to their loved ones;
  - provide the next of kin, wherever possible, with better opportunities to be informed about the purpose and outcome of post-mortem examinations;
  - provide, in occasional and exceptional circumstances, for examinations to be carried out other than by medically qualified practitioners.

4. 44 Our proposals would achieve this by enabling the coroner to request a suitable practitioner (who may be a registered medical practitioner or a practitioner of a type designated by the Chief Coroner as suitable to make post-mortem examinations) to make an examination of a type specified by the coroner, with the results to be reported to the coroner as soon as is practicable. The body may be moved to any suitable place for the purposes of such an examination, so the restrictions on movement of the body would no longer exist.
4. 45 To enable us to ensure that any underpinning secondary legislation is clear and covers all eventualities the consultation asks for views on issues such as the purpose of a coroner commissioned post-mortem examination; what consultation should take place with the next of kin before an examination takes place; who might be designated as suitable to conduct post-mortem or related examinations if they are not registered medical practitioners; whether the maximum time within which the body of someone who has died should be released for a funeral or cremation should be 30 days; and how the number of post-mortem examinations may be reduced.

### Costs of Proposal 3

#### *Families*

4. 46 The fees for post-mortem examinations will not change under this proposal. However, this proposal may increase the number of less-invasive post-mortem examinations. Currently the difference in cost from a traditional post-mortem examination and a less invasive examination is met by the estate. For example, a traditional post-mortem costs approximately £100 and an MRI scan costs approximately £800.

#### *Coroners' offices*

4. 47 Coroners, or their officers, may find that they spend more time explaining to next of kin the reasons for the post-mortem examination to be carried out on their loved one and obtaining the necessary advice about what should happen to organs and tissues removed during a post-mortem examination after the coroner's jurisdiction over the body has finished. We would anticipate that this would have a negligible overall effect on coroner resources.
4. 48 Coroners and their officers and staff will require training on the new regulations in the first year. The Ministry of Justice has set aside £600k in total for training on the reformed system.

#### *Local authorities*

4. 49 We would anticipate that there may be increased costs from requests for more detailed and specialist types of examination, or from the need to transport bodies to specialist facilities in other jurisdictions.

#### *Post mortem practitioners*

4. 50 Pathologists may see a small reduction in the number of fully invasive post-mortem examinations they carry out. This would be a cost as they would incur a loss of revenue.

### Benefits of Proposal 3

#### *Coroners' offices*

4. 51 These proposals will give greater control to coroners as to:
- when they request post-mortem examinations;
  - the type of examination and who carries it out;
  - the method of examination they can choose;
  - the location where it is carried out (as the previous restrictions on this would no longer exist).

4. 52 Coroners will therefore be able to tailor their requests to suit not only their own needs - for the purposes of exercising their legal functions – but also the religious or cultural needs of a bereaved family.
4. 53 There is likely to be a general reduction in the number of post-mortem examinations required – largely as a result of national guidance from the Chief Coroner and the introduction of dedicated new medical advice to coroners, including through the parallel medical examiner system.

#### *Post mortem practitioners*

4. 54 Pathologists may see an increase in the number of requests for more specialised tests being carried out on specific organs or using specialist methods.

#### *Bereaved people*

4. 55 Bereaved people will benefit from coroners being able to bear in mind any religious or cultural needs they have. They will as a result be able to become more engaged with the post-mortem examination process. As there will be more scope for their views as to the method of post-mortem examination to be taken into account, there are likely to be fewer delays due to disputes over the method of examination to be carried out, and they are therefore more likely to get the body of their loved one released to them sooner for a funeral.

#### Net Impact

4. 56 Our proposal will enable coroners to have greater control and a wider choice over the method of post-mortem examination they wish to use, reduction in the number of post-mortems examinations, and bereaved people being far more engaged with the process.

### **PROPOSAL 4: Entry, search and seizure powers**

#### **Description**

4. 57 This proposal would grant coroners the power to enter and search premises, and seize evidence and documents related to the death they are investigating.

#### **Economic Rationale**

4. 58 Coroners currently do not always have access to all the information they require. This can limit their ability to reach an appropriate decision. This proposal will allow them access to more information and will therefore increase their capability

#### **Current Position**

4. 59 Coroners currently conduct their investigations without the power (either in person or via a delegate) to enter and search premises and seize evidence and documents related to the death they are investigating. They generally have to rely on the powers of the police, or other investigating authorities, in this respect. This can prove problematical, however, in that not all deaths investigated by a coroner will necessarily have had police involvement to any great extent, or there can be local difficulties where not all the necessary or relevant evidence has been collected by the police or other investigating authorities or is passed on to the coroner. Anecdotal evidence has shown that whilst this problem is not widespread, on the rare occasions where it does occur it can cause an undue amount of delay in attempting to collate the evidence necessary for the coroner



to conduct his or her legal duties. If the proposed changes are not implemented, this situation would continue.

4. 60 It is also possible that doing nothing will allow certain illegal activities to remain undetected. A key driver to introducing our policy regarding powers of entry, search and seizure was a recommendation of the Shipman Inquiry, which argued that if such powers had existed then Shipman's activities may well have been exposed far earlier than was the case.

### Proposal – Implement coroner entry, search and seizure powers

4. 61 We propose to give coroners powers of entry and search of premises and seizure of evidence so they can access all the information they need to carry out their statutory functions to investigate deaths. Our proposals will mean these powers are used fully but proportionately in every case. We estimate that these powers will be used 10-15 times per coroner area per year.
4. 62 We have asked a number of questions as part of this consultation exercise to inform the secondary legislation that will underpin the statutory power contained in paragraph 3 of Schedule 5. The issues on which we are seeking views include who coroners envisage carrying out these functions on their behalf; whether the person entering, searching and seizing should have in their possession, in every circumstance, some form of documentation stating their authority to be on the land or premises and to remove items and documents; and whether some form of notice (48 hours has been suggested as a reasonable period) should be given to the landowner / occupier that entry, search and seizure is to be undertaken.

### Costs of Proposal 4

#### *Coroners' offices*

4. 63 It is possible that coroners may delegate their powers of entry, search and seizure to their officers and staff. Given the small number of cases concerned, however, we estimate that this will have minor cost implications.
4. 64 Coroners and their officers and staff will require training on the new regulations. The Ministry of Justice has set aside £600k in total for training on the reformed system.

#### *Police*

4. 65 There may be a small cost impact on police officers if coroners delegate this power to them, and it is additional to their policing duties. Our consultation asks who coroners would wish to delegate this power to, in order to help us to identify what the source of any costs might be and the level of those costs.

### Benefits of Proposal 4

#### *Coroners' offices*

4. 66 Coroners will be better able to accurately ascertain those matters they are statutorily obliged to find out when investigating a death. They will benefit from having access to more and better information upon which to base their decisions.



*Bereaved people*

4. 67 Bereaved families will benefit in that they can be more certain that coroners have had access to all relevant evidence and have thus been in the best position possible to accurately ascertain the cause of death of their loved one.

**Net Impact**

4. 68 There will be costs from this proposal. Responses to consultation should help us identify the source and level of these costs. Coroners will benefit from having access to more and better information upon which to base their decisions. Bereaved families will have assurance that the cause of death has been correctly ascertained.

## PROPOSAL 5: Disclosure of information by coroners

### Description

4. 69 This option would create clearer secondary legislation on disclosure of documents to clarify and standardise disclosure of documents by coroners to families and other interested parties.<sup>6</sup>

### Economic Rationale

4. 70 The current lack of clear statutory provision for disclosure of documents has led to inconsistency of the provision of information to bereaved people and other interested persons. For instance bereaved families have complained that they have received few or no papers before an inquest, whereas official bodies may have files of material which appear to be relevant to the case. Our proposal will improve the choices available to families in respect of disclosure while removing the need for them to pay a fee for the material being disclosed.

### Current Position

4. 71 Coroners are required, on the application of a properly interested person and on their payment of a prescribed fee, to supply a copy of a report of a post-mortem examination, a related special examination, certain notifications, any notes of evidence, or of any document put in evidence at an inquest. A coroner may also, on application and without charge, permit any properly interested person to inspect (i.e. in the coroner's office) such documents. The Coroners' Records (Fees for Copies) Rules 2002 also provide for charges for photocopies and other copies.
4. 72 As set out above the current lack of clear statutory provision for free disclosure of documents has led to inconsistency in making information available to bereaved families.
4. 73 If we do nothing, this inconsistency will continue, as will uncertainty for coroners about what they should and should not disclose, and for interested persons about what they may expect to receive and at what cost. Bereaved people will continue to have to pay for copies of many documents.

### Proposal - Secondary legislation and guidance for disclosure of information by coroners

4. 74 Secondary legislation made under the Act in respect of disclosure of information by coroners will improve the standing and involvement of bereaved families in coroner investigations; and make the investigation process more transparent. It will do this by:
- making clear what may or may not be disclosed;
  - providing bereaved people with more opportunity for direct involvement in coroner investigations;
  - making disclosure practices more consistent across coroner areas;
  - capturing current coroner best practice; and
  - taking account of the resources needed to disclose information.

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<sup>6</sup> Rules and regulations will be consistent with the draft Charter for Bereaved People [www.justice.gov.uk/publications/charter-bereaved.htm](http://www.justice.gov.uk/publications/charter-bereaved.htm)

## Costs of Proposal 5

### *Coroners' offices and local authorities*

4. 75 There is likely to be a cost impact of our reforms on coroners' offices, both in terms of time taken to copy documents and distribute them, and in terms of physical resources such as copiers, paper and postage. Our consultation seeks views on the impact on coroners' offices (and the local authorities which fund them) in order to better quantify this.
4. 76 Coroners and their officers and staff will require training on the new regulations. The Ministry of Justice has set aside £600k in total for training on the reformed system.

### *Interested persons other than bereaved people*

4. 77 Under our proposals coroners may charge interested persons other than bereaved people for copying documents for disclosure.

## Benefits of Proposal 5

### *Coroners' offices and local authorities*

4. 78 Coroners' offices will benefit from the standardisation of disclosure, making requests for information easier to deal with.

### *Bereaved people*

4. 79 Bereaved people will benefit from this proposal as they will, if they wish, receive more information than at present.

### *Interested persons other than bereaved people*

4. 80 Interested persons will benefit from greater clarity and consistency of disclosure, and a right to request documents.

## Net Impact

4. 81 This proposal will impose some costs on coroners' offices. Bereaved people will benefit from improved access to free information.

## PROPOSAL 6: Inquests

### Description

4. 82 We propose to standardise and improve the conduct of inquests.

### Economic Rationale

4. 83 By standardising and improving the conduct of inquests we will improve the service provided to families. Increasing the provision of evidence available to coroners will help ensure that the causes of death are fully and accurately identified, and lessons can be learned to prevent future deaths.

## Current Position

4. 84 If a ‘do nothing’ policy was adopted, the improvements the Act provides for – for example, the processes for summoning jurors and witnesses and the provision of evidence in the best and most appropriate format possible for coroner and witnesses alike (especially young or potentially vulnerable witnesses) – would not be delivered. Problems that have been identified within the current system include the unavailability of a power to compel witnesses to attend and give evidence at an inquest; that not all the evidence is available in the best format possible; inconsistencies in what happens to exhibits after the inquest has been completed; and inconsistencies in the use and application of ‘short form’ and ‘narrative’ verdicts. These factors can be combined to prevent the inquest and death investigation process from providing the clearest answers to bereaved families about how their loved one came by their death, and could prevent effective “lessons learned” reports from being made.

## Proposal - Secondary legislation for inquests

4. 85 In certain key areas the current secondary legislation could be improved, and it is in those areas that we have specifically asked for comments from respondents to the consultation. The four main areas concerned are:
- the promptness of the inquest;
  - improved provisions for summoning witnesses by putting the procedures for summoning witnesses on a formal basis and enabling witnesses to give better quality evidence that is of more value to coroners in carrying out their legal functions;
  - the admissibility of hearsay, opinion, unsworn or documentary evidence at inquest and the retaining of exhibits and evidence after the inquest has concluded;
  - the availability and use of short form and narrative verdicts.<sup>7</sup>

## Costs of Proposal 6

### *Witnesses*

4. 86 There may be increased costs for witnesses (e.g. time and travel expenses) who will now be compelled to attend the coroner’s court and who might not have attended previously.

### *Coroners’ offices*

4. 87 Coroners and their officers and staff will require training on the new regulations. The Ministry of Justice has set aside £600k in total for training on the reformed system.
4. 88 There may be increased storage costs incurred by local authorities due to an increase in the amount of evidence and number of exhibits in a particular case that will need to be stored and retained. However, this may be offset by a reduction in the period of time for which such items need to be retained.

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<sup>7</sup> “Short form verdicts” are those verdicts which fit into one of a series of established categories as laid out on the inquisition form – Form 22 – contained within schedule 4 of the Coroners Rules 1984. “Narrative verdicts” are those which do not rely upon or fit into the categories laid down in Form 22 but where the coroner or jury rely on a written ‘narrative’ to express their conclusions as to the cause of death

## Benefits of Proposal 6

### *Coroners' offices*

4. 89 Coroners will benefit in that they will have the best possible evidence on which to base their decisions, and will therefore be able to carry out their functions in a prompt, effective and efficient manner. It will be clearer to them what evidence can and cannot be accepted during the course of the inquest, and what options are available to them to ensure that the young and the potentially vulnerable are given the necessary protection whilst allowing them to give the best evidence possible.
4. 90 They will also have clearer guidance as to the use of the various forms of determinations available to them, so that they can ensure that the most appropriate form and format of determination is given and the bereaved family get the clearest possible answers to questions.
4. 91 Coroners' officers and staff will have clearer guidance as to how witnesses should be summoned, and how long exhibits and evidence need to be retained for once the inquest has finished. It may well be that if, as a result of our consultation, the period for keeping exhibits and evidence is reduced, there may be savings for local authorities in that less space will be required to store such material.
4. 92 Clarifying the position with regard to retention of evidence and exhibits after an inquest will have benefits in that it may remove some of the discrepancies that exist and can cause confusion, due to the differences that exist in this area between coronial law and criminal law. It will also be beneficial with regard to the new appeals process which may rely heavily on exhibits and evidence from the original inquest hearing.
4. 93 With regard to short form and narrative determinations, clarifying the position on the use of these will be of benefit to coroners in that they will have a clearer understanding as to the meaning and usage of such verdicts. It will also be of benefit to Government statisticians and others who make use of coroner verdicts in establishing public health and death trends, which are highly important in informing long term public health policy decisions.

### *Bereaved people*

4. 94 Bereaved people will benefit in that inquests should be completed without undue delays, and they should be more confident in the final conclusions reached as they will know that it has been reached on the basis of the clearest possible evidence.

### *Witnesses*

4. 95 Enabling the inquest to take place as promptly as possible will not only allow the bereaved family to achieve public closure sooner, but has the added benefit of ensuring that witnesses' recollection of events that may have to be given in evidence will be clearer due to the shorter period of time to have elapsed since the death occurred.
4. 96 Improving the method in which witnesses are summoned by putting it on a formal footing should ensure that more witnesses are contacted and attend at the correct time and place to give evidence.
4. 97 Enabling witnesses to give better evidence – for example, by allowing children or potentially vulnerable witnesses to give evidence by way of video link, or allowing children to give unsworn evidence – will ensure that the coroner or jury are making their decisions on the basis of the very best evidence available. In the same way, clarifying the position with regard to validity of hearsay evidence, opinion evidence and documentary evidence will have a similar effect.

## **Net Impact**

4. 98 As well as the costs associated with training for coroners and their officers and staff on the requirements of the new provisions, we anticipate that there may be minimal additional costs associated with the new procedures for summoning witnesses to attend and possibly also for storage requirements for evidence and exhibits. The main anticipated benefits are that bereaved persons would benefit from inquests being completed with minimal delays, and the increase in confidence in the final conclusions; whilst society as a whole will benefit from the lessons that can be learned from those conclusions with regard to the avoidance of similar deaths in the future.

## **PROPOSAL 7: Appeals and complaints**

### **Description**

4. 99 This proposal would implement a new appeals system for interested persons. We intend to pilot the system in advance of full implementation in order to be able to consider the impacts before the full appeals system comes into effect, something that will occur a year later than the bulk of the proposals considered in this IA.

### **Economic Rationale**

4. 100 The current appeal system is expensive and complicated. This proposal will improve the service provided to bereaved families.

### **Current Position**

4. 101 The current system has few means of redress for bereaved people and other interested persons who are dissatisfied with a particular coroner decision or standard of service.
4. 102 On appeals, the only recourse currently is a potentially lengthy and expensive judicial review,<sup>8</sup> or by asking the Attorney General to refer the case to the High Court either for an order to be made for a new inquest to be held, or for an inquest to be held at all if the reason for the representations is that no inquest was held.
4. 103 On complaints about standards of service, while some coroners have published local arrangements in place, others do not - and, in any event, these arrangements vary from area to area.
4. 104 To do nothing would be inconsistent with the draft Charter for Bereaved People, on which the Government has consulted and which has had widespread support, and which sets out our proposals for systems of appeals and complaints for bereaved people.
4. 105 Legal aid is not generally available for coroner investigations. This is because an inquest is an inquiry concerned with the facts surrounding a death, rather than issues such as civil or criminal liability. The proceedings are generally less formal than a court hearing, and legal representation is considered unnecessary generally.

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<sup>8</sup> Her Majesty's Courts Service website advises that, 'A fee of £50.00 is payable when you lodge your application for permission to apply for Judicial Review. A further £180.00 is payable if you wish to pursue the claim if permission is granted (Civil Proceedings Fees (Amendment) Order 2007)' ([www.hmcourts-service.gov.uk/cms/1220.htm#six](http://www.hmcourts-service.gov.uk/cms/1220.htm#six)).

## Proposal – Implement new systems for appeals and complaints<sup>9</sup>

4. 106 This proposal would enable interested persons to appeal against a range of coroner decisions set out in the Act. In addition we propose that bereaved people should be able to complain to the Chief Coroner if they feel that they have not received the services set out in the Charter and they are dissatisfied by the coroner's response after they have brought the matter to his or her attention.<sup>10</sup>
4. 107 The Chief Coroner will then take any action he or she decides is appropriate and will inform the complainant of that action. Other interested persons will also be able to give feedback to the Chief Coroner about the standards of service that coroners give, including complimentary feedback.

## Costs of Proposal 7

### *Coroners' offices and local authorities*

4. 108 We have identified that as the appeals system is entirely new, it is likely to involve new work and costs for coroners' offices in responding to requests for information when an appeal is made. We have estimated these costs to be up to £1.8m plus an additional burden on local authorities to be up to £0.4m. Both these costs will fall within the Access to Justice remit and hence will be funded by the Ministry of Justice. We aim to pilot the appeals system to better quantify these costs.
4. 109 There are certain circumstances in which a higher judge may hear an appeal. This may lead to additional costs.
4. 110 We have undertaken to work with the Local Government Association, local authorities and coroners to assess the impact on coroner workloads.
4. 111 Coroners and their officers and staff will require training on the new regulations. The Ministry of Justice has set aside £600k in total for training on the reformed system.

### *Legal Services Commission*

4. 112 Legal aid would be available to those families that require it in order to make an appeal. Our current estimate based on an assessment of likely volume is that the new process will increase pressure on the legal aid budget by an estimated £370k per year, which breaks down into £270k for legal help and £100k for exceptional funding. This is included in the £6.629m annual running costs of the new central functions created by the Act and falling to the Ministry of Justice.

## Benefits of Proposal 7

### *Bereaved people and other interested persons*

4. 113 Bereaved people and other interested persons will have a free and accessible way to challenge a range of decisions made by the coroner and any poor service that they have received during a coroner's investigation.

<sup>9</sup> Section 40 of the Act provides a right for interested persons to appeal, to the Chief Coroner, against a range of coroner decisions.

<sup>10</sup> The draft Charter for Bereaved people, which the Government proposes to issue under section 42 of the Act, sets out that bereaved people will be able to complain to the Chief Coroner

## **Net Impact**

4. 114 The annual average costs are around £2.2m per year based upon an estimation of volume of appeals. This includes an estimated figure of £0.375m anticipated as a new burden on local authorities, to be funded by the Ministry of Justice, because of additional administrative resources required by coroners and their offices to respond to appeals. It has not been possible to quantify all the impacts outlined above. We do not expect the impact on coroners' offices and local authorities to be great, however the appeals pilot should be able to assist in obtaining an accurate figure of the cost of this proposal.
4. 115 To help quantify the impact more immediately, our consultation seeks views on the reasonableness of appeals, the method of hearing them, and timescales for appeals. In addition we have asked for suggestions as to how the benefits of the appeals and complaints systems for all users can be maximised and costs mitigated.

## **PROPOSAL 8: Training of coroners, their officers and staff**

### **Description**

4. 116 This proposal provides for regulations about the kind of training, amount of training and frequency of training in a reformed coroner system for:
  - senior coroners, area coroners and assistant coroners;
  - the Coroner for Treasure and Assistant Coroners for Treasure (who are also assistant coroners);
  - Coroners' officers and other staff assisting coroners (including those assisting the Coroner for Treasure).

### **Economic Rationale**

4. 117 The Ministry of Justice currently provides some training for coroners and their officers, but this is inconsistent across the country. The economic rationale for this proposal is to improve the capability of coroners by providing for the Chief Coroner to set national standards for training.

### **Current Position**

4. 118 No current or previous legislation on the coroner system has made reference to the training of those who work within it. Currently the Ministry of Justice provides some training for coroners and their officers – namely induction training; continuing professional development training for coroners; and training on particular issues.
4. 119 The current position has led to inconsistency in the provision of, and access to, training across the country. We understand that some coroners' officers in particular have found it difficult to take time away from their duties to undergo training. Doing nothing will mean that the Chief Coroner, who will be the national leader of the coroner service in England and Wales and will set national standards that coroners should meet, will have little formal remit over the training of coroners, their officers and staff.
4. 120 If training is substandard, or non-existent, this may have a knock-on effect on bereaved people and other interested persons, who may receive a standard of service that is lower than they deserve, and lower than the standard that the Charter and other Chief Coroner guidance indicates they will receive. This may in turn lead to a higher number of appeals and complaints against, respectively, coroner decisions and standards of service.



## Proposal - Secondary legislation for training

4. 121 The Chief Coroner will be responsible for overseeing the training undertaken by coroners, their officers and staff, and may make regulations about the kind, frequency and amount of training to be undertaken in order to facilitate this.

### Costs of Proposal 8

#### *Employers – local authorities and police authorities*

4. 122 We envisage that the costs of delivering training will be approx. £0.8m. Travel and subsistence costs and deputising cover costs will continue to be met locally by employers (local/police authorities). As our proposal would not change this arrangement we anticipate no new cost burden on employers. However we should be grateful for stakeholder views on whether our proposal would create new travel and subsistence costs for employers (perhaps if they are currently supporting less training than we propose).
4. 123 The central and local budgets for training will continue to be limited and as such we are considering how to obtain best value for money for the training. Our consultation therefore seeks views on the content of training; what training should be compulsory and/or voluntary; who should deliver training; and the training's format, accessibility and value for money.

### Benefits of Proposal 8

#### *Coroners' offices*

4. 124 Our proposal will benefit coroners, coroners' officers, and other coroner support staff, by standardising the training they receive, and thus better equipping them to provide a better service.

#### *Bereaved people*

4. 125 Improved and more consistent and transparent training provision will also benefit all others who come into contact with the coroner system – such as bereaved people and other interested persons - by providing in turn for a more consistent and improved service.

### Net Impact

4. 126 The annual monetised costs are estimated around £0.8m per year. The consultation exercise seeks views on training in order to help us to better quantify the costs.

## PROPOSAL 9: Short Death Certificates

### Description

4. 127 This proposal would amend the Births and Deaths Registration Act 1953 to provide for an additional short death certificate omitting the cause of death. The new provision also includes a power for the Registrar General to prescribe a fee for the certificate.

## Economic Rationale

4. 128 This proposal will allow for an additional service to be provided to bereaved families.

### Current Position

4. 129 Currently there is no short form death certificate, and a death certificate must include the cause of death. If we do nothing the current position will continue - namely that causes of death that might cause embarrassment or upset to bereaved relatives will have to be disclosed to an organisation – such as a bank or utility company - which does not need to know the cause of death, but only requires confirmation of the death.

### Proposal - Secondary legislation for short death certificates

4. 130 This proposal amends the births and deaths registration legislation to provide for a short death certificate in addition to a full certificate.<sup>11</sup>

## Costs of Proposal 9

### *General Register Office*

4. 131 At present the General Register Office has funding responsibility for registration services. The Registrar General, rather than MoJ, is seeking views on whether families should be charged fees for the new short death certificate, and on the content of the certificate.

## Benefits of Proposal 9

### *Bereaved people*

4. 132 This proposal will benefit bereaved people as they will no longer need to disclose the cause of death to organisations which require confirmation only of a death, and not of the cause. This is especially important where the cause of death is sensitive, for instance from a suicide or drug abuse, and the family wishes this cause to not be widely known.

## Net Impact

4. 133 The General Register Office is seeking views on charging fees on the content of the short death certificate, in order to assess the impact of this proposal. The benefits would accrue mainly to bereaved people.

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<sup>11</sup> This is not directly linked to the changes to the coroner system but as a result of Parliamentary debate on the Act, the Government agreed to make these changes to enable the Registrar General to prescribe this additional new form of short death certificate.

## 5. Specific Impact Tests

### Small Firms Impact Test

5. 1 The coroner system has limited interactions with three groups of small firms - funeral directors, pathologists and body removers. We anticipate that the reforms in our 9 proposals, and in the Act more generally, do not affect the nature or quantity of those interactions and so the impact on small businesses will be minimal.
5. 2 *Question: Do you agree with our assessment of the impact on small firms of our proposals? If not please let us know explaining why in your response.*

### Funeral Directors

5. 3 Around 4,000 businesses in England and Wales operate in the funeral market. Some 3,300 are currently registered with the National Association of Funeral Directors. Some are large national organisations (e.g. Co-Operative Funeral Services) and some are small local businesses that fall within the small business criteria.
5. 4 The National Association of Funeral Directors responded to the consultation on the draft Bill in 2006 and also to the 2008 discussion paper on the Charter for Bereaved People. We anticipate that the reforms in the Act will not impact on the way in which these firms do business.
5. 5 The Ministry of Justice will work with representative groups to establish what information should be provided to the funeral industry about coroner reform.

### Pathologists

5. 6 There are estimated to be around 700-800 pathologists who regularly carry out post-mortem examinations in England and Wales (a total of 108,360 post-mortem examinations in 2008). Pathologists are commissioned by the coroner, generally on a private fee-based arrangement. Most are also employed by the NHS. While the introduction of national guidelines may reduce the number of post-mortems each year this would only happen gradually over time. The impact on pathologists is expected to be minimal. As a result of our proposals pathologists may see a small reduction in the number of fully invasive post-mortem examinations they carry out, but this would be balanced by a possible increase in the number of requests for more specialised tests being carried out on specific organs or using specialist methods.

### Body removals

5. 7 In a number of coroner areas the local authority has contracted a private firm to move bodies from the scene of death to a mortuary. In other areas this is carried out by a local undertaker. The number of private body removal firms is not large (less than 100 in England and Wales). Again the Act is expected to have a minimal impact on these firms. As now the local authorities would need to consider the effect on existing contracts when planning local changes to coroner area boundaries.

### Gender, Disability and Race Equality

5. 8 The draft Ministry of Justice Equality Impact Assessment, which is attached at Annex B, covers these three areas.

## Human Rights Impact Assessment

5. 9 Part 1 of the Coroners and Justice Act 2009 contains a number of sections that may engage various articles of the European Convention on Human Rights.
5. 10 Sections relating to the duty to investigate certain deaths, in particular those deaths that occur in custody or some other form of state detention (section 1(2)(c)); the requirements as to when an inquest must be conducted with a jury (section 7); and those provisions regarding the purpose and outcome of an investigation (sections 5 and 10 – in particular section 5(2) which makes explicit the need for an investigation to look at the wider circumstances surrounding and leading up to the death in question when convention rights are engaged) are designed to ensure that the Article 2 right to an effective investigation is fulfilled in all cases where the death engages Article 2. The provisions within the Act on interested persons (section 47), appeals (section 40) and allowing cases to be transferred between one jurisdiction and another (sections 2 and 3) are also all designed to address the Article 2 requirement to ensure that the next of kin of the deceased are involved to the extent necessary to safeguard their legitimate interests. The Article 2 requirement to take appropriate steps to safeguard lives is met by the reports to prevent future deaths that will be issued under paragraph 7 of Schedule 5.
5. 11 Section 14 on post-mortem examinations raises issues under Article 9 on religious freedom. There may be concerns that certain forms of post-mortem examination that involve dissection could run counter to certain religious beliefs. However, it is considered that use of invasive post-mortem examination procedures is justified even where it infringes on religious beliefs where it contributes to the greater public good by promoting and protecting public health and safety and the interests of justice. Similarly, powers of exhumation under paragraph 6 of Schedule 5 may engage Article 9, but do not, in our opinion, infringe Article 9 as they will only be exercised if deemed necessary by the coroner in the interests of justice. The sections on the new death certification process (sections 19 and 20) may also engage Article 9 in relation to religious groups whose faith requires that a body is disposed of as soon as possible after death. However, we consider the provisions do not infringe Article 9 because the procedures to be put in place will enable the additional scrutiny to take place without any undue additional delay.
5. 12 There are also provisions within Part 1 of the Act regarding evidence and the compulsion of witnesses, and the duty to deliver objects considered to be evidence or treasure that could engage Article 8 and Article 1, Protocol 1. For example, Article 8 will be engaged by some of the search and seizure powers in Schedule 5 of the Act, and Article 1 Protocol 1 will be engaged by some of the provisions on Treasure. It is considered that these provisions are a reasonable balance between the rights of the individual and the public interest in carrying out an investigation that has access to all the evidence. Whether any interference with Article 8 is justifiable will depend on the circumstances of the particular case and it will be for the coroner to ensure that he only exercises the powers in a way which ensures that any interference is in pursuit of a legitimate aim and proportionate to the aims, thus falling within Article 8(2). The Government is satisfied that any interference with Article 1, Protocol 1 rights will be justified in the public or general interest because an investigation of a non-natural death must reach conclusions based on all relevant information.

## Rural Proofing

5. 13 We do not anticipate any impact arising from the 9 policy areas on which we are consulting but should be grateful for views on this. The coroner sections of the Act focus on providing an improved service to bereaved people, the introduction of national leadership and the improvement of coroners' investigations. Therefore we anticipate that they will not have a particularly significant impact on rural areas. Some stakeholders have raised concerns about the implications of moving to a

whole-time coroner service. In practice, however, this would not reduce coroner resource in rural areas, as under the new system there will still be scope to appoint area and assistant coroners to ensure that there is adequate cover across the entirety of each coroner area, including those that cover largely rural jurisdictions. Nor would the creation of larger coroner areas mean reduced access locally as inquests could still be held in a number of different locations within that area.

5. 14 *Question: Do you agree with our assessment of the impact on rural areas of our proposals? If not please let us know explaining why in your response.*

### Carbon Assessment and other environmental assessments

5. 15 Defra's environmental impact guidance lists six areas which are key sources of green house gases: energy; industrial processes; solvents and other product use; agriculture; land-use change and forestry; and waste. While cremation is a source of greenhouse gas emissions, the way that crematoria operate is outside the scope of the Coroners and Justice Act.

### Health Impact Assessment

5. 16 The Department of Health has developed a checklist to help assess whether there might be adverse impacts on health as a result of new legislation. The three questions, and our responses, are as follows:

*Will your policy have a significant impact on human health by virtue of its effects on the wider determinants of health?*

5. 17 The wider determinants listed cover income, crime, environment, transport, housing, education, employment, agriculture and social cohesion. Nothing has arisen in any of the work done for this Act and our 9 proposals to suggest that there would be an impact on any of these areas that might lead to a significant impact on human health.

*Will there be a significant impact on any of the lifestyle-related variables?*

5. 18 The variables listed are: physical activity; diet; smoking, drugs or alcohol use; sexual behaviour; and accidents and stress at home or work. Bereavement is undoubtedly a stressful time for those involved. However, a key aim of these reforms is to improve the service for bereaved people and so it is not considered that there would be a detrimental impact on any of these variables.

*Is there likely to be a significant demand on any of the following health and social care services?*

5. 19 The services listed are: primary care; community services; hospital care; need for medicines; accident or emergency attendances; social services and health protection and preparedness response. The Act focuses on improving the service provided to bereaved people and it will not have a significant impact on demand for these services. As part of the reform programme we will be looking at ways to make better use of the lessons learned at inquest in order to prevent further deaths.

## Competition Assessment

5. 20 This competition assessment applies to the funeral industry. In our view the Coroners and Justice Act and the 9 policy areas on which we are consulting will have no direct impact on business or competition between businesses.

5. 21 The Office for Fair Trading (OFT) asks nine questions in order to carry out a competition assessment for any new policies.

5. 22 The nine questions, and our responses, are as follows:-

1) In the market affected by the new regulation, does any firm have more than 10% market share?

Yes – the Co-Operative Funeral Service has a 14% share of the market, and Dignity has approximately 12%.

2) In the market affected by the new regulation does any firm have more than 20% market share?

No. See 1.

3) In the market affected by the new regulation, do the largest three firms together have at least 50% market share?

No. While there are around 4,000 funeral directors in the UK, 60% of them are independently owned.

4) Would the costs of the regulation affect some firms substantially more than others?

No. There is no direct cost to business.

5) Is the regulation likely to affect the market structure, changing the number or size of firms?

No. The Act focuses on improving the service to bereaved people. There is nothing to suggest that legislative changes will have this effect on the funeral industry.

6) Would the regulation lead to higher set-up costs for new or potential firms compared with the costs for existing firms?

No. As above, there is nothing to suggest that this would be the case.

7) Would the regulation lead to higher ongoing costs for new or potential firms compared with the costs for existing firms?

No. As above, there is nothing to suggest that this would be the case.

8) Is the market characterised by rapid technological change?

No. This is not the case.

- 9) Would the regulation restrict the ability of firms to choose the price, quality, range or location of their products?

No, there is nothing in the Act that would lead to such restriction of practice.

### Privacy Impact Test (an MoJ Specific Impact Test)

5. 23 We believe a privacy impact assessment is not required in relation to our consultation.

### Legal Aid and Justice Impact Test

5. 24 Legal aid is not generally available for coroner investigations. This is because an inquest is an inquiry concerned with the facts surrounding a death, rather than issues such as civil or criminal liability. The proceedings are generally less formal than a court hearing, and legal representation is considered unnecessary generally.
5. 25 In relation to the new appeals system on which we are consulting, our current estimate, based on an assessment of likely volume, is that the new process will increase pressure on the legal aid budget by an estimated £370k per year, which breaks down into £270k for legal help and £100k for exceptional funding. This has been agreed with the legal aid team in the Ministry of Justice and is included in the £6.629m annual running costs falling to the Department.
5. 26 It is recognised that the new appeals system could create a new burden because of additional resources required by coroners and their offices to respond to appeals. However the system will be piloted in a number of areas, to test the new system and quantify the additional burden more accurately.

Test	Impact Test carried out?	Significant impact?	Commentary
Competition Assessment	Yes	No	The Office of Fair Trading asks nine questions about potential impacts. We do not believe that the coroner sections of the Coroners and Justice Act will have an adverse impact on business or competition.
Small Firms	Yes	No	The coroner service has limited interaction with three groups of small firms – funeral directors, pathologists and body removers. The impact on these groups is assessed as minimal.
Legal Aid	Yes	No	Assessment of likely volume is that the new appeals process will increase pressure on the legal aid budget by an estimated £370k per year, which breaks down into £270k for legal help and £100k for exceptional funding.
Carbon and greenhouse gases	Yes	No	According to Defra’s guidelines crematoria are not recognised as a key source of greenhouse gas emissions. In any event, the coroner measures in the Act will not have an impact on the number of cremations.
Other Environmental Issues	Yes	No	No significant impact on the areas listed.
Health Impact Assessment	Yes	No	No significant impact on the areas listed.
Race, Gender and Disability Equality	Yes	No	Please see the draft Equality Impact Assessment at Annex B.
Human Rights	Yes	No	Consideration of the impact of the Act on human rights is covered through consideration of ECHR and Article 2 issues in the Act’s Explanatory Notes.
Rural Proofing	Yes	No	No significant impact.
Sustainable Development	Yes	No	No detrimental effect on domestic or global policies to improve sustainable development.

5. 27 An assessment of the coroner sections of the Act against the Hampton Review Principles is included at Annex A.



## 6. Other Issues

### Enforcement and Implementation

6. 1 In order to improve the service provided to bereaved people, the Act creates new central functions and strengthens coroners' powers, rather than imposing a host of new statutory requirements. It will be for the Ministry of Justice and the new Chief Coroner to consider how well the new service is operating in relation to guidelines and standards as well as the Charter for Bereaved People. The annual costs of enforcement are expected to be negligible.

### Post Implementation Review

6. 2 The Ministry of Justice is responsible for implementation of the coroner provisions in the Coroners and Justice Act. This work will be managed as a formal change programme and will be subject to regular review. It will be managed in parallel and, as far as possible, aligned with the implementation of the Department of Health death certification reforms which are also included in the Coroners and Justice Act.
6. 3 The costs and benefits of the coroner reforms will be assessed 12-18 months after implementation of the coroner sections of the Act, as part of a regular review process.

### Compensatory Simplification measures

6. 4 The proposed reforms will provide for more consistent and improved standards of service. As part of our implementation of reform we intend to repeal the current coroner legislation.

### Implementation and Delivery Plan

6. 5 We plan to implement the bulk of our reforms in April 2012, with the exception of the new appeals system which we intend to pilot for a year from April 2012, with a view to implementation a year later.

### Communicating change

6. 6 The Ministry of Justice and / or Chief Coroner will provide information and training for coroners, coroners' officers and support staff about the changes resulting from the Coroners and Justice Act. We will also work with organisations representing other professionals who interact with the coroner service in order to agree how best the changes should be communicated to them. The Chief Coroner and Ministry of Justice will also be able to provide information and guidance on the operation of the new system for other stakeholders that interact with the coroner system. This will include the Charter for Bereaved People.

## Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

**Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.**

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	Yes	No
Small Firms Impact Test	Yes	No
Legal Aid	Yes	No
Sustainable Development	Yes	No
Carbon Assessment	Yes	No
Other Environment	Yes	No
Health Impact Assessment	Yes	No
Race Equality	No	Yes
Disability Equality	No	Yes
Gender Equality	No	Yes
Human Rights	Yes	No
Rural Proofing	Yes	No

## Annexes

### ANNEX A

#### COMPLIANCE WITH HAMPTON PRINCIPLES

The Hampton Review was aimed primarily at business and reducing administrative and regulatory burdens for that sector. It set out ten principles for regulatory enforcement. These covered areas such as the use of comprehensive risk assessment, the way in which regulators should behave and the enforcement of regulations.

The review's central objective was to raise both the quality and effectiveness of the regulatory system, and sought to build on the strengths of the regulatory system as it exists at present, especially regulatory independence. It also considered that over time its proposals had the potential to reduce the direct cost of regulation to Government and regulated sectors.

The reform of the coroner system has minimal impact on business. The commentary below is a brief assessment against Hampton principles where they are relevant.

The Chief Coroner will collect information from coroners about the service provided and will be able to use this to identify particular issues that may arise and, in conjunction with inspection of the administration of the service, focus attention as appropriate on those.

Inspection has been identified as a key part of reform of the coroner service, and in particular to the raising of standards. This will provide an external, independent review of the service and create a greater level of accountability.

The draft 2006 Coroners Bill was consulted on with a wide range of stakeholders, and their comments were taken on board in developing the coroner sections of the Act. The legislation has an extremely minimal impact on business, and no information was requested from business as a result of it. The new sanctions introduced do not impact on business.

Information about the reformed service, and in particular access to appeals, will be provided through the Chief Coroner's office and website, as well as local coroners.

## ANNEX B



### **Draft Equality Impact Assessment Initial Screening – Relevance to Equality Duties**

Before you complete an EIA you must read the guidance notes and unless you have a comprehensive knowledge of the equality legislation and duties, it is strongly recommended that you attend an EIA training course

The EIA should be used to identify likely impacts on:

- Disability
- Gender (including gender identity)
- Race
- Age
- Caring responsibilities (usually only for HR policies and change management processes such as back offices)
- Religion and belief
- Sexual orientation

1. Name of the proposed new or changed legislation, policy, strategy, project or service being assessed

Coroners and Justice Act 2009 - Part I - coroners

We are running a consultation, from 11 March 2010, on the policy that will inform the drafting of the secondary legislation that will be made under the Coroners and Justice Act 2009. A further consultation will take place on the rules and regulations themselves before the new coroner system goes live from April 2012.

The consultation will be published on the MOJ website and will run for at least 12 weeks.

2. Individual officer(s) & Unit responsible for completing the Equality Impact Assessment:

Olga Kostiw – Coroners and Burials Division, Coroner Reform Policy & Bill Team, Policy Advisor  
Geoff Bradshaw – Coroners and Burials Division, Head of Coroner Reform Policy & Legislation

3. What is the main aim or purpose of the proposed new or changed legislation, policy, strategy, project or service and what are the intended outcomes?

**1.1.1 Aims/objectives**

The objectives of reforming the coroner system are:

- an improved service for bereaved people and others who interact with the service;
- the introduction of national leadership and improvements to enhance the local delivery of the service;
- more effective coroners' investigations.

Bereaved people who have to deal with the coroner service will benefit, as will the general public as a result of the improved arrangements for and greater priority given to reports on actions to prevent future deaths.

**1.1.2 Outcomes**

- Bereaved people and other interested persons will be able, easily and without charge, take action if they are dissatisfied with a coroner's decision, the standard of service they have received, or if they have concerns about a coroner's conduct.
- The 'Charter for Bereaved People' will ensure that bereaved people have a better understanding of the coroner's role and of their own rights and responsibilities.
- More consistent level of service for the bereaved, from new national standards to be issued by the new Chief Coroner.
- More effective investigations and inquests as a result of additional medical advice and new powers for the coroner to obtain evidence. This includes search and entry of land or premises for the coroner investigation process.
- Boundary restrictions will be relaxed allowing improved co-ordination in situations such as incidents with mass fatalities. The new measures will enable investigations to be transferred quickly and simply, by Chief Coroner direction where necessary, to assist with operational efficiency so that delays are kept to a minimum for bereaved families and other interested persons. There will be flexibility to transfer service personnel inquests to Scotland, when the bereaved family live there and it is more convenient for them.
- Changes to practice in post-mortem examinations and retention of bodies will ensure that coroners have access to all relevant medical information as to the medical cause of death in every case, where they have commissioned a post-mortem examination. Some of the outcomes will be to remove geographical restrictions on where examinations may be carried out; to enable less invasive examinations to be conducted when they are scientifically proved, to provide the required information; that examinations, at whatever level of invasiveness, are carried out only when required; to enable the bodies of those who have died to be returned as promptly as possible to their loved ones to avoid distress; to provide the next of kin, wherever possible, with better opportunities to be informed about the purpose and outcome of post-mortem examinations; to provide, in occasional circumstances, for examinations to be carried out other than by medically qualified practitioners.
- Information collected by coroners during investigations will be more readily available to bereaved families. Secondary legislation made under the Act will make clear what may or may not be disclosed and when.
- Training of coroners and their officers and staff will be the responsibility of the Chief Coroner. This will help ensure that all those working within the coroners' system are aware of and apply up to date relevant law, best practice, guidance and standards.

4. What existing sources of information will you use to help you identify the likely equality on different groups of people?

*(For example statistics, survey results, complaints analysis, consultation documents, customer feedback, existing briefings submissions or business reports, comparative policies from external sources and other Government Departments)*

We have consulted widely and publicly on a variety of aspects of our reform proposals – the 2006 draft Bill, the Charter for Bereaved People, and issues around sensitive reporting in coroner courts, as well as stakeholder contact in the form of Ministerial meetings, meetings with officials, and email and written correspondence. We have also provided regular updates on reform to around 200 stakeholders. This contact has shown no specific equality and diversity impacts specific to race, disability and gender (including gender identity), age or sexual orientation. However religion & belief has been significant. Individuals and groups representing certain faiths, notably the Muslim and Jewish faiths, have been concerned about possible delays in releasing bodies for funerals, and believe that there should be an increase in the availability of less-invasive post-mortem examination methods. Both these issues have been addressed in our reforms. Further information on this is attached in section 7 of the document.

Throughout the policy development process, the Ministry of Justice has also worked closely with the Coroners' Society to ensure that its views, and experience in dealing with people from different equality and diversity groups, have been taken account of in developing coroner reform policy. This has taken place through policy specific meetings, general ongoing discussions about reform, feedback from a small group of coroners selected by the Society to comment on the practicality of the draft Act's provisions, and through the regular meetings of the Coroners Advisory Group facilitated by the Ministry of Justice. The Coroners and Burials Division (MoJ) has also established a stakeholder forum which meets quarterly and facilitates discussion with a wide range of stakeholder groups on issues affecting the coroner service (including reform). No further diversity and equality impacts have been identified via these media. More detailed information about how other stakeholder views shaped the Act's provisions was set out in the Impact Assessment which was published alongside the Bill. A sample of these stakeholder groups and the steps taken to address their particular concerns in relation to diversity and equality, are listed in the table at the end of this document. (Table A)

5. Are there gaps in information that make it difficult or impossible to form an opinion on how your proposals might affect different groups of people? If so what are the gaps in the information and how and when do you plan to collect additional information?

*Note this information will help you to identify potential equality stakeholders and specific issues that affect them - essential information if you are planning to consult as you can raise specific issues with particular groups as part of the consultation process. EIAs often pause at this stage while additional information is obtained.*

The policy consultation and impact assessment, which this equality impact assessment accompanies, seek views on the content and impact of our proposals. Responses to the consultation will inform the secondary legislation we will make under the Act. Our existing sources of information in section 4 above have not identified any specific diversity and equality impact in relation to race, disability and gender age, gender or sexual orientation. We have taken into account the views of faith groups and others through our consultation which is discussed in more detail below. The impact assessment ('Cost Benefit Analysis' section) seeks views on whether we need to be aware of and factor in any further equality and diversity issues, by asking whether any of our proposals may have any further impact on any of these areas, that we may not have taken into account already.

The consultation on the draft Coroners Bill in 2006 and the draft Charter for Bereaved People suggests that the reform of the coroner system will not discriminate (directly or indirectly) against any specific group of people. We will aim to ensure that there is a balance between the coroner's statutory duty to investigate certain deaths and the equality and diversity needs of bereaved people and others who come into contact with the service. A major thrust of reform is to spread best practice about ways of meeting the needs of different service users.

6. Having analysed the initial and additional sources of information including feedback from consultation, is there any evidence that the proposed changes will have a **positive impact** on any of these different groups of people and/or promote equality of opportunity?

Please provide details of who benefits from the positive impacts and the evidence and analysis used to identify them.

People may come into contact with the coroner system in either a personal capacity (i.e. after bereavement) or a professional capacity (police, doctors, pathologists, civil registrars etc.)

Both the Shipman Inquiry and the Luce Review found that the bereaved were not always involved in the processes of death certification and investigation. They also showed that the needs and expectations of the bereaved are sometimes not given the consideration that they deserve, but did not find that any one group fared any better or worse than any other. None of the consultation processes which have taken place have given any indication that any of the groups listed are at risk of having less opportunity than others for involvement or engagement in a reformed coroner system.

The Act also provides for an Annual Report to be issued by the Chief Coroner and provided to the Lord Chancellor, and published. The positive impacts therefore include that this will increase openness and transparency of the coroner system and will benefit bereaved people and different groups of people which form part of the public in general.

Under section 37 of the Act the Chief Coroner will be responsible for the training of coroners, coroners' officers and other staff, to standardise and improve the quality of investigations and service to the bereaved. We anticipate that this will include training on increasing understanding of the cultural and social diversity of the many people who pass through the coroner system.

In particular, we believe it will have a positive impact in recognition of the needs of particular faith groups, as the Act also provides for less invasive post-mortem examinations (for example by magnetic resonance imaging scan) where a coroner decides this is appropriate. This is further set out at Question 7.



7. Is there any feedback or evidence that additional work could be done to promote equality of opportunity?

If the answer is yes, please provide details of whether or not you plan to undertake this work. If not, please say why.

There is no evidence that additional work could be done to promote equality of opportunity, but the impact assessment seeks views on this.

The draft Charter for Bereaved People sets out the role of the coroner and the rights and responsibilities of bereaved people who come into contact with a reformed coroner system. This will standardise and disseminate best practice and equality of opportunity in the system, and will help to ensure that the reformed coroner service is more consistently sensitive to the equality and diversity needs of bereaved people, providing them with information at the right time and consulting them on key aspects during investigations and inquests.

The draft Charter states at paragraph 10 that the coroner's office will: *'take account, where possible of individual, family, and community wishes, feelings and expectations, including family and community preferences, traditions and religious requirements, relating to mourning and to funerals, and respect for individual and family privacy.'* We published a revised draft Charter for Bereaved People following consultation early in 2009. This included changes suggested by our stakeholders. We plan to consult on and publish a final version of the Charter after the Chief Coroner comes into office.

It is for local authorities to ensure that coroners' courts and offices comply with the **Disability Discrimination Act**, at operational level. The draft Charter states at paragraph 50 that: *'Coroners will, as far as practicable and taking account of their statutory responsibilities, provide appropriate access to coroners' courts and offices. Reasonable adjustments will be made, wherever possible, to meet the needs of those with disabilities.'* We envisage that the Chief Coroner will provide coroners with information on disability awareness via training events and guidance, and monitor progress in this area.

We also envisage that the Chief Coroner will liaise with faith groups and other stakeholders to keep them up to date with, and seek their views on, issues. **Table A** at the end of this document, outlines the views received on equality and diversity issues during the coroner reform consultation process so far.

We envisage that the Chief Coroner's office will produce guidance in different languages, in addition to Welsh, and in accessible formats, such as Braille or large print, either as standard, or on request.

We will pilot the new appeals system before full implementation. This will allow us to identify any barriers that may exist and to take steps to overcome them.

We have considered the impact on various equality and diversity groups through our previous consultations in relation to each of the following areas:

- a) Whether their access to the benefits of the legislation may be inhibited through any barriers.
- b) Whether there was any evidence that different groups are likely to have different needs, experiences, issues and priorities in relation to the changes - as mentioned, some of the proposals will be piloted before full implementation.
- c) Whether the legislation will create exclusion or hold specific challenges for organisations, individuals and stakeholders.
- d) Whether there is evidence that the legislation could directly or indirectly discriminate against any group of people.
- e) Whether there is any evidence that different groups of people have different participation rates

The results are shown in the table below. There was no evidence of any impact except regarding point b) in relation to faith issues.

On the question of faith, coroners are increasingly aware of the religious and cultural sensitivities and needs in their area. Many coroners have built up good local links with specific groups such as Muslims, Hindus and Jews. Where possible, coroners respond to the need for prompt burial or cremation and can be flexible in making arrangements to meet those needs – for example by prompt scheduling of a post-mortem examination. People of certain faiths may want to bury or cremate the deceased's body as soon as possible after death. This will continue under the new system with good guidance and disseminating of best practice by the Chief Coroner. Under the new proposals, coroners will be able to commission a post-mortem examination in any area, potentially enabling greater access to less-invasive post-mortem examination techniques. This will make it easier for a coroner to take account of a bereaved family's wishes about a post-mortem examination.

In relation to point a) on any barriers inhibiting the benefits of legislation, we anticipate that the new Chief Coroner will produce guidance on the new system. This may be printed in different languages and formats. On point c) we are aware that certain faiths may wish to bury or cremate the deceased's body as soon as possible after death. On point e) there is no evidence that only certain groups of people use the coroner system as a coroner has a duty to investigate all violent, unnatural deaths, or those of unknown cause, regardless of equality and diversity group. The Shipman Inquiry and Luce Review both showed that the needs of the bereaved are sometimes not given the consideration they deserve, but did not find that any one group fared any better or any worse than any other. None of the consultation processes which have taken place have given any indication that any of the groups listed are at risk of different participation rates for their involvement with a reformed coroner service.

	Yes	No	Not Known		Yes	No	Not Known
<b>Age</b>		<b>X</b>		<b>Racial Group</b>		<b>X</b>	
<b>Caring Responsibilities</b>		<b>X</b>		<b>Religion or Belief</b>	<b>Point b) X</b>		
<b>Disability</b>		<b>X</b>		<b>Sexual orientation</b>		<b>X</b>	
<b>Gender</b>		<b>X</b>					

8. Is there any evidence that proposed changes will have **an adverse equality impact** on any of these different groups of people?

Please provide details of who the proposals affect, what the adverse impacts are and the evidence and analysis used to identify them.

We believe that none of our proposals will have an adverse equality impact on any of these different groups of people.

As set out above, some faiths and cultures, for example people of the Jewish, Hindu and Muslim faiths, require the deceased's body to be disposed of (buried or cremated) as quickly as possible after death. Post-mortem examinations and appeals relating to them will therefore need to be dealt with quickly. The Act provides for this and, in addition, we anticipate that the Chief Coroner will also issue guidance on this. Post mortem practice is one policy area on which our current consultation seeks views.

Coroners are already increasingly aware of the religious and cultural sensitivities and needs in their areas. Many have built up good local links with groups who have specific religious requirements, such as Muslims, Hindus and Jews. Coroners can respond to the need for prompt burial or cremation and be flexible in making arrangements to meet those needs – for example by scheduling a prompt post-mortem examination.

In the reformed service, the Chief Coroner's guidance will build upon existing best practice. The Chief Coroner will consider this in consultation with relevant stakeholder groups.

The Act removes the current restrictions whereby post-mortem examinations have to be carried out in the coroner's own area or a neighbouring area. In the reformed service, a coroner will be able to commission a post-mortem examination in any area, potentially enabling greater access to less invasive post-mortem examination techniques (such as magnetic resonance imaging (MRI) techniques). This will make it easier for a coroner to take account of a bereaved family's wishes about post-mortem examinations, a particular issue for certain faith groups.

The draft Charter makes clear that where the next of kin has concerns about the decision to conduct a post-mortem examination, or for additional scientific examinations on specific organs or tissues, they should direct these to the coroner's office to consider. However, the coroner's decision as to whether the examination should take place, and the type of examination appropriate, is final. Appeals will only be admissible from those families who believe that a post-mortem examination should take place and the coroner is refusing to commission one.

9. Is there any evidence that the proposed changes have **no equality impacts**?

Please provide details of the evidence and analysis used to reach the conclusion that the proposed changes have no impact on any of these different groups of people.

No

10. Is a full Equality Impact Assessment Required?

No

(If no, please explain why not)

Responses to consultation suggest that the coroner sections of the Coroners and Justice Act will not have an adverse impact on particular equality and diversity groups. The role of Chief Coroner and the new Charter for Bereaved People will provide a framework for equal access to the service and will improve the standard of service provided to all.

We are continuing to engage with our stakeholders through this and further consultations on the rules and regulations that will be informed by the Act and to take into account the views of these groups in further formulation of our policy. A decision on whether a full Impact Assessment is required will be made after we have received feedback from the further consultation.

NOTE - You will need to complete a full EIA if:

- the proposals are likely to have equality impacts and you will need to provide details about how the impacts will be mitigated or justified
- there are likely to be equality impacts plus negative public opinion or media coverage about the proposed changes
- you have missed an opportunity to promote equality of opportunity and need to provide further details of action that can be taken to remedy this

**If your proposed new or changed legislation, policy, strategy, project or service involves an Information and Communication Technology (ICT) system and you have identified equality impacts of that system, a focused full EIA for ICT specific impacts should be completed. The ICT Specific Impacts template is available from MoJ ICT or can be downloaded from the Intranet and should be referenced here.**

11. If a full EIA is not required, you are legally required to monitor and review the proposed changes after implementation to check they work as planned and to screen for unexpected equality impacts. Please provide details of how you will monitor evaluate or review your proposals and when the review will take place.

We are continuing to engage with our stakeholders through this and a further consultation as we produce the rules and regulations that will be made under the Act.

We have undertaken an OGC gateway review whose recommendations will assist with developing our reform plans further. We have factored in an ongoing post-implementation review, to ensure that the implementation meets our objectives as set out in section 3 above.

## 12. Name of Senior Manager and date approved

(Note - sign off at this point should **only** be obtained if:

- there are no equality impacts
- the changes have promoted equality of opportunity

You should now complete a brief summary (if possible, in less than 50 words) **setting out which policy, legislation or service the EIA relates to, how you assessed it, a summary of the results of consultation a summary of the impacts (positive and negative) and, any decisions made, actions taken or improvements implemented as a result of the EIA**, including the review mechanism. The summary will be published on the external MoJ website.

Coroners and Justice Act 2009 rules and regulations policy consultation.

This equality impact assessment will be reviewed and updated following the closure of the policy consultation.

Name (must be grade 5 or above): Elizabeth Gibby

Department: Ministry of Justice

Date: 11 March 2010

Note: If a full EIA is required hold on to the initial screening and when the full EIA is completed send the initial and full screening together. **If a full EIA is not required send the initial screening by email to the Corporate Equality Division (CED), for publication.**

**Where an EIA has also been completed in relation to ICT specific aspects, email this to CED and copy to MoJ ICT**

**Table A**

**Views received on equality and diversity issues during the coroner reform consultation process so far:**

<b>Stakeholder</b>	<b>Main Issues</b>	<b>Amendments to policy as a result</b>
Burials and Coroners Unit Faith Liaison Group	Were concerned that the reforms would introduce greater delays before a body was available for burial.	Reassured them that the reforms will not introduce greater delays. The draft Charter for Bereaved People makes clear that coroner's office should 'take account, where possible, of individual, family, and community wishes, feelings and expectations, including family and community preferences, traditions and religious requirements relating to mourning and to funerals, and respect for individual and family privacy.'
Voluntary groups such as: Cruse Bereavement Care; Child Bereavement Trust; The Compassionate Friends; Victim Support; Victims' Voice; The SAFE Justice Foundation; Inquest; Road Peace; Support after Murder and Manslaughter (SAMM).	Felt there should be improved information channels for bereaved families and many comments on the provisions in the Charter for Bereaved People.	The Act places a statutory duty on the relevant local authorities to provide coroners' officers and staff as required by the coroner to enable him / her to carry out his / her functions and duties.  The draft Charter for Bereaved People promises greater and timelier provision of information for bereaved families and has been amended in response to comments. This provides a positive impact in terms of religion and belief issues through timely holding of inquests, improvements in provision of post-mortems and burial issues.
Individual meeting with the Support Abroad For Equal Justice Foundation and The Compassionate Friends	Had concerns over the treatment of the bereaved, consistency of information provision, channels of communication and having one consistent coroner's officer/family liaison officer. Also had concerns over the situation with deaths overseas and the co-operation of overseas agencies.	The Charter for Bereaved People will ensure consistency of standards. The Chief Coroner will be able to request assistance and evidence from abroad and encourage greater cooperation with authorities overseas. This benefits all who use the system regardless of gender, age, race, sexual orientation, disability and religious belief.
Victims' Voice, medical voluntary organisations meeting with Coroners and Burials Division officials.  These groups included: Cardiac Risk in the Young (C-R-Y); Epilepsy Bereaved; Sudden Arrhythmic Death UK (SADS); Foundation for the Study of Infant Death (FSID); Action versus Medical Accidents(AvMA); The Grief Centre; Bromley Bereavement Centre.	There was concern that there would be no national coroner service. There was also concern over the role of the Chief Coroner and how it would work. Mixed views over sensitive reporting policy.	Role of Chief Coroner as national leader of the coroner service was developed further and set out during Parliamentary debate (see annex C of IA for details on the Chief Coroner role). We anticipate that he or she will also provide guidance in relation to age, gender, disability, race, religious and faith related issues.  An event dedicated to reporting restrictions was held on 12th July 2007 and the consensus was that this measure should not be included and that instead administrative measures would be taken to curb abuses of privacy. Reports will abide by the Editor's Code of Practice, upheld by the Press Complaints Commission which sets out the guidance for print journalists in the UK. The code includes specific rules in cases involving grief and shock.

Stakeholder	Main Issues	Amendments to policy as a result
Department of Health: Human Rights and Equality Division	Had concerns that there wasn't enough awareness of the needs for faith groups to be considered regarding the provision of alternative methods to invasive autopsies, namely MRI and CT scanning.	We consulted with faith groups bi-annually and outlined the provisions that, for example, allow coroners to have more power over post-mortem decisions, and that there will be a right of appeal against coroners either not holding a post-mortem or ordering the holding of a second post mortem. (In addition, regulations will contain new limits for the retention of human remains.)The Department of Health was content with this approach.
Epilepsy Bereaved	Concerned with the examinations ordered by coroners when a death is suspected from SUDEP (Sudden Unexpected Death from Epilepsy), as well as misleading reporting of SUDEP deaths. They also raised the matters of availability of data for research purposes.	The draft Charter for Bereaved People states that SUDEP deaths might be appropriate for the Chief Coroner to set standards about. Bridget Prentice assured Epilepsy Bereaved that the Chief Coroner and National Medical Adviser will be in a position to answer most concerns and that we will continue to liaise with Epilepsy Bereaved, and other stakeholders, on matters requiring consultation.
British Lung Foundation	Concerned with the investigation of deaths from mesothelioma (caused by asbestos exposure).	The Justice Minister has acknowledged BLF's work to date in providing best practice for coroners in mesothelioma deaths and expressed a wish to continue with this relationship.

## Background on coroner reform

### What are we trying to achieve?

The Ministry of Justice will deliver a reformed coroner service by implementing Part 1 of the Coroners and Justice Act 2009 (excluding sections 19 – 21 which deal with death certification, on which the Department of Health leads).

The aims of the Act are to:

- Introduce **national leadership** to the service through the appointment of a Chief Coroner, while ensuring that the service remains firmly grounded locally.
- Deliver an **improved service for bereaved people** coming into contact with the coroner system, by publishing a Charter for Bereaved People setting out what sort of information and services they can expect to receive; and by giving them rights of appeal against certain decisions made by the coroner.
- Introduce **national standards**. The new Chief Coroner will have an ongoing role in setting national standards, issuing best practice guidance and monitoring performance. Alongside the new inspection arrangements this will ensure delivery of an improved and consistent quality of service across England and Wales.
- Ensure **more effective investigations and inquests** by providing coroners with access to medical advice (from medical examiners); giving coroners additional powers to obtain evidence; and by removing outdated boundary restrictions and allowing business to be allocated more effectively.
- Introduce arrangements to **support coroners**. The Chief Coroner will oversee arrangements for training coroners, officers and staff; and support coroners as necessary in discussions or negotiations with local authorities, the police and other interested groups.
- Increase **openness** by developing a public website for the Chief Coroner's office and by introducing an annual report to be laid before Parliament.

The Department of Health is responsible for implementing sections 19 – 21 of the Coroners and Justice Act. These introduce a new system of medical scrutiny (by medical examiners) that will apply to all deaths that are not investigated by a coroner. The Ministry of Justice will continue working closely with the Department of Health to manage any transitional issues.

Working with the Department of Health we aim to ensure that deaths are referred appropriately to either a medical examiner or a coroner, by providing guidance to medical practitioners, police and registrars.

Although it is outside the scope of this programme, the Chief Coroner and his/her Medical Adviser will have an ongoing role in support of the Department of Health's aim to improve the quality and accuracy of death certification, which will strengthen local clinical governance and public health surveillance. It is anticipated that the Chief Coroner and his/her Medical Adviser will work closely with the National Medical Examiner and local medical examiners.



## How will the Act achieve these aims?

The Act will achieve these aims in the following ways.

### **Chief Coroner**

The Chief Coroner will be the head of the coroner service, providing national leadership for the coroner system in England and Wales. The Lord Chief Justice (head of the judiciary) will appoint the Chief Coroner, after consulting the Lord Chancellor. Only High Court and Circuit judges are eligible for appointment.

The role of Chief Coroner comprises a mix of leadership and judicial functions. These are both statutory and non-statutory. He/she will be responsible, among other matters, for:

#### *Leadership*

- Setting national service standards and issuing guidance and practice directions. This will ensure that bereaved people received an improved and more consistent level of service.
- Monitoring performance, particularly in relation to delayed investigations.
- Developing a programme of induction and on-going training for coroners; and making regulations about the training of coroners' officers and other staff.
- Dealing with non-judicial complaints against coroners, to ensure that investigations/ inquests are handled appropriately and that interested persons are treated fairly.
- Providing an annual report to Parliament, ensuring greater accountability and transparency in the coroner service.
- Liaising and working with local authorities, the police and other local stakeholders.

#### *Judicial*

- Hearing appeals against coroners' decisions.
- Monitoring coroner workloads across England and Wales, transferring investigations from one coroner to another where appropriate, in order to make best use of the expertise and resources available and to avoid delays.

The Chief Coroner will be supported by one or more Deputy Chief Coroner(s), a Medical Adviser and a team of staff.

### **Medical Adviser to the Chief Coroner**

The Medical Adviser to the Chief Coroner will provide national leadership on medical issues, and will be responsible for:

- Developing national standards and guidelines for coroners on a range of issues including the use of post-mortems and other tests; the release of bodies; and organ and tissue retention.
- Representing the Chief Coroner in discussions with organisations such as the British Medical Association (BMA), the General Medical Council (GMC), the Royal College of Pathologists, the Human Tissue Authority and the Department of Health.
- If appropriate, advising the Chief Coroner on medical issues relating to appeals.

The Medical Adviser will be supported by a small team which is likely to be co-located with the Chief Coroner's staff.

### **Coroner for Treasure**

The Coroner for Treasure will investigate all reported treasure finds in England and Wales. He/she will have the skills and resource to deal with treasure investigations quickly and effectively. Local coroners will cease to have jurisdiction over treasure finds, allowing them to focus on death investigations.

## **Reform of the coroner system – next stage** consultation paper

The Coroner for Treasure will be a part-time post. He/She will be supported by an Assistant Coroner(s) for Treasure and a small team of staff.

### **Appeals system**

Bereaved people and other interested persons will have new rights of appeal against certain decisions made by the coroner during the course of an investigation and/or the outcome of that investigation, as prescribed in section 40 of the Coroners and Justice Act 2009. The appeal system will be readily accessible to the public.

Appeals will be dealt with by the Chief Coroner or a Deputy Chief Coroner. Onward appeals (on a point of law) will be made to the Court of Appeal. Separate arrangements will apply if the initial coroner investigation is conducted by a High Court Judge or more senior judge.

*We are seeking stakeholder views on certain aspects of the appeals system, including as part of our policy consultation on the Act's rules and regulations.*

### **Inspection**

The coroner service will be monitored and assessed to ensure compliance with the new national standards; to identify problems and to identify and spread best practice. This will help to drive up service standards for the public, and to ensure greater accountability and value for money within the system.

The way in which inspection will be carried out is yet to be determined. The Coroners and Justice Act 2009 created a duty for Her Majesty's Inspectorate of Court Administration (HMICA) to inspect and to report to the Lord Chancellor on the operation of the coroner system. In December 2009, however, it was announced that HMICA would be abolished as part of a Government-wide initiative to focus resources on the frontline: *Smarter Government – Putting the Frontline First*.

### **More effective investigations**

The reforms will allow for more effective investigations and inquests, including:

- Doctors having a duty to report deaths to the coroner in prescribed cases or circumstances. Linked to the new death certification arrangements, this will ensure that all deaths are either scrutinised by a medical examiner or investigated by a coroner, as appropriate, before it is registered.
- Coroners having new powers to compel evidence to be produced, and to enter and search premises and to inspect, copy or seize items that are relevant to their investigation.
- No restrictions as to where post-mortem examinations and inquests may be held.
- Flexibility to transfer investigations from one coroner to another. This will make best use of expertise and resources, and better facilitate a co-ordinated response to mass fatality incidents. The changes will also prevent delays and backlogs, which will help with military inquests amongst others.

### **Charter for Bereaved People**

The Charter will set out the standard of service that bereaved people can expect from a reformed coroner system, including:

- The right to report a death to the coroner
- Progress reports from the coroner's office
- What to expect from a coroner investigation
- Rights to participation
- Rights of appeal and complaint
- Responsibilities of family members

The Charter will be issued by the Lord Chancellor under section 42 of the 2009 Act. The Chief Coroner will be consulted before it is issued, amended or revoked. A draft Charter was published when the Coroners and Justice Bill was introduced into Parliament (<http://www.justice.gov.uk/publications/charter-bereaved.htm>).

### ***National standards, training and guidance***

The Chief Coroner, supported by his/her Medical Adviser will set national standards and be responsible for the training of coroners, their officers and staff, and issue guidance for coroners. This will help to deliver an improved and more consistent service in England and Wales.

*We are seeking stakeholder views on certain aspects of the proposed system for training coroners, their officers and staff, as part of our policy consultation on the Act's rules and regulations.*

### ***Coroner appointments***

Local authorities will be responsible for all coroner appointments, making the process more consistent and transparent. The Lord Chancellor and the Chief Coroner will be required to consent to any appointment.

### ***Coronial council***

A Coronial Council will be established to provide independent advice on any issue affecting the operation and administration of the coroner system. The Council will advise Ministers, support the Chief Coroner and ensure that the users of the coroner system have a voice at the highest level.

### ***Coroners and Justice Act implementation timetable***

The Coroners and Justice Act received Royal Assent on 12 November 2009. Key dates from now on are as follows:

- First half of 2010 - Appointment of Chief Coroner
- Spring to summer 2010 – Ministry of Justice (MoJ) policy consultation on the Act's secondary legislation
- Late 2010 – MoJ drafts secondary legislation following the consultation
- First half of 2011 – consultation on draft secondary legislation
- Late 2011 – finalise secondary legislation
- April 2012 – launch new coroner service (except for new appeals system which will be a year later)

### ***The current coroner system***

Every death in England and Wales must be certified by a doctor or investigated by a coroner before it can be registered by a registrar.

Coroners investigate deaths that are violent or unnatural, or where the cause of death is unknown. All deaths in prison and police custody are referred to the coroner.

The purpose of the coroner's investigation is to establish who the deceased was and how, when and where he or she came by their death; and the details needed to register the death (such as the cause of death).

As part of his or her investigation the coroner may order a post-mortem examination, which is generally conducted by a pathologist. In a significant proportion of cases the post-mortem examination reveals a natural cause of death and the investigation can be concluded. In the remaining cases the coroner opens an inquest, which is a public hearing to establish the cause and circumstances of the death.

In 2008 nearly half of all registered deaths in England & Wales (47% or 234,800 deaths) were reported to the coroner. The proportion of deaths reported increased slightly from 2007, continuing a long-term trend, and was the highest proportion recorded to date.

From those deaths reported to coroners in 2008, there were around 110,000 coroner commissioned post-mortem examinations and 31,000 inquests (46% and 13% of reported deaths respectively). Coroners decided that the other deaths – just over half of those reported – could be certified by a doctor.

The proportion of deaths reported to coroners in England and Wales is higher than in many other jurisdictions. Since the Shipman murders came to light about a decade ago, there has been much concern about proper process and this may go some way to explaining the increase in reported deaths. The rise is probably also due in part to the growing use, over at least the last twenty years, of deputising services by general practitioners. This means there are more deaths which cannot be certified by a doctor immediately (because they have not seen the deceased within a certain timeframe) and which are therefore reported to the coroner.

Coroners also investigate treasure finds to establish whether or not an object is treasure or treasure trove under the Treasure Act 1996. In 2008 just over 600 treasure finds were reported to coroners resulting in nearly 300 inquests.

Central Government (the Ministry of Justice) is responsible for the legislative framework in which coroners operate and for policy more generally. It does not have any operational responsibility. Local authorities are responsible for appointing coroners and for the funding and operation of the service in their area.

As at 1 December 2009 there were 115 coroner jurisdictions in England and Wales. The majority of coroners are part-time. They are generally supported by a deputy coroner and one or more assistant deputy coroners. They also work with coroners' officers who manage investigations and liaise with bereaved people. The majority of coroners' officers are employed by the relevant police authority. The coroner may also be supported by staff employed by the local authority.

The current process for the investigation of deaths by coroners is illustrated in the process map on the next page. Ways of working – to support this process – can vary between coroner districts at present.

### ***Drivers for the Coroners and Justice Act***

Since the mid-1990s, questions about the effectiveness of the coroner system have been voiced, particularly following major disasters such as Hillsborough, Zeebrugge and the sinking of the *Marchioness*. Cases concerning the unauthorised removal and retention of body parts from post-mortem examinations (Alder Hey and Bristol Hospitals) – largely without the coroner's knowledge – have also raised concerns about how the service operates.

The system has come under increasing scrutiny in the context of the European Convention of Human Rights (ECHR). Coroner inquests are the main vehicle by which the State's duty under Article 2 of the ECHR is discharged i.e. a broad inquiry into the full circumstances surrounding the death. This applies when someone dies in state custody or as the result of a police shooting, or where state agents are otherwise implicated in the death. Article 2 inquests can be particularly high profile and/or complex and are mostly held with a jury.

Tom Luce's Fundamental Review of Death Certification and Investigation (2003) and Lady Justice Smith's Third Report of the Shipman Inquiry (2003) examined the coroner system. Both found a service that was fragmented, variable in quality and consistency, ineffective in part, and very much dependent on the abilities of those working within it. In particular the reports found:

- Inconsistent levels of service.
- Families and friends insufficiently involved in the coroner's investigation.
- An absence of quality controls and independent safeguards.
- A lack of consistency, leadership or training by or for coroners.
- An absence of medical knowledge

## The consultation criteria

The seven consultation criteria are as follows:

1. **When to consult** – Formal consultations should take place at a stage where there is scope to influence the policy outcome.
2. **Duration of consultation exercises** – Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.
3. **Clarity of scope and impact** – Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.
4. **Accessibility of consultation exercises** – Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.
5. **The burden of consultation** – Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.
6. **Responsiveness of consultation exercises** – Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.
7. **Capacity to consult** – Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

**These criteria must be reproduced within all consultation documents.**

## Consultation Co-ordinator contact details

If you have any complaints or comments about the consultation **process** rather than about the topic covered by this paper, you should contact Julia Bradford, Ministry of Justice Consultation Co-ordinator, on 020 3334 4492, or email her at [consultation@justice.gsi.gov.uk](mailto:consultation@justice.gsi.gov.uk)

Alternatively, you may wish to write to the address below:

**Julia Bradford**  
**Consultation Co-ordinator**  
**Ministry of Justice**  
**102 Petty France**  
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**SW1H 9AJ**

If your complaints or comments refer to the topic covered by this paper rather than the consultation process, please direct them to the contact given under the **How to respond** section of this paper at page 109.



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