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Department for Constitutional Affairs
Justice, rights and democracy

# Coroners Service Reform

## Briefing Note

February 2006

# Reform of the Coroner System

## Overview and purpose

The Government is committed to reforming the coroner service for England and Wales.

Our proposals for reform are under-pinned by three main aims:

- an improved service for bereaved families and others who are touched by the service
- a service with good national leadership, as well as the best features of a locally based service
- more effective investigations and coroners service.

There will be six key reforms of death investigation by coroners.

- Bereaved people will have a right to contribute to coroners' investigations. They will be able to bring their concerns to coroners even where a death certificate has been issued. A coroners' charter will set out the service bereaved people can expect.
- We will introduce national leadership, guidance and support, with a Chief Coroner, and an advisory Coronial Council. The Chief Coroner will be accountable to Government. Coroners will continue to be appointed and funded by their local councils, and served by coroners' officers drawn from the local police or local authority.
- We will create a body of full-time coroners, and will reshape current boundaries to create a smaller number of coroner jurisdictions.
- We will modernise investigation and inquest processes, and give coroners new powers to obtain information to help their investigations. Archaic boundary restrictions will go, so as to improve co-ordinated action, for example in incidents with mass fatalities,
- In limited and specific cases, such as some suicides and child deaths, coroners will have a new discretion to complete their investigations and decide on the facts without holding inquests, where no public interest is served by doing so. Such public hearings can intrude unnecessarily into private grief.
- Coroners will have better medical advice and support at local and national level to help them in their investigations.

These changes will enable the Government to address the weaknesses in the present coroner system, which were identified in the 2003 reports of the two major reviews which examined the service, the Fundamental Review of Death Certification and Investigation, under the chairmanship of Mr Tom Luce, and the Shipman Inquiry, under Lady Justice Dame Janet Smith. The Government is grateful for their exhaustive work, and also for the contributions and views of voluntary organisations, coroners, their officers, and other individuals.

In parallel with considering reforms for the coroner service, the Government has continued to examine the earlier proposals that all deaths, some 500,000 a year in England and Wales, should be subject to an additional, independent medical scrutiny by the coroner service. These reforms do not stand alone. The Government is taking forward initiatives aimed at improving patient safety and promoting quality in the NHS.

We are seeking a system which strikes the right balance between cost, risk, delays, and the rights of families to proceed quickly with funeral arrangements. We are not sure that the proposals to have all deaths referred to coroners achieves this

delicate balance, but we will be looking further at this, and the possibility of wide ranging change is not excluded in the long term.

The Government will bring forward a draft Bill in the spring on the measures requiring legislation, for pre-legislative scrutiny. More detail about the measures outlined in this briefing note will be available then. A Bill proper will follow when the legislative timetable allows, with implementation as soon as possible after that.

## Need for reform

Our public commitment to reforming the coroner system stems not only from public concern about the effectiveness of the system, but also from a recognition that we have a 19th century system for a 21st century population.

Since the mid-1990s, questions about the effectiveness of the inquest system have been voiced, particularly following major disasters such as Hillsborough, Zeebrugge, the sinking of the Marchioness and the complexities which arise in investigating particular cases, such as deaths occurring in police custody or in prison.

Cases concerning the unauthorised removal and retention of body parts from post mortem examinations - largely without the coroner's knowledge - have also raised concerns about how the service operates.

The subsequent Fundamental Review of Death Certification and Investigation (2003) and the Third Report of the Shipman Inquiry (2003) examined the coroner system, and both found a service which is fragmented, non-accountable, variable in quality and consistency, ineffective in part, and very much dependent on the abilities of those working within it at present. Most coroners are part time and some of the legislative framework in which they work is archaic. In some areas bereaved people have limited information available to them, and limited opportunities to be involved. In particular the reports identified

- an absence of quality controls and independent safeguards
- the exclusion of the family or friends of those who have died
- a lack of consistency, leadership or training by or for coroners
- a lack of involvement of the family in coroner investigations
- the unnecessary use of public inquests in some cases, and
- an absence of medical skills.

## A better service for bereaved people

- Bereaved people will have better opportunities to raise concerns about a death with the coroner, even if the doctor has already signed a death certificate.
- They will have clear legal standing in the coroner's investigation and processes.
- The standard of service that bereaved people can expect to receive throughout the coroner service will be set out in a coroners charter for bereaved people.
- The charter will set out guidelines and standards to ensure there is an effective response in cases of sudden and unexpected deaths, including fewer unnecessary delays at every stage. Better contact between coroners and bereaved people, will help improve understanding of the cause and circumstances of the death.
- The charter will ensure that bereaved people understand the coroner system and their rights within it - for example, the right to be informed and consulted about post-mortems, other aspects of the coroner's investigations, and their opportunities for involvement in the inquest process.

- There will be easy to access rights to seek a review of coroners' decisions about how they have carried out the investigation and inquest, which will not require hiring lawyers.
- Better information on support and bereavement services will be made available.

## Avoiding unnecessary inquests

- Coroners will have discretion not to hold a public inquest in limited cases, for example some suicides and child deaths, where no public interest would be served by a public hearing. In these cases, the coroner will investigate the death and publish a report. In such cases the pain and grief that can arise for the families from a public hearing can be avoided.
- The duty to inquire into deaths that appear to be more than 50 years old will be removed.
- Coroners will have discretion not to proceed to an inquest where there are criminal or other investigations or other proceedings in connection with the death that appear likely to resolve the issues that an inquest would have determined.

## National leadership, national standards

- A Chief Coroner, supported by a small team, will be appointed to give professional leadership, to raise standards, and to respond to representations from bereaved people or other interested parties to investigations about how the service has handled their case.
- The Chief Coroner will have power to commission audits or inspections.
- The Chief Coroner will be responsible for the monitoring of the coroner's charter for bereaved people, co-ordinating training for coroners and producing national leaflets and other information about the coroners system.
- The Chief Coroner will be accountable to Government ministers for his or her performance.
- An advisory Coronial Council will be appointed to act as a further check on standards and will advise the Chief Coroner on what service and strategic issues may need further scrutiny. The Council will include independent lay members and representatives of voluntary groups.

## Full time coroners

- A service made up of full-time coroners, operating in line with national guidance and responding to the needs of the bereaved, and to cultural sensitivities in the areas they serve, but committed to ensuring that investigations are carried out efficiently and effectively, will lead to improved all round performance.
- Ministers will have new powers to determine the size and boundaries of coroner districts to create a smaller number of full time coroner areas aligned largely with local justice boundaries, to which full time coroners (probably 60-65) will be appointed.
- Most county areas will have one coroner and most metropolitan areas will have two or more.
- The coroners will be supported by a pool of assistant coroners to act for the coroner in his or her absence.

## Local as well as national accountability

- Local authorities will continue to appoint coroners with the Chief Coroner having an active role in ensuring that all appointments follow standard procedures for fair and open recruitment.

- All new appointments to the service will be required to have a legal qualification, with transitional provision for those few coroners who have medical qualifications only to apply for jobs in the new service.
- Coroners' officers will continue to be employed by either the police or local authority, with the transfer between the two subject to local agreement as is the case now.

## Improved investigations and inquests

- We will publish criteria for deaths which should be reported to, and investigated by, coroners.
- Outdated boundary restrictions on investigations and post-mortems will be relaxed.
- Bereaved people will be given the opportunity to contribute at significant stages of the investigation.
- We will give new powers to coroners to obtain information from those reluctant to provide it.
- We will provide for judges, or counsel to inquests, to be appointed in particularly complex cases.
- Coroners will be able to hold pre-inquest hearings in which the scope, issues and conduct of the inquest can be established.
- We will provide for coroners to investigate deaths outside England and Wales in specified circumstances or when directed by the Lord Chancellor.
- We will remove doubt concerning the compliance of coroners' inquests with the requirements of Article 2 of the European Convention on Human Rights.
- New measures will be introduced for the protection of children who are witnesses in inquests.

## Improved medical capacity

- A Chief Medical Adviser will be appointed to support the Chief Coroner to give advice on medical best practice and medical issues related to coroners' investigations.
- At a local level, funding will be provided to coroners to ensure appropriate independent local medical advice to support their investigation.

## Treasure

- Assessing whether a particular find should be classed as treasure will be removed from the mainstream of coroners' work. A new national coroner for treasure will be appointed, to take on the work currently carried out by coroners at a local level. The rights, under the Treasure Act 1996, of those who use the coroners' service in this way will not otherwise be affected.

ANNEX

**These are proposals from the reports by Tom Luce and Dame Janet Smith which we are taking forward in the draft Bill**

- Coroners should have powers to enter premises and seize property required for their investigation.
- There should be no duty to hold a public inquest where there is no public interest in a public hearing. These cases should be concluded by written report equivalent to an inquest.
- Chief Coroner should have power to appoint judges in complex cases
- Provision for coroners to hold pre-inquest hearings and to appoint counsel to the inquest in complex cases.
- Provisions on organ retention in line with Human Tissue Act – Provisions already made in Coroners Rules will be reinforced in the draft Bill with a new duty to release remains when no longer required for the functions of the coroner
- Juries should only be mandatory in cases of death in custody and during the course of a police operation. Juries should no longer be mandatory in workplace deaths, railway deaths and other deaths which are subject to a separate investigation by the Health and Safety Executive or other body, although coroners will have discretion to summon a jury in any case.
- Coroners should have discretion to investigate deaths abroad where the body is returned to England and Wales (rather than automatically investigate if the body is returned)
- Whole-time coroner appointments – move away from present position where the majority of coroners divide their time between public duties as coroner and private practice.
- A retirement age of 70 should be introduced
- Legally qualified coroners with medical support – the Chief Medical Advisor will work with the Chief Coroner to ensure that all coroners have medical support available to them.
- Appropriate involvement for families secured through a charter for bereaved people.
- Rights of appeal or review for bereaved people and other interested parties. For example families will be able to take up with the Chief Coroner issues of non-compliance with the charter.
- Provision for better deployment of coroners through a creation of new National Jurisdiction covering England and Wales and power for Chief Coroner to deploy coroners outside their areas. (At present coroners have to be appointed as a deputy coroner for an area before they can have jurisdiction. There is also no power to require a coroner to renounce jurisdiction at present)
- Chief Coroner – to provide leadership and issue guidance to coroners, monitor the coroner's charter for bereaved people, respond to complaints, co-ordinate training and publish national service information
- An Advisory Coronial Council will provide advice on policy and procedure at a national level and will include representatives from key bereavement groups.
- Chief Medical Advisor – to provide medical advice and leadership on medical issues at a national level and to work with the Chief Coroner to ensure coroners have medical support locally.
- Provision will be made for the service to be inspected and or audited

## Recommendations that will not be taken forward in the draft Bill:

We will not be creating a new national coroner organisation but there will be national leadership and national standards. We will not be introducing a requirement to report every death to a coroner for a second scrutiny. We will be working across Government to consider affordable and proportionate further reforms in these areas.

Appointment and funding responsibilities will remain with Local Authorities but procedures for appointments will be more robust and be in line with national guidance. Coroners Officers will remain police or local authority employees rather than being brought into a new service.

A duty to report a death will not be extended to doctors and the police but we will be pursuing non-statutory alternatives.

Responsibility for Treasure finds will remain but the responsibility will be removed from the day to day workload of coroners and will fall to a single specialist national coroner for treasure.

Many of the more detailed recommendations such as the requirement to give public notice of the time and place of inquests will be taken forward in secondary legislation. Other recommendations such as those relating to the type and content of training provided to coroners and their staff are already being implemented and will continue to be taken forward by the Chief Coroner and Coronial Council in the reformed service.

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**Key Statistics for England and Wales 2004**

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| Deaths per year | 514,000 |
| Burials | 156,000 |
| Cremations | 358,000 |
| Cases referred to the coroner | 225,500 |
| Post Mortems | 115,800 |
| Investigations concluded without inquest (some can involve considerable work, others very little) | 197,200 |
| Inquests | 28,300 |
| Inquests with juries | 570 |
| Inquest outcomes (%) | Death by accident/misadventure 37%<br>Natural causes 21%<br>Suicide 13%<br>Open Verdicts 10%<br>Others 19% |
| Treasure cases | 412 |

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DCA 06/06
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