Briefing on coronial reform

Report Stage of Public Bodies Bill

October 2011
KEY POINTS IN THE BRIEFING

In December 2010 the House of Lords removed the Chief Coroner and associated offices from the list of bodies to be abolished in schedule 1 of the Public Bodies Bill. In a written ministerial statement of 14 June 2011 the government announced its intention to press ahead with dismantling the Chief Coroner’s office, distribute a small number of the post-holder’s statutory powers to the Lord Chancellor (currently the Secretary of State for Justice) and the Lord Chief Justice, and, in effect, shelve the other powers of the post. The government have said nothing about implementation or not of the rest of the reforms contained in the Coroners and Justice Act 2009.

INQUEST asks all MPs to vote for the amendment tabled by Andrew Percy MP (Conservative Member for Brigg and Goole) which would remove the Chief Coroner from the Bill. If the post is dismantled and the reforms set out by Parliament in the Coroners and Justice Act are abandoned, a once in a generation opportunity to create an inquest system which saves lives and is fit for the 21st Century will be squandered.

This briefing answers the questions that INQUEST is frequently asked about the government’s proposals for coronial reform. Below is a summary of the questions and answers in this briefing:

Why is the Chief Coroner essential to fundamental reform of the inquest system?
The current system is fragmented and unaccountable with no national leadership. Bereaved families currently face significant delays and a ‘postcode lottery’ of service. Tom Luce, the government-appointed independent reviewer concluded in 2003 that the system was “not fit for purpose.” INQUEST welcomed the objective of the Coroners and Justice Act 2009 “to put the bereaved at the heart of the process,” as that framework has the potential to make remedy many of the problems in the current system.

We welcome the government’s acknowledgement that the coronial system is in need of reform. However, contrary to the Ministry of Justice’s view, we believe a Chief Coroner is crucial to fundamental reform of the inquest system. See paras 1-4.

Why is the government trying to include the Chief Coroner in the Public Bodies Bill?
It is difficult to justify why the post is included in the Public Bodies Bill as it does not meet the government’s own criteria for reform of public bodies to “increase transparency and accountability, to cut out duplication of activity and to discontinue activities that are simply no longer needed.” The Chief Coroner was intended, for the first time, to bring transparency and accountability to the coronial service by providing judicial oversight and national leadership. The need for the post and the substantial reform the post-holder would lead has been recognised in numerous high-profile reviews, parliamentary reports or inquiries, and by Parliament itself in enacting the Coroners and Justice Act 2009. See paras 5-7. The reason the government has given for including it in this Bill is cost.

What are the government’s arguments?
“We can’t afford it”
Dismantling the Chief Coroner’s Office is a false economy. The existing system results in huge financial costs to the public purse and human costs to bereaved families and others engaged in the system through delayed or postponed hearings, judicial reviews of coroners’ decisions and
repeated investigations and inquests into similar deaths. The costings relied on by the Secretary of State for Justice do not take these fully into account and do not demonstrate that his proposal will result in significant savings or improvements.

INQUEST has repeatedly questioned the Ministry of Justice’s reliance on the outdated December 2008 costings and, given the current economic climate, their refusal to re-evaluate their estimates of £11 million set up and £6 million running costs. Although the Minister has told MPs “we have looked at those figures and we agree with them,” we would question whether it is necessary to spend £564,000 on publications and a public launch of the Chief Coroner’s Office or £3.85 million on a new IT system in the current economic climate.

INQUEST believes the government’s refusal to establish the Chief Coroner’s post and implement the fundamental reforms contained in the 2009 Act simply reflects that insufficient political priority is being given to coronial reform and the interests of bereaved people - in stark contrast to the recent announcement that £250 million would be made available to local authorities to re-introduce weekly refuse collections. See paras 8-14.

“The Chief Coroner’s office was intended to be largely administrative and had few powers to formally govern the system”
This is inaccurate. The judicial office of Chief Coroner was designed to spearhead reform of the system and, through the Coroners and Justice Act, Parliament gave the post-holder specific and significant powers. Some of the statutory powers of the office are listed at paras 15-19.

“The most important outcomes can be achieved without a Chief Coroner”
The Coroners and Justice Act 2009 is a tightly-crafted piece of legislation of inter-linked changes which would address the problems of the current system. Central to this model approved by Parliament, with overwhelming cross-party support, is the Chief Coroner’s role at the heart of the reformed system. Without the clear judicial authority of the Chief Coroner, individual coroners will continue to operate in isolation and without the support and benefit of an overarching framework giving clear direction and leadership whilst they deal with their complex and important work.

Ministers have stated that they will implement “all” or “the majority” of the provisions under Part 1 of the Coroners and Act. However, the 2009 Act contains 52 sections relating to coronial reform including the Chief Coroner. The government has only announced that it will attempt to transfer 10 of the powers or duties of the Chief Coroner in their entirety and to partially implement a further two. The government has been unable to confirm what it intends to do in relation to the all of the other clauses in Part 1 of the Act. This is equivalent to implementing less than 23% of the original provisions.

Some of the important reforms that will not be taken forward under the government’s proposals include those relating to a new system of appointment, retirement and discipline for coroners which would professionalise the service and bring them in line with other judicial post-holders. See paras 20-28.

“The functions of the Chief Coroner can be transferred to alternative bodies”
The proposal for a Ministerial Board on coroner issues which meets a few times a year, whilst a positive step, is no substitute for a single, dedicated, judicial office with statutory powers to implement changes and lead change in the system.
The Chief Coroner’s office is a single senior judicial post with statutory powers. The government’s proposal to dismantle the office of the Chief Coroner and transfer some of the post’s powers to other judicial and political figures will exacerbate the problems of the current system where lines of accountability are opaque and clear leadership is absent.

Based on our experience of supporting thousands of families over thirty years, we believe that the government’s piecemeal approach to reform will simply not bring about the meaningful reform necessary to improve bereaved families’ experiences. See paras 29-31.

“The draft charter will improve people’s experiences of the current inquest system”

The charter which the Ministry of Justice recently consulted on is for all who interact with the coroners system (not specifically for bereaved people as previous versions have been). Central to previous versions of the charter was the Chief Coroner’s role in resolving complaints and adjudicating in appeals. In the absence of a Chief Coroner, the charter is toothless. The new version does not set out credible alternative proposals to ensure that the new document has any impact in improving the service offered to bereaved people who come into contact with the coroners’ courts. See paras 32-35.

“We need to dismantle the Chief Coroner’s post if we are to take forward any reform”

This is disingenuous. If the Ministry of Justice did wish to press ahead with reform they could, for example, table a statutory instrument to bring into force ss.43 and 45 of the Coroners and Justice Act which gives the Lord Chancellor the power to make regulations and Coroners Rules about the practice and procedure at inquests. Reform of these Rules would address some of the very practical issues such as disclosure and conduct of hearings that matter to families. Anticipating that it would take some time to appoint a Chief Coroner, the 2009 Act agreed by parliamentarians was drafted to ensure that the Lord Chancellor could delegate this function to either the Lord Chief Justice (in the short term) or the Chief Coroner (once appointed in the medium term) so that they could take forward this important work. There are no legal or legislative barriers preventing the Ministry of Justice from progressing this, yet nothing has happened despite their stated commitment to urgent coronial reform. See para 36.

“Those who oppose our proposals are frustrating any reform of the system”

Over thirty years, INQUEST has supported tens of thousands of bereaved people facing an investigation and inquest. We have consistently argued for reform of the system and were supportive of the proposals in the Coroners and Justice Act 2009 because these were the result of a consultation and parliamentary process which lasted more than six years during which bereaved families freely shared their painful experiences of the inquest system with policy-makers. It is these experiences that directly inform the views expressed by INQUEST in this briefing.

Our firm view is that the government has failed to propose a credible alternative to the provisions in the 2009 Act that guarantees implementation of all the substantial reforms that are needed. INQUEST and the Royal British Legion have tried to engage constructively with the government and have put forward an alternative proposal which recommends the Ministry of Justice’s current costings are revised and then implemented over an elongated period so that the fundamental reform carefully laid out by Parliament in the Coroners and Justice Act (including establishing a Chief Coroner) can go ahead, even in the current economic climate. See paras 37-41 and Appendix 1.
Why is the Chief Coroner essential to fundamental reform of the inquest system?

1. The current, antiquated system is built on a statutory framework set out in the Coroners Act 1887 with the most recent statute, the Coroners Act 1988, being largely a consolidating measure.

2. The significant problems include:

   I. The coroners system operates as a fragmented, non-professional assortment of individual coroners who operate with no compulsory training and little accountability. There are a growing number of coroners who adopt an efficient, modern approach to running inquests but, overall, there is a ‘postcode lottery’ of service for bereaved families with good practice dependent on the approach of individual coroners rather than agreed and inspected quality standards;

   II. Delays of two or three years to the inquest process are not uncommon. This causes difficulty for all concerned but particularly so for bereaved people who have described how their lives have been put on hold until they have been through the inquest process. As there is no public scrutiny of the death for such a long period, the opportunity for identifying what went wrong and to prevent other deaths is hindered;

   III. Compounding this problem, the current system has no robust mechanism to monitor inquest findings or to take any follow up action with the relevant public bodies based on any issues that arise out of inquests. Findings of inquests proceedings are not effectively and routinely recorded, shared, analysed and acted upon so that issues of systematic failure are properly addressed.

3. INQUEST has extensively documented the failings of the current inquest process and how too often it adds to families’ distress rather than providing a mechanism for addressing concerns and preventing future deaths.¹ We are not lone critics. Successive governments have recognised the system is in need of fundamental reform and commissioned three extensive reviews in 1936, 1965 and 2001. The most recent review, chaired by Tom Luce, was a £1.1 million comprehensive analysis of the current system which involved evidence gathering and consultation with over 200 coroners, families, lawyers and organisations. In their final report the independent reviewers concluded that the coronial system had been seriously neglected over many decades and it “must undergo radical change if [it is] to become fit for the purposes of a modern society and capable of meeting future challenges.”² They went on to make a number of recommendations to deal with critical defects in the current system. Central to their recommendations was the creation of the post of Chief Coroner for England and Wales. Since then there have been a number of other high-profile reviews, parliamentary reports or inquiries also calling for an overhaul of the system.³

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² Para 1, the independent review of Coroner Services commissioned by the Home Office and chaired by Tom Luce, Death Certification and Investigation in England, Wales and Northern Ireland, 2003.
³ See, for example: Luce (op. cit.), 2003; Joint Committee on Human Rights Deaths in Custody: Third Report of Session 2004-05; Select Committee on Constitutional Affairs Reform of the coroners’ system and death certification: Eighth Report of Session 2005-06; final report of the Redfern Inquiry into the analysis of human tissue taken from individuals who had worked in the nuclear industry, 16 November 2010.
We welcome the government’s recent explicit acknowledgement that the coroners system is in need of reform. Our experience of working with bereaved people over thirty years has informed our firm belief that, contrary to the Ministry of Justice’s view, a Chief Coroner is crucial to fundamental reform of the inquest system.

**Why is the government trying to include the Chief Coroner in the Public Bodies Bill?**

4. In his announcement to the House of Commons on 14 October 2010 the Cabinet Office Minister, Francis Maude MP, set out government plans for the reform of public bodies “to increase transparency and accountability, to cut out duplication of activity and to discontinue activities that are simply no longer needed.” On the same day the Parliamentary Under-Secretary of State for Justice Jonathan Djanogly MP made a written ministerial statement\(^4\) outlining the government’s intention to abolish, through the Public Bodies Bill, the office of Chief Coroner and associated posts.

5. It is difficult to justify why the post is properly included in the Public Bodies Bill\(^5\). The Chief Coroner was intended, for the first time, to bring transparency and accountability to the coronial service by providing judicial oversight and national leadership. The judicial office holder would also carry out highly technical and specialised activities including presiding over an appeals system and conducting some inquests which involve complex concerns about individual and systemic failings by state agencies and breaches of the right to life\(^6\) – both of which require independence and impartiality. The overwhelming need for the functions that a Chief Coroner has been recognised in numerous high-profile reviews, parliamentary reports or inquiries, by Parliament itself in enacting the Coroners and Justice Act 2009, and implicitly by the coalition government who have pledged to transfer the functions of the Chief Coroner to other bodies.

6. The government has acknowledged that the fundamental reason for trying to abolish the Chief Coroner’s office is cost.

**What are the government’s arguments?**

“We can’t afford it”

7. Jonathan Djanogly MP explained to the House of Commons in October 2010 that:

> ...the purpose of abolishing the Chief Coroner post is, first, to save the £10 million start-up costs and then the £6.5 million running costs, but also so that some of the Chief Coroner’s leadership and operational functions can be transferred to an alternative body.\(^7\)

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\(^5\) In response to queries in correspondence from INQUEST the government has side-stepped the question of whether the Chief Coroner is correctly included in the Bill by stating "as the office of Chief Coroner has not been set-up there are no activities currently being carried out under the 2009 Act."

\(^6\) Article 2, European Convention on Human Rights

\(^7\) *Hansard* HC Deb, 19 October 2010, Col 795 in response to a parliamentary question from Caroline Lucas MP.
8. INQUEST believes the Ministry of Justice’s costings are no more than estimates based on an outdated and partial impact assessment from December 2008. Jonathan Djanogly MP has recently told parliamentarians that “we looked at those figures and we agree with them.” INQUEST would question the Minister’s acceptance of these figures in the current economic climate and, for example, why he would agree that it is necessary to spend £564,000 on publications and a public launch of the Chief Coroner’s Office or £3.85 million on a new IT system.

9. It is peculiarly inappropriate for the Ministry of Justice to rely on calculations in the December 2008 impact assessment because that exercise was conducted on the assumption that the fundamental reforms in the Coroners and Justice Bill would be implemented. As a result, the 2008 impact assessment did not evaluate the costs of the current failing system, including:

- Financial costs of adjourned and delayed hearings.
- Expensive judicial reviews against coroners’ decisions.
- Costs to the NHS of the impact of delays in the current system on bereaved families' physical and mental health. Research conducted by INQUEST in 2002 has demonstrated this is likely to be substantial.

10. Most significantly, given the current system is failing to learn from previous fatalities, the costs of repeated and expensive investigations and inquests into similar deaths are not included in this cost assessment. The government has been unable to respond to requests, through parliamentary questions, to provide comprehensive information about the public funds currently spent on deaths in all forms of custody (police, prison and psychiatric detention). The Home Office has been unable to provide figures for the costs to the public purse of IPCC investigations and legal representation at inquests following deaths in police custody. The Ministry of Justice has confirmed that in relation to deaths of prisoners, the costs for legal advice and representation of Ministry of Justice bodies at inquests was £2.7 million in 2009/10 alone. The average cost of each Prisons and Probation Ombudsman investigation is approximately £16,000 and 179 deaths were investigated in 2009-10 at a cost of £2.8 million.

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8 The two page document setting out the Ministry of Justice’s estimation of costs has been deposited with Parliament and can be found at: www.parliament.uk/deposits/depositedpapers/2010/DEP2010-2203.doc. The original Ministry of Justice, Impact Assessment of the coroner sections of the Coroners and Justice Bill (December 2008) is available from www.justice.gov.uk/publications/docs/coroners-justice-bill-ia-coroner-reform.pdf

9 See Hansard HC Deb 13 September 2011, Col 876.

10 See the answer of 27 June 2011 to Bob Ainsworth MP’s parliamentary question about the Ministry of Justice’ estimate of the average cost of appealing against a coroner’s decision through judicial review, to which the Parliamentary Under-Secretary of State responded: “No analysis of the cost of judicial review applications against coroners’ decisions has been made by this Department.”

11 In 2002 INQUEST published the results of a detailed survey which indicated that the majority of bereaved families facing inquests suffer some serious adverse effect to their health and personal lives in the medium to long term. Given the number of sudden deaths each year in the UK, this translates into a finding of a major social and public health problem at a national level – which, to date, has escaped the attention of government and decision makers almost entirely. We asked respondents whether their physical health had “improved, deteriorated or stayed the same” since the death. Of the 130 families surveyed, almost two-thirds (64%) identified a deterioration. Asked the same question in relation to their “state of mind,” again two-thirds (66%) felt this had deteriorated. Of yet more serious concern was that, when asked subsequently whether they had experienced “serious physical” or “serious mental health problems” since the inquest, approximately one-third of all respondents answered positively in response to each category (30% and 31% respectively).

11. Setting up the Chief Coroner’s office and implementing the reforms in the Coroners and Justice Act would improve the ability of the coronial system to learn from deaths and, ultimately, prevent further unnecessary deaths which saves emotional costs to families and financial costs to society. When the government’s figures are analysed in the light of this, proper reform of the inquest system with a Chief Coroner and implementation of reforms in the Coroners and Justice Act offers good value for money.

12. The government’s approach to date has been “we can’t afford” to implement Chief Coroner’s office. INQUEST argues that a brief examination of the costs of the current system - in relation to failing to prevent deaths in custody alone - demonstrates that the government’s approach should be “we can’t afford not to.”

13. INQUEST believes the government’s refusal to establish the Chief Coroner’s post and implement the fundamental reforms contained in the Coroners and Justice Act simply reflects that insufficient political priority is being given to coronial reform and the interests of bereaved people – in stark contrast to the announcement in September 2011 that £250 million is to be made available to local authorities to re-introduce weekly refuse collections.

“The Chief Coroner’s office was intended to be largely administrative and had few powers to formally govern the system”

14. The government's attempt to re-cast the Chief Coroner’s office as a largely administrative post is inaccurate and disingenuous.

15. In reality, the Chief Coroner was intended to spearhead reform of the system and, through the Coroners and Justice Act 2009, Parliament gave the postholder specific and significant powers to tackle deep-seated issues relating to the operation of the coroners system as a whole. Even the Ministry of Justice’s own ‘Job Description’ or ‘Main Activities of the Chief Coroner’ make clear that the post was envisaged to be a judicial and leadership role.

16. The Chief Coroner would have powers and responsibilities to:

I. Manage coroners’ courts by allocating cases 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 (s.3 of the Coroners and Justice Act 2009 and paras 5-6, ‘Main Activities of the Chief Coroner’). Crucially, this would have been a step towards tackling the unacceptable delays that plague the current system.

II. Drive up standards in the system through training (s. 37 of the Act gives the Chief Coroner powers and responsibilities to make regulations about training). It was also envisaged the Chief Coroner would issue guidance to coroners on ways of working, lay down practice directions, set national standards of service (s.42 of the Act and paras 8-9, ‘Main Activities of the Chief Coroner’).

III. Work with the Lord Chancellor and Ministry of Justice to make regulations and rules overhauling practice and procedure at inquests (s.43(2) sets out regulations may be made if a judicial office holder, envisaged as the Chief Coroner, agrees).

IV. Deal with appeals made against coroners’ decisions, including on issues such as whether to investigate a death or not or any finding as to cause of death (s.40 of the Act). The new appeals system overseen by the Chief Coroner would have offered families a route to resolve poor decision-making by coroners and spared some of them from only being able to challenge decisions through expensive and time-consuming judicial reviews.

V. Develop and operate an effective scheme for ensuring that recommendations and warnings relating to public safety emerging from coroners’ investigations are brought to the attention of those responsible for creating the relevant risks, regulatory bodies and the public. Critically, the Chief Coroner would be able to take steps to ensure that such recommendations and warnings are acted upon (para 20 ‘Main Activities of the Chief Coroner’).

VI. Monitor the performance of the coronial system, including via provision of an annual report to the Lord Chancellor addressing, amongst other things: levels of consistency between coroner areas; the number of investigations that have been ongoing for over a year; identification of specific resource issues; and any other matters which the Chief Coroner wishes to bring to public attention (s.36 of the Act and paras 11-12 of ‘Main Activities of the Chief Coroner’). The annual report would have been published and laid before Parliament, offering an opportunity for further scrutiny and debate.

17. In addition, it is clear from the Coroners and Justice Act that the Chief Coroner is a judicial office. The post holder, who must be a High Court or Circuit Court judge, is appointed by the Lord Chief Justice for a term decided by the Lord Chief Justice. Section 35 and schedule 8 of the Coroners and Justice Act 2009 set out the main provisions governing this new office and were brought into force on 1 February 2010. A senior Circuit judge, HHJ Peter Thornton QC, was appointed to the office by the Lord Chief Justice shortly afterwards but did not take up his position as the process was halted by the coalition government. If Parliament accepts the government’s proposed amendment for the Public Bodies Bill, then a Minister would be empowered to dismantle the judicial office of the Chief Coroner by ministerial order alone and INQUEST is concerned that this would be a serious blow to judicial independence.

18. Following concerns expressed in the House of Lords during debate on the Public Bodies Bill the government agreed to remove 18 offices from the legislation because they performed some kind of judicial function and the Cabinet Office Minister wanted to protect their independence. INQUEST questions the government’s logic in removing some bodies performing judicial functions from the Bill yet persisting with their plans to dismantle the judicial office of Chief Coroner.

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14 In December 2010, INQUEST instructed Bindmans LLP to seek leading counsel’s opinion on the constitutional implications of the government’s proposals. Rabinder Singh QC’s Opinion on the Proposed Abolition of the Chief Coroner, Appeals System and Medical Adviser was written in January 2011. Mr Singh concluded that the Chief Coroner’s post was a judicial office and to attempt to abolish it through secondary legislation could be unconstitutional. He pointed out that “if Parliament can authorise the abolition of the office of Chief Coroner by ministerial order, it is difficult to see why it could not also authorise the abolition in that way of the office of Lord Chief Justice or even the entire Supreme Court.” INQUEST wrote to both the Cabinet Office Minister and the Parliamentary Under-Secretary of State to raise our concerns and ask for their response to leading counsel’s opinion. The government responded in March 2011 making clear they “fundamentally disagree” that there are constitutional difficulties in using secondary legislation to abolish the office of Chief Coroner. Copies of Rabinder Singh’s Opinion, INQUEST’s letter to Ministers and their response can be provided on request.

15 See coverage of the decision via http://www.bbc.co.uk/news/uk-politics-12271426
“The most important outcomes can be achieved without a Chief Coroner”

19. The Coroners and Justice Act 2009 is a tightly-crafted piece of legislation of inter-linked changes which would address the problems of the current system. Central to this model approved by Parliament, with overwhelming cross-party support, is the Chief Coroner’s role at the centre of the reformed system. Without the clear judicial authority of the Chief Coroner individual coroners will continue to operate in isolation and without the support and benefit of an overarching framework giving clear direction and leadership whilst they deal with their complex and important work.

20. The government’s proposals for coronial reform are no more than tweaks of a system that is in need of fundamental root and branch reform. Part 1 of the 2009 Act contains 52 sections relating to coronial reform including the Chief Coroner. The government has announced that it will attempt to transfer only 10 of the powers or duties of the Chief Coroner in their entirety and to partially implement a further two. The government has remained silent on what it intends to do in relation to all of the other clauses in Part 1 of the Act. This equates to implementing no more than 23% of the provisions in the 2009 Act not “all” or “the majority” of the Act as Ministers have claimed.  

21. Some of the provisions that will not be implemented include:
   • the re-organisation of the current system including the appointment of senior coroners, area coroners and assistant coroners (s.23) who: must satisfy the judicial-appointment eligibility condition on a 5-year basis (s.3 of schedule 3); must retire by the age of 70 (s.10 of schedule 3); could be removed from office for incapacity or misbehaviour (s.13 of schedule 3); and would be subject to the discipline procedures that apply to other judicial office holders as set out in the Constitutional Reform Act 2005. The problems that can occur in the current system where a coroner holds a “freehold office” and is not subject to the type of provisions contained in the 2009 Act have recently been illustrated by difficulties with the coroners service in Teesside;
   • the requirement for an annual report on the coroner’s system addressing levels of consistency between coroner areas, length of delays and other issues which would have been laid before Parliament (s.36).

22. In his June 2011 written ministerial statement on coroner reform, the Secretary of State for Justice proposed the creation of a Ministerial Board which would look at specific issues which “may” exist and “consider whether there may be appropriate action to address these.” The deep-seated problems that do exist in the current system have already been identified in the numerous previous independent reviews, parliamentary inquiries and other reports. Many of these reports also made recommendations for change and action and helped to shape the structure laid out in the Coroners and Justice Act 2009. What is now needed is action and implementation of the reforms already extensively debated and agreed by Parliament.

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16 See Jonathan Djanogly MP’s answer to questions on the Office of the Chief Coroner on 13 September 2011 (Hansard HC Deb, Col 876) via: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110913/debtext/110913-0001.htm#11091385000394

17 See Iain Wright MP at Second Reading of the Public Bodies Bill (Hansard HC Deb, 12 July 2011, Col 237 via: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110712/debtext/110712-0003.htm#11071287000190
23. INQUEST sits on, and supports, the valuable work of the current Ministerial Board on Deaths in Custody. Based on this experience we think that a Ministerial Board on coroner issues is potentially a useful forum to raise specific issues. However, we do not think the proposed Ministerial Board on coroner issues which would meet a few times a year is a substitute for the single, dedicated judicial post-holder empowered to implement changes in the form of the Chief Coroner.

24. It is worrying that the government’s proposals do not include a proper support structure for the Ministerial Board on coronial policy – to mirror the model of the Independent Advisory Panel on Deaths in Custody whose work successfully feeds into and informs the Ministerial Board on Deaths in Custody’s discussions and decisions.¹⁸ The IAP consists of six independently-appointed members with expertise in key areas who lead a number of funded work-streams to facilitate research and learning. They are supported by a small, full-time secretariat.

25. The Ministry of Justice instead proposes that a Bereaved Organisations Committee would monitor the implementation of standards of service set out in the Charter for the Coroner Service that the Ministry of Justice recently consulted on (see paras 30-33 below for an analysis of the strength of that document). A committee made up of charities and non-profit organisations inputting their views and experience on a voluntary basis is in no way comparable to the enforcement, monitoring and oversight that would be provided by the Chief Coroner (alongside independent inspection of the system by a specialist body such as Her Majesty’s Inspectorate of Court Administration – which was recently abolished).

26. The government’s current proposals are strange in the context of the Ministry of Justice’s decision, in January 2011, to abolish a similar body – the Coroners Service Stakeholders Forum (CSSF). INQUEST was a member of this high-level body whose purpose was “to provide a forum for all key stakeholders of the system to participate in identifying, considering and resolving significant current and future issues affecting the Coroners Service.” The Voluntary Sector Forum sat alongside the CSSF and was a regular meeting of bereavement organisations, attended by the Minister, through which charities were able to give direct feedback to the Minister on the operation of the coroners’ system. However, after several years of operation, in January 2011 the Ministry of Justice informed members that these Forums had been abolished because they were no longer needed. Four months later, the Secretary of State proposed the creation of similar bodies to those recently abolished and presented this as part of a package of new “reform.”

27. The government’s plan to reconstitute these forums as a Ministerial Board and a Bereavement Organisations Committee also raises the question: what guarantee is there that the issues raised by these new forums will be acted on by the Minister given that the views of independent reviewers, expert bodies, bereaved people and voluntary sector organisations have been so comprehensively ignored thus far?

The functions of the Chief Coroner can be transferred to alternative bodies

28. Initially the government proposed the outright abolition of the Chief Coroner and associated posts.\(^1\) The government has now re-inserted the Chief Coroner into schedule 5 (Power to Modify or Transfer Functions) of the Public Bodies Bill.\(^2\) This would dismantle the office and would have a similar effect to abolishing the role. The government also proposes transferring a limited number of the Chief Coroner’s powers to the Lord Chancellor and some to the Lord Chief Justice. The rest of the postholder’s statutory responsibilities will not be transferred and will remain unimplemented, including the requirement for an annual report to Parliament on the coroners system addressing levels of consistency between coroner areas, length of delays and other issues (see para 17(VI) for details).

29. The Secretary of State himself acknowledges the limited nature of the proposed changes: “as the functions to be transferred are limited, and the Office of Chief Coroner not filled, neither the judge nor any other individual will be responsible for the leadership, culture or behaviour of coroners.” In contrast, the Coroners and Justice Act created a single senior judicial post with the statutory powers to lead legal and cultural reform to make the system more effective, responsive and transparent. For example, the Chief Coroner would oversee the re-organisation and professionalisation of the coroners’ system to bring it in line with the rest of the judiciary (see para 22).

30. Instead, the government proposes to add yet another layer to the current fragmented structure where lines of accountability are opaque and clear leadership is absent. Based on our experience of supporting thousands of families over thirty years, we believe that the government’s piecemeal approach to reform will simply not bring about the meaningful reform necessary to improve bereaved families’ experiences.

The draft charter will improve people’s experiences of the current inquest system

31. The written ministerial statement of October 2010 announced plans to take forward “a national charter for bereaved families.” However, in May 2011,\(^3\) the Ministry of Justice published a consultation paper on a Charter for all interested persons who come into contact with the inquest system. This is fundamentally different.

32. Two comprehensive consultations on a Charter for bereaved people were conducted in 2006 and 2008. The Charter for the Bereaved\(^4\) that resulted from that process was published alongside the 2009 Act. It was intended to supplement the provisions of the Act and enshrine the standards of service bereaved families could expect from the reformed system thus

\(^1\) INQUEST notes that when the Public Bodies Bill was published, the government vigorously asserted that it had to abolish the Chief Coroner’s post to take forward any of the reforms to the system they proposed.\(^5\) INQUEST questioned this reasoning and, in correspondence, repeatedly asked the government to clarify the legal basis on which they asserted it was necessary to abolish the Chief Coroner’s post in order to transfer the functions of the office to an alternative body. No answer to this specific question was ever received. However, by now proposing to transfer selected statutory powers without needing to abolish the Chief Coroner’s post, the government is implicitly acknowledging that its earlier stance was wrong. This is another stark example of the poor policy-making process that has led to the government’s current proposals.


\(^3\) http://bit.ly/k9F2PK

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supporting the intention to “put the bereaved at the heart of the system” and rebalancing a system that so often overlooked the needs of bereaved people. It was systemically linked to the new legislation. The current charter for all who interact with the coroners service will not achieve this without implementation of the legislation.

33. Central to previous versions of the Charter was the Chief Coroner’s role in resolving complaints and adjudicating in appeals. The Chief Coroner was to have overall responsibility for establishing and overseeing a system for responding to, investigating, resolving and acting on complaints about the service provided by coroners. In the absence of a Chief Coroner, the Charter is toothless. It is telling that the government’s version does not set out any credible alternative proposals for enforcement and monitoring to ensure that the new document has any impact in improving the service offered to bereaved people who come into contact with the coroner’s courts. Instead, the government proposes to ask already hard-pressed voluntary organisations to “monitor” the implementation of the charter as part of their involvement in the Bereaved Organisations Committee.

34. INQUEST and other bereavement organisations were disappointed that what had originally intended to be a robust set of standards putting bereaved people at the heart of a reformed system has been watered down to a generic document with no enforceable provisions. As one of the centrepieces of the government’s proposed reforms it is concerning that the Charter is lacking in substance and will have little real impact on the experience of bereaved families going through the inquest system.

“We need to dismantle the Chief Coroner’s post if we are to take forward any reform”

35. This is disingenuous. In February 2010, the government laid a statutory instrument to bring into force s.35 and schedule 8 of the 2009 Act in order to appoint Peter Thornton QC, a high court judge as Chief Coroner. If the Ministry of Justice did wish to press ahead with reform they could, for example, table a statutory instrument to bring into force ss.43 and 45 of the Coroners and Justice Act which gives the Lord Chancellor the power to make regulations and Coroners Rules about the practice and procedure at inquests. Reform of these Rules would address some of the very practical issues such as disclosure and conduct of hearings that matter to families. Anticipating that it would take some time to appoint a Chief Coroner, the 2009 Act agreed by parliamentarians was drafted to ensure that the Lord Chancellor could delegate this function to either the Lord Chief Justice (in the short term) or the Chief Coroner (once appointed in the medium term) so that they could take forward this important work. There are no legal or legislative barriers preventing the Ministry of Justice from progressing this yet nothing has happened despite their stated commitment to urgent coronial reform.

“Those who oppose our proposals are frustrating any reform of the system”

36. The Ministry of Justice could take forward reform of the coronial system by implementing the provisions laid down by Parliament in the Coroners and Justice Act 2009. INQUEST and the Royal British Legion have worked together to come up with a proposal for a pragmatic way forward. Our joint proposal addresses the issue of cost whilst also recognising that the 2009 Act is a tightly-crafted piece of legislation of inter-linked changes which offer the best way to address problems of the current system. In essence, we propose an elongated timetable for establishing a Chief Coroner and fully implementing the reforms in the 2009 Act. By rigorously analysing and revising the outdated costs the Ministry of Justice has been relying on and
spreading these revised costs over a period of four years in a staged implementation process we believe the reform of the system envisaged by the 2009 Act could be implemented even in the current economic climate. The proposal is set out at Appendix 1 of this Briefing.  

37. Over thirty years, INQUEST has supported tens of thousands of bereaved people facing an investigation and inquest. This experience directly informs our work to ensure bereaved families are better treated in a fundamentally reformed coronial system. Our firm view is that the government has failed to propose a credible alternative to the provisions in the 2009 Act that guarantees implementation of all the substantial reforms that are needed. The piecemeal reforms proposed will simply not bring about the meaningful reform necessary to improve bereaved families' experiences of the inquest process.

38. We have consistently argued for reform of the system and were supportive of the provisions in the Coroners and Justice Act 2009 because they were the result of a consultation and parliamentary process which lasted more than six years during which bereaved families freely shared their painful experiences of the inquest system with policy-makers. Families did so with the expectation that the system would be reformed and other families would not have to undergo the unnecessarily distressing process they were forced to endure. Having been fully engaged in the governmental and legislative processes to reform the coronial system, INQUEST was dismayed at the inclusion of the Chief Coroner in the Public Bodies Bill.

39. Other organisations have also condemned the government’s decision, including:  

- The Royal British Legion  
- CRUSE Bereavement Care  
- Victim Support  
- Samaritans  
- Action against Medical Accidents (AvMA)  
- Cardiac Risk in the Young  
- Child Bereavement Charity  
- Sands  
- Disaster Action  
- Support after Murder and Manslaughter (SAMM National)  
- Survivors of Bereavement by Suicide  
- The Compassionate Friends  
- Mencap  
- RoadPeace  
- BRAKE  
- CO-Gas Safety

40. INQUEST is urging all MPs to support the amendment to remove the Chief Coroner from the Bill. If the post is dismantled and the reforms set out by Parliament in the Coroners and Justice Act are abandoned, a once in a generation opportunity to create an inquest system which saves lives and is fit for the 21st Century will be squandered.

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23 On 27 September 2011, the Secretary of State for Justice responded to the Royal British Legion and INQUEST’s proposal by stating that the “requisite funding for the office of the Chief Coroner is simply not available” and that he could “implement key objectives of Part 1 of the 2009 Act without creating the office.”

24 See letters to the editor signed by the listed organisations in The Times on 13 December 2010 and 25 October 2011.
OUR PROPOSAL: A PRAGMATIC WAY FORWARD

Reform of the coronial system – a proposal from INQUEST and The Royal British Legion

The treatment of bereaved families goes to the heart of both the Royal British Legion’s and INQUEST’s work; how we treat bereaved families facing inquests – including bereaved Armed Forces families – speaks volumes about us as a society. The inescapable reality is that bereaved families are not involved through choice in the inquest process following a sudden or unnatural death. The state is obliged to hold the inquiry and it is usually the only public forum for the family to try to find answers to their questions about the circumstances of their relative’s death.

In the context of the current parliamentary debates on coronial reform, we have worked together to come up with a principled but pragmatic way forward. Our proposal addresses the issue of cost while also recognising that the Coroners and Justice Act 2009, passed with cross-party support, is a tightly-crafted piece of legislation of inter-linked changes which would address the problems with the current system. Our organisations, and other leading charities supporting bereaved people, believe the framework approved by Parliament less than two years ago still offers the best way forward. Crucial to fundamental reform is the Chief Coroner who will provide leadership, judicial oversight and accountability.

In essence, we propose an elongated timetable for establishing a Chief Coroner and fully implementing the reforms in the 2009 Act. By rigorously analysing and revising the costs currently relied on and spreading these revised costs over a period of four years in a staged implementation process, we believe the fundamental staggered reform of the system envisaged by the 2009 Act could be implemented, even in the current economic climate. The details of our proposal are set out in section 2 below.

1. Costs
The Royal British Legion and INQUEST would share the government’s concerns about costings if they were as high as Ministry of Justice figures suggest, with the estimated set-up costs for full establishment of the Chief Coroner being £11 million and annual running costs over £6.5 million. Our two organisations, and a number of parliamentarians, have consistently queried the figures supplied by the Ministry of Justice because we dispute the basis on which they have been calculated. No supporting documentation or calculations have been made available to explain them or why certain budget lines are included. Through correspondence with the Ministry of Justice, Freedom of Information Act requests and parliamentary questions, we have attempted, unsuccessfully, to obtain coherent information about these figures to improve our understanding.

We believe the costings represent no more than over-inflated ‘guesstimates’ based on a partial impact assessment from December 2008 and could be substantially revised to reflect the current economic situation. For example, we cannot see that it would be necessary to spend £564,000 on publications and a public launch of the Chief Coroner’s Office. We also question the £3.85 million estimate for a new IT system.

25 INQUEST and the Royal British Legion have attempted to draw up alternative costings based on our proposal, but given the lack of concrete information about the assumptions, calculations and budget lines contained in the Ministry of Justice’s current figures, accountants have been unable to provide accurate alternatives for us to supply to parliamentarians.
The costs cited by the Ministry of Justice do not evaluate the financial drain of the current failing system. These include, for example, the costs of adjourned and delayed inquest hearings, expensive judicial reviews against coroners’ decisions, the cost to the NHS of the impact of delays in the current system on bereaved families’ physical and mental health and, given that the current system is failing to learn from previous fatalities, the cost of repeated investigations and inquests into similar deaths. Taken together, this is a considerable amount of avoidable expenditure.

The efficiency savings that were built into the Act are also overlooked. These include, for example, a complete re-organisation of coroner jurisdictions to streamline and professionalise the service, which would have created coroner jurisdictions that support a full-time coroner caseload and would have actually reduced the number of coroners overall.

Indeed the Ministry of Justice have not provided costings for the government’s revised proposals as outlined in the Written Ministerial Statement of 14 June 2011. Neither have they produced a proper cost-benefit analysis of fully implementing the framework in the Coroners and Justice Act or even a more robust and cost-effective set of figures to reflect the current economic climate.

2. **An elongated timetable for implementation**

In order to benefit from the medium to long-term efficiency savings that were built into the Act and spread the short-term costs of implementation we propose that the reforms are implemented over an elongated timetable.

Coroner reform, as set out in the Act, was never intended to be an overnight process. Indeed, it was always intended to be incremental because it was accepted that the changes proposed were fundamental and would require time to implement.

This is borne out by the table below. For example, as the second column shows, it was always planned that, once appointed, there would be a shadow year before the Chief Coroner became operational and that there would then be a year of running the new system without the new appeal process whilst a pilot was designed. Once appointed, it was intended that the Chief Coroner could then review, with Ministry of Justice officials, the precise structure that would need to be in place to pilot and establish necessary mechanisms. (Please see separate section on this below.)

We do not accept the Secretary of State’s argument that the Chief Coroner is unaffordable in the present economic climate. We believe the government’s refusal to introduce the position simply reflects that insufficient political priority is being given to it – in stark contrast to the announcement that £250m is to be made available to local authorities to re-introduce weekly refuse collections. Nevertheless, recognising the financial constraints within which the government is operating, we propose a different, elongated timetable for the Act’s implementation as outlined in the final column of the table below. The benefit of this is that, while fundamental reform would still go ahead as Parliament intended, the reduced costs would be spread over a much longer period of time (from 2012 to 2016).
Table 1 – elongated implementation of the Act

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Original date proposed by Ministry of Justice (Nov 09) 26</th>
<th>Our proposed revised timetable (Sept 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and appoint Chief Coroner</td>
<td>Early 2010</td>
<td>Early 2012</td>
</tr>
<tr>
<td>Develop policy and draft secondary legislation</td>
<td>2010-2011</td>
<td>2012-13</td>
</tr>
<tr>
<td>Shadow Year</td>
<td>April 2011-March 2012</td>
<td>April 2013-March 2014</td>
</tr>
<tr>
<td>Implement new coroner legislation and practices (except appeals, search, entry and seizure)</td>
<td>April 2012</td>
<td>April 2014</td>
</tr>
<tr>
<td>Introduce Medical Examiner system (Department of Health)</td>
<td>From April 2012</td>
<td>April 2013 (NB this date has been confirmed by the Department of Health who plan to go ahead with implementation of the Medical Examiner system)</td>
</tr>
<tr>
<td>Pilot appeals system, search, entry and seizure</td>
<td>From April 2012</td>
<td>From April 2014 – March 2015</td>
</tr>
<tr>
<td>Review pilot, roll out training on appeals, search, entry and seizure</td>
<td>2013/14</td>
<td>From April 2015 – March 2016</td>
</tr>
<tr>
<td>Implement new appeals system (please see below for details)</td>
<td>From April 2016</td>
<td></td>
</tr>
</tbody>
</table>

Under our proposal the government would leave the Chief Coroner out of the Public Bodies Bill completely and commit to full implementation of the reforms in the Coroners and Justice Act over an elongated timetable between 2012 and April 2016.

3. Appeals

One of the aspects of the Coroners and Justice Act we have scrutinised most closely is the new appeals process. We accept that there is, and indeed was, uncertainty about what level of work the new system would generate. Whilst the Royal British Legion and INQUEST wish there was not a need for such a process, it cannot be denied that the need exists.

Far from creating a litigious culture, we believe (as Parliament did) that the carefully-crafted framework in the Act has the potential to reduce the need for so many bereaved people to engage in expensive litigation. Currently, the only avenue of appeal for bereaved families about the decision-making of coroners and their conduct of an inquest is through complicated and expensive judicial reviews or by persuading the Attorney General to exercise his or her power of fiat. Having

26 Dates in column 1 taken from a presentation to the Coroners Service Stakeholders Forum by the Ministry of Justice Coroners and Burials Unit, November 2009
a High Court judge as Chief Coroner (as envisaged by the 2009 Act) would mean some legal issues that are currently resolved in the Administrative Court could be resolved by the postholder but in a much more cost effective and efficient way for both families and the public purse. We would also expect that appeals would increasingly prove unnecessary as a Chief Coroner spearheads reform from within and ensures best practice becomes the norm thereby both reducing the number of disputes and raising standards.

The precise details of how the appeals system was to work and when it would be implemented was always to be a matter for the Chief Coroner and Ministry of Justice to determine. It was for that reason that detailed rules and regulations, in the form of secondary legislation, were not published at the same time as the Bill made its way through Parliament. Instead it was envisaged that the process of drafting the new rules and regulations would be presided over by the Chief Coroner. We reflect this in our proposed timetable (see above). If adopted, our proposal would ensure a fully-informed decision could be made about appeals and that the costs associated with piloting and implementing any appeals process would not be incurred in the immediate future.

Under our proposal a full pilot and review of the appeals process would be undertaken before a decision is taken about rolling it out across England and Wales. The terms of the pilot and review would be decided between the Chief Coroner and the Ministry of Justice and, subject to a successful pilot, the appeals process would come into effect on a date to be decided after April 2016.
About INQUEST

INQUEST is the only organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths and their investigation to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. It has a proven track record in delivering an award-winning free in depth complex casework service on deaths in state detention or involving state agents. It works on other cases that also engage article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability. It monitors public interest inquests and inquiries into contentious deaths to ensure the issues arising inform our strategic policy and legal work.

INQUEST undertakes research and develops policy proposals to campaign for changes to the inquest and investigation process. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; holds those responsible to account and disseminates the lessons learned from the investigation process in order to prevent further deaths occurring. INQUEST is represented on the Ministerial Council on Deaths in Custody and sat on the Ministry of Justice Coroner Service Stakeholder Forum until it was abolished in January 2011.

INQUEST publications include: briefings on individual cases and on thematic issues arising; Inquest Law, the journal of the INQUEST Lawyers Group; specialist leaflets on deaths in prison and in police custody; a regular e-newsletter; and three groundbreaking books: In the Care of the State? Child Deaths in Penal Custody in England and Wales (2005); Unlocking the Truth – Families’ Experience of the Investigation of Deaths in Custody (2007) and Dying on the Inside – Examining Women’s Deaths in Prison (2008).

INQUEST was the Winner of the Longford Prize in 2009; Joint Winner of the Liberty/JUSTICE Human Rights Award in 2007 and Winner of a Campaign for Freedom of Information Award in 1999.

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