Public Bodies Bill 2010 [HL]
Briefing for Committee Stage

November 2010
Introduction

1. INQUEST urges Peers to support Baroness Finlay of Llandaff’s amendment to the Public Bodies Bill to remove the Chief Coroner’s post and associated officers from schedule 1 of the Public Bodies Bill.

2. INQUEST believes it is inappropriate that the government has chosen this Bill to force through what amounts to reversal of the fundamental reforms to the flawed coronial system enacted by Parliament less than a year ago. This briefing argues that the government’s plans have not been adequately justified on the government’s own criteria for abolition of “accountability” or “cost.”

“Not fit for purpose” - the existing coronial system

3. The inquest is often the only official public hearing where a sudden or contentious death, such as a death in custody, is subjected to public scrutiny in the absence of a criminal prosecution. The coroner is the key public authority responsible for fulfilling the obligation imposed by article 2 of the European Convention on Human Rights to investigate possible violations of the right to life. In this context, the inquest process is of crucial importance in the search for the truth and accountability and usually the only opportunity for the family to establish the exactly how their relative died. In addition, inquests can and should perform a vital public health and safety role by identifying problems and making recommendations for change so as to prevent further, unnecessary deaths.

4. Nearly three decades of working with bereaved people, monitoring post-death investigations and attending inquests around the country has informed INQUEST’s view that the coroners system is no longer fit for purpose in the 21st Century. We have 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.

5. The coroner’s system is one of the most neglected areas of law in England and Wales. The current system is built on the statutory framework set out in the Coroners Act 1887 with the most recent statute, the Coroners Act 1988, being largely a consolidating

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1 The amendment would remove the Chief Coroner’s Office from the list of public bodies to be abolished at Schedule 1 of the Bill. The wording of the amendment is: Page 16, line 17, leave out “Chief Coroner, Deputy Chief Coroners, Medical Advisers to the Chief Coroner and Deputy Medical Advisers to the Chief Coroner.”


measure. It operates as a fragmented, non-professional assortment of coroners who operate with no compulsory training and little accountability. This results in a postcode lottery of service with good practice dependent on the approach of individual coroners rather than agreed and inspected quality standards. Families’ legal rights in proceedings are restricted (the rules governing inquests create a structure where the inquiry is not for them) and the administrative framework is not directed at their full inclusion in the process.

6. 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. Compounding this problem, the current system has no 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. Unless the findings of inquests proceedings are recorded, analysed and acted upon issues of systematic failure will never be addressed and more unnecessary deaths could occur.

7. Successive governments have recognised the system is in need of reform and have commissioned three extensive reviews in 1936, 1965 and 2001. The most recent review, chaired by Tom Luce, was a 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.” 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.

Proposed abolition of Chief Coroner through the Public Bodies Bill

8. Having been fully engaged in the governmental and legislative processes to reform the coronial system, INQUEST is bitterly disappointed at the inclusion of the Chief Coroner for England and Wales and associated officers in the list of public bodies to be abolished in Schedule 1 of the Public Bodies Bill. Other organisations including the Royal British Legion and AvMA (Action against Medical Accidents) have condemned the government’s decision.

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4 For an insight into the impact of lengthy delays on bereaved people listen to BBC Radio 4’s Face the Facts investigation into “Delayed Inquests” originally broadcast in August 2010 but available to listen again via: www.bbc.co.uk/programmes/b00tb993

5 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.


9. INQUEST welcomed the objective of the Coroners and Justice Act 2009 “to put the bereaved at the heart of the process.” The Act has the potential to make real progress in remedying many of the inherent problems with the current system. However, the new model agreed by Parliament a year ago would be rendered completely hollow without the driving force and national leadership of a Chief Coroner. The government’s proposals to take forward a small number of provisions in the Act and to amend secondary legislation are no more than tweaks of a system that is in need of fundamental root and branch reform.

Lack of consultation and evaluation

10. INQUEST is deeply concerned that the decision to abolish the Chief Coroner’s post is being rushed through Parliament under the guise of the Public Bodies Bill. The coalition government is proposing to jettison key elements of the Coroners and Justice Act 2009 with no apparent consultation with stakeholders, no real opportunity for parliamentary debate and without publishing any evidenced policy or cost analysis to explain their decision.

11. The sweeping, enabling powers given to Ministers under the proposed Bill have been a subject of concern to Peers. The House of Lords’ Select Committee on the Constitution has strongly criticised the lack of parliamentary oversight in the provisions and stressed “... the Public Bodies Bill is concerned with the design, powers and functions of a vast range of public bodies, the creation of many of which was the product of extensive parliamentary debate and deliberation. We fail to see why such parliamentary debate and deliberation should be denied to proposals now to abolish or to redesign such bodies.”

12. INQUEST welcomes the Select Committee’s findings and believes the concerns expressed in the report apply with particular force to the proposed abolition of the Chief Coroner’s office. If the Bill is enacted as it stands then, without additional consultation or scrutiny, the order abolishing the Chief Coroner’s post could be laid before Parliament – either as a separate order or as an omnibus order intended to roll up the abolition of several public bodies. Under the affirmative resolution procedure any order would be incapable of amendment and could be voted through after a relatively short debate in each House. This stands in stark contrast to the extensive six year consultation and parliamentary process leading up to the establishment of the Act and the creation of the Chief Coroner’s post, a post that received cross party support throughout the passage of the Bill.

The government’s rationale for abolishing the Chief Coroner’s post

13. When pressed by Members of Parliament to explain why the government supported the creation of the Chief Coroner’s post during the parliamentary passage of the Coroners and Justice Act 2009 but now wished to abolish the role before it was even established, the Minister for the Cabinet Office, Francis Maude MP stated: “... in government, you

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8 Select Committee on the Constitution, Public Bodies Bill: sixth report of Session 2010-11
have to look very carefully at the costs and accountability. Ministers have not been convinced that setting up an independent overarching body of that nature is essential to the proper delivery of this important national function.”

14. INQUEST believes it is impossible to understand how any considered application of the government’s “accountability” and “costs” criteria has led to proposals to abolish the Chief Coroner’s office.

Accountability and judicial oversight

15. The Chief Coroner’s post introduces accountability and judicial oversight to coroners courts where there is a currently a wide variation in (good and bad) services delivered to bereaved people.

16. Under the Coroners and Justice Act 2009, the Chief Coroner, who must be a High Court or Circuit Court judge, has powers to:

- 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. Crucially, this would have been a step towards tackling the unacceptable delays that plague the current system.
- 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. 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.

11. The government has trumpeted its intention to revisit and proceed with a Charter for Bereaved People. The original Charter was developed in tandem with the Coroners and Justice Act and sets out the levels of service bereaved people could expect to receive from coroners in a reformed system and, if they did not, set out the ways in which they could rectify that. Central to this in the existing Charter is the Chief Coroner’s role in resolving complaints. 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. Without this role it is impossible to envisage how the government’s proposals to issue a revised Charter will offer bereaved people anything other than a list of laudable but unenforceable empty promises.

National leadership

12. The Chief Coroner’s post was designed to introduce national leadership of coroners courts and improve grossly inconsistent standards of service delivery. The Coroners and Justice Act 2009 gives the Chief Coroner powers and responsibilities to issue guidance to

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9 In response to an oral question from Kevan Jones MP, HC Deb, 14 October 2010, col 517
coroners on ways of working, lay down practice directions and set national standards of service.

13. The Chief Coroner would also have played a crucial role in monitoring the overarching performance of coronial system. The Act places a duty on the post-holder to provide 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. The annual report would have been published and laid before Parliament offering an opportunity for further scrutiny and debate.

14. INQUEST believes the Chief Coroner’s role as an independent, dedicated, national figure would have been crucial in driving up standards and improving the experience of the more than thirty thousand bereaved families who are faced with a poorly functioning and unaccountable system each year.¹¹

Public health and safety

15. The government’s proposals are not only a set-back for bereaved families but also society, which should have an inquest system able to perform its vital public health and safety role by identifying problems, holding bodies accountable and making recommendations for change. The Coroners and Justice Act enabled the Chief Coroner to 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 so far as possible that such recommendations and warnings are acted on. Creating a Chief Coroner’s office with the power to tackle deep-seated issues relating to the operation of the coroners system as a whole was an opportunity to embed learning and accountability at the heart of the system. Abolishing the post will mean the opportunity is lost.

Costs

16. Jonathan Djanogly MP, Parliamentary Under-Secretary of State for Justice, explained to the House of Commons 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.”¹²

17. The figures relied on by the Minister appear to be taken from an impact assessment conducted by the Ministry of Justice in December 2008.¹³ INQUEST believes it is

¹¹ Statistics published by the Ministry of Justice in May 2010 record that 31,000 inquests were opened into deaths in 2009: [www.justice.gov.uk/publications/docs/coroners-deaths-reported-2010.pdf](http://www.justice.gov.uk/publications/docs/coroners-deaths-reported-2010.pdf)
¹² 19 October 2010, HC Deb, col 795 in response to a parliamentary question from Caroline Lucas MP
inappropriate to rely on these calculations as the impact assessment was conducted on the assumption that the fundamental reforms in the Coroners and Justice Bill would be implemented.

18. For example, the 2008 impact assessment did not evaluate the costs of the current failing system including, for example, the financial drain from adjourned and delayed hearings or the costs to the public purse of judicial reviews against coroner’s decisions. Significantly, given the current system is failing to learn from previous fatalities, the costs of repeated and expensive investigations and inquests into similar deaths is not included.

19. Most worryingly, the coalition government has also completely failed to take account of the human cost - the impact that the current, dysfunctional system has on the health and well-being of bereaved people forced to grapple with the current investigation and inquest process. The impact assessment carried out in December 2008 explicitly states that it did not examine the cost to the NHS of this impact on bereaved families’ physical and mental health.

20. 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).

21. Despite direct requests from INQUEST, the Royal British Legion and AvMA in face-to-face meetings, the Ministry of Justice has failed to provide any up to date, evidenced and costed proposals to support their proposals. Without this information it is difficult to evaluate the real costs and benefits of establishing or abolishing the Chief Coroner’s office. It also makes it impossible to clearly analyse the feasibility of alternative options. For example, whether, during the current financial crisis, it would be cost effective for the Chief Coroner’s post to be established as a part-time role with a smaller office.

22. Given the urgent and overwhelming need for reform of the inquest system and the lack of properly evidenced justification for the government’s proposals we urge Peers to support the amendment tabled by Baroness Finlay. INQUEST is deeply concerned that if the Chief Coroner’s office is abolished, the opportunity to create an inquest system fit for the 21st Century which saves lives will be wasted. This is a false economy if there ever was one.

14 How the inquest system fails bereaved people INQUEST, 2002. Copies available on request.
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 the Ministry of Justice Coroner Service Stakeholder Forum.

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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