Response to Consultation Paper CP 5/2011
“The draft Charter for the current coroner service”

August 2011
INTRODUCTION

1. The Ministry of Justice consultation paper on the revised Charter proceeds on the basis that the government’s plan to abolish the Chief Coroner’s office will be successful. INQUEST believes that the proposal to abolish this key post are short-sighted and a blow to bereaved people, and the voluntary sector organisations who support them. The judicial oversight and accountability that a Chief Coroner would bring are central to much-needed, fundamental reform of the current, archaic system. A Charter without a Chief Coroner is toothless. It is telling that the consultation paper does not set out any effective, alternative proposals for monitoring and enforcement to ensure that the Charter has any impact in improving the service offered to bereaved people who come into contact with the coroners’ courts. If the government is committed to reforming the existing system to put bereaved families at its heart, INQUEST urges them to reconsider their plan to abolish the Chief Coroner’s office and set out proposals for implementing the role which take into account the current financial situation.

2. The version of the Charter set out in the consultation paper betrays a lack of understanding of the extent of the structural problems in the current system. INQUEST has extensively documented the failings of the existing process in evidence based reports and how too often it adds to families’ distress rather than providing a mechanism for addressing concerns and preventing future deaths. We re-iterate the recommendations we made in those reports that dealt with the needs of bereaved people and the comprehensive changes to the administrative processes that are still urgently needed.

3. Others have also made similar recommendations and there have been a number of high-profile reviews, parliamentary reports or inquiries calling for an overhaul of the system. Most compelling was the comprehensive review of 2003, chaired by Tom Luce. This was an in-depth analysis of the current system which involved evidence gathering and consultation with over 200 coroners, families, lawyers and organisations. The Luce report:
   a. noted that “in particular there is a need to give bereaved families better support and to recognise that many will suddenly and unexpectedly experience these systems about which they have no prior knowledge.”
   b. Identified one of the critical weaknesses in the existing system as “a lack of clear participation rights for bereaved families, and of standards for their treatment and support.”
   c. Stated one of the main reasons for proposing changes was to make “good service to bereaved families a major priority”
   d. Called (as one of six core recommendations) for “consistency of service to families to be underpinned by a Family Charter having legal effect”

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1 Including, for example, Shaw, H. and Coles, D. Unlocking the Truth: Families’ Experiences of the Investigation of Deaths in Custody, INQUEST 2007; How the inquest system fails bereaved people INQUEST, 2002. Copies provided to the Coroners and Burials Unit, Ministry of Justice.


4 Page 16, ibid

5 Page 17, ibid

6 Page 21, ibid

7 Page 22, ibid
4. INQUEST is disappointed that comments on previous versions of the Charter made by voluntary sector organisations and bereaved people seem to have been overlooked. The drafters of this revised Charter do not seem to have taken proper account of recommendations from previous, detailed consultations with a wide range of stakeholders, including:
   a. the initial consultation on the draft ‘Charter for bereaved people who come into contact with a reformed coroner system’ which took place in 2006 as the draft Coroners Bill was published;
   b. the Coroners Service Stakeholders Forum which was set up in 2007 and was regularly consulted on plans for reforming the coronial system;
   c. the 2008 discussion paper with a revised draft ‘Charter for bereaved people who come into contact with a reformed system’;
   d. the final version of the revised draft Charter published when the Coroners and Justice Bill 2009 was introduced to Parliament.

5. INQUEST, and a number of the families who we have supported through the inquest process, welcomed the proposed changes in previous Charters. INQUEST believes the revisions in the consultation paper have diluted the standards set out in previous Charters to such an extent that this version has nothing concrete to offer bereaved people. What was 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. We set out the reasons for our view below.

**QUESTION 1 – DO YOU AGREE THAT THE CHARTER AND THE CURRENT GUIDE ARE COMPLEMENTARY AND BEST PUBLISHED TOGETHER IN ONE BOOKLET?**

6. Although INQUEST thinks the two documents are complementary we are concerned that amalgamating the Charter with a short information guide would mean that, rather than standing out as a distinct set of standards to be enforced, the Charter will be seen as a postscript to the general information in the guide. For that reason we think, following substantial revision of the Charter, the two documents should be published separately but circulated together.

7. The current information guide makes no specific reference to the services provided or information produced by the voluntary sector to support and guide bereaved people through the inquest process. In January 2011 INQUEST published a revised version of *The Inquest Handbook: a guide for bereaved families, friends and their advisers*. This 104 page guide has been developed in collaboration with other specialist advice agencies and bereaved people who have been through the difficult circumstances of a death involving a coroner’s inquest. There is an up to date, comprehensive contacts section listing other sources of help and information, further reading and a directory of voluntary, government and professional organisations. For example, we are aware of other useful guides that are also produced by AvMA and the Royal British Legion. The guide published by the Ministry of Justice should include a list of organisations and websites.

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8. Available to download from: [http://handbook.inquest.org.uk](http://handbook.inquest.org.uk). Free copies are provided on request to bereaved families. A link to the website is listed on the Direct Gov website as is a link to CRUSE for bereavement counselling and advice.
QUESTION 2 – DO YOU AGREE THAT THE CHARTER SHOULD INCLUDE WITNESSES AND ALL OTHER ALL PROPERLY INTERESTED PERSONS, AS WELL AS BEREAVED PEOPLE? IF NOT, WHY?

8. No. Charters are intended to be clear, user-friendly documents that enable specific groups of people to understand and access services (see Patient’s Charter in the NHS, Code of Practice for Victims etc). Widening the scope of this Charter to include all who come into contact with the coronial service turns the document from a Charter (as properly understood) into a statement about coronial practice. We note that what is being consulted on is not in keeping with the Written Ministerial Statement given to Parliament on 14 October 2010 by the Parliamentary Under-Secretary of State for Justice where he specifically referred to the government’s intention to issue and monitor “a national charter for bereaved families”. What is set out in the consultation paper is entirely different.

9. The last time views were sought on the scope of the Charter was during the 2008 consultation where, following responses from 84 organisations and individuals, the decision was made that a Charter specifically for bereaved people was needed. The Revised draft Charter and response to 2008 discussion paper (published in January 2009) explained:

“16. Some respondents felt that the draft Charter focussed on bereaved family members to the detriment of other interested parties such as paramedics, insurance companies, and NHS Trusts. As a result these respondents felt that the Charter risked being unfair and unbalanced.

19. To mitigate these concerns, we have clarified that this Charter is for the bereaved and have reiterated that it is our intention that guidance will be provided to other interested persons at inquests at a later stage. It is not our intention that families receive a preferential service, but having their own Charter recognises the different and specific needs they have in comparison with others with an interest in coroners investigations.”

10. INQUEST believes that this should still be the position. The evidence from previous reviews and reports (in particular the Luce Review – see paragraph 3 above) has clearly demonstrated the need for a specific Charter for bereaved people. Not least because the needs of a bereaved family caught up in the inquest process following the sudden or contentious death of their relative are completely different to, for example, an insurance company involved in an inquest. Attempting to sweep up all properly interested persons in a single Charter is inappropriate.

QUESTION 3 – DOES THE DRAFT CHARTER CONTAIN ENOUGH DETAIL ABOUT THE CURRENT CORONIAL PRACTICE? IF NOT, WHAT ELSE SHOULD BE INCLUDED?

11. INQUEST has extensively documented bereaved families’ concerns about problems in the current coronial system (see our research reports on families’ experiences from 2002 and 2007). These reports found that families’ were particularly concerned by:
   a. poor communication from coroners;
   b. lack of access to information about the ongoing investigation;
   c. delays in hearing inquests;
12. In light of this evidence, the lack of any information in this version of the Charter as to the likely length of investigations; concrete service standards on response times when contacting the coroners’ office (eg “where possible will return calls within 72 hours”) are regretttable.

13. We note and welcome the removal of the reference to charging for disclosure of documents (as floated in the January 2011 Discussion paper). For clarity we suggest the inclusion of the following at paragraph 3.15: “Disclosure of all relevant documents to be used in an inquest will take place, on request, free of charge and in advance of an inquest, to those family members whom the coroner has determined to have an interest in the investigation” (as in the paragraph 25 of the 2009 Charter).

14. The provision, in paragraph 3.7, that “the coroner’s office may charge a fee for copies” should be removed so that families are able to access copies of the post-mortem examination report free of charge - as in paragraph 19 of the 2009 Charter.

**QUESTION 4 – ARE THE SECTIONS ON HOW TO COMPLAIN ABOUT THE CONDUCT OF CORONER, AND THE LEVEL OF SERVICE RECEIVED, EASY TO UNDERSTAND?**

15. The consultation paper asserts that the Charter sets out “how people might complain if those services are not delivered”. Central to the effective system set out in the 2009 Charter was the Chief Coroner’s role in establishing and overseeing an appeal system. The proposed Charter removes all references to the Chief Coroner and an appeals process (paragraphs 38 to 44 in the 2009 Charter). In INQUEST’s view these are serious omissions which completely undermine the utility of the Charter.

16. The main complaint route envisaged in the consultation paper is the Office for Judicial Complaints. The OJC’s narrow remit is limited to judicial conduct alone and relates only to coroners (not Deputy Coroners, Assistant Deputy Coroners, coroner’s officers). This means that only a small number of the complaints bereaved families may wish to make could properly be dealt with by the OJC. Indeed the OJC’s annual report for 2009-10 states that of the 36 complaints received about coroners only 3 resulted in any action being taken. The reasons for dismissing the other complaints are not documented. In that context, it is interesting to note that 35% of respondents to the OJC’s survey of its own work stated that the body’s response to their complaint covered none of the points that they raised.

17. INQUEST believes that, in the absence of a complaint mechanism overseen by a Chief Coroner, the process envisaged in the present Charter will not allow proper examination of legitimate complaints from bereaved families. This will make it difficult to identify problems in practice leaving the coronial system unable to learn from mistakes and then rectify them through improved training and/or guidance. This is short-sighted.

**QUESTION 5 – WHAT ARE YOUR VIEWS ON OUR PROPOSAL FOR A COMMITTEE OF VOLUNTARY BEREAVEMENT ORGANISATIONS TO ASSESS THE IMPACT THAT THE CHARTER HAS ON THE CORONER SERVICE AND TO REPORT THEIR FINDINGS TO THE SECRETARY OF STATE?**

18. We note that the current Charter contains no details of organisations who could be responsible for enforcing the standards in the Charter or any information about concrete sanctions that are available if coroners and their offices do not comply with the provisions.
19. The role of the Chief Coroner was crucial to the effective monitoring and enforcement of the standards in the 2009 Charter. For example, in the two sections about monitoring standards and the complaints system in that document, all four provisions rely on the role of the Chief Coroner. Without the Chief Coroner, the revised Charter offers bereaved people only unenforceable promises.

20. The 2009 Charter also envisaged that “independent inspections of the service will be carried out and will include consultation with bereaved people” (paragraph 53). As Lord Ramsbotham, in debates on the Public Bodies Bill, has explained “in order to make the coroners service work, there has to be someone to ensure that the courts in which that service functions are working”.

21. INQUEST notes that HM Inspectorate of Court Administration carried out thorough inspections of the Coroners Service for Northern Ireland in both 2007 and 2009 which focussed specifically on the administrative systems supporting bereaved families and reported on key issues such as: information and communication; progression of cases; operational communication with partner agencies and leadership. This is a good model and one which should have adopted in relation to the coronial system in England and Wales. It is highly regrettable that the government is seeking to abolish the HMICA through the Public Bodies Bill and the body ceased to function on 31 December 2010.

22. The lack of credible alternative proposals or models in the consultation paper are worrying. Instead the only reference in the proposed Charter is to “assessing the impact” by a committee of voluntary sector bereavement organisations (paragraph 5.1). This is in no way comparable to the enforcement, monitoring and oversight that would be provided by the Chief Coroner and the independent inspection of the system by an experienced, properly resourced body. Removing all effective oversight from this version of the Charter creates a gap in accountability and enforcement which can not be filled by a committee of voluntary organisations.

QUESTION 6 – IS THE CHARTER A USER FRIENDLY DOCUMENT, AND ARE THERE ANY OTHER TERMS THAT NEED TO BE INCLUDED IN THE GLOSSARY?

23. As INQUEST highlighted in earlier responses to previous versions of the Charter, substantial work is needed to make the document accessible and user-friendly (for example one family member commented on an earlier version of the document: “I have read through the charter, word for word, but being a layman on these matters most of it was over my head”). The language in the document must be clearer and simpler to understand. The Charter should meet the “Crystal Mark” standard administered by the Plain English Campaign.

QUESTION 7 – HAVE ALL RESPONSIBILITIES OF BEREAVED PEOPLE AND OTHERS WHO COME INTO CONTACT WITH THE CORONER SERVICE BEEN INCLUDED? IF NOT, WHAT OTHER RESPONSIBILITIES SHOULD BE INCLUDED?

QUESTION 8 – DO YOU HAVE ANY OTHER COMMENTS ON THE DRAFT CHARTER?

24. As one of the key parts of the government’s stated commitment to reform of the coronial system, INQUEST is deeply disappointed that the revised Charter has been diluted to the extent that it now offers nothing concrete to bereaved families. In the absence of proper

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*Hansard, 11 January 2011, Col 1295*
reform of the system and full implementation of the provisions in the Coroners and Justice Act 2009 we think this Charter for the current coroner service will prove to be an expensive wasted opportunity.

**QUESTION 9 – DO THE IMPACT ASSESSMENT AND ACCOMPANYING EQUALITY IMPACT ASSESSMENT ACCURATELY ASSESS THE COSTS AND BENEFITS OF OUR PROPOSAL TO PUBLISH THE CHARTER?**

25. No – an effective, robust Charter in a reformed system would have a positive impact on the health and well-being of bereaved people. 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\(^\text{10}\). 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. 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).

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\(^{10}\) How the inquest system fails bereaved people INQUEST, 2002
APPENDIX 1 - 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.