Public Bodies Bill [HL]
Briefing for Second Reading

November 2010
Proposed abolition of Chief Coroner through the Public Bodies Bill

1. 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. We are not lone critics. Since 2003 there have been a number of high-profile reviews, parliamentary reports or inquiries calling for an overhaul of the system.

2. 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 have also condemned the government’s decision.

3. 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 and reforming one of the most neglected areas of law. 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

4. 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.

5. 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

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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


“... 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.”

6. 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

7. 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 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.

8. 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

9. 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.

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

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5 Select Committee on the Constitution, Public Bodies Bill: sixth report of Session 2010-11
6 For example, the 2001-3 Fundamental Review, was a comprehensive analysis of the current system involving a £1.1million consultation to gather evidence from 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.”
7 Central to their recommendations to deal with critical defects in the current system was the creation of the post of Chief Coroner for England and Wales.
8 In response to an oral question from Kevan Jones MP, HC Deb, 14 October 2010, col 517
• 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 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.

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9 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
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.”

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. INQUEST believes it is 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. The 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.

18. The coalition government has also 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 2008 impact assessment did not examine the cost to the NHS of the impact on bereaved families’ physical and mental health because of prolonged delays in existing system.

19. Despite direct requests from INQUEST, the Royal British Legion and AvMA (Action against Medical Accidents) 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.

20. 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

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10 19 October 2010, HC Deb, col 795 in response to a parliamentary question from Caroline Lucas MP

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.

21. Most significantly perhaps in terms of both human and financial costs the current system is failing to learn from previous deaths. This leads to similar fatalities and further expensive investigations and inquests.

22. INQUEST urges Members of the House of Lords to remove the Chief Coroner’s post and associated officers from schedule 1 of the Public Bodies Bill. It is inappropriate that the government has chosen this Bill to force through what amounts to reversal of the fundamental reforms to the coronial system enacted by Parliament less than a year ago. INQUEST believes that the government’s plans have not been adequately justified on grounds of “accountability” or “cost.” The proposal to abolish the Chief Coroner’s office would frustrate the opportunity to create an inquest system fit for the 21st Century which saves lives. This is a false economy if there ever was one.
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 occuring. 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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