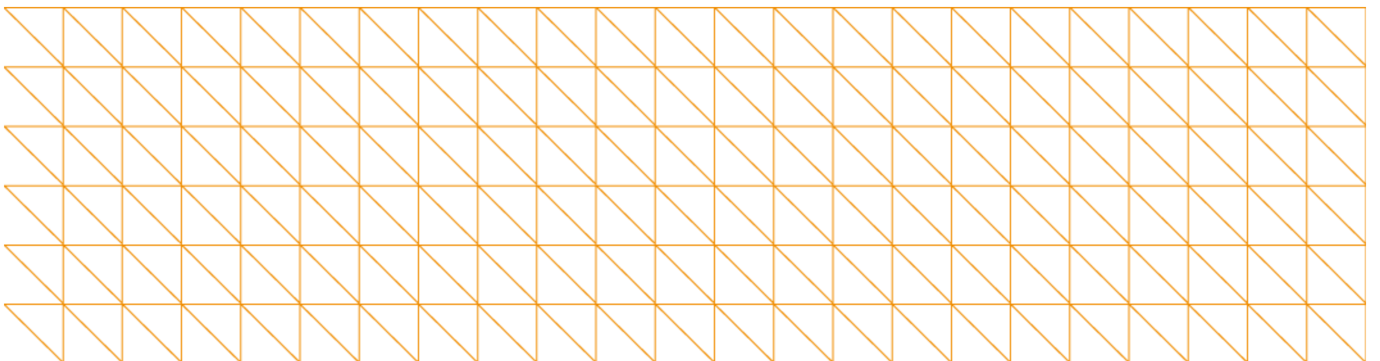
Charter for current coroner services

Response to consultation

Response to consultation CP(R) 5/2011

This response is published on 15 December 2011



Charter for current coroner services

Response to consultation

Response to consultation carried out by the Ministry of Justice.

This information is also available on the Ministry of Justice website:
www.justice.gov.uk

About the consultation

To:	Coroners and those who work within and who fund coroner services; civil society partners; and the general public.
Duration:	From 19 May 2011 to 5 September 2011
Enquiries (including requests for the paper in an alternative format) to:	Hazra Khanom Ministry of Justice Access to Justice Justice Policy group 4th floor (post point 4.32) 102 Petty France London SW1H 9AJ Tel: 020 3334 6403 Fax: 020 3334 2233 Email: coroners@justice.gsi.gov.uk

Contents

Foreword	3
Introduction and contact details	5
Background	6
Summary of responses	7
Conclusion and next steps	22
The consultation criteria	24
Annex A – Impact Assessment and Equality Impact Assessment	25
Annex B – List of respondents	26

Foreword

By Jonathan Djanogly, Parliamentary Under Secretary of State for Justice

As many people who have lost loved ones and then had contact with a coroner's inquiry can testify, the coronial system plays a vital role in our society, clarifying the causes and circumstances of death. When the system works as it should it can help bring peace of mind to those who have suffered or witnessed a tragic bereavement. But when inquiries go wrong or aren't handled properly, families and witnesses can be left feeling worse, their loss aggravated by a process that sometimes seems confusing and unaccountable, even unfeeling.

The Government is committed to improving the coronial system in England and Wales. We want to ensure a greater level of consistency across the country, to improve efficiency and to put the needs of bereaved families, including bereaved service families, at the heart of these services. That is why we are introducing wide-ranging reforms, including a Chief Coroner, the establishment of a Bereavement Organisations Committee and, the subject of this document, a new Charter for current coroner services in England and Wales.

As we said in our consultation document published in May, our aim is to create national standards that allow for local management and delivery of coroner services. We received 135 responses to the proposals we put forward, and have listened carefully to those views, which included views from coroners, local authorities, bereaved people, bereavement organisations, the medical professions, and registrars.

The new version of the Charter will, we believe, be an important step forward. It will set out, for the first time, uniform standards of service that bereaved family members, other properly interested persons and witnesses can expect to receive from coroners' services across the country. It will also ensure that all coroners' offices in England and Wales are aware of the standards they should be meeting. And clarify too what someone can do if they wish to complain about the level of service they have received, or the personal conduct of a coroner.

The Government is committed to ensuring that the Charter makes a real difference, and isn't just a piece of paper left on the shelf. Accordingly, the impact of the Charter will be considered by the new Bereavement Organisations Committee, which will report to Ministers. Our intention is that this, along with the Chief Coroner, will provide strong, proper and effective oversight of the non-judicial aspects of the coronial system, giving those who represent the bereaved a direct line to Ministers.

We plan to publish the Charter in early 2012, alongside our *Guide to Coroners and Inquests*, at which time the Charter will go live. The Guide will explain the role of a coroner and the inquiry process, and the Charter will set out the

standards that should be met during that process. A combined document will give people access to all the information they are likely to need in one easy-to-read document.

I am extremely grateful to everyone who responded to our consultation for taking the time to read the document and comment on it. I hope that together we will have taken some tangible steps towards delivering a modern, effective and accountable coronial system.

Introduction and contact details

This document is the Government's response to its consultation on the draft Charter for current coroner services.

It covers:

- the background to the consultation
- a summary of the responses to the consultation
- a detailed response to the specific questions asked in the consultation
- the next steps following this consultation.

If you would like a copy of this document please contact Hazra Khanom at the address below:

Access to Justice
Administrative Justice, Court Fees, Coroners and Burials
Ministry of Justice
4th floor (post point 4.32)
102 Petty France
London SW1H 9AJ
Telephone: 0203 334 6403
Email: coroners@justice.gsi.gov.uk

This document is also available on the Ministry's website: www.justice.gov.uk.

Alternative format versions of this publication can be requested from coroners@justice.gsi.gov.uk

Background

1. Our consultation on the draft Charter for current coroner services was published on 19 May 2011. It invited comments on the Government's proposal to publish a Charter for current coroner services in England and Wales.

2. The consultation closed on 5 September 2011. This document summarises the responses, including how the consultation process will influence the redrafting of the Charter. We have also updated the Impact Assessment and Equality Impact Assessment following the consultation, and revised versions are at **Annex A**.

3. The Charter aims to help those who come into contact with the current coroner system, by setting out the service standards that bereaved family members and other 'properly interested persons'[1] in a coroner inquiry should expect to receive from a coroner inquiry. The Charter will also set out what someone can do if they wish to complain about the level of service they have received or the personal conduct of a coroner.

4. The Charter will apply to coroner services as they currently operate under the Coroners Act 1988 and the Coroners Rules 1984 (as amended). It will be published alongside the Ministry of Justice's *Guide to Coroners and Inquests* (the Guide). We will update the Guide and the Charter as and when there are changes to coroner legislation and policy.

---

1 "Properly interested person" is defined in rule 20 of the Coroners Rules 1984 as follows:
- a parent, child, spouse, civil partner, partner and any personal representative of the deceased;
- any beneficiary of a life insurance policy on the deceased;
- any insurer having issued such a policy;
- a representative from a Trade Union to whom the deceased belonged at the time of death (if the death may have been caused by an injury received in the course of [1]the person's employment, or was due to industrial disease);
- anyone whose action or omission may, in the coroner's view, have caused or contributed to the death;
- the Chief Officer of Police (who may only ask witnesses questions through a lawyer);
- any person appointed as an inspector or a representative of an enforcing authority or a person appointed by a Government Department to attend the inquest; or
- anyone else who the coroner may decide also has a proper interest.

Summary of responses

We received 135 responses to the consultation.

Category	Number of respondents
Coroners	31
Coroners' officers	4
Faith groups	3
Government organisations	8
Individuals	14
Lawyers	6
Local authorities	4
Medical professionals	13
Palliative care / hospices	5
Police	4
Registrars	9
Voluntary organisations	16
Other	10
Anonymous	8

Question 1 – Do you agree that the Charter and the Guide are complementary and best published together in one booklet?

1. The majority of respondents agreed that the Charter and the Guide should be published together in one booklet as they were complementary.

2. Overall, coroners, local authorities and voluntary organisations were supportive of publishing one booklet that contained both the Charter and the Guide, as it would be simpler and more cost-efficient to give bereaved family members and others a single document, containing all the information they needed. Kent County Council stated:

   "This makes sense in terms of providing a comprehensive overview of the service, clarifying what the public and stakeholders can expect and making it easier to understand the service and its complexities. Producing the Charter and the Guide together would support the 'green' agenda and save money and other resources, which is to be commended."

3. The UK Missing Persons Bureau also welcomed the publication of the Charter and the Guide in one booklet. They stated:

   "Having the Charter and Guide in one booklet will make it less confusing and will ensure that families can access all the necessary information. If they are kept separate there is a risk that families will be given either the Charter or the Guide (or will only find one online). Also having two separate booklets may seem like an overload of information to families experiencing a very distressing and upsetting event."

4. However, some voluntary organisations expressed concerns about publishing the two documents together in one single booklet, arguing that it weakened the Charter and that there was a danger of 'losing' the Charter at the back of the Guide. Cardiac Risk in the Young (CRY) said:

   "We believe that these two documents must be published separately. This will prevent the dilution of the proposed Charter; make it easier for the bereaved to carry a pocket sized document with them and facilitate the updating of the Charter if/when this is required."

5. A handful of respondents were concerned that a combined document would be more costly to update as if either the Guide or Charter was updated the entire booklet would need to be reprinted and redistributed.

6. Some respondents made suggestions for revising the format of the Charter. For instance, one member of the public suggested that there ought to be a distinction other than colour between the two documents as the colours would not be evident to those printing the document in black and white. It was also suggested that there ought to be more cross-referencing between the Guide and the Charter to enable a reader to more easily find additional information on a topic.

7. ***We will publish the Charter and Guide as one document. We agree that the distinction between the Guide and the Charter could be made clearer. We will continue to use two different colours, but will differentiate the two documents further by inserting a blank page between them and enlarging the titles of the Guide and Charter. We will also insert more cross-references between the two documents.***

Question 2 – Do you agree that the Charter should include witnesses and all other properly interested persons, as well as bereaved people? If not, why?

8. The majority of respondents agreed that the Charter should not be restricted to bereaved people and should also apply to witnesses and all other properly interested persons. Overall, coroners and local authorities were supportive of treating all service users equally.

9. However, several voluntary organisations, (such as Cruse Bereavement Care, CRY, the Child Bereavement Charity, RoadPeace and INQUEST), were disappointed that this Charter was not specifically for bereaved

people. In their view widening the scope of the Charter to include other properly interested persons and witnesses has moved the focus of the Charter and the coroner system away from bereaved people. Cruse Bereavement Care stated:

> *"Whilst of course all properly interested parties should be treated fairly, helpfully, promptly and politely the needs of bereaved people should be at the heart of the system. Bereaved people have some specific and distinct needs which are different to those of other 'interested persons' involved in the inquest process. The main aim of coroner reform was to deliver better care for bereaved people. With the broadening of the scope of the Charter, the aim of putting bereaved people at the heart of the system is not achieved."*

10. ***We appreciate that some voluntary organisations are disappointed that this Charter will not be solely for bereaved people. The Government remains committed to improving the experiences of bereaved families who come into contact with coroner services. However, we believe that these services should also treat other properly interested persons and witnesses in accordance with the standards set out in the Charter.***

11. ***The Coroners and Justice Act 2009 provides for the Lord Chancellor to issue statutory guidance about the way in which the system operates specifically in relation to bereaved family members. We plan to revise the Charter when we implement the coroner provisions in the Act.***

Question 3: Does the draft Charter contain enough detail about current coronial practice? If not, what else should be included?

12. The majority of respondents either said that the Charter contained enough detail, or did not answer this question. A number of respondents made useful suggestions on sections of the Charter that they felt should be revised, or new sections that should be included. Below are some of the comments we received, and our response to these:

13. Some coroners and a local authority said that the Charter took insufficient account of the fact that coroners' services are local and that practices differ in different areas. Andre Rebello, HM Coroner for Liverpool and Honorary Secretary of the Coroners' Society, stated:

> *"The Charter should explain that there are many local coroners' services and that coronial practice has to be adapted to the local infrastructure to make the law work."*

14. ***The Charter will provide a national framework that sets out the standards of service that people can already expect from coroners' services in England and Wales. The Charter will enable bereaved family members, witnesses and other properly interested persons to know the standards of service they should expect to receive***

from coroner services, as well as ensuring that all coroners and coroners' officers in England and Wales know the standards they should meet.

15. ***While we accept that there is local variation in demographics and coroners' services in different coroner jurisdictions we believe that the standards set out in the Charter should be achievable by coroners across the country. We recognise that not all areas will be able to provide all facilities that the Charter mentions (such as a private waiting room for bereaved family members at an inquest, or the Coroners' Courts Support Service being present). The Charter will manage expectations by making clear that these facilities are not available in every area.***

16. Several respondents were concerned at the use of a variety of terms throughout the draft Charter such as 'family', 'bereaved people', 'bereaved family members', 'properly interested persons' and 'service users'.

17. ***We will amend the language used, so that a box at the start of the Charter will define who it is for, that is bereaved family members, other 'properly interested persons', and witnesses (the Glossary will define these terms). The rest of the Charter will address these readers as 'you'. We believe this redrafting will also make the Charter more readable, as well as making its style more distinct from that of the Guide.***

18. The Home Office, the Association of Chief Police Officers and several coroners pointed out that the timeframe for the release of a body under paragraph 3.9 of the draft Charter was incorrect.

19. ***We will reword the text to rectify this error.***

20. Several respondents from within the medical profession, including those working in palliative care and hospices, raised concerns about procedures in one area of the country following an out-of-hours death at home of someone with a terminal illness (where the illness caused the death). In this area, difficulties in contacting a doctor or surgery out of hours in order to obtain a Medical Certificate as to the Cause of a Death (MCCD) had meant that a death would be reported to the police who were then required to investigate it on behalf of the coroner, and the body was taken to a mortuary. This was the case even where a death had been expected, because at that stage the cause of death would not be known.

21. These respondents wanted the Charter to set out national standards for all coroners to comply with when dealing with expected deaths from terminal illness.

22. ***We are aware of concerns about 'out of hours' deaths from terminal illnesses in this particular area. However, we have been advised that local coroners have now put in place a protocol to address this issue. As a result we understand that doctors within the jurisdictions concerned can now advise the out of hours doctors' service that an MCCD will be issued if a patient's death occurs out of hours. This means that it is no longer necessary for the local police to attend or for the body to be taken to the mortuary, provided that the doctor contacting the out of hours service is the same doctor who will issue the MCCD.***

23. ***As this was a specific local issue which we understand has now been resolved, the Charter will not cover this.***

24. Some respondents felt that the Charter should provide more detail on reports to prevent deaths ("Rule 43 reports"). Action Against Medical Accidents (AvMA) suggested that the Charter should provide more information on what the coroner is required to do by law when he or she proposes to make a Rule 43 report. Kent County Council and the Local Government Group suggested that the Charter should outline the timescale in which those who receive such a report have to respond.

25. ***We will redraft the paragraph on Rule 43 reports to provide more detail on the process and outline the timescale for responding to the reports.***

26. Many people commented that the flow chart at section 2 was helpful. However several respondents highlighted inaccuracies in it, or made suggestions as to how it could be made clearer. For instance, Cambridgeshire County Council stated that the start of the coroner inquiry process needed to be made clearer. Some coroners highlighted that it is the registrar and not the coroner who issues a death certificate.

27. ***We will amend the flow chart to make it clearer as to where the coroner's involvement begins, and to amend inaccuracies or elements that were previously unclear.***

28. Several respondents, including the Local Government Group and faith groups, the Brethren Christian Fellowship, the Muslim Burial Council of Leicestershire and the Indian Muslim Welfare Society, suggested that the Charter should set out that bereaved family members may request a less invasive post-mortem examination as an alternative to a conventional one.

29. ***Less invasive post-mortem examinations using Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) scanning are permitted under the existing coroner legislation. However, their availability is, at the time of publishing this document, limited to the four coroners' districts in Manchester (where MRI scanning alone is used), and coroners' areas in Leeds, Leicester and parts of London.***

30. ***Any less invasive post-mortem examination is performed only with the agreement of the coroner and is paid for by the family of the bereaved, or by a faith or community group on their behalf. It should be noted that there is currently no overarching protocol or guidelines governing the use of less invasive post-mortem examinations. It follows that the view of most coroners, as well as pathologists and radiologists, is that it is unwise to use an untested technique without any clinical governance to determine the cause of death. Therefore the Charter will remain silent on this issue.***

31. The Crown Prosecution Service suggested that the Charter ought to provide information on the coronial process in the event of criminal proceedings potentially being instituted.

32. Organisations with a remit of protecting children – such as the Department of Education, West of England Child Death Overview Panel and the Royal College of Paediatrics and Child Health - felt that the Charter should make reference to the duty of coroners to inform the Local Safeguarding Children Board (LSCB), for the area in which the child died, of the fact of an inquest or post-mortem examination. Furthermore, they argued that the Charter should say that coroners share information with LSCBs for the purposes of carrying out their functions, which include reviewing child deaths and undertaking Serious Case Reviews.

33. ***We have striven to keep the Charter as simple as possible. Therefore the document will not go into great detail on specific types of deaths for which the inquiry process may vary from the norm for a coroner inquiry. However, to acknowledge such cases we will insert a new section into the Charter. This will outline some types of inquiry where the process may be different, and will include child deaths and criminal investigations.***

34. Concerns were also raised by coroners about the section (3.7 in the draft Charter) on the disclosure of post-mortem examination reports to bereaved people. They pointed out that under the current legislation, coroners cannot charge a fee for disclosure of documents before an inquest. They can charge only for disclosure of documents after the inquest.

35. ***We will clarify the provisions on disclosure of documents to ensure that they accurately reflect the current legislation.***

36. We also received comments suggesting that the Charter needed to make clear that a coroner inquest is a fact-finding process and that a coroner cannot apportion blame for a death. The Aneurin Bevan Community Health Council said that emphasising that an inquest is a fact-finding process would address the misunderstanding that the coroner process is the first step in finding blame before a criminal investigation takes place. The Police Federation of England and Wales argued that the Charter should make it clear that when witnesses and legal representatives ask questions in court, they should bear in mind that the purpose of the inquest is not to apportion blame.

37. ***We will make it clearer in the Charter and its Glossary that the purpose of an inquest is to establish who has died, and how, when and where the death occurred, and that an inquest does not establish any matter of liability or blame.***

38. Epilepsy Bereaved suggested that the Charter should signpost specialist bereavement support organisations. CRY also felt that there should be a national list of support organisations.

39. ***It would not be appropriate for the Charter to attempt to signpost all specialist organisations, as it would be impractical to monitor changes in every organisation and revise the Charter each time there was a change. However, to ensure that families can find information about bereavement organisations, the Charter will say that the coroner's office will be able to provide information on local and national organisations that may be able to offer bereavement support. We will also add that the NHS Choices website contains details of support organisations.***

Question 4: Are the sections on how to complain about the conduct of a coroner, and the level of service received, easy to understand? If not, how could they be improved?

40. Overall respondents agreed that the complaints processes detailed in the Charter were easy to understand, although some respondents felt that the processes should be different from those set out in the Charter.

41. However, the Coroners' Society and several individual coroners raised concerns about the wording of the complaints section. The Coroners' Society felt that the Charter focused too much on how to lodge a complaint, which could lead to complaints increasing unnecessarily. The Society believed there was a risk of diverting coroners' resources away from inquiring into deaths in order to deal with complaints.

42. The Honorary Secretary of the Coroners' Society suggested that this section was incomplete, as:

    "If the complaint is about the service it might actually be a complaint about the relevant council not funding the service. That is why the relevant council is a glaring omission from the Charter."

43. Similarly Ian Arrow, HM Coroner for Torbay and South Devon District, felt that the Charter should make it clear that coroners may not be sufficiently resourced to meet the expectations of the Charter and that coroners had no means to require local authorities or police authorities to provide the necessary resources for the service. This view was supported by several other coroners.

44. Kent County Council suggested that all complaints about the local coroner's service should be referred to the local authority, as, "The local authority is responsible for providing the service and meeting all the costs". In their opinion, it is not right for someone to complain about a coroner to that coroner, as this puts the coroner in the role of both "judge and jury". Furthermore, where a complaint or comment received is about the actual service itself, it is important that these complaints or comments are received directly by the local authority in order to be able to improve service delivery. The Local Government Group made the same point, arguing that:

    "It is important that councils are informed of any complaints being made about coroners and coroner services whether this means complaints coming directly to local authorities or being copied to them. Local authorities are ultimately responsible for providing coroner services and meeting those costs and the public holds those local authorities to account for those services."

45. However, in contrast Mike Howells, Assistant Deputy Coroner for Pembrokeshire, felt that the section on complaining about a coroner's service should be removed as it implied that councils' authority over coroners extended beyond resources.

46. Finally, some respondents felt that the Charter should be clearer on what types of complaints the Office for Judicial Complaints hears, and what types of complaints should be made to coroners and local authorities.

47. ***It is not possible to change the complaints procedures that the Charter describes as the Charter's remit is to set out current complaints processes rather than create new ones.***

48. ***With regard to the concerns raised by local authorities and coroners, the Charter will make it clear that all feedback and complaints about a service should be copied to the relevant local authority, and that a complaint may be made direct to the local authority. This will ensure that local authorities are aware of what problems are being faced in a coroner service, and whether appropriate action to prevent a recurrence is possible within the available resources a coroner receives.***

49. ***We note coroner concerns that setting out means of redress could lead to an increase in complaints. However, we hope that setting out standards in the Charter will help manage expectations of the levels of service that bereaved family members and other interested persons and witnesses can expect to receive. This should help to ensure that complaints are made only where warranted. However, the revised Impact Assessment notes coroners' concerns.***

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 coroner services and to report their findings to the Secretary of State?

50. Responses fell in to two broad groups – one supportive of having a Bereavement Organisations Committee to monitor the impact of the Charter, and one which had concerns about this proposal.

51. The majority of bereaved family members and voluntary organisations supported the idea of a Bereavement Organisations Committee. They felt that voluntary organisations were in the best position to monitor the impact of the Charter as they supported the bereaved. For instance, Sudden Arrhythmic Death Syndrome (SADS) UK viewed the proposal as a practical way of auditing how effective and helpful the Charter was to those who had been bereaved. The UK Missing Persons Bureau agreed that the charitable sector was the most appropriate one to represent bereaved families and most likely to hold services to account. Similarly, Dorset Registration Services believed it was important for bereaved people to have a voice to assess the effectiveness of services. The Brethren Christian Fellowship said that the proposal would introduce some element of accountability to the coroner.

52. However, AvMA raised concerns that the proposal did not make any provision for providing voluntary organisations with any training or funding to carry out their roles on the Committee. In their opinion the proposal appeared to have shifted the Government's responsibility on to voluntary organisations in order to save costs. AvMA also argued that voluntary organisations did not have the power to impose penalties or other sanctions on coroners. INQUEST said that the Committee was no substitute for having a Chief Coroner and an accompanying inspection system. Cruse Bereavement Care shared this concern.

53. The Coroners' Society and several individual coroners opposed the proposal for the Bereavement Organisations Committee. For instance Mary Hassell, HM Coroner for Cardiff and the Vale of Glamorgan, said that voluntary organisations represented only one set of properly interested persons. She said that other organisations and professions also needed to be involved in such a committee. Coroner Ian Arrow stated:

    "It is a matter for the Minister as to who he chooses to advise him. I think to seek the advice of such a voluntary limited interest group is naïve and likely to result in a slanted view."

54. Local authorities tended to agree with this view. Some (including Sheffield and Kent) said that there ought to be local government representatives on the panel, to reflect the local authority role in funding coroner services.

55. Many respondents, including the Coroners' Courts Support Service, Cruse Bereavement Care and the Bereavement Services Association as well as some local authorities (including a joint response from eight London Boroughs) and coroners, wanted to see more information on, for instance, how the Committee would monitor the Charter, what sanctions it would be able to use, and how it would be funded.

56. ***The Bereavement Organisations Committee will be represented by a range of bereavement voluntary organisations and its main function will be to monitor the implementation of the Charter. The Government is currently considering the need for a steering group to guide the implementation of policy ahead of the implementation of the Chief Coroner.***

Question 6: Is the Charter a user-friendly document, and are there any other terms that need to be included in the Glossary?

57. The vast majority of respondents said that the draft Charter was user friendly and easy to understand. However, INQUEST and the Defence Bereaved Families Group felt that it needed to be clearer and simpler.

58. The Child Bereavement Charity commented that:

    "It is important that the nature of distress is understood and accounted for in writing material of this nature which will be supplied to people in the midst of tragedy. We would like to see the glossary extended to include more basic terms such as post-mortem examination, inquest etc."

59. ***We will add the following definitions to the Glossary: bereaved family member, coroner's office, inquest, next of kin, pathologist, post-mortem examination, pre-inquest hearing or review, witness.***

Question 7: Have all the responsibilities of bereaved people and others who come into contact with coroner services been included? If not, what other responsibilities should be included?

60. The majority of respondents agreed that the draft Charter provided a comprehensive list of responsibilities that bereaved family members and other interested persons would have when coming into contact with coroners' services.

61. Some coroners suggested that the Charter should say that bereaved family members should ensure that they wear appropriate clothing and behave appropriately at an inquest.

62. Several respondents (including Sunderland Royal Hospital, Browne Jackson LLP and the Forum of Insurance Lawyers (FOIL)) stressed the need for the Charter to say that properly interested persons should treat documents disclosed to them confidentially.

63. Colchester University hospital suggested that the Charter should say that bereaved family members ought to inform the coroner's office at the earliest opportunity of whether they wanted to bury or cremate the deceased and who the appointed funeral directors would be. Two respondents (a member of the public and a doctor) felt the Charter should include the responsibilities of doctors.

64. ***We will revise the list of responsibilities at the start of the Charter, to include reference to dressing appropriately for an inquest, and to strengthen the statement that documents that are disclosed are treated with confidence, given the number of respondents who suggested this.***

Question 8: Do you have any other comments on the draft Charter?

65. Overall, the majority of respondents welcomed the Charter. For instance the Association of Personal Injury Lawyers said that the Charter provided the opportunity to offer bereaved families a good understanding of the coroner process and the level of service to expect at a distressing time:

> *"Even though the document does not appear to be legally binding it may lead the way in creating a standard level of service or accepted culture from the coroner's service. We welcome the Government's commitment to address inconsistencies and inefficiencies in the delivery of services through the coroner system to bereaved families, witnesses and other interested parties."*

66. Other comments on the draft Charter, and our responses to them, are set out below:

67. Several respondents were concerned about the Charter being a set of voluntary standards. The Commission for Victims and Witnesses stated:

> *"The commissioner welcomes the aim of the draft Charter to create a more transparent coroner service and offer families clear and accessible information about what to expect from this service/ to this effect there are some positive provisions which we endorse. However this Charter, as drafted with its current voluntary status, is a missed opportunity to really tackle the imbalances of the current system."*

68. ***It may be helpful to clarify that the Charter is voluntary because it is a Charter for current coroner services - provided for under the Coroners Act 1988 and Coroners Rules 1984 (as amended) - under which there is no provision for it to be statutory. Although the Charter is voluntary, it will make it easier for bereaved family***

members and other properly interested persons, as well as coroners and their officers and other staff, to understand their rights and responsibilities in the coroner inquest process.

69. ***We plan to revise the Charter when we implement the coroner provisions in the Coroners and Justice Act 2009. The 2009 Act provides for the Lord Chancellor to issue statutory guidance about the way in which the system operates in relation to bereaved relatives. Once implemented, we intend to use this power to give the revised Charter the status of statutory guidance.***

70. The Newspaper Society suggested that bereaved family members should be informed at the earliest possible opportunity that inquests are judicial proceedings open to the public and can be reported by the media. This matter was also raised by a member of the public. The respondent stated that they were not informed that the press would be present at the inquest. They were very distressed to later discover that what they had said at the inquest had been published in the press without their knowledge.

71. ***We agree that bereaved family members and other properly interested persons and witnesses should be aware that the press maybe present at the inquest, as almost all inquests are held in public. This will be made clear in the Charter.***

72. Several respondents (including INQUEST, CRY and the Child Bereavement Charity) expressed their disappointment that the Government was not proceeding with having a Chief Coroner.

73. ***The Government has amended the Public Bodies Bill to provide for the implementation of a Chief Coroner.***

74. Some respondents (e.g. Royal College of Pathologists and the Bereavement Services Association) felt that the coroner's office should update properly interested persons more frequently than every three months as stated in the draft Charter. However, others (e.g. Andrew Tweddle, HM Coroner for the North and South Districts of Durham and Darlington) felt that this contact should be less frequent than every three months.

75. ***On balance we will keep the three monthly update as in the draft Charter, but add that three months will be the 'usual' frequency for updates, to take account of the fact that this might not be appropriate in every case.***

76. Two responses – from RoadPeace and a bereaved mother and father – suggested that at the end of an inquest bereaved people should have the option of completing a feedback form on the standards of service they had received.

77. ***We agree that a feedback form may be useful and are considering what such a form should include and how it could be issued, collected and used.***

78. Other respondents made many minor but helpful comments on where the Charter's text could be amended in order to clarify, correct or simplify the text.

79. ***We will amend the Charter where appropriate to address these comments.***

Question 9: Do the Impact Assessment and accompanying Equality Impact Assessment accurately assess the costs and benefits of our proposal to publish the Charter? If not, what have we missed?

80. Nearly half of respondents didn't answer this question, or said that they felt unable to comment on it.

81. Of those who did comment, there was a mixed response. Just under half said that the Impact Assessment and the Equality Impact Assessment accurately reflected the costs and benefits of publishing the Charter. However, the remainder, in particular coroners and local authorities, were concerned that the Impact Assessment did not accurately reflect the costs that would arise from publishing the Charter. None of the respondents quantified the additional costs they would incur, but coroners and local authorities said they would incur extra costs to meet the standards set out in the Charter. For instance Kent County Council said:

    "It will set standards that councils may have to incur expenditure to avoid being criticised publicly for not achieving the Charter's minimum standards".

82. These respondents felt the Charter should contain more detail on what the costs would be that related to adapting to the Charter's standards; coroners compiling a list of local bereavement support organisations; and convening the Bereavement Organisations Committee.

83. Some coroners indicated that there would be 'increased expectations' and thus an additional cost to them to meet some of the Charter's standards – such as giving people at least four weeks' notice of an inquest, contacting bereaved families regularly, and providing a private waiting room for relatives. They felt that the Impact Assessment should reflect this. The London Borough of Southwark stated that:

    "It is inevitable that increased transparency will lead to increased requests for transcripts and demands on the service. There is also a growing trend for increased legal representation of interested parties at inquests and coroners relying on legal advice and counsel. These require additional resources and increase the duration of inquests. It

is therefore likely that the costs to local authorities funding the service and to the employers of support and coroners officers will increase at a time of severe budget reductions and cuts."

84. Two group responses, from eight London coroners and eight London local authorities, expressed concern that the Charter's complaints section would lead to an increase in the number of complaints about the level of service received. Kent County Council said:

    "If the number of complaints increases as a result of promoting the mechanisms to do so through the Charter, costs will be incurred when responding to, and investigating these complaints".

85. A couple of respondents argued that, as the Charter was not statutory, it would in fact have few benefits for bereaved family members and other properly interested persons. The eight London coroners stated:

    "The benefit to bereaved people, other interested persons and service users of course depends entirely on compliance with the Charter, which…. is voluntary. In circumstances where those benefits are derived from a supposed increase in standards, but for which central government will provide no resources, and ….. the coroner will have no right to reimbursement and so will spend no money, it is difficult to see how any such voluntary compliance is at all likely, and thus how any such benefits will materialise."

86. Concerns relating to costs were also raised by voluntary groups in relation to the Bereavement Organisations Committee. For instance, Survivors of Bereavement by Suicide were concerned about "increased expenditure by the voluntary groups e.g. in providing information. We would hope that funds would be available, especially for small charities, to enable them to contribute to this work". AvMa and the Child Bereavement Charity shared this concern about the costs that members of the committee may need to meet.

87. ***Given that no respondents quantified the additional costs they felt they would incur, and that the Charter is designed to reflect the existing standards that local coroners' services should be meeting wherever possible, we have not inserted new cost details into the Impact Assessment. However, in relation to the suggestion that the Charter will increase expectations, we have amended the Impact Assessment to make it clearer that the Charter contains many standards that should be met 'wherever possible' (such as providing a waiting room for relatives). The Impact Assessment recognises that it may not be possible to meet these standards in some cases and therefore the Charter will not impose an additional cost on coroners or their local authorities. The revised Impact Assessment also notes the concerns that the Charter may lead to more requests for disclosure of documents, or complaints; and that there may be costs to coroners' offices to maintain information about bereavement support groups.***

88. ***We have amended the Impact Assessment to provide more detail on the costs associated with the Bereavement Organisations Committee. This clarifies that there may be costs to the Ministry of Justice from setting up the committee. There may also be operational costs associated with the committee's functions, including the collation of information and data already held by the organisation each member represents and potentially collation of new data by the committee. We do not expect that collation of existing information will incur significant costs; however, we appreciate that any new undertakings may incur greater costs.***

Conclusion and next steps

1. We plan to print hard copies of the combined Guide and Charter booklet and distribute these in the New Year to all coroner jurisdictions in England and Wales. At this time the document will be published on www.justice.gov.uk/ and go live.

2. The Charter will be available in English, Braille and Welsh.

Consultation Co-ordinator contact details

If you have any comments about the way this consultation was conducted you should contact the Ministry of Justice Consultation Co-ordinator at consultation@justice.gsi.gov.uk.

Alternatively, you may wish to write to the address below:

Consultation Co-ordinator
Legal Policy Team, Legal Directorate
6.37, 6th Floor
102 Petty France
London SW1H 9AJ

The consultation criteria

The seven consultation criteria are as follows:

1. **When to consult** – Formal consultations should take place at a stage where there is scope to influence the policy outcome.

2. **Duration of consultation exercises** – Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.

3. **Clarity of scope and impact** – Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.

4. **Accessibility of consultation exercises** – Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.

5. **The burden of consultation** – Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.

6. **Responsiveness of consultation exercises** – Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

7. **Capacity to consult** – Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

These criteria must be reproduced within all consultation documents.

Annex A – Impact Assessment and Equality Impact Assessment

Annexed separately on Ministry of Justice consultation webpage.

Annex B – List of respondents

Coroners

Andre Rebello OBE – HM Coroner for Liverpool
Andrew Haigh – HM Coroner for South Staffordshire District
Andrew Scott Reid – HM Coroner for Inner North London
Andrew Tweddle – HM Coroner for North and South Districts of Durham
Chris Dorries – HM Coroner for South Yorkshire (West District)
Christopher Johnson – HM Coroner for Merseyside (Wirral District)
David Horsley – HM Coroner for Portsmouth and South East Hampshire
David Masters – Assistant Deputy Coroner for Wiltshire and Swindon
David Ridley – HM Coroner for Wiltshire and Swindon
David Roberts – HM Coroner for North and West Cumbria
Derek Winter – HM Coroner for the City of Sunderland
Dr Elizabeth Carlyon – HM Coroner for Cornwall
Dr James Adeley – HM Coroner for Preston and West Lancashire
Dr Roy Palmer – HM Coroner for Southern District of London
Edward Thomas – HM Coroner for Hertfordshire
Elizabeth Earland – HM Coroner for Exeter and Greater Devon District
Geraint Williams – HM Coroner for County of Worcestershire
Ian Arrow – HM Coroner for Torbay and South Devon
Ian Smith – HM Coroner for Stoke on Trent and North Staffordshire
Jennifer Leeming – HM Coroner for Manchester (West) District
John Ellery – HM Coroner for Mid and North West Shropshire and the Borough of Telford and Wrekin
Mary Hassell – HM Coroner for Cardiff and the Vale Glamorgan District
Michael Oakley – HM Coroner for North Yorkshire (Eastern District)
Michael Rose – HM Coroner for Somersetshire (Western District)
Michael Howells – Assistant Deputy Coroner for Pembrokeshire
Nigel Meadows – HM Coroner for Manchester (City) District
Paul Matthews – A group response from 8 London Coroners
Robin Balmain – HM Coronerfor Black Country District
Tony Brown – HM Coroner for North Northumberland
Veronica Hamilton-Deeley – HM Coroner for County of Brighton and Hove
The Coroners' Society of England and Wales (response submitted by Michael Burgess OBE – HM Coroner for Queen's Household)

Coroners' officers

Adam Trewerne – Kent Police
Catherine Lake – Devon and Cornwall Police
Stephen Hepplestone – West Yorkshire Police Authority
Coroners' Officers and Staff Association

Voluntary organisations

Action Against Medical Accidents (AvMA)
Bereavement Services Association
British Lung Foundation
Cardiac Rick in the Young (CRY)
Child Bereavement Charity
Coroners Courts Support Service
Cruse Bereavement Care
Death After Medical Negligence
Defence Bereaved Families Group
Disaster Action
Epilepsy Bereaved
INQUEST
RoadPeace
SADS UK
Survivors of Bereavement by Suicide
The Foundation for the Study of Infant Deaths

Local authorities

Kent County Council
Local Government Group
London Borough of Croydon and London Local Authority Chiefs' Steering Group (8 London boroughs)
Sheffield City Council

Medical professionals

Calderdale and Huddersfield NHS Foundation Trust
Colchester Hospital University Foundation Trust
Dr Elizabeth Foster - GP
Dr Matthias Hohmann - MacMillan GP
Dr Joanna Bircher - Lockside Medical Centre GP
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Pathologists
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal Liverpool University Hospital (Linda McCartney Centre)
Sunderland Royal Hospital
The Faculty of Forensic and Legal Medicine

Registrars

Buckinghamshire County Council Registration and Coroner's Service
Cambridgeshire County Council Registration and Coroner Services
Dorset Registration Service
East Riding Registration and Celebratory Services
London Borough of Southwark
Plymouth Register Office
Redcar and Cleveland Council Register Office

Solihull Registration Services
Sunderland City Council Bereavement and Registration Services

Police

Association of Chief Police Officers
City of London Police
Police Federation of England and Wales
UK Missing Persons Bureau (National Policing Improvement Agency)

Government organisations

Commission for Victims and Witnesses
Crown Prosecution Service
Department for Education
Human Tissue Authority
Independent Advisory Panel on deaths In Custody
Ministry of Defence
Office of Rail Regulation
Offender Safety Rights and Responsibilities Group (National Offender Management Service)

Lawyers

Association of Personal Injury Lawyers
Birmingham Law Society
Browne Jacobson LLP
Forum of Insurance Lawyers
The Law Society
Thompson Solicitors

Faith groups

Brethren Christian Fellowship
Indian Muslim Welfare Society
Muslim Burial Council of Leicestershire

Hospices/Palliative care

Cumbria and Lancashire End of Life Care Network
Kirkwood Hospice
Milton Keynes Community Health Service (End of Life Care team)
St Luke's Hospice
The National Council for Palliative Care

Individuals

Anthony and Yvonne Brown
Dr J T Lofthouse
Elaine Isaacs
Harvey Ward
Henryk Pycz
Hilary Van de Watering
Lesley Cullen

Michael Brennan
Nicole and Chris Taylor
Phil Walsh
Sandra Dermott
Sandra Strachan
Sylvie Montgomery
Yvonne M Wurtzburg

Other

Aneurin Bevan Community Health Council.
BUPA Care Homes
Independent Police Complaints Commission (IPCC)
Madeleine Moon MP
Press Complaints Commission
Shergroup
The Medical and Dental Defence Union of Scotland
The Newspaper Society
Wales Institute of Forensic Medicine
West of England Child Death Overview Panel
8 Anonymous responses

© Crown copyright
Produced by the Ministry of Justice