Title:	Impact Assessment (IA)
Charter for current coroner services	**IA No:** MOJ116
Lead department or agency: Ministry of Justice	**Date:** 31/10/11
Other departments or agencies:	**Stage:** Final
	Source of intervention: Domestic
	Type of measure: Other
	Contact for enquiries: Elizabeth.Knapp@justice.gsi.gov.uk

Summary: Intervention and Options

What is the problem under consideration? Why is government intervention necessary?

Coroner services are local public services and there is variation in how services operate from area to area, because of differing local demographics and local authorities providing different support. There are inconsistent levels of service across the country, and evidence (meetings with and correspondence from stakeholders over many years) suggests bereaved people and others who come into contact with a coroner service often feel uninformed about how they can participate in a coroner inquiry. We propose to publish a voluntary Charter that would address this by setting out the standards coroners and their staff should meet in order to deliver a good standard of service, and the rights and responsibilities of bereaved people and other coroner service users.

What are the policy objectives and the intended effects?

The Charter aims to standardise the level of service bereaved family members, other properly interested persons and witnesses might expect to receive from a coroner service by setting the benchmark in a single document. It is essential that all coroners and coroners' officers in England and Wales know the standards they should meet, and that bereaved people and other service users know their rights and responsibilities. To enhance this, we propose to publish the Charter along with the MoJ's current 'Guide to coroners and inquests', so people can access information about the inquiry process, and standards of service, within one document. The aim is to make the access to information about the coroner system much more transparent, which would help to improve the experience of bereaved people and others coming into contact with the coroner services.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

This final impact assessment considers 2 options:
(0) Do Nothing.
(1) Publish a national Charter for coroner services in the same document as the MoJ *Guide to coroners and inquests*. Also involves convening a Bereavement Organisations Committee to feed back on the impact of the charter.

The Government considered alternative options in the Impact Assessment at consultation stage, and concluded that its preferred option is Option 1. This means that bereaved people and others coming into contact with a coroner service would be able to obtain information about the coroner inquiry process, their role in it, and the standards they should receive from one accessible information source.

Will the policy be reviewed? It will be reviewed every 3 years.	
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Yes

Ministerial Sign-off For consultation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: Jonathan Djanogly Date: 21/11/11

Summary: Analysis and Evidence

Policy Option 1

Description: Publish a national Charter for current coroner services alongside our 'Guide to coroners and inquests'

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low: n/a	High: n/a	Best Estimate: n/a

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate	n/q		n/q	n/q

Description and scale of key monetised costs by 'main affected groups'

There is expected to be a small annual resource cost for providing MoJ secretariat support to the Bereavement Organisations Committee of less than £10,000 which will be met from within existing MoJ staffing. All other costs are not quantifiable. A quantitative assessment of these costs would require specific data and estimates that are unknown and cannot be estimated with any degree of precision.

Other key non-monetised costs by 'main affected groups'

A minority of coroner offices may face costs in adapting to the voluntary standards set out in the charter. There would be minor costs for coroners who chose to compile a list of local bereavement organisations for the charter. There would be a minor cost to MoJ to publish the combined document. There would be minor costs to members of the Bereavement Organisations Committee associated with attendance at meetings, carrying out committee work and providing information for committee research.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low				
High				
Best Estimate	n/q		n/q	n/q

Description and scale of key monetised benefits by 'main affected groups'

Benefits are not quantifiable. A quantitative assessment would require specific data and estimates that are unknown and cannot be estimated with any degree of precision, for example the number and extent to which bereaved people and others will benefit from the charter.

Other key non-monetised benefits by 'main affected groups'

Bereaved people and other service users would find it easier to understand their rights, responsibilities and the timelines involved in the coroner inquiry process. The Charter may help to standardise coroner practice, by setting out national standards. Coroners will benefit from more certainty over what standards are expected. Coroners would be able to devote fewer resources to informing people about how the system works. Society may also benefit from increased transparency from the Charter's setting out standards..

Key assumptions/sensitivities/risks **Discount rate (%)**

The Charter is voluntary and the exact behavioural changes it may lead to are unknown but it is anticipated that performance improvements and greater consistency will result.

It is assumed there will be minimal additional costs on coroners and the voluntary sector. To the extent that coroners or the voluntary sector face additional costs, these are likely to be at least partially offset by benefits to bereaved and other individuals. It is assumed that the Charter would be easily accessible to bereaved people and others. It is assumed there will be no significant change in the number of appeals and complaints. There are risks that some people who need it may not be able to access the Charter.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure qualifies as
Costs: n/q	**Benefits:** n/q	**Net:** n/q	No	n/q

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?			England & Wales		
From what date will the policy be implemented?			Spring 2012		
Which organisation(s) will enforce the policy?			MoJ, coroners' offices and local authorities, Bereavement Organisations Committee		
What is the annual change in enforcement cost (£m)?			n/q		
Does enforcement comply with Hampton principles?			Yes		
Does implementation go beyond minimum EU requirements?			No		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** n/q	**Non-traded:** n/q	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			**Costs:**	**Benefits:**	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	**Micro**	**< 20**	**Small**	**Medium**	**Large**
Are any of these organisations exempt?	n/a	n/a	n/a	n/a	n/a

Specific Impact Tests: Checklist

Does your policy option/proposal have an impact on…?	**Impact**	**Page ref within IA**
Statutory equality duties[1]	No	15
Economic impacts		
Competition	No	15
Small firms	No	15
Environmental impacts		
Greenhouse gas assessment	No	15
Wider environmental issues	No	15
Social impacts		
Health and well-being	No	15
Human rights	No	15
Justice system	No	16
Rural proofing	No	16
Sustainable development	No	16

[1] Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Evidence Base (for summary sheets) – Notes

References

No.	Legislation or publication
1	Draft Charter for bereaved people who come into contact with a reformed coroner system January 2009 www.justice.gov.uk/publications/charter-bereaved.htm
2	Guide to Coroners and Inquests www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDoAfterADeath/DG_066713
3	Consultation on the draft Charter for current coroner services May 2011 www.justice.gov.uk/consultations/cp52011.htm

Evidence Base (for summary sheets)

1. Introduction

1.1. This Impact Assessment (IA) is a final IA. It considers the costs and benefits of implementing a national Charter for the current coroner services that will allow users to be aware of the standards of performance they can expect from local coroner services, and their rights of redress if those standards are not met.

1.2. The Charter applies to all service users, which include bereaved family members, witnesses, and other properly interested persons, as defined by Rule 20 of the Coroners Rules 1984. It explains what can be expected at each stage of the coroner's inquiry. It also sets out the rights and responsibilities of the coroner's office and users of a coroner service.

1.3. The IA examines the impacts of Option (0): Doing nothing; and Option (1) Publishing a national Charter for current coroner services alongside the Guide to coroners and inquests. Option 1 is the preferred option.

Background

Coroners

1.4. The operation of the coronial system in England and Wales is governed by the Coroners Act 1988 and the Coroners Rules 1984 (as amended). The core purpose of the coroner system is to establish the identity of the deceased person and how, where, when and - in some cases – in what circumstances they died. A coroner is an independent judicial office holder, appointed and paid by the relevant local authority. Coroners' officers are mostly employed by the local police authority but may be employed by the local authority. Coroners inquire into violent or unnatural deaths, sudden deaths of unknown cause, and deaths which have occurred in prison or police custody. A coroner's authority to inquire flows from the report of a body being within the coroner's district (and not from where the death occurred). In 2010 over 230,000 deaths were referred to coroners, representing just under half of all deaths (47%)[1]. Of these 44% involved a post mortem examination and 13% an inquest.

1.5. The role of a coroner, when a death is reported to him/her, is:

- to establish whether a coroner's inquest is required;
- if so, to establish the identity of the person who has died, and how, when, and where the person came by their death;
- to assist in the prevention of future deaths; and
- to provide public reassurance

1.6. After an inquest the coroner sends the necessary details to the Registrar of Births and Deaths for the death to be registered if it occurred in England and Wales. An inquest is not permitted to determine or appear to determine criminal liability by a named person or civil liability. It is about what happened, not who was responsible for what happened, for which the civil and criminal courts have jurisdiction.

1.7. The Ministry of Justice's 'Guide to coroners and inquests'[2] sets out the role of a coroner and outlines the coroner inquiry process.

The Charter

1.8. A draft Charter for bereaved people who come into contact with coroner services in England and Wales was first published for consultation alongside the draft Coroners Bill in 2006. The Government consulted on the Charter again in summer 2008, and a subsequent draft was published in January 2009, alongside the Parliamentary introduction of the Coroners and Justice Bill. The Bill became the Coroners and Justice Act 2009 in November of that year. It was intended for the Charter to be statutory guidance under the Act and come into effect when the Act was implemented.

[1] www.justice.gov.uk/publications/statistics-and-data/coroners-and-burials/deaths.htm

[2] www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDoAfterADeath/DG_066713

1.9. In the past, the Charter was limited to bereaved people. However in response to the comments we received to the 2010 consultation on the coroner system,[3] the scope of the Charter was extended to include all properly interested persons and witnesses. In this way we aimed to ensure that everyone involved in an inquiry receives the same standard of service. With this objective in mind we held discussions with some of our civil society stakeholders as well as coroners, their officers and local authorities in January 2011, to establish how we could best take forward the Charter. We produced a new draft of the Charter and consulted on this between May and September 2011[4].

Problem under consideration

1.10. In 2003 the Shipman Inquiry and the Fundamental Review of Death Certification and Investigation found a number of problems with the current coroner inquiry system. These included an inconsistent level of service provided to bereaved people, and lack of involvement of family and friends in coroner inquiries. They found that the needs and expectations of the bereaved were sometimes not given the consideration they deserve. Our 2011 consultation on the draft Charter indicated that bereaved people and the organisations that support them supported the Charter, although some expressed disappointment that we were issuing a Charter for the current coroner system rather than for a reformed system (as previous draft Charters had been for).

1.11. The Charter will address the problems as detailed below:

- **Inconsistency of service**

  Stakeholders have advised MoJ in meetings and correspondence that there is inconsistency in the way coroner services are delivered as coroners have no published national standards of service. While many coroner jurisdictions are likely to already meet the standards set out in the Charter, others jurisdictions may fail to do so, which may be because they are not fully aware of them (although MoJ has facilitates some training for coroners in order to raise performance levels across the country). As a result, the level of service received by service users is likely dependent on which coroner district is responsible for investigating a death, leading to accusations of a 'postcode lottery'.

- **Low involvement of families**

  The Shipman Inquiry and the Fundamental Review of Death Certification found that some bereaved people felt excluded from the coroners' process. At present bereaved people and other users of coroner services can be confused about what to expect from the coroner inquiry process and unclear about what options they have if they are dissatisfied with the level of service received. This can cause unnecessary concern and distress, especially for bereaved people who are not supported by national bereavement organisations,.

  Bereaved people have also reported being confused about the inquiry process in general and the stages a coroner must go through before an inquiry concludes. Currently, families and other properly interested persons are sometimes not regularly kept updated on the progress of a coroner inquiry or made aware of reasons for any delay. An inquiry may legitimately take longer than average but if bereaved people and others with an interest are not advised of this they have the inaccurate perception of an unnecessary delay or inaction by the coroner or coroner's officers.

- **Inconsistent disclosure of information**

  There is little guidance currently on how bereaved people and others involved in a coroner inquiry may access documents and information used in the inquiry. The current lack of clear guidance for the disclosure of documents has led to inconsistency in making information available to the bereaved families. There is uncertainty for coroners about what they should and should not disclose, and for interested persons about what they may expect to receive. This can lead to inconsistent access to documents and misunderstandings. The Fundamental Review of Death Certification found that some bereaved people were dissatisfied with the level of information provided by coroners, for

[3] www.justice.gov.uk/consultations/docs/reform-of-coroner-system.pdf

[4] www.justice.gov.uk/consultations/cp52011.htm

example the lack of notification in advance of inquests and the lack of explanation around what happens in an inquest.

- **Lack of awareness of how to give feedback or complain**

  Bereaved people and other interested persons are currently often not aware of their right to complain about a coroner's conduct, or the level of service they have received, or to challenge a coroner's decision. There is also inconsistency in the way in which each coroner's office deals with complaints.

- **Poor understanding of post-mortem examinations**

  Currently, bereaved people are not always informed about why a post-mortem examination is necessary. There is also sometimes a lack of clarity as to when a deceased person's body should be released from the coroner's custody to the family, to enable a funeral to take place.

- **Insufficient support from bereavement services**

  Currently, bereaved people and witnesses are not always aware of where they can go for the bereavement support they need. While some coroner offices keep a list of national and local bereavement services, not all coroner offices do, leading to inconsistency of support.

Economic Rationale

1.12. The conventional economic approach to government intervention to resolve a problem is based on efficiency or equity arguments. The Government may consider intervening if there are strong enough failures in the way markets operate (e.g. monopolies overcharging consumers) or if there are strong enough failures in existing government interventions (e.g. waste generated by misdirected rules). In both cases the proposed new intervention itself should avoid creating a further set of disproportionate costs and distortions. The Government may also intervene for equity (fairness) and redistributional reasons (e.g. to reallocate goods and services to the more needy groups in society).

1.13. Intervention in this case would be justified primarily on efficiency grounds. The Charter will mean that everyone has access to the same information which will reduce the search costs that bereaved people and others accessing coroner and bereavement services face. It will also result in increased efficiency as National Standards will result in greater clarity, and certainty, for coroners about what is expected from them, and therefore reduce any costs they currently incur in assessing their obligations.

1.14. In addition, society might consider that the Charter will introduce greater fairness by setting out guidelines around minimum standards of practice and providing greater transparency about the coroner system.

Policy objective

1.15. The MoJ already publishes a 'Guide to Coroners and Inquests'[5]. This explains the role of a coroner, and the process and people involved in a coroner inquiry.

1.16. The Charter will be complementary to the Guide. The aims of publishing the Charter are to improve the transparency of coroner services, and bereaved people and other service users' experience of it. We aim to do this by:

- Publishing the standards of service that all coroners in England and Wales should already be meeting in order to provide a good service. These standards are based on generally accepted standards of behaviour and what is accepted as good practice within the industry. They are also based on requirements in the Coroners Act 1988 and Coroners Rules 1984 (as amended). The Charter will clarify for coroners, their officers and other staff, and local authorities across the country, the standards they should already be providing
- Improving service users' knowledge of how the coroner inquiry process works, and what they can expect;
- Ensuring bereaved people and other service users know what role they can play, and what information and support they can expect to receive, throughout the inquiry process;
- Setting out for bereaved people and other service users what they can do if they feel the standards set out in the Charter are not met.
- Making monitoring of the standards of service (by the Bereavement Organisations Committee) easier by setting out what those standards are.

Policy Proposals

1.17. The Impact Assessment which accompanied the consultation contained 3 options.

- Option 0: Do nothing;
- Option 1: Publish a national Charter for current coroner services alongside our 'Guide to coroners and inquests'.
- Option 2: Publish a national Charter for current coroner services in isolation from our 'Guide to coroners and inquests'.

1.18. The final proposal is to proceed with Option 1. The majority of consultation responses supported this. Furthermore, it will be more efficient for those that come into contact with coronial services to have access to both the Guide and the Charter within one booklet as the two documents are complementary. The Guide is a step by step walkthrough of the process, outlining the role of the coroner and similar areas. The Charter will focus on specifying service standards. The overlap is minimal.

1.19. The Charter document will be a result of public consultation. The aim of the Charter is to set out national standards for the following aspects of a coroner's inquiry.

- Responsibilities of the coroner's office - The Charter will set out the standards of good practice expected from coroners and their staff. For instance, it will state that they must: keep people affected by the inquiry informed about progress; consult them where appropriate; treat them with respect; and take account (where possible) of their religious and cultural needs.
- What happens when a death is reported – The Charter will set out a good practice requirement for the coroner's office to contact the next of kin within one working day and explain why the death has been reported and what the next steps would be. The coroner's office will also need to provide information, where possible, on where the body can be viewed.

[5] www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDoAfterADeath/DG_066713

- Post-mortem examinations – The Charter will set out that the next of kin, wherever possible, should be informed about the purpose and outcome of post-mortem examinations and say to whom families can raise concerns about conducting a post mortem. It will also expressly state that post-mortem reports can be made available to the families but a fee may have to be payable.

- Keeping in touch – The Charter will set out that the next of kin should be kept updated about the progress of the inquiry once every three months, unless they do not wish for this. It will also signpost a flow chart that explains the coronial process, which will clarify all the stages that follow once a death has been reported to a coroner.

- Providing information about inquests – The Charter will set out that the coroner's office should provide the relevant information about the timing and location of the inquest before it starts, taking into account the views of family and other interested persons. It will also explain the position on disclosure of documents and providing waiting facilities (if possible) for bereaved family members and other interested persons.

- Other rights to participation – The Charter will clarify what an interested person can expect if a case is transferred to another jurisdiction; when a body can be released; and when tissues and organs can be retained for additional examinations.

- What happens when a death occurs abroad – The Charter will explain what someone can expect from a coroner service if a death occurs abroad.

- Responsibilities of bereaved people and other interested persons – The Charter will clearly state what the coroner's office can expect from bereaved people and other interested persons, such as providing information promptly, keeping the coroner's office updated about change of contact details, etc.

- Availability of support and bereavement services – The Charter will set out a good practice requirement for coroner offices to have a list of local bereavement organisations which can be made available to bereaved families and other interested persons.

- Assessing service standards – As part of wider reforms to the coroner system a Bereavement Organisations Committee (BOC) will have the specific remit of feeding back the impact that the Charter has had on coroner services to the relevant Minister within the Ministry of Justice.

- Dissatisfaction - The Charter will also set out how to:

    - Challenge a coroner's decision or the outcome of an inquest
    - Complain about coroner conduct
    - Complain about standards of service
    - Give feedback on the service

Affected stakeholder groups, organisations and sectors

1.20. The proposals are likely to affect the following sectors and groups in England and Wales:

- Bereaved people and other properly interested persons;
- Coroners and coroners' officers and other staff, including local authorities who fund coroners and police authorities who employ most coroners' officers;
- Bereavement services and support organisations, and other organisations working with and supporting bereaved people, including faith groups;
- Ministry of Justice; and
- Office for Judicial Complaints, local authorities and the Local Government Ombudsman.

2. Costs and Benefits

2.1. This Impact Assessment identifies both monetised and non-monetised impacts on individuals, groups and businesses in the UK, with the aim of understanding what the overall impact to society might be from implementing these options. The costs and benefits of each option are compared to the do nothing option. Impact Assessments place a strong emphasis on valuing the costs and benefits in monetary terms (including estimating the value of goods and services that are not traded). However there are important aspects that cannot sensibly be monetised. These might include how the proposal impacts differently on particular groups of society or changes in equity and fairness, either positive or negative.

2.2. This final IA covers one proposal which has been compared with the base case (Option 0). The base case for this IA has been assumed to be "do nothing".

2.3. A qualitative assessment is provided here for all benefits and most of the costs as the aggregate impacts could not be quantified. A quantitative assessment would require specific data and estimates that are unknown and cannot be estimated with any degree of precision. For example, to quantify the potential cost to coroners of the standards set out in the Charter would require specific data on the number of coroners that are not currently meeting the standards set out in the Charter, the number of coroners that would be likely to increase or decrease their service levels as a result of the charter, how the service would change and cost to coroners of changing their service levels.

2.4. This Impact Assessment therefore provides some qualitative information that has informed this Impact Assessment. The information is mainly drawn from consultation responses .

Option 0 – Do Nothing (base case)

2.5. HM Treasury's Green Book Guidance requires that all options are assessed relative to a common "base case". The base case for this IA has been assumed to be "do nothing", which in this case means not publishing the Charter and only updating the existing 'Guide to coroners and inquests', as and when this is needed.

2.6. The current lack of clear national guidance on what to expect from coroners' services has led to an inconsistency of the provision of services to bereaved people and other interested persons. This in turn promotes a variation in the level of expectations that users of services have between local areas. If we do nothing the existing problems in the system identified above will remain.

2.7. Because the do-nothing option is compared against itself its costs and benefits are necessarily zero, as is its Net Present Value.

Option 1 – Publish a national Charter for current coroner services alongside our 'Guide to coroners and inquests'

Description

2.8. Option 1 is to publish a voluntary national Charter for current coroner services in a combined booklet with the Ministry of Justice 'Guide to coroners and inquests'. The combined document will provide national guidance for coroners, their officers and other staff as to the minimum standards bereaved people and other service users might expect from them. It will also set out for bereaved people and other interested persons what they may do if something goes wrong. Further details about what the Charter will contain are provided in the introduction section above. The combined document will be updated as and when it is needed. After the first publication, the current Guide will have to be disposed of and replaced with the combined document containing the Charter and Guide.

2.9. The Ministry of Justice plans to publish the Charter and Guide both online and in hard copy. Hard copies will be sent to coroner offices (as the Guide is now), and we anticipate that the cost of printing this would be borne by the Ministry of Justice. The Charter will set out the standards the coroners and their officers and staff should meet in order to provide a good service. It will introduce no new sanctions for coroners who fail to meet quality standards. Compliance with the Charter is voluntary and the language in the Charter will make this clear.

2.10. It is also proposed that a Bereavement Organisations Committee will be established with the remit of monitoring and feeding back the impact that the Charter has had on coroner services.

Costs of option 1

2.11. There may be one-off adjustment costs for all affected parties in terms of the time it would take to read the Charter to clarify the standards of service coroners should provide. These costs are not expected to be significant.

Costs to coroners, coroners' officers and other associated staff

2.12. There may be costs to coroners that currently do not meet the service standards that will be set out in the Charter if such coroners choose to change their services and processes as a result of publication of the Charter. In response to the 2011 consultation some coroners indicated that 'increased expectations' would lead to additional costs to them, for example giving people at least four weeks' notice of an inquest and providing a private waiting room. In other cases coroners indicated that they would not be able to meet the Charter's standards. It is assumed that the majority of coroners currently meet the Charter's standards, and only a small minority of coroners' officers will choose to change their services and processes as a result of the Charter. Ongoing costs would be incurred where a service is expected to change permanently to comply with the standards. These costs would reflect as benefits to individuals using coroners' services, as well as a possible reduction in dissatisfaction with the service and complaints. Any coroners that chose to continue with their current standards would not incur additional costs, although they could incur some additional costs if they receive more complaints as a result.

2.13. The Charter will ensure that those coming into contact with a coroner service are made aware of, and able to access, the relevant complaints procedure. It is possible that this could lead to increased costs to coroners if there is an increase in complaints about coroners' services or an increase in the number of judicial reviews. We have assumed any increase in complaints will be minimal. One local government consultation response highlighted concern that there would be an increase in complaints and an associated increased burden in dealing with them. However no cost estimate was provided. Similarly one coroner was concerned that dealing with complaints may delay inquests.

2.14. By setting out what information bereaved and other persons are able to access from coroners, the Charter may also increase the number of requests for information that coroners receive, for example requests for post mortem reports. Some coroner and local authority consultation responses said that there might be an increase in such information requests. Any cost associated with an increase in information requests may be partially offset by fee income if coroners' offices were able to charge for the provision of such reports. No consultation response gave an indication of what (if any) additional costs might be incurred. We have assumed that any additional costs will be minimal.

2.15. There may be a one-off cost associated with compiling a list of local organisations providing support and bereavement services. It is assumed that many jurisdictions already have such lists. For those that do not have and choose to compile one, it is assumed that this would not be a long process and costs would be minimal. Once the list has been made, there will be minimal costs in updating it when necessary. There may be a small cost impact on coroner offices, both in terms of time taken to copy documents and distribute them, and in terms of physical resources such as copiers, paper and postage.

2.16. There may be additional costs to associated staff and other professions that work closely with coroners in doing inquiries. These would be associated with familiarisation, and where necessary, working with coroners in meeting the standards. One coroner response suggested that the earlier impact assessment had not considered the impact of the Charter on the police or pathologists. However no details of an impact were given, and we expect any such impact to be marginal.

Costs to bereavement services organisations

2.17. A response from an organisation expressed the view that it is possible that the Charter's proposal for coroners' offices to hold details of local and national bereavement support groups, may increase the burden on those groups and organisations if there is an increase in the

number of people that access their services. Any such costs are likely to be at least partially reflected as benefits to bereaved individuals.

2.18. Organisations represented on the Bereavement Organisations Committee might face some small additional costs associated with attendance and preparation for meetings, for example costs associated with carrying out committee work, providing information for committee research and travel costs. It is expected that committee work and research will largely draw off existing information and data held by committee member organisations; any new undertakings would result in higher costs. Two organisations and a coroner expressed concerned that there would be a cost to organisations represented on the Bereavement Organisations Committee (but no costs were given).

Costs to bereaved people and service users

2.19. Individuals using coroners' services in future will become more aware of the complaints and appeals procedures, as described above. If service users decide to make more complaints as a result of this they may incur costs associated with making complaints and potentially going through an appeals process. However, the benefits to service users associated with succeeding in making complaints and appeals are expected to outweigh the costs of going through the process.

Costs to Ministry of Justice

2.20. There may be associated costs to MoJ from setting up a Bereavement Organisations Committee with the remit of feeding back the impact that the Charter has had on coroner services. This will have some associated costs such as MoJ secretariat costs. It is assumed these would be low, taking up a portion of one staff member's time at an annual resource cost of around £8,000 which would be met from within existing MoJ staffing. Depending on the committee's work, there may also be some other additional resource costs to MoJ, for example costs associated with assisting the committee collate existing information and data. It is expected that these costs will not be significant and will be met from within existing MoJ staffing.

2.21. There will be minor additional costs for MoJ associated with printing the combined Charter and Guide (as opposed to just the Guide as at present). The combined document will need to be reprinted every time either the Charter or Guide is updated.

2.22. It is possible that greater awareness of the option to apply for judicial review of coroners' decisions could lead to an increase in such judicial reviews and thereby an increase in MoJ court and legal aid costs. Legal aid is available for most public law challenges. Two consultation responses highlighted concern that there would be an increase in complaints.

Costs to the Office for Judicial Complaints, local authorities and the Local Government Ombudsman

2.23. There may be an increase in complaints about coroners' services to the Office for Judicial Complaints, directly to the local authority, or to the Local Government Ombudsman. This is because the Charter will ensure that those coming into contact with coroner services are made aware of, and able to access, the relevant complaints procedure. One local government consultation response highlighted concern that there would be an increase in complaints and an associated increased burden in dealing with them. However no cost estimate was provided.

Costs to Society

2.24. There are no expected additional costs to society.

Benefits of Option 1

Benefits to Coroners, coroners' officers and other associated staff

2.25. The Charter will give coroners (funded by local authorities) and coroners' officers (mostly employed by police authorities) clear guidance on the standards of service they should provide. This may raise efficiency benefits in offices where currently coroners are unclear or uncertain of what the service standard should be. For example, the Charter should reduce the time and effort that may currently be required to explain the inquiry process and the service that bereaved people and other service users should expect. All coroners will benefit from knowing whether their current service meets acceptable standards.

2.26. We understand anecdotally that a handful of coroner jurisdictions already have local charters (but we do not collect statistics on this). These offices would benefit from no longer needing to produce these charters.

2.27. If there is an increase in the number of requests for reports as a result of the charter, this may generate additional fee income for coroners where they are able to charge for the reports (i.e. after an inquest). This would help offset some of the costs associated with the provision of the information. As indicated above, a handful of consultation responses from coroners suggested there may be additional requests for information as a result of the Charter, but did not cost this impact.

Benefits to bereaved people and other service users

2.28. Bereaved people and other service users will benefit from improved information, and more transparent coroner services. They will become more aware of what to expect from a coroner's office throughout an inquiry, and the level of service they should receive. The Charter's flow chart will also help them understand which stage they are currently at. They will also benefit from being made aware of their own rights and responsibilities.

2.29. The Charter setting out national standards will result in higher efficiency as the information will become centralised and more accessible, therefore reducing the costs of acquiring information about service levels. This may lead to more informed decision making from individuals in relation to complaints and appeals.

2.30. Bereaved people and others involved in a coroner inquiry that currently receive below-the-standard services would benefit from an improved service if in future, such coroners, provide services that meet the set standards. Service users would also benefit from more easily seeing how they can complain or appeal if they are dissatisfied with any aspect of the service they have received.

2.31. Bereaved individuals in areas where such information is not currently available will benefit from a list of support organisations, as they may be given contact details of their local bereavement organisations, and therefore be able to more easily obtain further support if necessary.

2.32. The establishment of the Bereavement Organisations Committee will ensure that representatives of the bereaved, whom the Charter is likely to impact most, will be actively involved in assessing its impact and feeding into the continuous improvement of services.

Benefits to bereavement services organisations

2.33. Voluntary bereavement support organisations will benefit as they will be able to access those bereaved people they wish to support.

Benefits to society and wider economy

2.34. There will be wider benefits in the economy from increased efficiency associated with increased transparency and therefore reduced search costs, which will lead to resources being freed up and used more productively elsewhere in the economy.

2.35. There will be increased benefits to society if society perceives that the Charter will provide a more just service from coroners and the future complaints and appeals system improves equality.

Risks and Assumptions

2.36. As compliance with the Charter is voluntary and it is assumed that the majority of coroners currently meet the Charters' standards, it is assumed that any adjustment costs incurred by coroners are minimal. While the actual effect of the Charter on the behaviour of coroners is unknown, any additional costs to coroners are likely to be at least partially reflected as benefits to bereaved and other individuals. The consultation IA also suggested that there was a risk that with the publication of the Charter some coroners that currently meet or exceed the defined standards may lower their current standards. This would represent a cost to bereaved individuals and other interested parties that deal with those coroners but a benefit to coroners. As coroner responses to the consultation argued strongly that this would not be the case, we have not included it as a possible impact above.

2.37. It has been assumed that there will be not be a significant increase in the number of complaints, appeals or requests for information as a result of the processes for each of these becoming clearer with the publication of the Charter.

2.38. It has been assumed that there will be minimal impacts on the voluntary sector arising from the provision in the Charter that coroners' offices maintain a list of bereavement organisations. Any additional costs to the voluntary sector are likely to be at least partially reflected as benefits to bereaved individuals.

2.39. It has been assumed that the additional printing and distribution costs to MoJ associated with printing the combined Charter and Guide will be minimal.

2.40. There is a risk that the Charter might not be easily accessible to bereaved people and others who might benefit from it.

3. One-In One-Out

3.1. Compliance with the Charter is voluntary and not a regulatory proposal, therefore the proposal presented in this IA is not within the scope of One-In One-Out.

4. Enforcement and Implementation

4.1. The Ministry of Justice is preparing to set up the Bereavement Organisations Committee to assess the impact of the Charter. We anticipate that the Committee's assessment of coroner standards will be based on an analysis of complaints and feedback information that the Committee receives. Further details will be available on the Justice website when the Committee is convened.

5. Specific Impact Tests

Statutory equality duties - gender, disability and race equality

5.1. The draft Ministry of Justice Equality Impact Assessment, which is attached at Annex 2, covers these three areas.

Competition Assessment

5.2. In our view the Charter on which we are consulting will have no direct impact on business or competition between businesses. This is because it will not:

- Directly limit the number or range of suppliers (or providers)
- Indirectly limit the number or range of suppliers (e.g. by altering demand)
- Limit the ability of suppliers to compete
- Limit suppliers' incentives to compete vigorously

Small Firms Impact Test

5.3. The coroner system has limited interactions with three groups of small firms - funeral directors, pathologists and body removers. We anticipate that our proposal to publish a national Charter will not affect the nature or quantity of those interactions and so would have no impact on small businesses.

Carbon Assessment

5.4. The Charter will not lead to change in the emission of Greenhouse Gases

5.5. We anticipate no impact of the policy on carbon emissions. This is because there will be no changes in energy use or travel; and no new buildings (or demolishing of buildings).

Other Environment

5.6. We anticipate no environmental impacts. This is because the Charter will have no effect on climate change in terms of waste management, air quality, material change to the appearance of the landscape or townscape, water pollution, habitat or wildlife, or exposure to noise.

Health Impact Assessment

5.7. We believe there is no health impact, for the following reasons:

- The Charter will have no significant impact on the following wider determinants of health: Income; crime; environment; transport; housing; education; employment; agriculture; social cohesion.
- There will be no significant impact on any of the following lifestyle related variables: Physical activity; diet; smoking, drugs or alcohol use; sexual behaviour; accidents and stress at home or work.
- It will not lead to any new demand on the following health and social care services: Primary care; community services; hospital care; need for medicines; accident or emergency attendances; social services; health protection and preparedness response.

Human Rights Impact Assessment

5.8. We do not anticipate any impact.

Legal Aid and Justice Impact Test

5.9. We anticipate no impact on legal aid or the justice system.

Rural Proofing

5.10. We do not anticipate any specific impact on rural circumstances and needs arising from our proposal to publish the Charter. This is because:

- It will not affect the availability of public and private services; result in closures or centralisation; or have a disproportionate effect in rural areas (where services are already more limited)
- It will not affect travel needs or the ease/cost of travel; and the impact will not be different in sparsely populated or remote rural areas where, typically, journey times are longer, public transport is poor, and alternative travel options are limited or expensive, especially for low income groups.
- It will not target disadvantaged people or places.

5.11. MoJ plans to publish the Charter online. There may be an impact on rural areas where broadband quality may be poorer. However MoJ also plans to publish hard copies of the Charter which it would dispatch to coroner offices free of charge (as it does with the current 'Guide to coroners and inquests'). This will mitigate the impact of possible poor broadband quality in rural areas.

Sustainable Development

5.12. The Government has committed to five principles of sustainable development:

- Living within environmental limits;
- Ensuring a strong, healthy and just society;
- Achieving a sustainable economy;
- Promoting good governance;
- Using sound science responsibly.

5.13. Publishing the Charter will contribute to ensuring a strong, healthy and just society; and promoting good governance. This is because it would increase transparency of the coroner system by setting out the standards coroners should be meeting in a way that is easily accessible to those who use a coroner service.

Privacy Impact Test (an MoJ Specific Impact Test)

5.14. We believe a privacy impact assessment is not required.

Equalities Impact Assessment (EIA)

5.15. This is attached at annex 2.

Annex 1: Post Implementation Review (PIR) Plan

Basis of the review: The Ministry of Justice aims to update the Charter when provisions in the Coroners and Justice Act 2009 are implemented in around 2 years' time. We will review the impact of the Charter after it is implemented.
Review objective: The objective of the review would be to identify change in the standards for provision of coroners' services following the publication of the Charter for bereaved people and other interested persons who have come into contact with a coroner service. It would aim to identify whether the national standards are being met in all jurisdictions.
Review approach and rationale: We will conduct an Implementation Review. This would focus on the impact of publishing the Charter, and whether publishing it has led to any difficulties. Most importantly, it will try to identify if there has been an improvement in the system. In carrying out this review, views will be obtained from stakeholders. These would include coroners, coroners' officers, local authorities, voluntary organisations. The Bereavement Organisations Committee, whose remit will be to assess how coroners are meeting the Charter's standards, will contribute to this work.
Baseline: Where possible, we would measure future change against the current system, or provide a qualitative assessment.
Success criteria: A reduction in the number of coroners' services that provide services below the standards set out in the Charter. Bereaved people and other users or coroners' services have a better understanding of the coroners' process and are more satisfied with the level of service they are receiving.
Monitoring information arrangements: Where possible, we will obtain feedback from stakeholders, through meetings and correspondence to see what impact the Charter has had and would feed this into the Bereavement Organisations Committee, given its specific remit of monitoring and feeding back the impact that the Charter has had on coroner services to the Minister.
Reasons for not planning a review: