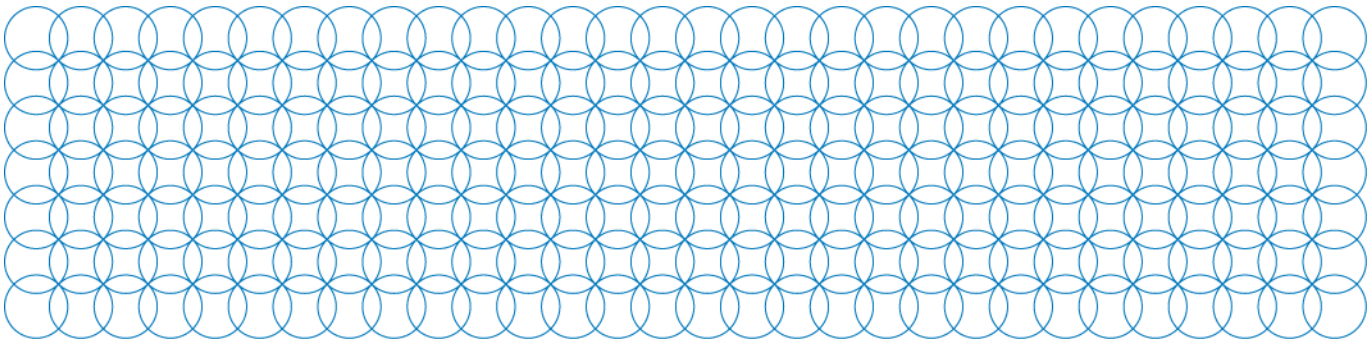
Ministry of JUSTICE

The draft Charter for the current coroner service

Consultation Paper CP 5/2011

This consultation begins on 19 May 2011

This consultation ends on 5 September 2011



Ministry of JUSTICE

The draft Charter for the current coroner service

A consultation produced by the Ministry of Justice. It is available on the Justice website at www.justice.gov.uk

About this consultation

To:	Coroners and those who work within and who fund the system, 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 4.38) 102 Petty France London SW1H 9AJ Tel: 020 3334 6403 Fax: 020 3334 2233 Email: hazra.khanom@justice.gsi.gov.uk
How to respond:	Please send your response by 5 September 2011 to: Hazra Khanom Ministry of Justice Access to Justice Justice Policy Group 4th Floor (post point 4.38) 102 Petty France London SW1H 9AJ Tel: 020 3334 6403 Fax: 020 3334 2233 Email: coroners@justice.gsi.gov.uk
Response paper:	A response to this consultation exercise is due to be published by 5 December 2011 at: http://www.justice.gov.uk. We aim to publish the final version of the Charter on the website at the same time.

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Foreword

I am very pleased to launch this public consultation on a Charter for the current coroner service in England and Wales.

The Government is committed to improving the coroner system, by addressing inconsistencies and inefficiencies in the delivery of services to bereaved people, witnesses and others who come into contact with the system. We propose to do this by creating national standards that allow for the local management and delivery of the coroner service. It is also vital that we set out those standards in an accessible and user-friendly way.

The Charter is a very important mechanism for achieving this. It will set out the standards that those who come into contact with the coroner service can expect to receive from coroners, their officers and other staff. This is an important step in ensuring that everyone knows what to expect and receives the same standard of service.

I appreciate how distressing a coroner's investigation can be for those who are involved with and affected by it. I therefore hope that the Charter will improve what can be a bewildering process, by making the standards of service clearer. The Charter will also set out what someone can do if they are not happy with the service they receive. Furthermore, by incorporating the Charter with our current *Guide to Coroners and Inquests*, we hope we can give people all the information they need about a coroner's investigation in one, easy-to-read document.

I am grateful for all the input we have received on the Charter's content so far, as this has been invaluable to the drafting of this version.

I hope that you will comment on the draft Charter. Your input will be crucial in helping us to improve the experience of all those who come into contact with the coroner service.

Jonathan Djanogly

Parliamentary Under Secretary of State for Justice

Introduction

This consultation paper sets out the draft Charter for the current coroner service in England and Wales (**Annex A**). This consultation is conducted in line with the Code of Practice on Consultations and falls within the scope of the Code. The consultation criteria, which are set out on page 13, have been followed.

An Impact Assessment, including an Equality Impact Assessment, has been completed and indicates that no specific groups are likely to be particularly affected. The Impact Assessment also indicates that no additional costs are likely to be imposed on coroners or the local authorities that fund them. The Impact Assessment is at **Annex B** and we welcome comments on this.

The consultation is aimed at all those with an interest in the coroner system in England and Wales.

A list of organisations which have been sent a copy of this consultation paper can be found at **Annex C**. However, this list is not meant to be exhaustive or exclusive, and we welcome responses from anyone with an interest in or views on the subject covered by this paper.

Introduction to the draft Charter for the current coroner service

Aim and Scope of the draft Charter

1 The Charter is intended to help those who come into contact with the current coroner system by setting out the service standards that bereaved people, witnesses and others should expect to receive. The Charter also sets out how people might complain if that public service is not delivered.

2 The Charter applies to the coroner service as it currently operates under the Coroners Act 1988 and the Coroners Rules 1984 (as amended).

3 We will update the Guide and Charter as and when there are changes to coroner legislation and policy.

Background

4 The current legislation governing the role of the coroner and the conduct of inquests is contained in the Coroners Act 1988 and the Coroners Rules 1984 (as amended).

Background – Charter for the Bereaved

5 A draft *Charter for bereaved people who come into contact with the coroner service in England and Wales* was first published for consultation alongside the draft Coroners Bill in 2006. The most recent consultation on the Charter was 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.

Background – 2010 policy consultation

6 In spring 2010 the previous Government consulted on aspects of policy to inform the drafting of secondary legislation to underpin the Coroners and Justice Act 2009. The consultation sought views on nine policy areas:

- the specific types of deaths which should be reported to coroners for investigation;
- the criteria and financial arrangements for transferring cases from one coroner to another;
- post-mortem examinations;
- the application of coroner powers of entry, search and seizure;
- coroners' disclosure of relevant documents;
- the conduct of inquests;

- the proposed new appeals and complaints systems;
- the training of coroners, their officers and other support staff; and
- Short Death Certificates.

Background – Policy developments since 2010

7 On 14 October 2010 the new Government announced its plans for changes to the coroner system in England and Wales, putting forward proposals to improve the system and address current inconsistencies and inefficiencies in the way the coroner service is delivered.

8 The Government announced that, due to the current economic climate, it could not go ahead with plans to implement national leadership from a Chief Coroner or have an appeals system. Nevertheless, the Government confirmed that it was still committed to change including issuing a national Charter for the coroner service. So the draft Charter within this consultation is for the current system, with no Chief Coroner. (Previous Charter consultations dealt with how the service would be different if full implementation of the Coroners and Justice Act 2009 took place, and there had been a Chief Coroner.)

9 Previous versions of the Charter were limited to the service for bereaved people. The 2010 consultation on the coroner system[1] did not specifically seek views on the scope of the Charter. However, some responses suggested that the Charter's scope should be extended to include all properly interested persons and witnesses in order to ensure that everyone involved in an investigation receives the same standard of service.

10 In January 2011 we held discussions with some of our Civil Society partners (such as bereavement support organisations) as well as coroners, their officers and local authorities. These discussions explored whether we should widen the Charter's scope beyond bereaved people, and what its contents should be. The new draft Charter is the result of these discussions. It is for **everyone** who comes into contact with the coroner service, rather than just bereaved people.

Guide to Coroners and Inquests (Part 1) and Charter for the Coroner Service (Part 2)

11 We propose to publish the Charter alongside our existing *Guide to Coroners and Inquests* ('the Guide'). We believe it will be helpful for those who come into contact with the coroner service to have access to both the Guide and the Charter within one booklet.

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

12 Furthermore (as set out in the Impact Assessment at Annex B), it is more cost-efficient for the Ministry of Justice to publish and distribute the Guide and Charter as one document rather than as two separate ones; and more efficient for coroners' offices to store, display and direct people to one document rather than two.

13 The Guide will continue to provide general information about coroners and inquests (but it is important to bear in mind that the Guide is not intended to be an exhaustive explanation of current coroner law in England and Wales).

14 The Charter will complement the Guide by setting out the standards of service that those who come into contact with the coroner system can expect to receive from it, and what they can do if they are dissatisfied with the standards they have received.

15 This combined document will support the Government's aims to:

a. improve the coroner system by addressing current inconsistencies and inefficiencies in the delivery of services to bereaved families; and

b. create minimum national standards and issue improved guidance on important procedures such as the commissioning of post-mortem examinations, while supporting the local management and delivery of the service.

16 The combined Guide and draft Charter is attached for comment at **Annex A**. To ensure that the Charter is not lost within the Guide, the Charter and the Guide will have their own coloured headings, the Guide (Part 1) in **Purple** and the Charter (Part 2) in **Blue**.

17 We should be grateful for comments on the draft Charter to help us to improve it prior to publishing the final version. As the Guide has already been consulted upon in the past, and no major changes are proposed, we are **not** consulting on the content of the Guide.

What Next?

18 We plan to publish the final version of the Charter alongside our response paper to this consultation in December 2011. An online version will also be available on the Ministry of Justice website and on DirectGov.

19 Following this, hard copies of the Charter will be printed and distributed to all coroners' offices in England and Wales. We aim to complete this early in 2012.

20 We will update the Charter as and when we implement provisions in the Coroners and Justice Act 2009.

Changes made to the Guide and the draft Charter

Changes made to the Guide

21 The Guide has been updated to ensure that it is in line with the revised Charter. We have made changes where necessary to ensure that there is no repetition and that it is consistent with the Charter, but no major changes have been made. (Wording that has been added to the Guide since publication is underlined, with deleted wording set out in footnotes.)

Changes made to the draft Charter

22 A number of changes have been made to the draft Charter since we published the previous version in January 2009. The main changes are:

- The scope of the Charter has been widened to include not just bereaved people but witnesses and other properly interested persons. By widening the scope of the Charter we aim to ensure that everyone who comes into contact with the coroner service is treated fairly, helpfully, promptly and politely, in accordance with the standards set out in the Charter. The Charter does not contain specific provisions for people such as journalists, researchers and members of the public with an interest in a coroner's investigation, but these groups may also find the Charter's contents helpful.
- The Charter describes the minimum standards that users of the coroner service can expect to receive from the current system. General information about inquests and coroners has been removed and is now included in the Guide, where appropriate.
- A flowchart is now included, which illustrates the process following a death that has been reported to a coroner. This flowchart only applies to non-criminal cases. It seeks to make it easier for those who come into contact with the coroner service to understand the stages of the coronial process.
- There are no references to the Chief Coroner as this draft Charter reflects the current law under the Coroners Act 1988. For this reason the new draft does not set out a complaints and appeals system headed by the Chief Coroner (see paragraph 8 above for more detail).
- The Charter does make it clear how to complain about the conduct of a coroner, his or her officers or staff, pathologists, and about the level of service received, as well as how to challenge a coroner's decision.
- The performance of the coroner service will be monitored against the standards set out in the Charter. We would like to hear your views on the Charter's proposal for this monitoring to be carried out by a committee of voluntary bereavement organisations.

Questionnaire

We would welcome responses to the following questions relating to the draft Charter for the current coroner service.

The Guide to Coroners and Inquests ('the Guide') and the Charter for the Coroner service ('the Charter')

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

The draft Charter

2. Do you agree that the Charter should include witnesses and all other properly interested persons, as well as bereaved people? If not, why?
3. Does the draft Charter contain enough detail about current coronial practice? If not, what else should be included? (Please bear in mind that some information is contained in the Guide rather than the Charter.)
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?
5. What are your views on our proposal for a committee of voluntary bereavement organisations to assess the impact that the Charter has on the coroner service and to report their findings to the Secretary of State?
6. Is the Charter a user-friendly document, and are there any other terms that need to be included in the Glossary?
7. Have all the responsibilities of bereaved people and others who come into contact with the coroner service been included? If not, what other responsibilities should be included?
8. Do you have any other comments on the draft Charter?

The Impact Assessment

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?

Thank you for participating in this consultation exercise.

About you

Please use this section to tell us about yourself

Full name	
Job title or capacity in which you are responding to this consultation exercise (e.g. member of the public etc.)	
Date	
Company name/organisation (if applicable):	
Address	
Postcode	
Email address	
If you would like us to acknowledge receipt of your response, please tick this box	☐ (please tick box)
Address to which the acknowledgement should be sent, if different from above	

If you are a representative of a group, please tell us the name of the group and give a summary of the people or organisations that you represent.

How to respond

Please send your response by 5 September 2011 to:

Hazra Khanom
Ministry of Justice
Access to Justice
Justice Policy Group
4th floor (post point 4.38)
102 Petty France
London SW1H 9AJ
Tel: 020 3334 6403
Fax: 020 3334 2233
Email: coroners@justice.gsi.gov.uk

Alternative formats

Alternative format versions of this publication can be requested from Hazra Khanom at the above address.

Publication of response

A paper summarising the responses to this consultation will be published in December 2011. The response paper will be available on-line at www.justice.gov.uk

Representative groups

Representative groups are asked to give a summary of the people and organisations they represent when they respond.

Confidentiality

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic

confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Ministry.

The Ministry will process your personal data in accordance with the DPA and in the majority of circumstances this will mean that your personal data will not be disclosed to third parties.

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.

Consultation Co-ordinator contact details

Responses to the consultation must go to the named contact under the How to Respond section.

However, if you have any complaints or comments about the consultation **process** 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:

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

Annex A: The Guide to Coroners and Inquests and the draft Charter for the coroner service

Guide and Charter

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1. What is a coroner?
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4. Are all deaths reported to a coroner?
5. When is a death reported to a coroner?
6. What will a coroner do when a death is reported?
7. What is a post-mortem examination?
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10. Will organs be retained after a coroner's post-mortem examination?
11. Donation of tissue and organs for transplantation
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14. What is an inquest?
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23. What if future deaths may be prevented?
24. Will the inquest be reported by the media?
25. What about other proceedings?
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Part 2: Draft Charter for the Coroner Service

1. Summary of the roles of the coroner's office, bereaved people and others who come into contact with the coroner service.
    - Responsibilities of the coroner's office
    - Responsibilities of bereaved people and others who come into contact with the coroner service
    - Support during an investigation
    - Bereavement support organisations
2. Overview of the coroner investigation process after a death is reported
3. Standards to expect throughout the investigation process
    - When a death is reported
    - Post-mortem examinations
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    - Inquests
    - Transferring an investigation
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4. Feedback, challenging a coroner decision and complaints
    - Feedback
    - How to challenge a coroner's decision or the outcome of an inquest
    - Complaints about a coroner's conduct
    - Complaints about the coroner's service
    - Complaints about a pathologist
5. Monitoring the service standards contained in this Charter
    - Monitoring service standards
6. Glossary

Part 1: Guide to Coroners and Inquests

Some questions answered and issues explained

This Guide is for information purposes only and is not intended to be an exhaustive explanation of current coroner law in England and Wales. If you are a 'properly interested person' in a specific inquest (see Glossary in Charter on page 39) and have questions about it, you should raise these with the coroner's office.

The Coroners and Justice Act 2009 received Royal Assent on 12 November 2009. Further information about the Coroner Change programme can be found at http://www.justice.gov.uk/publications/coroners-justice-bill.htm.
A revised version of this guidance will be published when **relevant provisions of the Act** are[2] implemented.

1. What is a coroner?

1.1 A coroner is an independent judicial office holder, appointed and paid by the relevant local authority. A coroner must be a lawyer or a doctor, and in some cases is both. Each coroner has a deputy and usually one or more assistant deputies, and either personally or through a deputy he or she must be available at all times. The costs of the coroner's service are generally met by local authorities, not by central Government. In some districts the local police force may also contribute towards a coroner's resources, usually by providing and paying the costs of coroner's officers.

2. What do coroners do?

2.1 Coroners inquire into violent or unnatural deaths, sudden deaths of unknown cause, and deaths which have occurred in prison. 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. The coroner's inquiries may take one of several forms and may result in the holding of an inquest.

2.2 The purposes of the coroner service, when a death is reported to it, are:

- 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.[3]

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[2] Deleted: has been

[3] Deleted: It is a coroner's duty at an inquest to establish who the deceased was and how, when and where the deceased came by his or her death.

2.3 After an inquest the coroner will send 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.

2.4 In some cases a death may be referred to the police for investigation on behalf of a coroner. In other cases a separate investigation into a death may be undertaken by an independent body such as the Health and Safety Executive, the Prisons and Probation Ombudsman, the Care Quality Commission or the Independent Police Complaints Commission, and the coroner will be given the results of the investigation.

3. What is the role of a coroner's officer?

3.1 Coroners' officers work under the direction of coroners and liaise with bereaved families, the police, doctors, witnesses, mortuary staff, hospital bereavement staff and funeral directors. They receive reports of deaths and make inquiries at the direction, and on behalf, of a coroner.

4. Are all deaths reported to a coroner?

4.1 No, more than 50% of deaths are not reported to the coroner. In many cases the deceased's own doctor, or a hospital doctor who has been treating him or her during the final illness, is able to issue a Medical Certificate of the Cause of Death (MCCD) without reference to a coroner. The death can then be registered by the Registrar of Births and Deaths, who will issue the death certificate. Sometimes doctors may discuss the case with the coroner and this may result in the coroner deciding that he or she does not need to make further inquiries, because the death is from natural causes. In the light of that discussion the doctor concerned may be able to issue the MCCD and the coroner will issue a certificate to the Registrar stating that it is not necessary to hold an inquest.

4.2 However, if the coroner has decided to investigate a death the Registrar of Births and Deaths must wait for the coroner to finish his or her inquiries before the death can be registered. These inquiries may take time, so it is always best to contact the coroner's office before any funeral arrangements are made. In many cases the decision to investigate will not hold up funeral arrangements or sorting out benefits.

5. When is a death reported to a coroner?

5.1 Registrars of Births and Deaths, doctors or the police report deaths to a coroner in certain circumstances. These include where it appears that:

- no doctor attended the deceased during his or her last illness;
- although a doctor attended during the last illness the deceased was not seen either within 14 days before death nor after death;
- the cause of death appears to be unknown;

- the death occurred during an operation or before recovery from the effects of an anaesthetic;
- the death was due to an industrial accident, disease or poisoning;
- the death was sudden or unexpected;
- the death was unnatural;
- the death was due to violence or neglect;
- the death was in other suspicious circumstances; or
- the death occurred in prison or police custody.

5.2 If someone believes that a doctor, or other relevant professional, has not reported a death to the coroner when they should have done, they may report the death to the coroner themselves. This should normally happen before there has been any interference with the body and before a funeral takes place. The coroner will inform the person what action he or she proposes to take when reports are made in this way.

6. What will a coroner do when a death is reported?

6.1 The coroner may decide that a post-mortem examination and inquest are unnecessary because the cause of death is evident and there is a doctor who can sign an MCCD to that effect. In such cases the coroner will advise the Registrar of Births and Deaths that no further investigation is needed.

6.2 The coroner may ask a pathologist to examine the body and carry out a post-mortem examination (also known as an autopsy). If so, the examination must be made as soon as possible.

7. What is a post-mortem examination?

7.1 A post-mortem examination is a medical examination of a body. A coroner's post-mortem examination is carried out for a coroner by a pathologist of the coroner's choice, in order to establish the cause of death.

7.2 The coroner is not required to obtain the consent of the relatives for a post-mortem examination to be made, but is required to inform certain persons of when and where the examination will take place. These include the deceased's relatives and others with an interest in the death, for example, the deceased's regular medical practitioner and the Chief of Police. Such persons are entitled to be represented at the examination by a doctor of their choice, but they have to pay any fee the doctor may charge. Coroners will where possible take account of religious and cultural needs.

7.3 If concerns remain about the cause of death, the relatives can ask the coroner for a separate, additional post-mortem examination, which would be at their own expense.

8. Post-mortem examination report

8.1 The post-mortem report gives details of the examination made of the body, and is sent to the coroner by the person who carried out the post-mortem examination. It will also give details of tissues and organs removed from the deceased, and any tests which have been carried out to help determine the cause of death. Copies of the report are normally available only to properly interested persons. A fee for the copies may be payable.

8.2 A coroner may[4] decide not to hold an inquest after a post-mortem examination if he or she thinks an inquest is unnecessary and there is no reason to suspect that the person died a violent or unnatural death, and they did not die in prison. The coroner will release the body for the funeral and send a form to the Registrar of Births and Deaths stating the cause of death as disclosed by the post-mortem examination report, so that the death can then be registered. Generally this will happen when the post-mortem examination establishes that the person died of natural causes and the coroner decides no further investigation into the death is necessary.

9. Medical records

9.1 Medical records remain confidential after death but may be made available to the deceased's personal representative or any person who may have a claim arising out of the deceased's death, subject to some restrictions, under the terms of the Access to Health Records Act 1990. These can be viewed online at www.opsi.gov.uk/acts/acts1990/Ukpga_19900023_en_1.

9.2 Coroners are entitled to obtain copies of medical information that is relevant and necessary to their inquiries. Medical information about the deceased may be disclosed at the inquest hearing if it is relevant to the cause of death.

10. Will organs be retained after a coroner's post-mortem examination?

10.1 Distressing though it can be for the deceased's family, organs and, more commonly, small pieces of tissue may sometimes be removed from a body and preserved by a pathologist if they have any bearing on the cause of death or the identity of the deceased. When the material no longer needs to be preserved it will either be returned to the deceased's family or representative, if requested, or disposed of by burial or cremation. If a pathologist believes it would be appropriate to retain organs and tissue, for example for use in research or for training purposes, the consent of the relatives **must** be obtained. In some exceptional cases, e.g. involving murder, the organs may have to be retained for a longer period.

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[4] Deleted; dispense with

10.2 Further general information on tissue retention and the legal requirements relating to consent can be obtained from the Human Tissue Authority on ☎ 020 7269 1900 or online at www.hta.gov.uk.

11. Donation of tissue and organs for transplantation

11.1 If the next of kin wishes to consider donation, immediate advice is essential. This can be sought from a hospital or from the local Donor Transplant Co-ordinator (DTC), who will be able to discuss the options for donation in more detail. The DTC must consult the coroner in any case which has been or is likely to be referred to him or her, and the coroner must agree before a donation can take place, since the removal could affect important evidence. These decisions are usually made very quickly. In a small number of cases, for example where there is a criminal investigation, organ donation may not be possible.

12. What happens after the post-mortem examination if the coroner decides to hold an inquest?

12.1 A coroner **must** hold an inquest if the cause of death remains unknown, or if there is cause for the coroner to suspect that the deceased died a violent or unnatural death, or died in prison. However, after the post-mortem examination is completed the coroner will normally issue the necessary authority permitting burial or cremation, so that the funeral can be held, even though an inquest may be required but has not been concluded.

12.2 In such circumstances the death cannot be registered. In order to assist the administration of the estate an interim certificate of fact of death can be issued by the coroner. This certificate should be acceptable to banks and financial institutions unless it is important for them to know the outcome of the inquest (for example, for an insurance settlement). This interim certificate can also be used for benefit claims and National Insurance purposes. When the inquest has been completed the coroner will notify the Registrar of Births and Deaths so that the death can be registered by the Registrar and a death certificate can then be obtained from the Registrar.

12.3 If criminal charges have been brought against somebody for causing the death, it may be necessary for a second post-mortem examination to take place or for further investigation, and the release of the body and the funeral arrangements may then have to be delayed.

13. Taking the body abroad or bringing it back to this country

13.1 In every case where someone wishes to take a body out of England or Wales, written notice must be given to the coroner in whose area the body is located. The coroner will then consider whether an inquest or post-mortem examination is needed and will notify the next of kin of his or her decision within four days.

13.2 If a body is being brought into England or Wales, the coroner in the area to where the body is brought may need to be involved. The coroner may need to determine the cause of death and will be required to hold an inquest if the death was unnatural, or violent, or sudden and of unknown cause. The coroner will issue a certificate for cremation in all cases coming from abroad where the body is to be cremated.

13.3 When death has occurred outside England and Wales and the body is returned to England or Wales, the death is not registered by the Registrar of Births and Deaths when the coroner has finished investigating or has concluded the inquest. Further information about what to do when a death occurs abroad can be found on the Foreign and Commonwealth Office's website, at: www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/death-abroad

14. What is an inquest?

14.1 An inquest is a limited, fact-finding inquiry to establish who has died, and how, when and where the death occurred. An inquest does not establish any matter of liability or blame. Although it receives evidence from witnesses, an inquest does not have[5] prosecution and defence teams, like a criminal trial; the coroner and all those with 'proper interests' simply seek the answers to the above questions.

14.2 An inquest is usually opened soon after a death to record that the death has occurred, to identify the deceased, and to enable the coroner to issue the authority for burial or cremation to take place without any unnecessary delay. It will then be adjourned until any other investigations (see paragraph 2.4) and any inquiries instigated by the coroner have been completed. It will usually take an average of 27 weeks to conclude this work, but some cases can take longer than this if the inquiries prove to be complicated. The inquest will then be resumed and concluded.

14.3 Sometimes the coroner may hold one or more hearings before the inquest itself, known as pre-inquest hearings (or pre-inquest reviews), where the scope of the inquest and any matters of concern, including about the arrangements for the hearing, can be considered. The coroner usually invites the properly interested persons and/or their legal representatives to the pre-inquest hearing, where they have the opportunity to make representations to the coroner.

15. What happens if somebody has been charged with causing the death?

15.1 Where a person has been sent for trial for causing a death, for example by murder or manslaughter, any inquest is adjourned until the criminal trial is over. On adjourning an inquest, the coroner must send the Registrar of Births and Deaths a certificate stating the particulars that

[5] Deleted: It does not have statements and examination of witnesses by

are needed to register the death and for a death certificate to be issued. When the trial is over, the coroner will decide whether to resume the inquest. There may be no need if all the facts surrounding the death have emerged at the trial. If the inquest is resumed, however, the finding of the inquest as to the cause of death cannot be inconsistent with the outcome of the criminal trial.

15.2 Paragraph[6] 25 below sets out the position where civil proceedings have been brought in connection with a death.

16. Attending an inquest

16.1 When a coroner's investigations into a death are complete, a date for a full inquest will be set. The 'properly interested persons' (essentially the relatives and others closely connected with the deceased – see[7] Glossary) will be informed of the date by the coroner's officer and any witnesses will be asked to attend to provide evidence. The process is held in the public interest and not on behalf of any individual. It is not always necessary for the bereaved relatives to attend the inquest, and some prefer not to, as the details of the death may need to be dealt with in graphic terms. If bereaved relatives wish to attend the inquest they can be accompanied by a supporter, for example a friend.

17. Is there always a jury at an inquest?

17.1 No, most inquests are held without a jury, but there are particular circumstances when a jury is called, including:

- if the death occurred in prison or in police custody; or
- if the death resulted from an accident at work.

17.2 In every jury inquest the coroner decides matters of law and procedure and the jury decides the facts of the case and reaches a verdict. The jury cannot blame someone for the death. If there is any blame, this can only be established by other legal proceedings in the civil or criminal courts, although the jury can state facts which make it clear that the death was caused by a specific failure of some sort or by neglect.

18. Who decides which witnesses to call?

18.1 The coroner will decide who should be called to give evidence as a witness and the order in which they give evidence. However, anyone who believes they may be of help or believes a particular witness should be called should inform the coroner. The coroner will then decide whether the evidence is relevant to the investigation of the death.

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6 Deleted: Section

7 Deleted: paragraph 21 below

19. Must a witness attend court?

19.1 Yes, if they live in England and Wales. In many cases the evidence of a witness may be vital in establishing the facts of the death. A witness may either be asked to attend the inquest voluntarily or receive a formal summons to do so, but if they live abroad they cannot be compelled to attend or to give evidence.

20. Who can ask witnesses questions?

20.1 Witnesses will be first questioned by the coroner and then additional relevant questions may be asked by any properly interested person or their legal representative. Whether a question is relevant to the purpose of the inquest is something the coroner decides. Where relevant, the coroner will warn a witness that he or she is not obliged to answer any question which might incriminate him/herself.

21. Is Legal Aid available?

21.1 Legal Aid is not generally available for representation at inquests because an inquest is a fact-finding process. Unlike other proceedings for which Legal Aid might be available, there are no parties in inquests, only the properly interested persons, and witnesses are not expected to present legal arguments. The coroner ensures that the process is impartial and thorough, and he or she should assist families to ensure that their relevant questions are answered.

21.2 Legal Aid may, however, be available to cover representation at the inquest in very exceptional cases. Generally, applicants must qualify financially and applications must meet strict criteria for representation to be funded. These criteria are that:

- there is a significant wider public interest (as defined in the Legal Services Commission's Funding Code) in the applicant being represented at the inquest; or
- the applicant is a member of the deceased's immediate family and the circumstances of the death appear to be such that funded representation is likely to be necessary to enable the coroner to investigate the case effectively and establish the facts[8] (as required by Article 2 of the European Convention on Human Rights).

21.3 [9]Legal advice and assistance – via the Legal Help scheme – is[10] available to those who qualify financially.[11] Further information about solicitors who carry out legal aid work can be found in the Community

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[8] Deleted: providing that the applicant was a member of the deceased's immediate family

[9] Deleted: However, legal advice

[10] Deleted: may be

[11] Deleted: Further information is available from the Legal Service Commission on ☎ 0845 345 4345 or online at www.legalservices.gov.uk

Legal Service directory on ☎0845 345 4345 or online at www.communitylegaladvice.org.uk.

22. Inquest verdicts

22.1 Possible verdicts include:

- natural causes;
- accident or misadventure;
- he or she killed him/herself (i.e. suicide);
- unlawful killing;
- lawful killing;
- industrial disease; or
- open verdict (where there is insufficient evidence for any other verdict).

22.2 Alternatively, the coroner can give a narrative verdict which sets out the facts surrounding the death in more detail and explains the reasons for the decision.

22.3 It is possible to challenge a coroner's decision. More detail on this is at section 4 of the Charter.

23. What if future deaths may be prevented?

23.1 Sometimes an inquest will show that something could be done to prevent other deaths. If so, at the end of the inquest the coroner may announce that he or she will draw this to the attention of any person or organisation that may have the power to take action. This is something referred to as a 'Rule 43 Report' – as the power to make such a report is found in Rule 43 of the Coroners Rules 1984. This Rule was significantly changed in 2008. Now anyone who receives such a report must send the coroner a written response. These reports, and the responses to them, are copied to all properly interested persons and to the Lord Chancellor. A summary of the reports is published twice a year, by the Ministry of Justice.[12,13]

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[12] Deleted: **What can you do if you are dissatisfied with the outcome of an inquest?** It is possible to challenge coroners' decisions and inquest verdicts, but the grounds for doing so are complex and advice should be sought from a lawyer with expertise in this area of the law. An application may be made to the High Court for judicial review of a decision, but this must normally be done within three months of completion of the inquest. There is a separate power under which the Attorney-General may initiate an application to the High Court for an inquest to be held if a coroner has neglected or refused to hold one, or for another inquest to be held on the grounds that it is necessary or desirable (e.g. because new evidence has come to light). (moved to Charter)

24. Will the inquest be reported by the media?

24.1 All inquests must be held in public in accordance with the principle of open justice, and so members of the public and journalists have the right to, and indeed may, attend (although parts of a very small number of inquests may be held in private for national security reasons). Whether journalists attend a particular inquest – and whether they report on it – is a matter for them. If any such report is fair and accurate it cannot be used to sue for defamation.

24.2 Those working on newspapers or magazines abide by the Editor's Code of Practice, upheld by the Press Complaints Commission (PCC), which sets out the guidance for print journalists in the UK. The Code, which can be seen at www.pcc.org.uk, has requirements on accuracy, privacy and discrimination. It also has specific rules in cases involving grief and shock. For instance, publication in such circumstances must be handled sensitively and, when reporting suicide, care should be taken to avoid excessive detail about the method used.

24.3 The PCC mostly deals with complaints about published material. However, it can also help to prevent physical harassment by journalists and will sometimes be able to assist with problems related to material that has not yet appeared in print. Its staff are always happy to discuss matters informally; the PCC can be contacted on ☎ 020 7831 0022 or ☎ 0845 600 2757. It also operates an out-of-hours number for emergencies only on ☎ 07659 152656.

24.4 Suicide notes and personal letters will not usually be read out at the inquest unless the coroner decides it is important to do so. If they are read out, their contents may be reported. Although every attempt is made to avoid any upset to people's private lives, sometimes, in the interest of justice, it is unavoidable. Photographs taken of the deceased and of the scene of death may also form part of the evidence presented in court.

25. What about other proceedings?

25.1 Any civil proceedings will normally follow the inquest. When all the facts about the cause of death are known it is possible that civil proceedings may be brought and a claim for damages made. A lawyer's advice

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[13] Deleted: **Is it possible to obtain a record of the inquest?** Once an inquest has been completed, a properly interested person may apply to see the notes of evidence, any document put in evidence at the inquest, or a copy of any post-mortem examination report. Copies may be obtained following payment of a fee to the coroner. The notes may be in the form of a transcript from a tape-recording or the coroner's own notes. The coroner's notes may not be a full, verbatim record.

should be sought about the time limits and procedures that apply. Inquest evidence cannot be used directly in other proceedings.[14]

26. How can you find out further information?

26.1 [15]A source of general information is the pre-recorded Metropolitan Police Bereavement Information Line on ☎ 0800 032 9996, which is available nationwide 24 hours a day. This information is also available to view online at www.met.police.uk/bereavement/index.htm.

26.2 The Department of Work and Pensions publish a booklet *What to do after death in England and Wales,* which covers legal and benefits procedures. Registrars of Births and Deaths will give a copy to people who register a death, and coroners may make copies available to bereaved families. The booklet is available from your local JobcentrePlus Office or it can be viewed online at www.dwp.gov.uk/publications/catalogue-of-information/all-products or by calling ☎ 0845 606 5065.[16]

26.3 Further information about coroners, death registration and related matters are available online at www.direct.gov.uk/en/governmentcitizensandrights/death/index/htm.

26.4 If you have any general queries about the contents of this Guide please email coroners@justice.gsi.gov.uk or phone ☎ 020 3334 3555.

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[14] Deleted: Rights of properly interested persons, including bereaved people, throughout the process

Essentially, properly interested persons at an inquest have the right:

- to be told the date, time and place of the inquest if one is needed; and
- to question witnesses at the inquest, or have a legally qualified representative do so.

Bereaved people may also:

- ask the coroner, via the funeral director, for reasonable access to see the body before it is released for the funeral;
- ask the coroner for a copy of the post-mortem examination report (for which a fee may be payable), or to arrange for it to be seen free of charge; and
- ask the coroner about a separate post-mortem examination. The costs of this examination, including any fee of the registered medical practitioner and mortuary charges, would have to be self-funded.

[15] Deleted: You can obtain more information, including details of any locally-operated 'Coroner's Charter', from your local coroner's office. This is usually listed in the telephone directory or on the website of the local authority for the area. Alternatively, your local police, hospital or Citizens Advice Bureau will be able to tell you where the office is situated.

[16] Deleted: Jobcentre Plus publish a booklet What to do after a death in England and Wales, (DWP 1027) which covers legal and benefits procedures. Registrars of Births and Deaths will give a copy to people who register a death, and coroners may make copies available to bereaved families. The booklet can be viewed online at: http://www.dwp.gov.uk/publications/catalogue-of-information/all-products/ or be obtained from your local Job Centre Plus

Part 2: Charter for the current Coroner Service

This Charter sets out the standards of service that bereaved family members, witnesses and other properly interested persons can expect to receive from the coroner service in England and Wales. This is a Charter for the service as it is currently structured and currently operates. It will be revised as and when relevant provisions in the Coroners and Justice Act 2009 are implemented.

Section 1 – Summary of the roles of the coroner's office, bereaved people and others who come into contact with the coroner service

Responsibilities of the coroner's office

1.1 The coroner's office will:

- inform people about the role of the coroner;
- help them understand the cause of death of the person who has died;
- explain, where relevant and on request, why the coroner intends to take no further action in a particular case;
- answer questions about coronial procedures as promptly and effectively as possible;
- provide contact details for the office i.e. a named individual with his or her phone number and email address;
- inform people of their rights and responsibilities;
- take account where possible of individual wishes, feelings and expectations, including family and community preferences, traditions and religious requirements relating to mourning, post-mortem examinations and to funerals;
- unless otherwise requested, contact bereaved people and others involved in the investigation at least every three months to inform them of the stage of the case, and explain reasons for any delays;[17]
- have respect for individual and family privacy;
- provide a welcoming and safe environment;
- treat everyone with fairness, respect, dignity and sensitivity;
- treat children and young people involved in an investigation in a way appropriate to their age;

[17] In England and Wales (2010) the average length of time from a death being reported to an inquest finishing is estimated as 27 weeks. A flow chart setting out the process is at Section 2 of this Charter

- make reasonable adjustments, where possible, to accommodate the needs of those with disabilities;
- help people to find further help where this is needed; and
- provide information about how to make a complaint about the coroner's decision or if a particular service is not delivered.

Responsibilities of bereaved people and others who come into contact with the coroner service

1.2 Bereaved people, witnesses and other coroner service users should:

- provide promptly all information to the coroner's office that is relevant to the investigation;
- treat with confidence any information or documents that are disclosed to them, if so requested;
- inform the coroner's office of any relevant considerations for the inquest, e.g. any disability so that reasonable adjustments can be made;
- inform the coroner's office of any change of circumstances, such as a change of address, so they can be contacted promptly;
- treat the coroner and his or her officers and other staff with courtesy and respect at all times; and
- in the case of bereaved people, nominate an appropriate representative as the 'appropriate next of kin' for all communication with the coroner's office.

Support during an investigation

1.3 A bereaved person may wish for an adviser to support them through the investigation process, and liaise with the coroner's office where appropriate. The adviser may be someone such as a friend or relative, a legal adviser or a member of a support organisation. The coroner's office and the bereaved person should discuss any such proposed arrangement, to agree how best to proceed.

1.4 A witness or other properly interested person in an investigation may also wish for support. This should be discussed with the coroner's office.

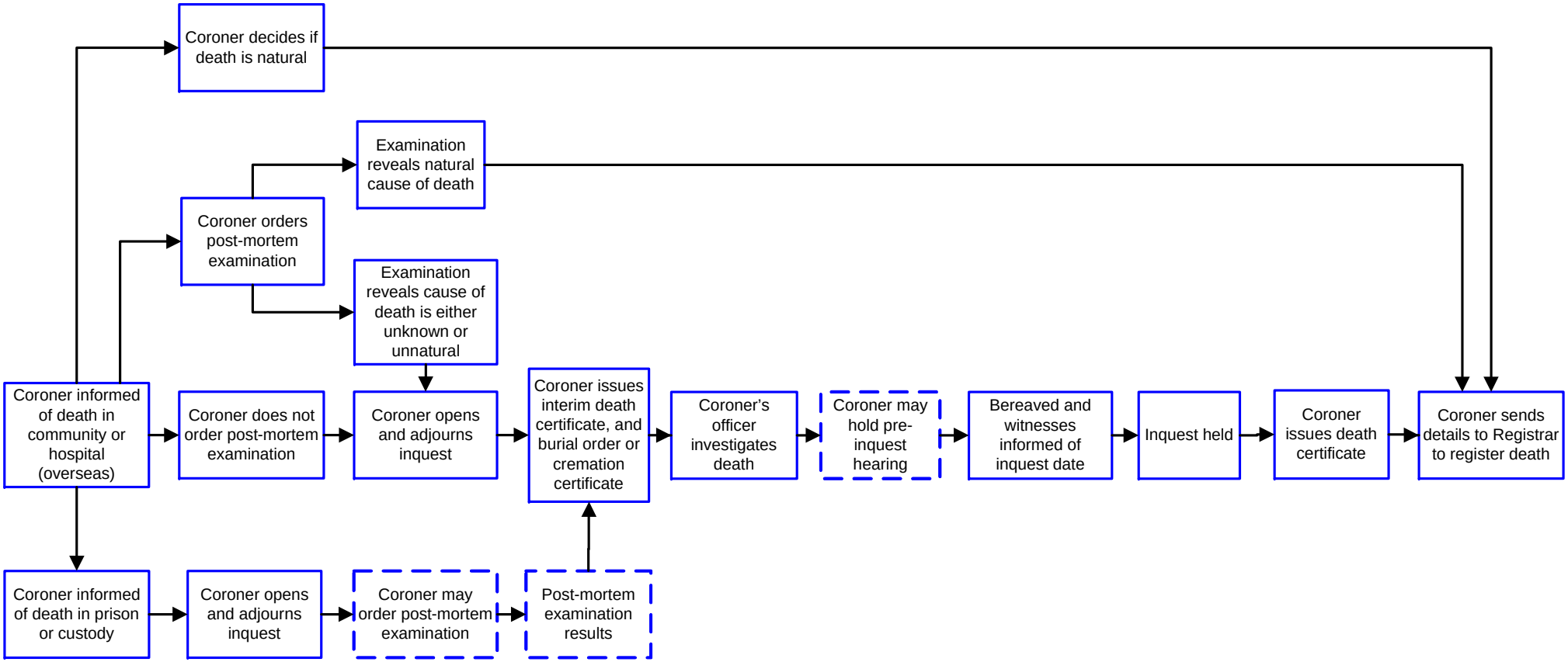
1.5 Useful information for everyone involved in a coroner's investigation is available from Directgov: www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDoAfterADeath/DG_066713

Bereavement support organisations

1.6 The coroner's office will be able to provide information on the main local and national voluntary bodies, support groups and faith groups which help people who have been bereaved, including as a result of particular types of incidents or circumstances, or specific medical conditions.

Section 2 – Overview of the coroner investigation process after a death is reported

(NB: This flow chart only applies in non-criminal cases. Where there is a criminal case, the inquest will be opened and adjourned until the outcome of the criminal trial.)



Section 3 – Standards to expect throughout the investigation process

When a death is reported

3.1 When a death is reported to the coroner, the coroner's office will contact the most appropriate next of kin, where known, and where possible, **within one working day of the death being reported**, to explain why the death has been reported and what steps are likely to follow.

3.2 The coroner's office will give the appropriate next of kin information, as soon as possible, on arrangements for viewing the body, if they wish to do so. In all cases, the coroner's office will advise the appropriate next of kin or their adviser sensitively of the procedure for viewing the body.

Post-mortem examinations

3.3 Where a coroner orders a post-mortem examination, the coroner's office will tell the most appropriate next of kin why it is necessary, when and where it will be performed, and what they should do if they would like to be represented by a doctor at the examination. If the appropriate next of kin, or any other service user, has queries or is unhappy with the decision to hold a post-mortem examination, they or their adviser should let the coroner's office know as soon as possible. However, it is the coroner who is responsible for deciding whether or not to hold a post-mortem examination. For service personnel deaths on operations overseas however there is always a post-mortem examination.[18]

3.4 When the coroner requests additional scientific examination of specific organs or tissues to assist with establishing the cause of death or the identity of the person who has died, the coroner's office will inform the appropriate next of kin, where possible. Again, if they have queries or concerns they should direct these to the coroner's office at the earliest opportunity, although it is the coroner who is responsible for deciding whether these examinations should take place.

3.5 In the unusual event of the coroner ordering a second post-mortem examination (for example, in a case of suspected murder) which is of the same type as one previously ordered, the appropriate next of kin may express their concerns to the coroner. However, it is the coroner who is responsible for deciding whether to order the second examination.

3.6 If the coroner decides not to hold a post-mortem examination, and the appropriate next of kin wishes to challenge the decision, they or their adviser should discuss this with the coroner's office. It is the coroner who is responsible for deciding whether or not to hold the post-mortem examination.

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[18] At present service personnel post-mortem examinations take place at the John Radcliffe Hospital, Oxford.

3.7 Bereaved people and other properly interested persons have a right to request copies of reports of any post-mortem examinations carried out, although they should be aware they may find the details distressing. The coroner's office may charge a fee for copies. A fee will not be payable where a coroner permits a properly interested person to come to the coroner's office and inspect the post-mortem examination report.

3.8 Different arrangements may apply in the event of deaths resulting from criminal or suspected criminal offences. In such cases, the coroner's office will explain the arrangements.

Release of a body and organs or tissues

3.9 Once the coroner no longer requires the body for his or her investigation he or she will retain the body only with the consent of the family, except in exceptional circumstances. An example would be where there is a dispute about to whom the body should be released. Where there is a criminal investigation into the death, the coroner's office must release the body for funeral **within 30 days** of the death, but normally it will be much sooner than this.

3.10 Sometimes organs or tissues are retained for additional examination. In this instance, the coroner will notify the appropriate next of kin of this and seek their instruction as to what should happen to the organs or tissues when he or she no longer requires them. See the Guide (paragraph 10) for more information.

Keeping in touch

3.11 If the case goes to inquest, and the coroner continues his or her investigation following the post-mortem examination, the coroner's office will contact the appropriate next of kin and others involved in the investigation **at least once every three months** to update them, and explain the reasons for any delays. This will not apply if they have indicated that they only wish to be contacted when there is progress to report.

Inquests

3.12 When there is to be an inquest, the coroner's office will provide information to bereaved people and others involved in the investigation about the timing and location of the inquest, as well as the facilities available at the venue, wherever possible **at least four weeks before the start of the inquest**.

3.13 The coroner's office will take the views of bereaved people, and others involved in the investigation, into account on the timing of the inquest. The office will also give them information about, for example, the purpose of the inquest, those who are likely to be present, and how they can participate in the proceedings, for instance by addressing the coroner directly or through a legal or other representative.

3.14 If the date and/or location of the inquest has to be changed, the coroner's office will provide information as soon as possible and **within five working days of the decision being made**.

3.15 In advance of the inquest, the coroner's office will disclose to properly interested persons, on request, relevant documents to be used in the inquest. However, it is possible that for legal reasons the coroner will either not be able to disclose all the documents or part of a document he or she intends to use at the inquest. The coroner will explain on request why he or she has not disclosed a particular document, or part of a document.

3.16 Where the coroner decides to hold a pre-inquest hearing, the coroner's office will inform properly interested persons of the time, date and location of the hearing, the purpose of the hearing and their rights to participate in it.

3.17 Wherever possible the coroner's office will provide properly interested persons and others he or she determines require it, with an appropriate private waiting room when they attend an inquest.

3.18 Some coroners now arrange for the Coroners' Courts Support Service, or other similar services, to operate on days when they hold inquests. The support service will welcome people on arrival at the inquest, explain the process where needed – working jointly with the coroner's office – and answer any queries people may have before and immediately after the inquest. Where there is no support service available, the coroner's officer will fulfil this role.

3.19 Except in rare circumstances where national security issues are raised, the media can attend all inquests. The coroner's office will not release any information to the media which has not already been made public through an inquest, without the consent of the appropriate next of kin. The coroner's office will never release photographs without the consent of the next of kin. The coroner's office will provide service users with the relevant section of the Editor's Code of Practice,[19] administered by the Press Complaints Commission, on request. This code sets out the ethical standards that all members of the press should meet.

3.20 Bereaved people and other properly interested persons have the right to ask witnesses relevant questions at the inquest, or have a legally qualified representative do so on their behalf. They may also nominate a third party to speak on their behalf at the inquest, provided the coroner considers them to be an appropriate person. The nominated third party does not have to be legally qualified. It is the coroner who decides whether a question is relevant or otherwise proper.

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[19] http://www.pcc.org.uk/cop/practice.html

3.21 If the coroner writes a report to prevent future deaths at the end of the inquest the coroner's office will send a copy of the report, and any response, or a summary of the response which an organisation makes, to all bereaved people and other properly interested persons (see paragraph 23 in the Guide). A summary of reports by coroners to prevent future deaths and responses from organisations are also published twice a year on the Justice website at www.justice.gov.uk/publications/policy-reports.htm. These are known as 'Rule 43' Reports.

Transferring an investigation

3.22 If the coroner decides to transfer an investigation to a different coroner, he or she will inform the family and other service users of his decision and the reason for it, after he or she has consulted them where possible.

Deaths abroad

3.23 A coroner will investigate a death that occurs abroad if the body is brought back into his or her district and the apparent circumstances of the death would have led them to do so had the death occurred in England or Wales (see section 13.2 of the Guide for further details). The standards of service outlined in this Charter, in particular (but not exclusively) in relation to post-mortem examinations and inquest hearings, may need to be varied because of the additional administrative difficulties in receiving information from overseas. Procedures may additionally vary for service personnel killed on operations overseas. For instance in these cases there is always an inquest.

Section 4 – Feedback, challenging a coroner decision and complaints

Feedback

4.1 Coroners are committed to providing a service which meets the needs of bereaved people and others who come into contact with the coroner service. They welcome feedback about people's experiences, including where the service has performed well. This should be directed to the coroner who dealt with the case.

How to challenge a coroner's decision or the outcome of an inquest

4.2 It is possible to challenge a coroner's decision or an inquest verdict but the grounds for doing so are complex and limited, and advice should be sought from a lawyer with expertise in this area of the law. An application may be made to the High Court for judicial review of a decision or verdict, but this must normally be done at the latest **within three months** of the decision or verdict.

4.3 Bereavement support organisations may be able to help bereaved people in deciding whether a coroner's decision could be challenged in this manner.

4.4 There is a separate power under which the Attorney-General may initiate an application to the High Court for an inquest to be held if a coroner has neglected or refused to hold one, or for another inquest to be held on the grounds that it is necessary or desirable (e.g. because new evidence has come to light).

4.5 Legal aid is currently available for most public law challenges (including judicial review proceedings), subject to the statutory tests of means and merits.

4.6 Information about which solicitors undertake legally aided work is in the Community Legal Services Directory, which can be found in most reference libraries and Citizens Advice Bureaux, or by calling ☎ 0845 345 4 345 or by visiting www.communitylegaladvice.org.uk. The Law Society also provides a database of solicitors, which can be accessed by calling ☎ 020 7242 1222 or by visiting www.lawsociety.org.uk/choosingandusing/findasolicitor.law.

4.7 In the consultation paper *Proposals for the Reform of Legal Aid in England and Wales*[20] the Government proposed to maintain the availability of legal aid in most public law challenges. The consultation closed on 14 February 2011 and the Government is carefully considering the responses received.

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[20] http://www.justice.gov.uk/consultations/index.htm

Complaints about a coroner's conduct

4.8 A complaint about a **coroner's** *personal* conduct should be made to the Office for Judicial Complaints (OJC). This incurs no cost and can be done online on the OJC website at http://judicialcomplaints.judiciary.gov.uk/. Alternatively, the complaints form can be downloaded and sent to OJC by fax, post or email. The complaint may either be made using the suggested form or by letter or email. The OJC's contact details are:

Office for Judicial Complaints
Steel House
11 Tothill Street
3rd Floor, 3.01-3.03
London, SW1H 9LJ

Tel: 020 3334 0145
Email: inbox@ojc.gsi.gov.uk
Fax: 020 3334 0031
Minicom VII 020 334 0146 (Helpline for the deaf and hard of hearing)

4.9 All complaints about the conduct of **deputy coroners** and **assistant deputy coroners** should be sent to the coroner in writing. If it is considered that the coroner's handling of a complaint about a deputy or assistant deputy amounts to personal misconduct of the coroner then that allegation might be referred to the OJC. However the OJC could not deal with or determine the actual complaint against the deputy or assistant deputy coroner.

4.10 Further information about complaints about coroners can be found on the OJC website at www.judicialcomplaints.gov.uk/index.htm.

Complaints about the coroner's service

4.11 All complaints about the administration of the coroner service or the conduct of coroners' officers should be raised first with the relevant coroner, in writing. The letter should also be copied to the local authority which funds the service.

4.12 A complaint may also be made direct to the relevant local authority. If dissatisfied with the council's response the next step is to complain to the Local Government Ombudsman, at www.lgo.org.uk/making-a-complaint, or by calling ☎ 0300 061 0614 or ☎ 0845 602 1983. Alternatively a complaint may be made in writing to:

The Local Government Ombudsman
PO Box 4771
Coventry CV4 0EH

There is no charge to complain about the standard of service from a coroner's office.

Complaints about a pathologist who conducts the post-mortem examination

4.13 Most complaints about pathologists can be dealt with locally through the doctor's employers, who will have their own local procedures for dealing with complaints. The General Medical Council (GMC), which is responsible for ensuring that doctors in the UK have the right knowledge and skills to practise medicine safely, deals with the most serious complaints about a doctor's practice. The GMC can take action to stop or restrict a doctor's practice. You can submit a complaint online at www.gmc-uk.org/patient_online_complaints. For further information, or if you wish to speak to an adviser, please telephone ☎ 0161 923 6602.

Section 5 – Monitoring the service standards contained in this Charter

Monitoring service standards

5.1 A committee of voluntary bereavement organisations, convened by the Ministry of Justice, will have the specific remit of assessing the impact that the Charter is having on the coroner service and feeding back to Ministers.

5.2 The Ministry of Justice publishes annual statistics on deaths reported to coroners. These cover deaths reported, post-mortem examinations ordered, and inquests held, and are used to monitor coroners' workloads, throughput of cases, and percentages of post-mortem examinations and inquests. Details are available at www.justice.gov.uk/publications/coronersannual.htm. The Ministry of Justice will also utilise these statistics, additional information about complaints and other statistical data to assess the standard of service being provided.

Section 6 – Glossary

6.1 **‘Appropriate next of kin’** means the person identified by the coroner or coroner’s office to act as the main contact point to receive information.

6.2 **‘Inform’**, or **‘informed’** means the giving of information by leaflet, letter, e-mail, telephone call, via a website or in person.

6.3 **‘Properly interested person’** is defined in rule 20 of the Coroners Rules 1984 as follows:

- a parent, child, spouse, civil 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 arose in connection with 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.

It is the coroner who decides who will be given properly interested person status.

6.4 **‘Service Users’** means bereaved people, witnesses and other ‘properly interested persons’ (see paragraph 6.3). It **does not** include journalists, members of the public or researchers, although these groups may find the Charter of interest.

6.5 **‘Working day’** means any day, except a designated bank holiday, between Monday and Friday inclusive.

Annex B: Impact Assessment

The impact assessment is available on the Justice website and throughout the consultation at http://survey.euro.confirmit.com/wix/p669921528.aspx.

Annex C: Organisations this paper has been sent to

A copy of this paper, which is also available on the Justice Website, has been sent to the following organisations:

Action against Medical Accidents

Adath Yisroel Burial Society

Adverse Psychiatric Reactions Information Link

Asbestos Group Forum

Assistance and Support in Surviving Trauma

Association of Chief Police Officers

Association of Personal Injury Lawyers

Board of Deputies of British Jews

Brake

Brethren Christian Fellowship (UK)

British Heart Foundation

British Humanist Association

British Irish Rights Watch

British Lung Foundation

British Medical Association

British Sikh Consultative Forum

Bromley Bereavement Centre

Buddhist Funeral Group

Cardiac Risk in the Young

Chief Constable of Hertfordshire

Chief Constable of West Yorkshire

Child Accident Prevention Trust

Child Bereavement Charity

Childhood Bereavement Network

Churches Funeral Group

CO-Gas Safety

Commissioner for Victims and Witnesses

Compassionate Friends

Coroners' Courts Support Service

Coroner's Officers Association

Coroners' Society of England and Wales
Cremation Society of Great Britain
Crown Office and Procurator Fiscal Service
Cruse Bereavement Care
Department for Communities and Local Government
Department for Culture, Media and Sport
Department for Education
Department of Health
Department for Transport
Department of Work and Pensions
Disaster Action
English Heritage
Epilepsy Bereaved
Evangelical Alliance
Families against Corporate Killing
Fire Service
Foundation for the Study of Infant Deaths
Funeral Service Times
General Medical Council
General Register Office
Health and Safety Executive
Hempsons Solicitors
Hindu Forum of Britain
Home Office
Human Tissue Authority
Independent Police Complaints Commission
INQUEST
Interfaith Network
JUSTICE
Justice for Victims
Lees Solicitors – Wirral and Chester
Liberty
Local Government Association
Local Government Employers

Local Government Regulations
London Borough of Croydon
London School of Hygiene and Tropical Medicine
Tom Luce CB (author of the Luce Report)
Marchioness Action Group
Media Lawyers' Association
Medical Defence Union
Medical Protection Society
Merseyside Asbestos Victim Support Group
Mesothelioma UK
Metropolitan Police
Mind
Ministerial Council on Deaths in Custody
Ministry of Defence
Muslim Burial Council of Leicestershire
Myeloma UK
National Association of Funeral Directors
National Bereavement Partnership
National Concern for Healthcare Infections
National Health Service
National Mental Health Development Unit
National Patient Safety Agency
National Policing Improvement Agency
National Spiritual Assembly of Baha'is of the UK
National Union of Journalists
Network of Buddhist Organisation UK
Network of Sikh organisations
Newspaper Society
Northern Ireland Court Service
National Society for the Prevention of Cruelty to Children
Office for Judicial Complaints
Office of Rail Regulation
Office of National Statistics
Pagan Federation

Police Federation
Press Association
Press Complaints Commission
Prison and Probation Ombudsman's Office
Michael Redfern QC (Chairman of the Redfern Inquiry)
Refuge
Rethink
Road Peace
Royal British Legion
Royal College of General Practitioners
Royal College of Pathologists
Royal College of Physicians
Royal Society for the Prevention of Accidents
Saad Foundation
SAFE Justice Foundation
Samaritans
SAMM Abroad
Society of Editors
Soldiers, Sailors, Airmen and Families Association
Southampton City Council (Legal and Democratic Services)
Stillbirth and Neonatal Death Society
Sudden Adult Death Trust (Sudden Arrhythmic Death Syndrome) UK
Support after Murder and Manslaughter (SAMM)
Survivors of Bereavement by Suicide
Trades Union Congress
Union of Orthodox Hebrew Congregations
Unitarian and Free Churches
Victim Support
Victims' Voice
Welsh Assembly Government, Department of Health and Social Services
War Widows' Association of Great Britain
Welsh Local Government Association
Youth Justice Board of England and Wales
Zoroastrian Trust Funds of Europe

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