Post-implementation review of the coroner reforms in the Coroners and Justice Act 2009
Call for Evidence

This call for evidence begins on 15 October 2015
This call for evidence ends on 10 December 2015
Post-implementation review of the coroner reforms in the Coroners and Justice Act 2009
Call for Evidence

A call for evidence produced by the Ministry of Justice. It is also available at https://consult.justice.gov.uk/
About this call for evidence

To: All interested stakeholders, particularly those involved in or affected by a coroner investigation since the coroner reforms came into effect in July 2013.

Duration: From 15 October 2015 to 10 December 2015

Enquiries (including requests for the paper in an alternative format) to: Coroners, Burials, Cremations and Inquiries Policy Team
Area 3.37
Ministry of Justice
102 Petty France
London SW1H 9AJ
Tel: 020 3334 3555
Fax: 020 3334 2233
Email: coroners@justice.gsi.gov.uk

How to respond: Please send your response by 10 December 2015 to:
Access to Justice Analytical Services
Ministry of Justice
102 Petty France
London SW1H 9AJ
Tel: 020 3334 3555
Fax: 020 3334 2233
Email: coroners@justice.gsi.gov.uk

Response paper: A response to this call for evidence is due to be published in early 2016 as part of a post-implementation review.
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Review of Coroners Reforms - call for evidence
Foreword

The Government is committed to making sure bereaved people are at the very heart of the coroner system.

I am therefore pleased to announce our post-implementation review of the coroner reforms in the Coroners and Justice Act 2009 (‘the 2009 Act’), which includes this call for evidence into people’s experiences of coroner services.

Before the last Government implemented the 2009 Act’s coroner reforms in July 2013, it undertook to review their impact after they had been in place for 18 months.

Since assuming responsibility for coroner policy and legislation following the general election I too have been considering this. The reforms have now been in place for just over two years and I believe that this is a good period of time against which to assess the impact of the reforms and seek views on people’s experiences of the system.

I am keen to hear the views of:

- Those who have used coroner services under the 2009 Act – bereaved people and the voluntary organisations, including faith groups, who support them;
- The providers of local coroner services – coroners, their officers and other staff, and the local authorities that fund coroner services;
- Others who interact with coroner services – such as pathologists, other doctors and registrars; and
- Others who have been affected by and have experiences of coroner services under the 2009 Act

As part of this review we have approached those stakeholders we are aware of via an email survey. This Call for Evidence allows anyone else with an interest the chance to feed in their experiences to the review.

Following this review we will consider the responses we have received and publish a post-implementation review report. Any proposed action arising from the findings of the review will be announced at that time.

Caroline Dinenage
Parliamentary Under Secretary of State for Women, Equalities and Family Justice
Executive summary

The coroner reforms in the Coroners and Justice Act 2009 (“the 2009 Act”) came into effect in July 2013. The aims of the Act were to put the needs of bereaved people at the heart of the coroner system; for coroner services to be locally delivered within a framework of national standards; and to enable a more efficient system of investigations and inquests. A number of changes were made to the role of coroners and the processes to be followed for post-mortem examinations, investigations and inquests. The role of the Chief Coroner was created to provide national oversight and leadership to coroners. Specific reforms included the following:

- Compulsory training for coroners and training for their officers.
- New eligibility requirements and a new appointments process for coroners, with the Chief Coroner and Lord Chancellor approving all new coroner appointments.
- Families getting information relevant to a coroner investigation earlier in the process and having greater access to documents and evidence before the inquest hearing.
- Removing rigid geographical boundary restrictions so that investigations and post-mortem examinations can be transferred between coroners more easily.
- The Chief Coroner publishing details of all inquests that take more than 12 months to complete and reporting annually on this.
- The Chief Coroner publishing all coroner ‘Prevention of Future Deaths’ reports and responses to them.

When we consulted on our proposed reforms in early 2013, the Department for Communities and Local Government, in conjunction with the Local Government Association, supported our approach on condition that we review them 18 months after implementation.

This review seeks to find out whether the reforms are operating as expected and whether there have been any unintended negative consequences. It will help support local delivery by identifying lessons and best practice that can be shared in the future.
Introduction

This call for evidence asks for your views relating to the 2013 reforms to coroners services under the Coroners and Justice Act 2009.

As part of the review, we are also sending surveys to the following stakeholders of which we are aware: coroners, representatives from local authorities, pathologists, registrars, and representatives from volunteer organisations and faith groups who work with bereaved people. The surveys will cover the aspects of the reforms relevant to each stakeholder group. Questions will elicit information on whether and how the reforms have affected respondents’ experiences and the way they work.

This call for evidence aims to primarily capture the views of anyone who will not be reached by the surveys. We are interested in hearing from you if you have experienced a coroner service since the reforms came into effect in July 2013.
Scope of the Review and Questions

The main aim of the coroner reforms in the Coroners and Justice Act 2009 was to put the needs of bereaved people at the heart of the coroner system.

We are interested in hearing about people’s experiences with the aspects of coroner services that were reformed under the 2009 Act.

The key areas of change were the following:

- Creation of the statutory guidance booklet, the “Guide to Coroners Services”, for bereaved people (available from coroners’ offices and on gov.uk)
- A requirement that coroners disclose information that bereaved people request during an investigation, free of charge
- A requirement for all inquests to be recorded (and elimination of the requirement that notes be taken during inquests)
- A requirement that coroners be available at all times to address matters which must be dealt with immediately
- A requirement that bereaved people and other interested parties be notified of inquest arrangements and any changes within a week of the arrangements or changes being made
- Flexibility of inquest and post-mortem examination locations, which may now be held anywhere in England and Wales rather than being restricted to the coroner’s area (and, for post-mortem examinations, a neighbouring area)

We are interested in hearing from people who have had experience of any of these, or other, aspects of coroner services since July 2013.

We appreciate that few people will have experience with all of the above. Respondents are invited to answer questions related to their own experiences and leave other questions blank.

Guide questions for each topic are given below and are also summarised in a box at the end of the document.

Guide to Coroners Services

The booklet “Guide to Coroners Services”1 explains the coroner investigation process, including the inquest, and sets out the standards of service that coroners should meet. It also explains what someone can do if they feel those standards are not met.

We are interested in knowing whether people who had contact with coroners’ offices were provided with, or pointed towards, copies of the Guide and whether the information it contained was useful. We are keen to receive feedback on your experience related to this, but also present some sample questions you might want to consider in giving your response:

• Did you receive a copy of the Guide to Coroners Services?
• If you received the Guide, did it help you understand the process of investigations and inquests? Why or why not?
• Did you feel the Guide’s standards were met? If not, which standards did you feel were not met in your case?

The release of bodies and post-mortem examinations

We are also interested in hearing the experiences of those who have requested a less invasive post-mortem examination (for instance a computerised tomography (CT) or magnetic resonance imaging (MRI) scan). Following are some questions you might want to consider in giving your response:

• If you requested a less invasive post-mortem examination, were you satisfied with the coroner’s service? Why or why not?

The 2009 Act introduced a provision that coroners should release bodies for burial or cremation as soon as is practicable, and that, if it is not possible for release within 28 days of being informed of the death, the coroner must inform the next of kin or personal representative of the reasons for the delay.

We are interested in hearing about the experiences of bereaved people in securing release of the body from the coroner. Here are some guide questions you might want to address in your response:

• If you experienced a delay in the release of a body, did you receive an explanation from the coroner’s office?
• Were you satisfied with the explanation for the delay?

Disclosure of information and inquest recordings

Coroners are now required to provide information or documents if an interested person requests them. If the request is made during an investigation, the disclosure is free. If the request is made after an investigation or inquest, there may be a fee for the disclosure. Here are some guide questions you might want to address in your response:

• If you requested any information or documents regarding an investigation, was this during or after the investigation, or both?
• Did you receive information as a result of the request?
• Were you satisfied with the information you received?
• If you had to pay a fee for disclosure, do you feel the fee was reasonable?

Prior to the 2009 Act, coroners were required to take notes of all inquests but this is not required now as there is a requirement to make a recording of all inquests. We are interested in hearing from people who requested a copy of a recording (audio or

2 http://www.legislation.gov.uk/uksi/2013/1629/regulation/20/made
transcript) of an inquest. Here are some questions you might want to consider in giving your response:

- If you requested a copy of a recording (audio or transcript) of an inquest, did you receive the recording?
- Were you satisfied with the recording (audio or transcript) you received?

**Out-of-hours availability**

Coroners are required to be available at all times to address urgent issues that cannot wait until the next working day.

We would like to hear from people who have attempted to contact coroners outside normal office hours. Here are some questions you might want to consider in giving your response:

- If you tried to contact a coroner outside normal office hours, why was this?
- Were you able to speak to the coroner’s office outside of normal hours?
- Were you satisfied with the response you received to your contact?

**Notification of inquest arrangements**

Coroners must inform next of kin of the arrangements for the inquest (for example, date and location) within one week of making the arrangements. If any of the details are changed, they must inform next of kin of the changes within one week of making them.

We are interested in hearing from people who have experienced an inquest, about whether they felt informed about the arrangements for the inquest. Here are some questions you might want to consider in giving your response:

- If you experienced an inquest, were you satisfied with how and when the coroner’s office notified you of the inquest arrangements and any subsequent changes?
- What aspects of the notification were you satisfied or dissatisfied with?

**Flexibility of inquest and post-mortem examination location**

Prior to the 2009 Act, inquests had to be held in the district of the coroner handling the investigation. A post-mortem examination had to be held in the coroner’s area or a neighbouring area. The Act introduced a change to this, so that inquests and post-mortem examinations may now be held anywhere in England or Wales.

We would like to hear from people who had experience with an inquest or post-mortem examination held outside the coroner’s area, whether by their own request or the coroner’s recommendation. Here are some questions you might want to consider in giving your response:

- If you requested that an inquest or post-mortem examination be held outside the coroner’s area, what was the reason?
- If the coroner requested that an inquest or post-mortem examination be held outside their area, what was the reason given?
- What benefits or problems did you experience as a result of the post-mortem examination or inquest being held, or not being held, outside the coroner’s area?
Other

If there is anything else you’d like to share about your experiences with coroners services, please share them with us here.

This call for evidence is focused on changes as part of the Coroners and Justice Act 2009. While we will read all responses, only those relevant to the 2009 Act will feed into the review.

- Are there any other experiences with a coroner’s service since July 2013 that you would like to tell us about?
Guide Questions

The text box below lists the guide questions that were presented above.

We welcome submissions of evidence relevant to this Call for Evidence. Please use the following guide questions to inform your response. Please note it is important that your responses relate to the topics indicated below.

Responses received which cover topics unrelated to these areas will be read, but may not be considered in the final report or recommendations.

Guide to Coroners Services
- Did you receive a copy of the Guide to Coroners Services?
- If you received the Guide, did it help you understand the process of investigations and inquests? Why or why not?
- Did you feel the Guide’s standards were met? If not, which standards did you feel were not met in your case?

The release of bodies and post-mortem examinations
- If you experienced a delay in the release of a body, did you receive an explanation from the coroners’ office?
- Were you satisfied with the explanation for the delay?
- If you requested a less invasive post-mortem examination, were you satisfied with the coroner’s service? Why or why not?

Disclosure of information and inquest recordings
- If you requested any information or documents during an investigation, was this during or after the investigation, or both?
- Did you receive information as a result of the request?
- Were you satisfied with the information you received?
- If you had to pay a fee for disclosure, do you feel the fee was reasonable?
- If you requested a copy of a recording (audio or transcript) of an inquest, did you receive the recording?
- Were you satisfied with the recording (audio or transcript) you received?

Out-of-hours availability
- If you tried to contact a coroner outside normal office hours, why was this?
- Were you able to speak to the coroner’s office outside of normal hours?
- Were you satisfied with the response you received to your contact?
Thank you for participating in this call for evidence.

**Notification of inquest arrangements**

- If you experienced an inquest, were you satisfied with how and when the coroner’s office notified you of the inquest arrangements and any subsequent changes?
- What aspects of the notification were you satisfied or dissatisfied with?

**Flexibility of inquest and post-mortem examination location**

- If you requested that an inquest or post-mortem examination be held outside the coroner’s area, what was the reason?
- If the coroner requested that an inquest or post-mortem examination be held outside their area, what was the reason given?
- What benefits or problems did you experience as a result of the post-mortem examination or inquest being held, or not being held, outside the coroner’s area?

**Other**

- Are there any other experiences with a coroner’s service since July 2013 that you would like to tell us about?
About you

Please use this section to tell us about yourself

<table>
<thead>
<tr>
<th><strong>Full name</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Job title</strong> or capacity in which you are responding to this call for evidence (e.g. member of the public etc.)</td>
</tr>
</tbody>
</table>

**Date**

**Company name/organisation (if applicable):**

**Address or email address**

**Postcode**

If you have had experience with coroner services, which coroner area(s) have you dealt with?

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

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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.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Contact details/How to respond

Please send your response by 10 December 2015 to:

Access to Justice Analytical Services
Ministry of Justice
102 Petty France
London SW1H 9AJ
Tel: 020 3334 3555
Fax: 020 3334 2233
Email: coroners@justice.gsi.gov.uk

Complaints or comments
If you have any complaints or comments about the call for evidence process you should contact the Ministry of Justice at the above address.

Extra copies
Further paper copies of this call for evidence can be obtained from this address and it is also available on-line at https://consult.justice.gov.uk/.

Alternative format versions of this publication can be requested from coroners@justice.gsi.gov.uk / 020 3334 3555.

Publication of response
A paper summarising the responses to this call for evidence will be published in early 2016 as part of the wider post implementation review of coroner reforms in the 2009 Coroners and Justice Act.

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 call for evidence, 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.