



House of Commons
Constitutional Affairs
Committee

Reform of the coroners' system and death certification

Eighth Report of Session 2005–06

Report, together with formal minutes

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The Constitutional Affairs Committee

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Summary

Reform of the systems of death certification and investigation is long overdue. The coronial system in England and Wales has been neglected for decades and coroners' service to society is constrained by limited legal, financial and human resources. The death certification system is over complex and vulnerable to dangerous abuse.

The Government's draft Bill will do much to improve the coronial system, building a reformed service around a reduced number of full-time, legally qualified coroners serving larger jurisdictions. National leadership will be provided by a Chief Coroner and a statutory Coronial Advisory Council. Coroners' powers of inquiry and investigation will be modernised and bereaved families and other interested persons will have new rights and status, including a right of appeal.

However, the Government has made no provision in the draft Bill to remedy the critical defects in the death investigation system. There is no effective supervision of or support for certifying doctors, nor is there any mechanism for ensuring, so far as possible, that deaths which should be investigated are reported to the coroner. The Government has ignored the recommendations of both the Shipman Inquiry and the Luce Review and drawn back from its own proposals for reform of death certification, put forward by the Home Office in 2004.

Moreover, the Government has failed to nationalise the coronial system, leaving local authorities as the main source of funding. It is, therefore, likely that the current inequalities of resourcing and variable levels of service to the bereaved in particular and society in general will continue.

The Government is in danger of wasting a golden opportunity for substantial reform of the systems of death certification and investigation in England and Wales. Much of the improvement which might come about as a result of the proposals in the draft Bill will be threatened by the paucity of resources which are likely to be devoted to this important area. We believe that this draft Bill falls well short of what is required to reform the system.

1 Introduction

Background to the Inquiry

1. This Inquiry was set up to investigate the systems of death certification and investigation in England and Wales against a background of continued inaction by the Government in response to two reports published in 2003: *Death Certification and the Investigation of Deaths by Coroners*, the 3rd Report of the Shipman Inquiry under Dame Janet Smith (the “Shipman Inquiry”);¹ and *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003* under Tom Luce (the “Luce Review”)². Both reports found the systems for the certification and investigation of deaths in England and Wales to be unfit for modern society.³

2. The Government published a position paper *Reforming the Coroner and Death Certification Service* in March 2004 (the “Home Office Position Paper”) in response to the Shipman Inquiry and the Luce Review.⁴ In this paper, the Government accepted many of the recommendations made by the Luce Review and stated that a Draft Bill and White Paper would be produced within one year.⁵ The Government’s 2004 proposals were broadly welcomed by stakeholders in the coronial system.⁶

3. In May 2005, responsibility for the coronial system passed from the Home Office to the Department for Constitutional Affairs (DCA). In January 2006, no draft Bill having been published, we launched our *Inquiry into Coroner Reform and Death Certification*, stating that we would consider:

- problems with the existing system of death certification and investigation;
- proposals for reform; and
- alternatives to a coronial system as practised in other jurisdictions.

We have not included within the scope of this Inquiry the reform of coronial jurisdiction over treasure.

4. On 6 February 2006, the Minister of State for Constitutional Affairs, Rt Hon Harriet Harman QC MP, made a statement accompanied by a short Briefing Note on reform of the coronial system.⁷ The Minister committed the Government to publishing a draft Bill for pre-legislative scrutiny in Spring 2006.⁸ The Government’s draft Bill on Coroner Reform (Cm 6849) was eventually published on 12 June 2006, the day before this Inquiry’s first session of oral evidence on the detailed provisions of the draft Bill.

1 Death Certification and the Investigation of Deaths by Coroners, the 3rd Report of the Shipman Inquiry, Cm 5854

2 Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003, Cm 5831

3 Luce Review, p 3; 3rd Report of the Shipman Inquiry, p v

4 Home Office, *Reforming the Coroner and Death Certification Service – A Position Paper*, Cm 6159, March 2004

5 Home Office Position Paper, p 33

6 Q94; Ev 62, para 21; BMA and COA submissions to the Home Office Position Paper

7 HC Deb, 6 February 2006, col 607; Department for Constitutional Affairs, *Coroners Service Reform: Briefing Note*, February 2006

8 Department for Constitutional Affairs, *Coroners Service Reform: Briefing Note*, February 2006

Pre-legislative scrutiny and the legislative process

5. Although we had intended to conduct pre-legislative scrutiny of the draft Bill, the DCA published it so late that any review leading to a report before the summer was inevitably limited. Publication of the draft Bill the day before the first oral evidence session was wholly unsatisfactory since witnesses were unable to give evidence on its detailed provisions.

6. The Minister told us that late publication of the draft Bill was due to “the fact that we were trying to do the plain English translation alongside the legalese”.⁹ She added that we should not have had to wait for the “translation” and should have been given the plain text of the draft Bill pending drafting of the explanatory notes.¹⁰ We agree.

7. Because of the late publication of the draft Bill, we could not take a complete range of detailed evidence from witnesses on its provisions. This means that, before the summer, only recommendations addressing the broad policy issues can be made. The Government will, therefore, be publishing a Bill without the benefit of detailed pre-legislative scrutiny on the provisions of the draft Bill. This will inevitably affect the quality of the Bill and may delay the passage through Parliament of this important and urgently needed legislation.

8. The Minister has asked for our views on three separate points: investigation of deaths abroad; abolition of juries at inquests on deaths at work; and the coroner’s powers to impose reporting restrictions.¹¹ She waited until the last oral evidence session, on 27 June 2006, to do this, leaving us no time to take evidence on these points before the summer. The Minister characterised these questions as engagement in the pre-legislative scrutiny process.¹² However, asking questions at a very late stage in the Inquiry does not constitute full engagement with the pre-legislative process, particularly in the light of late publication of the draft Bill. **We recommend that, in future, the Government makes known the particular issues with which it requires assistance at the same time as or, preferably, before publication of the draft Bill.**

9. The Minister has announced publicly that a separate process of consultation on the draft Bill will be conducted with a group of recently bereaved people who have had contact with the coronial system. She has called this exercise “pre-legislative scrutiny” and a meeting of a panel of bereaved, chosen by the Department following a filtering process, will be held in the Palace of Westminster. The panel will not take evidence; instead, a moderator will facilitate a discussion of the draft Bill. This discussion will be recorded in writing and published by the DCA as “scrutiny” of the draft Bill.¹³ This may lead to confusion, both as to the status of this exercise relative to the wide-ranging scrutiny performed by this Committee and as to the comparative status of our Report and the document which will be published as a result of the consultation with the bereaved.

10. The Government cannot claim to be engaging in the pre-legislative scrutiny process when it has published the draft Bill so late that there is insufficient time for scrutiny to

9 Q243

10 Q243

11 Q282

12 Q282

13 Letter from Rt Hon Harriet Harman QC MP to Rt Hon Alan Beith MP, Chairman of the Committee, June 2006

be carried out thoroughly and effectively. We recommend that the Department for Constitutional Affairs reviews its procedures for publication of draft legislation so that this Committee may in future have sufficient time to conduct proper pre-legislative scrutiny.

11. Despite the lack of time for taking detailed evidence on the provisions of the draft Bill, we have received a large amount of evidence on wide-ranging issues. Many provisions of the draft Bill, heralded in the DCA's Briefing Note of February 2006, have been welcomed by stakeholders in the coronial system.¹⁴ Coroners particularly have expressed the view that they would rather have the Bill in its current form than no Bill at all.

12. However, we have received evidence revealing a number of urgent issues which should be brought to the Government's attention before publication of the Bill itself. Accordingly, we have decided to publish this initial Report in order to address those issues and we will be returning to the subject of coroners later in the year.

14 Q105; Ev 153; Ev 64, para 5; Ev 147; Ev 96, para 2 and others

2 Background

The need for reform: the Shipman Inquiry and the Luce Review

13. The death certification and investigation systems have essential roles, providing each person who dies with a last, posthumous, service from the State; they serve families and friends by clarifying the causes and circumstances of the death; and they contribute to the health and safety of the public as a whole by providing information on mortality and preventable risks to life. However, Tom Luce – who reviewed the system in 2003 - states that:

the systems in England and Wales have been for decades a forgotten service. They are staffed in the main by people of competence and integrity, but their structures are obsolete, they have historically received only modest support from Governments and until recently they engaged little public and political attention.¹⁵

14. As a result of concern about undiscovered homicide in the mid-1960s, the Government established the Brodrick Inquiry which reported in 1971. According to Tom Luce, its main conclusion was that “there [was] no requirement to strengthen the present machinery of death certification simply in order more efficiently to prevent or detect secret homicide”, but subsequent events have shown this to be wrong. He adds that most of its recommendations for other improvements were not followed up.¹⁶

15. The conviction in January 2000 of Harold Shipman for multiple murder of many of his patients, together with some high-profile cases during the 1990s in which the effectiveness of the coroner service came under challenge, led to appointment of both the Shipman Inquiry and the Luce Review. The resulting reports were both published in summer 2003.

The Shipman Inquiry

16. In her Foreword to the 3rd Report of the Shipman Inquiry, Dame Janet Smith makes clear her view that the death certification and investigation systems failed in the case of Harold Shipman.

In the First Report of the Shipman Inquiry, I disclosed my finding that Shipman had killed at least 215 of his patients over a period of 24 years. It was clear that the current arrangements for death registration, cremation certification and coronial investigation in England and Wales had failed both to deter Shipman from killing his patients and to detect his crimes after they had been committed. The failure of the existing system prompted Parliament to set up the Shipman Inquiry...¹⁷

17. She argued that radical reform was necessary for two reasons. First, there were no guarantees that there would never be “another Shipman”:

15 Ev 60, para 2

16 Ev 60, para 3

17 3rd Report of the Shipman Inquiry, Foreword, p v

If there is a risk that a doctor might kill in the future and if, as is now clear, the present system would neither deter nor detect such conduct, surely the system must be changed.¹⁸

18. Second, there was a broader argument for reform:

the system is not working as well as it should. The evidence received by the Inquiry suggests that there is much dissatisfaction with the present arrangements. It is said that the existing system is fragmented, is not sufficiently professional, is applied to very variable standards in different parts of the country and does not meet the needs of the public, especially the bereaved. It is said that it does not satisfy the public interest in the discovery of the true causes of death in the population. It does not contribute, to the extent that it should, to the improvement of public health and safety. If these complaints are well founded, as I have found they are, then there are good reasons for radical change, quite apart from the need to ensure that, so far as possible, homicide does not go undetected.¹⁹

The Luce Review

19. The Luce Review also identified some “critical weaknesses of the death certification and coronial processes”:

- The systems are internally fragmented and not concerned with the identification of patterns or trends.
- The certification and investigation systems are separate from each other. There is no means of ensuring that a death which ought to be reported to a coroner for investigation is so reported. Moreover, a coroner has no jurisdiction to investigate deaths not reported to him. There are, therefore, inadequate safeguards against a doctor “certifying his way out of trouble”.
- The coronial system lacks leadership, accountability and quality assurance.
- The death certification and coronial systems are isolated from each other, from the mainstream healthcare and justice systems, and from other public health and safety agencies.
- The rights and expectations of the bereaved are unclear and their treatment within the coronial system “fall[s] below modern judicial standards of openness, fairness and predictability”.
- There is no consistent response to the wishes, traditions and religious beliefs of minority communities.
- There is a lack of expert medical assistance for the death certification and investigation processes.
- There is a lack of consistent training for coroners, coroners’ officers and other professionals working in the death certification and investigation systems.

18 *Ibid*

19 *Ibid*

- There is no full-time leadership in the coronial system and most coroners themselves work part-time.
- Complex and contentious inquests are inadequately resourced and there is a lack of clarity in the relationship between inquests and other formal death investigation processes.
- The death certification and investigation systems lack a clear, modern legal basis for their conduct; mechanisms to allow for evolution in response to changing needs; and agreed priorities and objectives.
- There is a general lack of resources and support.²⁰

20. We have heard evidence that coroners generally accept the need for change. Mr Michael Burgess, HM Coroner for Surrey & Coroner of The Queen's Household, told us that most coroners felt reform was needed and long overdue:

Many of us, individually and together in the Coroners' Society, have spent many hundreds of hours working with the two inquiries which resulted in the two reports. I think all of us see the need for reform. Maybe some of us see the need in quite different ways, but broadly speaking we have no difficulty at all in putting our hands up and saying reform is needed and the sooner the better.²¹

21. Coroners undertake their statutory function in a fragmented and localised system that has remained largely unchanged since the time of Queen Victoria. The current system is ill-equipped to deal with the modern expectations of society and our formal and informal evidence has shown us that coroners are amongst the greatest proponents of change.

Home Office proposals 2004

22. The Shipman Report and Luce Review were followed by the Home Office's Position Paper, published in 2004.²² The Home Office proposed retention of the coronial system, subject to reform, and an overhaul of the death certification system. There would be a national service under a chief coroner; between 40 and 60 coroners; dedicated, trained and integrated medical support for the coroner; and regional oversight of death trends through Regional Directors of Public Health (Directors of Public Health in Northern Ireland and Wales).²³

23. This was seen as a sensible compromise,²⁴ although the question remains whether it could have been delivered on the revenue-neutral basis demanded by the Home Office. The present system operates on a very limited budget, often dependent on hidden subsidies from local authorities which, for example, may provide premises free of charge or from police authorities, some of which do not charge for the time of police officers acting as coroners' officers. Even the most moderate changes are likely to need a substantial increase

20 Luce Review, Chapter 2, para 4

21 Q3

22 Home Office Position Paper

23 *Ibid*, p 10

24 Ev 62, para 21; Ev 95–98; Ev 76–78

in resources. Setting up a new system without sufficient resources risks a repeat of the difficulties seen with the inception of the Crown Prosecution Service or CAF/CASS²⁵ and may imperil much of the good work which the Government's proposals promise.

The draft Bill

24. Responsibility for the coronial system was transferred from the Home Office to the DCA in May 2005. As already noted, on 6 February 2006, the Minister of State for Constitutional Affairs, Rt Hon Harriet Harman QC MP, issued a statement accompanied by a short Briefing Note indicating the Government's intention to publish a draft Coroners Bill by Spring 2006.²⁶ The Government indicated that much of the detail of its proposals would be taken forward in secondary legislation.²⁷

25. The draft Bill was published on 12 June 2006. The broad areas of reform are as follows:

- A body of full-time coroners will be created and current boundaries will be reshaped to create a smaller number of coroner jurisdictions. Local authorities will appoint, with the consent of the Lord Chancellor, a full-time Senior Coroner for each area. They will also appoint as many full-time Area Coroners and part-time Assistant Coroners, if any, as the Lord Chancellor decides are necessary.
- A Chief Coroner and a Coronial Advisory Council will be introduced. The Chief Coroner will be accountable to the Lord Chancellor.
- As now, location of the body will determine the jurisdiction of the coroner, subject to certain circumstances in which the draft Bill will allow boundary restrictions to be relaxed. The duty to hold an investigation and the duty to hold an inquest will be distinguished, so that the duty to hold an inquest will only arise where the investigation has not been discontinued for some reason, such as where the post mortem reveals a natural cause of death.
- There will be a draft Charter for Bereaved People (the "draft Charter") setting out the rights of bereaved people in relation to coronial investigations and what they can expect from the system. The draft Charter will also set out the objectives and values of the coronial system, together with expected standards of service.
- A wide class of "interested persons", including but not limited to the bereaved, will have a right to appeal to the Chief Coroner from a decision of a coroner made in connection with an investigation. Appeals will not be limited to the outcome of an inquest. The Chief Coroner will also organise a system for dealing with complaints.
- During the course of an investigation, coroners will have new powers to obtain information to assist their investigations and boundary restrictions will be removed to allow for co-ordinated action between coronial jurisdictions.
- Coroners will have powers to impose reporting restrictions to protect the identities of the deceased and others. They will also be able to take evidence from children and

25 Children and Family Court Advisory and Support Service

26 Department for Constitutional Affairs, Coroners Service Reform: Briefing Note, February 2006

27 Ev 110, para 4.3

certain others via live link in a courtroom cleared of everyone except interested persons and the jury, if any.

- The Chief Coroner will make arrangements for the training and guidance of coroners and their assistants, including coroners' officers, although the specifics of how the training system will work are not the subject of statutory provision.
- A new Coroner for Treasure will be appointed (outwith the scope of this Inquiry).

26. Although not included in the draft Bill, the Government has indicated that a Chief Medical Adviser will be appointed to assist the Chief Coroner with medical issues and best practice. Funding will be provided at a local level to provide coroners with "appropriate independent local medical advice to support their investigation".²⁸

27. The DCA proposals set out in the draft Bill depart significantly from the Home Office position of 2004. In addition, some of the main recommendations of the Shipman Inquiry and Luce Review have been rejected. Most importantly, the Government no longer proposes to reform the current system of death certification in tandem with reform of the coronial system, drawing back from the proposals set out in its 2004 Position Paper and rejecting the recommendations of both the Shipman Inquiry and the Luce Review:

We are seeking a system which strikes the right balance between cost, risk, delays and the rights of families to proceed quickly with funeral arrangements. We are not sure that the proposals to have all deaths referred to coroners achieves this delicate balance, but we will be looking further at this and do not exclude the possibility of wide ranging change in the long term.²⁹

28. Other proposals and recommendations the Government has rejected for the purposes of the draft Bill include:

- Centralisation and nationalisation of the coronial system and support services for coroners. Coroners will continue to be appointed and funded by their local authorities and served by coroners' officers drawn from the local police or local authority.
- Standardisation of employment and funding of coroners' officers from within the coroners service.
- Unification of the coronial and death certification systems with a medical examiner to scrutinise all death certificates.
- Appointment of all coroners according to judicial standards.
- The creation of a general duty on doctors, police officers and other persons to report a death to the coroner.
- The power to hold inquests in private in sensitive cases such as infant and suicide deaths. All inquests will continue to be held in public, although the new reporting restrictions may be used.

²⁸ Ev 109, para 3.9

²⁹ Ev 110, para 5.3

29. In the context of deaths in custody which require investigation in accordance with the requirements of Article 2 of the European Convention on Human Rights, INQUEST argued that “for families to participate effectively in the investigation and inquest process, they need legal representation”.³⁰ The Luce Review concluded that although the current legal aid regime was broadly satisfactory, the criteria should be more liberally interpreted to ensure that families had access to legal representation in cases where public authorities were legally represented.³¹ The DCA does not propose any amendments to the current legal aid criteria.

Alternative systems

30. Both the Shipman Inquiry and the Luce Review considered alternatives to the coronial system as practised in other jurisdictions. During this Inquiry, we have visited Scotland to investigate the workings of the Scottish system, where rates of post-mortem examination are much lower than they are in England and Wales and very few deaths give rise to public proceedings comparable to an inquest (a Fatal Accident Inquiry).³² We have also heard witnesses’ views on the merits of the coronial system compared with other systems.

31. There is room for debate as to whether a coronial system is the most effective for the purposes of death investigation and promotion of public health and safety. However, evidence submitted to us indicated an overwhelming preference for the retention of a substantially reformed coronial system.³³ The Shipman Inquiry and Luce Review came to the same conclusion, although they differed in their recommendations as to what reforms would be necessary.³⁴ Although we would have preferred the Government to have consulted more widely on alternatives to the coronial system and whether lessons could be learned from other jurisdictions, we consider that our coronial system is appropriate for the purposes of modern society, subject to significant reforms.

30 Ev 17, para 44

31 Luce Review, Chapter 12, para 34

32 Q159

33 Qq 68, 102, 211, 212

34 3rd Report of the Shipman Inquiry, Recommendations 1; Luce Review, Chapter 3

3 Death certification

The existing system

Requirements for registration of death

32. There are over half a million deaths per annum in England and Wales, with 70% resulting in cremation and 30% resulting in burial.³⁵ After death, either a medical certificate of cause of death (MCCD) from a doctor or a certificate from a coroner is required before a death can be registered with the Registrar of Births, Deaths and Marriages. There are rare cases where deaths can be registered as “uncertified”.³⁶ Registration in the case of burial requires a certificate of the cause of death either from a doctor or the local coroner. If the body is to be cremated, a family member makes an application and two more doctors are involved – a second certificant and the crematorium medical referee. The second certificant is usually chosen by the first. Families pay fees totalling £100 for doctors’ cremation certification.³⁷

33. Many commentators have taken the view that death certification procedure should be standardised regardless of method of disposal of the body. The Shipman Inquiry reported that:

All the evidence received by the Inquiry and virtually all the opinions expressed during consultation suggest that the separate system of certification prior to cremation should be abolished. It was universally recognised that we must have an improved system of death certification applicable to all deaths, whatever mode of disposal is to follow.³⁸

The Luce Review also recommended that:

There should be a common certification process for all deaths not reported to the coroner, whether the body is to be buried or cremated, and that process should in each case bring two professional opinions to bear before disposal of the body is authorised.³⁹

Referral to the coroner

34. Around 45% of the half million deaths in England and Wales were referred to the coroner in 2005.⁴⁰ The Registrar of Births, Marriages and Deaths is obliged to refer to the coroner deaths:

- where the deceased was not attended by a medical practitioner during his last illness;

35 Richard Allen, DCA Statistical Bulletin: Statistics on Deaths Reported to Coroners, England and Wales 2005; Home Office Position Paper, p 5

36 Ev 93, Appendix

37 Ev 61, para 8

38 3rd Report of the Shipman Inquiry, para 19.36

39 Luce Review, Chapter 21, Recommendation 9

40 DCA Statistical Bulletin: Statistics on Deaths Reported to Coroners, England and Wales 2005, p 1

- where there is no duly completed certificate of cause of death;
- where the certifying medical practitioner did not see the deceased either after death or within 14 days before death (the “14-day rule”);
- where the cause of death is unknown;
- which may have been unnatural, violent, due to neglect or abortion, or attended by suspicious circumstances;
- which may have occurred during an operation or before recovery from anaesthetic;
- which may be due to industrial disease or industrial poisoning.⁴¹

35. Only the Registrar has a statutory duty to refer such deaths to the coroner.⁴² However, in practice, a very small percentage of deaths are referred by the Registrar. The vast majority are referred directly by the police and by doctors, on whom there is no statutory duty to refer such cases.⁴³ The general practice for doctors is to refer deaths to the coroner voluntarily where there is reason to suspect that the death was:

- an accident;
- a suicide;
- related to the deceased’s employment; or
- occurred during or shortly after detention in police or prison custody.⁴⁴

36. The wide variety of circumstances leading to referral of a death to a coroner and lack of specificity in the legislation has resulted in a great deal of confusion over when referral is appropriate. Dame Janet Smith remarked to us that:

In my report I drew attention to how very difficult it is for doctors to know when they ought to report a death to the coroner, that the existing statutory rules are opaque, that those rules have been built upon and there are lists in existence which try to elucidate the statutory rules, that local coroners have their own local rules and it is extremely difficult for doctors to form a view. I myself and my inquiry team tried to draft a list that would be comprehensive and easy to understand and easy to apply. We failed!⁴⁵

37. The rate of referral of deaths to coroners in England and Wales is very high in comparison with other jurisdictions. 232,400 deaths were referred to coroners in 2005, a rise of around 3% from the 2004 figures despite little change in the underlying number of registered deaths. The proportion of registered deaths being referred to coroners rose from 43.9% in 2004 to 45.3% in 2005, continuing a long-term upward trend.⁴⁶ These rates are

41 Births and Death Regulations 1987, Reg 41

42 Births and Death Regulations 1987; Luce Review, Chapter 4, para 6

43 Luce Review, Chapter 4, para 7

44 Ev 94

45 Q42

46 DCA Statistical Bulletin: Statistics on Deaths Reported to Coroners, England and Wales 2005, p 1

between 50% and 100% higher than those in other jurisdictions.⁴⁷ Of deaths referred to coroners, 49% required post-mortem examinations in 2005, in line with a continuing downward trend.⁴⁸

38. A DCA Statistical Bulletin attributes this long-term rising trend in referral of deaths to coroners to the death certification process itself, arguing that it:

may reflect increasing doubts among medical practitioners about signing death certificates without referral to the coroner.

This long-term upward trend in both the number and the proportion of deaths reported to coroners is probably due in part to the growing use, over at least the last twenty years, of deputizing services by general practitioners. In these cases the doctor attending at or after death cannot legally give a medical certificate showing the cause of death because he or she had not attended the deceased during the last 14 days. There is also considered to be a lack of adequate training in some pathology matters at medical schools; and in addition, people have become more concerned about proper process, a matter which has become more widely publicised since the Shipman murders.⁴⁹

39. The Luce Review also noted increases in the number and proportion of deaths referred to coroners where no further action is taken by the coroner, and an increase in the number of inquests with verdicts of natural causes. Research commissioned by the Luce Review found that:

All these trends suggest that the resources of coroners are being stretched by, and the primary purpose of the coronial system is being subverted by, an increase in referrals for reasons other than that an unnatural or accidental cause of death is suspected. These trends are not only unsustainable with current resourcing patterns, but are undesirable.⁵⁰

40. When asked by us about the very high rates of referral of deaths to coroners and of autopsy in England and Wales when compared with other jurisdictions, Tom Luce identified a lack of confidence among certifying doctors as one contributory factor:

It suggests to me that there is basically a serious problem of confidence and self-confidence amongst the doctors doing death certification.⁵¹

41. Victor Round, Honorary Secretary of the Coroners' Society, also gave evidence that doctors were untrained in death certification and did not know when to refer a death to the coroner.⁵² The BMA confirmed that:

There is a need for training and support in the certification process, particularly for newly qualified doctors. Such training could, for example, be included in the General

47 Luce Review, Chapter 2, para 6

48 DCA Statistical Bulletin: Statistics on Deaths Reported to Coroners, England and Wales 2005, p 1

49 DCA Statistical Bulletin: Statistics on Deaths Reported to Coroners, England and Wales 2005, p 3

50 Luce Review, Chapter 2, para 8

51 Q66

52 Q124

Medical Council's ... requirements for basic and postgraduate medical education. The assessment and audit of certification processes is also professionally appropriate and in keeping with the aims of clinical governance.⁵³

42. A significant burden could, therefore, be removed from the coronial system by providing training and support to doctors to give them more confidence in their death certification duties which might result in fewer unnecessary referrals to coroners. Given the apparently limited resources available for reform of the coronial system, this would be one sensible mechanism for limiting costs in the long term.

43. The Department of Health told us about various initiatives which are underway to address the need for doctors to be trained in death certification.⁵⁴ If such initiatives are in progress, it seems apparent from the increasing number and proportion of referrals to coroners that they are not working or, at least, do not go far enough.

44. Whilst there is evidence of a significant number of unnecessary referrals to coroners, there is also evidence of the opposite problem. A coroner can only investigate deaths of which he is aware, so the death investigation system is rarely engaged where there is, for whatever reason, failure to refer an otherwise referable death. There is currently no positive statutory duty on doctors to refer deaths to coroners. There is evidence of cases of doctors failing to refer deaths, which ordinarily should be referred, for a variety of reasons. For example, one study has found that deaths following therapeutic endoscopy are under-reported to coroners and are then less likely to be examined at autopsy compared with the average overall.⁵⁵

45. Clearly, a medical practitioner such as Dr Shipman who is inclined to falsify a Medical Certificate of Cause of Death will equally be disinclined to refer a death to the coroner, whether or not he has a duty to do so. Nevertheless, for otherwise conscientious doctors, a positive statutory duty to refer a death in certain circumstances, backed up with sanctions for failure to do so, may be sufficient to ensure compliance. The drawback to such a duty might be a greatly increased incidence of referral to coroners due to doctors' fears of being punished for non-reporting. Coroners, and particularly their officers, may not have the resources to cope with such an increase.⁵⁶

46. This highlights the importance of a properly functioning death certification system because abuse of this system can mean that serious cases are never brought to the attention of the coroner, as happened with the Shipman cases, with the risk that cause and circumstances of death are never properly established. The Luce Review reported that:

The certification and coronial processes are separate from each other. The coroner has no information on or responsibility for deaths not reported to him. No public authority is tasked or resourced to see that the certification process is being properly carried out and that deaths which ought to be investigated by the coroner are

53 BMA response to Home Office Position Paper

54 Q198

55 NCEPOD, 'Scoping our practice'. The 2004 Report of the National Confidential Enquiry into Patient Outcome and Death, Chapter 13

56 Q155; Ev 69, para 22

reported for investigation. There is thus little to stop an unscrupulous doctor from “certifying his way out of trouble”.⁵⁷

47. Tom Luce gave similar evidence to this Inquiry that:

... an absolutely essential part of the reform of the Coroners Service is to make sure that the critical link in the chain, which is the process of the cases being referred to the Coroners Service, is working properly. If you continue to have death certification which is conducted outside the Coroners Service ... there has to be some mechanism for ensuring that those cases which ought to be referred to the coroner are being referred to the coroner. If that is not done, I think that there will be a very serious issue about the integrity of the whole process and the degree to which the public can have confidence in it.⁵⁸

48. Dame Janet Smith told us that:

I think the key difficulty and problem is that too much is left to the individual doctor. The individual doctor’s decision warrants two things. He is saying I warrant that I know the cause of death and I warrant that the circumstances of the death do not require referral to the coroner. It was Shipman’s ability to certify false causes of death and avoid the coroner system completely that is the point because not one single death of Shipman’s victims was reported to the coroner. Occasionally he would have a quick telephone call with somebody in the coroner’s office saying that he proposed to certify the death as due to such-and-such and would that be all right and the answer he always got, and it only happened on a few occasions, was “Yes, it’s quite all right, Dr Shipman”. So there was no check.⁵⁹

49. Dame Janet added that it was of the utmost importance that, because of their procedural and processual links, the death certification and investigation systems be subject to synchronised reform.

I do think that we need a reform of death certification and that it needs to be completely dovetailed in with the reform of the coronial system. You have to decide how the two are going to be related to one another.⁶⁰

50. ACPO stated that:

The Shipman case demonstrated very serious failings in the process of death certification and ACPO agrees that further reform is necessary if adequate safeguards are to be put in place. It is clear that any system ultimately has to rest on the expertise of the medical profession.⁶¹

51. However, ACPO accepted a need for balance in any approach to reform of the death certification system:

57 Luce Review, Chapter 2, para 4b

58 Q94

59 Q38

60 Q42

61 Ev 84

There are undoubtedly very important lessons to be learnt from the [Shipman] case but at the same time it needs to be kept in perspective. Where there is an individual who knows intimately the workings of a system and is determined to frustrate the safeguards in that system there will always be a serious risk that the system will indeed be subverted. It is accepted that in moving forward the Government has to balance the need to establish greater safeguards with matters such as the degree of risk and the costs involved.⁶²

52. In summary, evidence submitted to us highlights three problems with the death certification system:

- **first, the difference in certification procedures for burial and cremation is anomalous;**
- **second, the complexity in the current death certification system and lack of sufficient training for medical practitioners are partially responsible for the very high rate of referral of deaths to coroners; and**
- **third, the problem of how Shipman-style abuse of the system might be prevented remains unsolved.**

Previous proposals for reform

Luce Review

53. According to the recommendations in the Luce Review, deaths from natural causes would continue to be certified first by the doctor looking after the deceased in his or her last illness. All such deaths, whether to be followed by burial or cremation, would need confirmatory second certification from a second doctor from a panel of doctors selected, appointed and supported by the new medical office-holder in the coroner service. The second certifying doctor would be sent copies of the attending doctor's recent file notes, specialist reports and prescribing records relevant to the death. The coroner service doctor would systematically monitor and audit the certification of all deaths in the locality, including the certification records of individual doctors.

Third Shipman Report

54. The Shipman Inquiry also recommended a double death certification process, although it would have some different features and be within a somewhat different structure. All deaths would be finally certified, not by a second medical certifier in clinical practice, but by investigators in the local coroner's office. Local coroners would be doctors and entitled "Medical Coroner". There would be legally qualified "Judicial Coroners" to deal with circumstantial investigations at a higher regional tier.

The Home Office proposals, 2004

55. In its first response to the Luce Review and Shipman Inquiry reports – *Reforming the Coroner and Death Certification Service*⁶³ – the Government outlined proposals for an

62 Ev 83

63 Home Office Position Paper

entirely new system, implementing a common approach for all deaths which would replace the existing processes, currently different for burials and cremations. The proposals, drawn up by the Home Office, included:

- verification of the fact of death;
- certification of the cause of death by a doctor;
- scrutiny of all certificates by a “medical examiner” in the coroner’s office;
- referral to the legally qualified coroner of all deaths which cannot be certified or which are unnatural.

These proposals were broadly welcomed by Tom Luce and others as introducing much needed reform, including appropriate safeguards, and integrating the death certification system with the coronial system.⁶⁴

The new Government proposals for reform

56. In its new proposals, however, the Government does not propose any immediate reform of the system of death certification, and appears to reject the previous Home Office position and the recommendations of both the Luce Review and the Shipman Inquiry as disproportionate and inconsistent with the needs of the bereaved. In her statement to Parliament on 6 February 2006, the Minister of State for Constitutional Affairs noted the recommendations made by the Shipman report in relation to death certification, but suggested that they did not strike a proper balance between identification and investigation of suspicious deaths on the one hand and the need for families to proceed quickly with funeral arrangements on the other.⁶⁵ No mention has been made, in this statement or since, of the abandoned Home Office proposals and why the Government has now departed from them.

57. Referring to the death certification system, the Minister stated that:

We need a system that can identify and investigate suspicious deaths yet allows families to proceed quickly with funeral arrangements where there is no cause for concern. We are not sure that the proposals to have all deaths referred to coroners achieves this, but we will be looking further at this and are not ruling out the possibility of further reform.⁶⁶

The Minister also referred to “further work being taken forward in the Department of Health aimed at improving patient safety and promoting quality in the NHS”.⁶⁷

58. This caused confusion as to the role of the Department of Health in these reforms. Michael Burgess, HM Coroner for Surrey & Coroner of The Queen’s Household, told us that:

⁶⁴ Q64; Ev 62, para 21; Ev 95; Ev 76–78

⁶⁵ HC Deb, 6 February 2006, Col 607

⁶⁶ HC Deb, 6 February 2006, Col 607

⁶⁷ HC Deb, 6 February 2006, Col 607

I did see in the Minister's statement yesterday and in the briefing paper a suggestion that the Department of Health was going to make a contribution. Precisely what form that contribution would take and how it would ease the lot of coroners on an individual case-by-case and a day-to-day basis I would not know, but it would certainly seem to me that there should be some cross-relationship between the medical services locally and the coroner service without it being too cosy.⁶⁸

59. We have tried to elicit from both the Department of Health and the Department for Constitutional Affairs exactly which of them is taking responsibility for reform of the death certification system in order to address the issues raised by both the Shipman Inquiry and the Luce Review. We have met with limited success.

60. In its written submission, the Department of Health has outlined its response to various issues raised in the 4th and 5th Reports of the Shipman Inquiry, focusing on professional regulation, clinical governance and regulation of controlled drugs. However, the Department of Health robustly denies responsibility for the issue of death certification, the subject of the 3rd Report of the Shipman Inquiry. Its written submission states that:

the General Register Office [and] the Office for National Statistics...have relevant expertise in the legislation and processes relating to the certification and registration of deaths.⁶⁹

61. A separate communication from an official at the Department of Health was more enlightening:

the legislation under which doctors complete medical certificates of the cause of death (MCCDs) is the Births and Deaths Registration Act 1953, which is "owned" by the General Register Office (GRO) which is part of the Office for National Statistics (ONS). Doctors do this as a personal statutory duty under the 1953 Act, not as a condition of employment by the NHS, so their conduct in respect of this activity is subject to regulation by the GMC like any other professional matter. Doctors completing statutory forms to enable bodies to be released for cremation do so under the Cremation Act and regulations, which are owned by DCA – doctors receive a fee directly from bereaved families for this, negotiated with the BMA by the DCA.⁷⁰

62. We also heard evidence from another Department of Health official, Dr Gina Radford, that:

The Department of Health is not responsible for everything around death certification by any means... As for the majority of the statutory responsibility, it sits outwith the Department of Health.⁷¹

Certainly, the whole process of death certification needs to be seen in the context of a much broader reform agenda that Shipman and Dame Janet highlighted in terms of issues to do with improving overall quality – quality of care and health care – and clearly death certification is one element of those. We have been working across the

68 Q33

69 Ev 90

70 Communication from Department of Health official, 5 May 2006

71 Q188

broad front of health care reform for a considerable time, as you will know, and quite significant changes have been made in terms of quality and patient safety improvements that have been made in the health care sector. Clearly, as to death certification we are working on issues with DCA in terms of what else can be done outwith the draft Bill to take account of some of the concerns raised by Dame Janet and others.⁷²

63. From this evidence, we deduce that the Department of Health is working on various issues raised by the Shipman Inquiry but that, in respect of reform of the death certification process specifically, the Department of Health see this as a “work in progress” with no firm decisions having been made. Dr Radford was particularly unclear on the details of what, exactly, is being done by the DCA and Department of Health:

We are certainly working with DCA to look at what other aspects, particularly around death certification, may be necessary to strengthen death certification in the light of the recommendations of both Shipman and Luce and the comments that clearly we have received and the context within which we are now operating. I can say that most definitely there is other work in progress.⁷³

64. Ms Harman was equally unclear in her evidence to us. When questioned on the relative responsibilities of her Department and the Department of Health on death certification, the Minister replied:

Obviously there is a very important Department of Health patient safety agenda in terms of recruitment of doctors, training of doctors, scrutiny of doctors, all of that, much of which feeds into the death certification process, whether it is in a primary care setting or whether it is in hospitals. It is something which is done by doctors and therefore obviously the Department of Health has an important involvement in that. They have also taken forward changes on controlled drugs management and there is going to be a forthcoming Chief Medical Officer report on doctor regulation. For our part we are reforming the situation in relation to cremation certification. We are going to have a more professional coroners’ service with coroners whose main job it will be so that they will be liaising with the health trusts and the primary care trusts.⁷⁴

65. When asked whether responsibility for death certification lies with the DCA or the Department of Health, the Minister replied:

It is both. We have our responsibilities and they have theirs. We would not seek to be running the peer review system in primary care and saying you should be qualified in terms of medical qualification for doing a death certification. We are also responsible for the coroners’ system, the coroners themselves and the inquests that they hold, so I think there is a responsibility across different departments. I have had meetings with my ministerial colleagues, both Jane Kennedy and Andy Burnham, who work closely on this. The point is to get a system that works and to have everybody who has a contribution to make to it focused on it.⁷⁵

72 Q195

73 Q194

74 Q273

75 Q274

66. We conclude that, because neither the DCA nor the Department of Health is taking responsibility for death certification there is no systematic and coordinated response to the serious issues raised in the 3rd Report of the Shipman Inquiry and in the Luce Review. When asked direct questions about the exact steps being taken to reform death certification, witnesses from both departments have given evasive and vague answers. We can only assume from their evidence that, if anything specific is being done at all, it amounts to tinkering at the edges of a system which has already been deemed unsafe and unsatisfactory by two Government-commissioned reviews.

67. The Minister has told us that “this is a good set of proposals”.⁷⁶ However, the evidence we have received is overwhelmingly to the contrary, indicating that the failure to reform the death certification system in tandem with reform of the death investigation system is both worrying and unsafe. In response to the proposed reforms, Tom Luce has commented that:

It seems to me that [the reforms] are likely to have very little effect, as they have so far been described on the death certification system, which seems to me to be a very serious lack in the present situation. ...⁷⁷

I find it extremely disturbing that there appears to be this hole in the Government’s thinking. ... It is a very significant retreat from the proposals they made in 2004 which though not absolutely consistent with either the Shipman Inquiry or our own proposals seem to me to be sensible proposals which should be supported. ... I feel this is the most serious issue to come up around their proposals. ...⁷⁸

I think it would be a deplorable failure. At the time of the publication of the Shipman Inquiry Report, and indeed of our own report, the Government gave commitments that the issues raised in these two reports would be very seriously considered. So far as I can see, in 2004 it looked as though they were fulfilling that commitment but it looks to me as though they are not fulfilling it in terms of death certification. ... I would respectfully like to offer the view that Parliament would not tolerate the Government getting very far with legislation that had this gigantic hole in the middle of the road.⁷⁹

68. Dame Janet Smith argues that reform of the coroners system and death registration “are inextricably linked and ought to be inextricably linked”.⁸⁰ In her evidence to the Committee she noted her view that the Government’s proposed reforms left “too much to the individual doctor” and expressed her concern in strong terms:

[The proposed reforms] would go no way at all towards remedying the defects that failed to detect or deter Shipman. If these reforms go through – and they are good in themselves and I have no criticism of them in themselves – there could still be a Shipman out there killing patients, handing the MCCDs⁸¹ to the member of the

76 Q281

77 Q65

78 Q94

79 Q95

80 Q62

81 Medical Certificate of Cause of Death (“MCCD”)

family who takes it to the Registrar's Office to register the death. Nothing will have changed and I think that is a cause for significant concern.⁸²

69. Victor Round, Honorary Secretary of the Coroners' Society, gave evidence that:

These reforms, with respect, have just nothing to do with the Dr Shipman problem at all. They do not impinge upon it at any point. One reason why they cannot is that nothing has been done about modernising the death certification system. It is dropped behind us.⁸³

70. The Government's decision not to reform the death certification and investigation systems in tandem does nothing to solve the fundamental problems with the current system which we identify above (paragraph 52): the anomaly of a different certification procedure for burial and cremation remains; defects in the current death certification system are responsible for many of the difficulties apparent within the coronial system, so that reform of the latter will inevitably be less effective without reform of the former; and it fails to set up a system to prevent future Shipman-style cases.

71. We strongly recommend that the Government revise its policy in order to address reform of death certification in tandem with reform of the coronial system. It should return to the proposals on death certification put forward by the Home Office in 2004, ensuring that they are supported with sufficient resources.

72. As a basic minimum, we recommend that the Government introduce a positive statutory duty for doctors to refer certain categories of death to the coroner and work with the General Medical Council and the General Register Office to establish suitable guidance and training to improve doctors' knowledge of death certification requirements and procedures.

82 Q37

83 Q121

4 The coronial system: local service, national framework

Existing structure

73. There is no national Coroners Service. Both appointments of staff to and funding for the coronial system occur at the local level. According to Michael Burgess, HM Coroner for Surrey, there are currently 112 coroners working in around 120 local jurisdictions. They are mostly barristers or solicitors of not less than 5 years standing, although 11 are registered medical practitioners, some of whom are also qualified lawyers. Each coroner is an independent judicial officer within his own district, appointed and resourced by the Local Authority. 27 coroners hold “whole-time” appointments, with the rest working as part-time coroners, free to carry on their medical or legal practice. The whole-time coroners deal with approximately 50% of all cases referred to coroners.⁸⁴

74. Coroners are supported by coroners’ officers who are their investigative support staff. There are approximately 420 coroners’ officers who are employed and resourced by the police authorities in some jurisdictions but by local authorities in others.⁸⁵ All other personnel and resources, including the coroner’s salary, mortuary and post-mortem examination fees and accommodation, if any, are provided by the local authority. In some jurisdictions, particularly in rural areas, the police officer who is first to deal with a suspicious death will also carry out the duties of a coroner’s officer.

75. Michael Burgess, HM Coroner for Surrey & Coroner of The Queen’s Household, categorised the resources of the coroner as:

- a) legal resources, being the statutory framework governing coroners and their function;
- b) human resources, being the coroners, their deputies, officers and other staff; and
- c) other financial and administrative resources, including accommodation.

It was his view that all were lacking in the current system: statutory provision is unclear; coroners and their staff are inadequately trained; and resources, particularly accommodation, are in short supply and are badly organised.

Legal resources

76. The legal framework for the functions of a coroner is by no means clear. Michael Burgess gave evidence that:

it is necessary to understand what the coroner’s function is and currently in statute that is not clear. All we have got is that we are to hold inquests and those inquests are expected to find certain things as proved or not as the case may be.⁸⁶

84 Ev 68, para 4

85 Ev 61, para 13

86 Q1

77. The legal framework for death investigation will be examined in more detail in Section 6 below. Here, we will focus on evidence that general coronial practice and standards of service across the country are variable. There are many reasons for this – including inconsistencies in training and funding, addressed below – but it is also argued that the localised nature of the coronial system, with no one in overall charge, has led to great inconsistency of practice.⁸⁷

78. Nevertheless, a localised system brings with it both advantages and disadvantages. It is usually considered an advantage that each coroner inherits local traditions. They are sovereign in their own district, responsible only to the law through judicial review and not to any regional or national hierarchy, nor to any national or local ‘organiser’. A newly appointed coroner will see how things were done in the past, with the assistance of the officers and staff, and will generally continue to manage the jurisdiction in the same way, unless there is a good reason for change. The coroner has complete freedom to change practice within the jurisdiction and may do so where, for example, this is considered necessary to meet changed local conditions. Part of the price of a national system would be a certain loss of responsiveness to local circumstances.

79. The disadvantages to localised practice include a non-standardised approach to similar problems of procedure and practice. What may be characterised as a sensible response to local conditions in some circumstances may appear capricious and arbitrary in others. Lack of standardisation means that the expectations of the bereaved and others, such as legal representatives, are difficult to manage. Some may have a good experience with the coronial system having encountered a sympathetic coroner with carefully considered and compassionately administered practices. We have certainly received evidence to this effect and witnessed for ourselves a carefully handled inquest.⁸⁸ However, we have also received evidence of horror stories, with accounts of unsympathetic and inflexible practice.

80. These characteristics were also noted by the Shipman Inquiry. The 3rd Report recommended radical change on the basis that:

the system is not working as well as it should. The evidence received by the Inquiry suggests that there is much dissatisfaction with the present arrangements. It is said that the existing system is fragmented, is not sufficiently professional, is applied to very variable standards in different parts of the country and does not meet the needs of the public, especially the bereaved.⁸⁹

Human resources

81. Michael Burgess underlined the importance of coroners, their deputies and officers being:

sufficient and well meaning as well as being properly trained and well disposed. I think we are fortunate in this country in that broadly speaking we have got a good cadre of coroners, even though on occasions they will fail, but we all fail at times.⁹⁰

87 Qq1, 87, 103, 247; Ev 61, para 15

88 Committee visit to the Medico-Legal Centre in Sheffield, 12 April 2006

89 3rd Report of the Shipman Inquiry, Forward p v

90 Q1

82. There have been concerns about the criteria by which coroners are appointed by their local authorities and whether individuals sitting on local authority appointment panels have any detailed concept of what the work of a coroner entails. It is well within living memory that some local authorities traditionally appointed successor coroners from the same legal practice as their predecessors.⁹¹ As a result, there have been calls for coroners to be appointed by a national judicial appointments board in order that the criteria for appointments may be standardised.⁹²

83. Coroners' officers are appointed by their employers, who may be the Local Authority or the Police Authority, depending on the jurisdiction. We have received much evidence which demonstrates the vital rôle that coroners' officers play, particularly as the main point of contact between the coronial system and the bereaved. It is, therefore, a matter of serious concern that rarely are sufficient resources made available to appoint enough staff to cope with the heavy workloads. Again, there are wide regional variations in the provision made for coroners' officers.⁹³

84. There is no national strategy for training. Neither coroners nor their officers are required to undergo any training, either upon appointment or at any time thereafter. Some training is made available: for coroners with assistance on a 'good-will basis' from the Judicial Studies Board; and, for coroners' officers, by the Coroners' Officers Association in collaboration with various providers. However, the training available is arranged on an ad hoc basis with no compulsion to attend. Indeed, both coroners and their officers often have to attend training courses in their own time because there is no cover available for them during working hours.

85. Michael Burgess also highlighted the pressure of heavy workloads on many coroners and their staff. He stressed that coroners, their deputies and officers must:

... have sufficient time to carry out their function. Many coroners I know spend long hours, well beyond the European time constraints that we are all supposed to work to, in order to get through their caseload and give attention to their cases.⁹⁴

Financial and administrative resources

86. Resourcing of the coronial system comes mostly from local authorities, with the police authorities resourcing coroners' officers in many areas. This fragmentation of resources means that no overall figures for spending on the coronial system are issued by Government. The Luce Review estimated that, in 2000-2001, public spending on the coroner service was £71 million, of which around half went on mortuary, autopsy and other testing costs. Registration cost a further £6 million. Cremation fees paid by families totalled £30 million.⁹⁵

87. Whilst the costs of the system may be estimated at around £71 million, these figures cannot take into account the "hidden subsidies" fed into the current system. These include

91 Q9

92 Qq8, 58; Ev 62, para 19

93 Qq130, 149, 153

94 Q1

95 Ev 61, para 15

resources, support services and accommodation provided by the private offices of those part-time coroners who are still in private practice, mostly as solicitors; and other resources, such as accommodation and administrative support for coroners' officers, provided by local police forces.⁹⁶

88. Whatever, the overall cost of the coronial system, the major problem we have identified from evidence we have received relates to the uneven distribution of resources across different jurisdictions, partly due to the lack of consistency in the resources granted to coroners by their local authorities. This inevitably has an impact on consistency of practice and standards of service offered by coroners across England and Wales. Michael Burgess states that:

The great weakness that flows from that is that there will not be consistency of practice and the resources available to individual coroners will be very varied ... The resource issue is something that constantly comes to the fore.⁹⁷

89. Michael Burgess has also highlighted the particular difficulty faced by many coroners in finding court space for hearing inquests.

Certainly, so far as courts are concerned, we are very poorly off. We do not form part of the main court structure of the country and therefore when it comes to requiring and seeking court accommodation, we often are unable to use courts, we are very much at the back of the queue. Indeed I heard very recently of coroners who have had to adjourn inquests part-heard with juries for months because their allotted time had expired and the case had not finished and that cannot be good.⁹⁸

90. In summary, the coronial system lacks national direction, with wide variations in regional practice. Whilst local and police authorities provide varying degrees of financial and administrative support for the coronial system, there are also hidden subsidies, the magnitude of which is almost impossible to calculate. The system is beleaguered, with insufficient training for coroners and their staff, inadequate funding, a lack of facilities and uneven distribution of resources, leading to inconsistent levels of service across England and Wales.

Government proposals

Local service, national framework

91. The Luce Review recommended that a new national, unified coroner and death certification service should be created. This service would be funded centrally and would have around 60 local offices manned by a full-time coroner and a medically qualified Statutory Medical Assessor. The Luce Review recommended that these local areas should mirror police authority boundaries, but that there should be a "flexible and sympathetic approach to rural areas with long travel distances".⁹⁹ In addition, the Luce Review recommended that coroners should be appointed after open advertisement through the

96 Home Office Position Paper, p 7, para 16

97 Q1

98 Q1

99 Ev 61, para 16

Judicial Appointments Commission and that coroners officers would be employed directly by the new national Coroners Service. Training and development would be an early priority and individuals would be encouraged to develop specialist areas of expertise.¹⁰⁰

92. However, under the reforms proposed in the draft Bill, the coronial system remains essentially local. Local authorities will remain responsible for appointing coroners with the consent of the Lord Chancellor¹⁰¹ but the Government promises that “procedures for appointments will be more robust and...in line with national guidance”.¹⁰² It remains the case that only the Lord Chancellor, with the agreement of the Lord Chief Justice, may remove a coroner from office.¹⁰³ Coroners will continue to be resourced by local authorities and coroners’ officers will remain employees of police or local authorities, according to local practice.

93. The LGA has registered serious concerns about accountability and governance with respect to coroners:

there is a widespread view that coroners are not accountable and do not always provide a consistent or effective service. The LGA believes that as long as the ultimate power to ‘hire and fire’ remains with the Lord Chancellor then the coroner will not be truly accountable, as councils will continue to pay the bills but have no control over performance and policy.

The LGA believes that an independent legal function, accountable to the head of the judiciary yet funded through local taxation, sitting alongside a local authority’s democratic role is an outdated anomaly in a political environment where council leaders, supported by ODPM ministers, are calling for local people to be given more control of public services through devolution of power to communities.¹⁰⁴

94. SOLACE, the Society of Local Authority Chief Executives and Senior Managers, has supported the LGA’s assertions, adding that:

There is no real partnership between local authorities and coroners. Neither do local authorities have genuine management responsibilities for coroners. ...

Local authorities are equally frustrated about having to fund a service that is costly and which they have little control over in terms of the quality of service provided to the community.¹⁰⁵

95. The LGA has given evidence that councils are already redesigning their other services around the user and that the coronial system should be brought in line with these efforts:

Parts of the coroners service are delivered not by local government, but locally by the police, health service or the private sector. Achieving a step change in re-designing coroners services around the user means joining up all service providers with local

100 Luce Review, Chapter 16

101 Draft Coroners Bill Schedule 1, Part 1, para 1

102 Department for Constitutional Affairs, Coroners Service Reform: Briefing Note, p 6

103 Draft Coroners Bill Schedule 1, Part 4, para16

104 Ev 87, paras 13 and 14

105 Ev 119, paras 8 and 10

government, as the current and likely future manager and funder of coroners services, in the driving seat.¹⁰⁶

96. The government proposes a “national framework” for coroners as an alternative to a national service. Specifically, the draft Bill provides for:

- New boundaries to be set by the Lord Chancellor, defining what will be known as coroner areas (Schedule 1, Part 1, paragraph 3). There will be around 60 new coroner areas.
- Appointment of a full-time Senior Coroner to each coroner area, supported where necessary by one or more full-time Area Coroners and part-time Assistant Coroners. These appointments will be made by local authorities with the consent of the Lord Chancellor (Schedule 1, Part 1, paragraphs 1 & 2). Local authorities will continue to be the main source of funding for the coronial system.
- Appointment of a Chief Coroner (Clause 56), accountable to the Lord Chancellor. The Chief Coroner will have many responsibilities – discussed further below – including responsibility for the preparation of rules and guidance and for collating the annual reports made to him by Senior Coroners. It is intended that the Chief Coroner will provide national leadership for local coroner services.
- The Chief Coroner will be advised by a new Coronial Advisory Council (Clause 63).

97. The Government argues that these reforms will provide both local and national accountability. The Minister stated:

I think this is a good set of proposals. I know that sometimes people think that taking something which is not working locally and making it national can improve it. Sometimes it can. Sometimes what we want to do is have national standards but a local partnership ... There is a really moot point, a machinery of government point, about what is the right balance between national and local. I think in this Bill we are building on the local strengths but we are having national standards. That is the right way to do it ... The question is can we build onto a local system national standards and get the right result and I hope that we have the balance right here.¹⁰⁷

98. However, whilst the office of the Chief Coroner is broadly welcomed, many argue that the Government’s failure to reform the way the coronial system is resourced will do nothing to address local inconsistencies in resourcing and service. Dame Janet Smith expressed her disappointment that a national coroner service has been rejected:

I detect a desire not to set up a central structure. There is going to be a chief coroner and he is going to have a chief medical adviser and there is going to be an advisory council but there is not going to be, as I understand it, an executive organisation. I would have liked to see one because, as I mentioned earlier, I would like to see coroners officers employed by the Coroners Service to give them a career structure

¹⁰⁶ Ev 88, para 5

¹⁰⁷ Q281

and to ensure that they get the right sort of training instead of the fragmentation that they have at the moment.¹⁰⁸

99. Michael Burgess suggested that the value of central leadership by a Chief Coroner might be undermined unless the distribution of resources was rationalised on a national basis:

I think we all support the concept of a Chief Coroner. He will be publicly recognised as a respected figurehead for the national service, but that presupposes that this is going to be a national service. It should result in some sort of consistency, but unless there is the consistency of resources the consistency may not be as all-encompassing as one might hope.¹⁰⁹

100. Victor Round added:

[The Coroners' Society has] doubts whether [the Chief Coroner is] going to be any better at winning an even supply of resources than we have been. There really is a postcode lottery about resources.¹¹⁰

We did rather hope to see a national system. We had almost got to the stage of assuming it would happen, and so we are a bit shaken to find that we still have the old battles to fight.¹¹¹

Mr Round added that inquests are getting longer, particularly in cases such as prison deaths which must comply with the requirements for investigations under Article 2 of the European Convention on Human Rights. This has:

put tremendous pressure on to court accommodation, on staff, and on back-logs; some of us are reeling under them now, and really quite frightened about the future. We did think this new national service would solve this problem, and it has done nothing for it at all.¹¹²

101. The Government's proposals lack detail and fail to tackle adequately the resource and structural problems currently facing the existing, outmoded coronial system. The limitations of the local structure of the current system, giving rise to uneven distribution of resources, will remain. It is difficult to see how a Chief Coroner can function effectively as a force for standardisation without being part of a national service. A national service would almost certainly involve significant extra cost, but the failure to introduce one will mean that the current inequalities of resource will continue.

A professionalised service

102. Coroners appointed under the Coroners Act 1988, most of whom are part-time, will cease to hold office once the draft Bill comes into force and the Lord Chancellor will have

108 Q59

109 Q22

110 Q103

111 Q104

112 Q107

power to make regulations to provide compensation for loss of office (Clause 71). The Government has stated that “It is intended that transitional arrangements will be made to ensure the system continues to function until the arrangements under the Bill take full effect.”¹¹³ It is possible that the expertise of existing coroners may be lost if they perceive that there is no financial benefit in applying for a full-time coroner post and giving up their, potentially more lucrative, professional commitments.¹¹⁴ Whilst there may be no shortage of potential applicants, many of them are likely to have no previous experience of coronial law.

103. Moreover, we have received evidence that neither existing coroners nor their officers and staff “can be regarded as having any continuing job security at all”, following redefinition of the jurisdictional boundaries. Coroners’ officers may be forced to reapply for their jobs without guarantee of success if their employment is moved from police authorities to local authorities as a result of negotiations in progress. Similarly, clerical staff currently working in solicitors’ offices have no guarantee of employment within the new service. Mr Ian G McCreath MBE, HM Coroner for North Northumberland, has stated that:

There must be major concern that many, who carry out an extremely valuable service to the bereaved at present, will seek to leave the Coronial service between now and April 2009 if opportunities for more secure employment elsewhere arise.¹¹⁵

It is vital to ensure that changes to the jurisdictional boundaries of the coronial system and to the staff involved in administering it do not inadvertently result in valuable skills and experience being lost.

104. Once the new jurisdictional boundaries are drawn up, there are potential problems in large rural jurisdictions. For example, under the proposed system, Cumbria and Northumberland, with a combined population of fewer than 500,000 taken together, can be expected to form one coroner area, which is an enormous geographical area for one person to cover.

105. On 6 February 2006, the Minister stated in Parliament that:

There is no reason why coroners should not travel to the families. We will ensure that Her Majesty’s Court Service buildings, county courts and magistrates courts are available for the coroners to exercise their jurisdiction locally, so that they can work around the families and circumstances, rather than expect the families to work around them or their private practice as solicitors.¹¹⁶

106. Coroners have expressed alarm at the notion that they may be expected to travel around their jurisdictions, particularly those which cover very large geographical areas. Victor Round made two important points in evidence:

The first is that the coroner is then sitting on a car seat instead of sitting on an inquest, and the second is that all those courts we used to travel out to have been

¹¹³ Explanatory notes to the Draft Coroners Bill, p 69

¹¹⁴ Ev 153

¹¹⁵ Ev 146

¹¹⁶ HC Deb, 6 February 2006, Col 614

shut. It is like cottage hospitals. It is the same situation. It may be a good thing but it does not provide us with anywhere to go. So 65 coroners, 41 jurisdictions, is really the death knell of any kind of local service.¹¹⁷

107. When this was put to the Minister, she appeared to change her mind. On the subject of coroners travelling, she said:

Coroners will have to make the decision about where they sit and whether or not they choose to ask people to come to them or they decide that they are going to go to people. That is one of the things that they will be in a position to decide. That is the best way to do it. We are not telling them where they have to hold their inquests. If they are going around in their car to go to a local place, to hold an inquest in a particular local village, that is a matter for them to decide. If they feel that it should be done locally rather than asking people to come to them, they will no doubt have good reasons for that and for therefore being in a car in order to get there.¹¹⁸

108. We then asked about the availability of accommodation in which travelling coroners might hold inquests. The Minister replied that she was satisfied that there would be sufficient accommodation available, adding that Clause 33 of the draft Bill makes provision for ordering that accommodation be made available.¹¹⁹ This is certainly true, although it is far from clear on the face of the draft Bill that the local authority could be obliged to provide more than one location in a given jurisdiction in which a coroner may hold inquests.

109. In widely scattered areas, it will be necessary to make use of part-time Assistant Coroners and to have means of access to the coroner's service which do not depend on visiting a coroner's office which is at a great distance or inaccessible by public transport.

110. The Government needs to clarify how their proposed system is intended to function in scattered and remote areas. If it is the Government's intention that local authorities responsible for large jurisdictions should provide a coroner with more than one place in which to hold inquests, we recommend that this should be made apparent on the face of the Bill when it is published.

Resources

111. The DCA has highlighted the possibility of economies of scale under the new regime, but admits that:

The reform of the coroner service will have some effect on public expenditure. Local authorities will retain responsibility for funding their local coroner but, in line with Government policy, the Department for Constitutional Affairs is committed to funding any net additional costs that fall on local government which arise from changes made by the reforms. The best current estimate is that the initial start up costs for the reformed service will be £14.5 million, with additional running costs in the region of £5 million per annum.¹²⁰

117 Q107

118 Q278

119 Q279

120 Explanatory Notes to the draft Coroners Bill, p 118

112. The Minister has confirmed that a large proportion of the funds estimated by the DCA will be dedicated to the office of the Chief Coroner, the Coronial Advisory Council, training for coroners and their staff and additional medical support for coroners.¹²¹ The Minister stated that the additional annual running costs would break down as follows:¹²²

Chief Coroner and Deputy Chief Coroner	£1,000,000
Coroner for Treasure	£370,000
Appeals	£1,100,000
Inspection of the coroner service	£250,000
Chief Medical Adviser and team	£430,000
Coronial Advisory Council	£120,000
Medical assistance for local coroners	£1,300,000
Ongoing training	£120,000

113. This makes a total of £4,690,000. Councillor Bryony Rudkin of the Local Government Association has questioned the DCA's financial estimates for additional funding for the coronial system, stating that the LGA was convinced neither of their accuracy nor that local authorities and police forces together would receive the whole of the sums projected.¹²³ It is apparent from the figures provided to us by the Minister that the majority of the projected budget is, indeed, destined for central projects, such as the office of the Chief Coroner, and will not be used to assist local and police authorities.

114. These estimates relate to the reforms only and do not address the problems inherent in the current system. The proposals do not offer funding to solve current problems, nor is there any indication of what new support, if any, is envisaged.

115. When we put it to the Minister that it was unreasonable to expect standardisation of service levels in the context of continuing inequalities of resources across coroner areas, the Minister replied:

I think that the things that will ensure that there are national standards and consistency of service is the leadership of a Chief Coroner, and I think that it is important not to underestimate the importance of having a national leadership figure for the coroners, who all operate in a very independent but also isolated way. ... And I think that coroners will have that national leadership of a Chief Coroner and a Deputy Chief Coroner with a Chief Medical Adviser and a National Coronial

121 Q248

122 Q252

123 Q136

Council and a Charter for the Bereaved and the opportunity to issue guidance, which I think will make a huge difference.¹²⁴

The Minister added that the proposed system of reporting from coroners to the Chief Coroner will expose those areas which are inadequately resourced. She did not, however, specify whether funds would be made available to address any deficits discovered. With or without a system of reporting, it seems clear that, if the Government were interested in addressing inequalities of funding, it could obtain the necessary information now, directly from coroners, without having to wait for this legislation to be passed.

116. If the main body of Coroners are to operate full-time, they will need to be adequately supported and this may lead to additional costs. Many hidden subsidies will cease to operate, not least those provided by solicitors' offices. Aidan Cotter, HM Coroner for Birmingham and Solihull and the President of the Coroners' Society, has publicly supported this concern:

law firms which have part-time coroners within their practices have also subsidised the service to a significant amount and the government is going to have to appreciate that if they do away with part-timers, they are going to have to provide a lot more resources.¹²⁵

117. Local authorities are particularly concerned about what they see as the escalating costs of coroners' services and the current shortfall in funding of the coronial system. Councillor Bryony Rudkin of the Local Government Association gave evidence that:

because, I think, local authorities have felt that reform was coming for such a long period of time, some authorities, police authorities and local authorities together, have perhaps not invested the money that they should have done because they have been waiting for something else to happen. Therefore there have been deficits. I have seen evidence of deficits in my own region.¹²⁶

118. Local Authorities consider that the Government's proposals "clearly represent new financial burdens for councils".¹²⁷ For example:

- Clause 33 of the draft Bill requires local authorities to provide and maintain proper accommodation to enable coroners to conduct investigations and hold inquests. This is a departure from the current position and will represent significant additional costs to many local authorities which do not, at present, provide dedicated accommodation for coroners.
- Clauses 44 to 46 make provision for coroners to take evidence by way of "live link" in certain circumstances, meaning a live television link or similar to the coroner's court so that the witness need not be present in person. Our specialist advisers tell us that coroners do not currently have this technology. It must, therefore, be made available by the local authorities if coroners are to make use of these provisions. Clearly there are significant cost implications here.

124 Q247

125 "Light after Death", Law Gazette, 23 March 2006

126 Q136

127 Ev 87, para 17

- Additional costs may also be incurred under the new arrangements for moving bodies to appropriate post-mortem facilities (Clauses 26 and 27) and as a result of the new appeals procedure (Clauses 60 and 61).

119. In relation to the funding of support for coroners, ACPO has made it clear its view that it is no longer appropriate for police forces to continue to provide coroners' officers from their ranks and resources:

Their main points are that the coroner service has moved away from its historic role as an important selector of criminal deaths and its case-work is now predominately in the non-criminal area; and that police priorities and resources should be concentrated on their law and order responsibilities.¹²⁸

Both ACPO and the Local Government Association have stated that police forces and local authorities do not have the resources to increase funding for coroners' officers.¹²⁹ The Coroners Officers Association believes that extra funding is now "urgent".¹³⁰

120. We are extremely concerned about the Government's approach to resourcing the reformed coronial system. When asked about this, the Minister stated that:

My own view ... is that they are sensible proposals which improve a system which, in many respects, is doing a very good job but, in some respects, is not. It is long overdue for improvement. I think they are sensibly building on the current system.¹³¹

121. The problem with this argument is that it assumes that the current system provides foundations sufficiently solid to build upon. It does not. The evidence we have heard paints a picture of a service managing to hold itself together through the determination of individual coroners and their staff and the local cooperation arrangements which have developed over the years. The service has, for decades, been chronically under-resourced and urgent repairs are needed to the existing structure before the Government can hope to achieve reforms which are intended to build on that structure. This requires money. When we put it to the Minister that the Treasury had refused funding for coroner reform and the Government's proposals were, therefore, tailored to fit what it could afford out of the existing DCA budget, the Minister responded:

The implication of what you are saying is that if I was given a tonne of money by the Treasury I would somehow do things completely differently. I can say to you completely honestly that I would not. I think this is a good set of proposals.¹³²

122. The Minister receives very little support for this view in the considerable quantity of evidence we have received. When asked for additional financial information about the specifics of funding for coroner reform, the Minister sent us the following:

In terms of the first issue, affordability; currently the DCA has allocated 2006/7 funds and will shortly be considering 2007/8 allocation for which the overall Departmental

¹²⁸ Luce Review, Chapter 15, para 40

¹²⁹ Q153

¹³⁰ Ev 77, para 15

¹³¹ Q280

¹³² Q281

funding limits are known. The relative priority of all programmes will be considered as part of this. Funding for 2008/9 and beyond, however, is dependant upon the CSR 07 settlement which has not yet been agreed, and therefore it is not possible to form firm views at this stage on how this will be allocated.

The Department will inevitably face challenges on prioritisation for both 07/08 and the SR07 period. However, we are committed to reforming the Coroners service as quickly as possible, taking account of the financial parameters in which we have to operate.¹³³

123. This gives no indication that the Government is in a position to achieve substantial reform of the coronial system, backed with sufficient resources. The DCA does not know how much it can dedicate to coroner reform in terms of funding and, in any event, coroner reform will be competing with other programmes for the funds that are available. We conclude that no new funding has been provided to the DCA by the Treasury for coroner reform and, consequently, the DCA is attempting to achieve these reforms on a shoestring.

124. The existing system is under-resourced and requires a significant injection of funding. The Government, however, has failed to make the necessary financial commitment and has not properly costed the reforms it has proposed. In addition, it seems likely that the Government has taken no account of the financial deficits in the existing system, nor of the hidden subsidies provided to the system by part-time coroners and others which will mostly be lost once coroners take on full-time employment.

125. The Government should address the problems of under-resourcing in the existing coronial system in order to create solid foundations on which reforms can be built. This will require a careful assessment of the aggregate costs of the existing system, to include hidden subsidies, together with an assessment of deficits in particular areas.

126. The Government should establish a mechanism for auditing the expenditure of local authorities on the coronial system and ensuring that coroners are given equivalent resources.

127. We further recommend that the Government should reform the structure of the coronial system by creating a national service with centralised and adequate funding so that all coroners are able to work to the same high standards.

5 The Chief Coroner

Functions of the Chief Coroner

128. The draft Bill (Clause 56) provides that the Chief Coroner, supported by an appropriate number of Deputy Chief Coroners, will have a large number of responsibilities, including:

- Making arrangements for training and guidance of coroners and their assistants (Clause 57).
- Investigation of complaints about investigations (Clause 58).
- Annual reporting to the Lord Chancellor on matters such as advice received from the Coronial Advisory Council, assessments of consistency in standards, complaints, appeals and matters reported by coroners to the Chief Coroner in their annual reports to him (Clause 59).
- Conducting investigations in his own right (Schedule 7, paragraph 1).
- Arranging for a judge to conduct an investigation (Schedule 7, paragraph 3).
- Giving advice to the Lord Chancellor (Schedule 7, paragraph 4).
- Conducting appeals from decisions of the coroner. Appeals can be made against decisions taken at any stage of the investigation (Clause 60) by all ‘interested persons’, the definition of which (Clause 76) is very wide.

129. Whilst acknowledging the general support for the office of Chief Coroner expressed in evidence to us,¹³⁴ we raise two issues in this initial Report:

- a) resourcing of the office of Chief Coroner; and
- b) the scope of the proposed appeals process.

Resourcing

130. The Chief Coroner will require significant resources in order to carry out his many functions effectively. The Minister has confirmed DCA projections for start-up and running costs of the Chief Coroner’s office:

It is envisaged that the office will comprise the Chief Coroner, a Deputy Chief Coroner and a support team of between six and eight. The start-up cost is around £1.3m and includes recruitment, IT and accommodation requirements. The running costs of the office are estimated at around £1m pa including all salaries, on-costs, accommodation, IT and some programme spend.¹³⁵

¹³⁴ Qq22, 72,103, 161

¹³⁵ Ev 112

131. The draft Bill provides for the possibility of more than one Deputy Chief Coroner to assist the Chief Coroner, the exact number to be decided by the Lord Chancellor.¹³⁶ We are, therefore, surprised that the Government envisages the appointment of only one, with a staff of between six and eight. We believe that such a small staff will struggle to cope with the onerous duties required of it. Victor Round agreed that the Chief Coroner would require many staff to perform his functions, adding that his office:

is also expected to move extremely fast, and I have no doubt that is a good thing, because if one is going to appeal against the decision to have a post mortem or to refuse it, for instance, then of course, the decision by its nature has to be very, very rapid indeed, but to have the resilience to react at that speed, there have to be staff able to turn round and drop everything.¹³⁷

132. The financial estimates also seem highly optimistic in the circumstances, but it is not possible to make further comment without the time to take more detailed evidence on this point.

133. The Government should reconsider its estimates for resourcing the office of the Chief Coroner on the basis of a detailed analysis of a projected daily workload. In conducting this analysis, the Government should draw on the experience of coroners who will be able to provide greater detail on how they are likely to deal with the Chief Coroner on a daily basis.

Appeals

134. Under the draft Bill, a wide class of “interested persons”, including but not limited to the bereaved (Clause 76), will have a right to appeal to the Chief Coroner from any decision, determination or finding of a coroner made in connection with an investigation. Appeals can be made against decisions taken at any stage of the investigation (Clause 60) and may include, for example, the decision to order an autopsy.

135. There is general agreement that a simplified appeals system is preferable to the existing mechanism of judicial review.¹³⁸ However, many have expressed concern at the scope of the right of appeal provided by the draft Bill. Victor Round considers the new appeals system to be alarmingly wide and potentially disruptive of coronial investigations.

The range of things that can be appealed, which witness one might call, what questions you could put to that witness, whether that witness will have the right to refuse to answer questions as self-incriminating, that whole range of things, because of the way it is currently set up and not restricted in regulations, would be able to stop inquest after inquest in mid flight. That does not happen in other courts. What happens in other courts is that you say to your clients ... “Wait to the end. You may still get the result you want, so this won't matter then.” [Post-mortem examinations] I accept are quite a different business; whether or not you have a PM needs a quick response, but so often the things that are vitally important or feel vitally important to people on day one or day two of an inquest diminish into nothing when you get to

¹³⁶ Draft Coroners Bill, Clause 56(2)

¹³⁷ Q158

¹³⁸ Ev 150, para 2.4

the verdict, and at the moment it seems to me the Chief Coroner system could get flooded with appeals very quickly indeed.¹³⁹

He added:

Quite how the coroner drops everything and does his or her side of the appeal, I do not see at the moment how that could possibly be done. But we are told by the Bill that is how it will be, and unless there is some sort of filter system, I do not think either the Chief Coroner or we will cope. Some other level is needed.¹⁴⁰

136. The BMA view the introduction of a right of appeal for the bereaved as a positive change to the current system, but express a particular concern that:

... procedures are carefully scrutinised so that the relatives do not use the appeals process as a way of venting their anger towards a member of the team that looked after their deceased relative. This is a potential source of abuse of the system.¹⁴¹

137. Given the wide definition of “interested persons” in Clause 76 of the draft Bill, it is possible that family members, “friends of long-standing” and others qualifying as interested persons may quarrel as to the best way to proceed. A death investigation might grind to a halt as different factions made a series of appeals according to their interests. Mr Round reassured us that coroners are used to dealing with disputes arising amongst families as to the best way to proceed. However, he noted the lack of a legal hierarchy in the draft Bill:

... at the moment we have the assistance of two things. We have the natural emotional hierarchy in a family, which tends to elect a ... family spokesman, and if it is a split family maybe two of them, but we cope with that regularly, and also then the legal hierarchy provided by the Administration of Estates Act and so on. That would appear to be removed by the Bill, as far as I can see, and one of the additions really alarms me, and that is the friend of long standing. How a friend of long standing can be equated as a properly interested person with members of the family mystifies me completely. A friend of long standing to look after the deceased’s interests because the family do not care would be a splendid thing and of course, we would welcome it, but the Human Tissue Act has ... a hierarchy, and that is recent legislation on the subject. I would have thought one could almost adopt the pecking order in the Human Tissue Act, otherwise you do, ... particularly with mental patients, have friends of long standing popping up all over the place, and nowadays we say to them, “Look, the family are in charge here, not you” and I would have hoped we would still be able to say that.¹⁴²

138. We accept that the right of appeal for those close to the bereaved is a valuable addition to coronial procedure. However, we consider that, unless the right of appeal is greatly reduced in scope, there is a serious risk that a substantial volume of appeals will be made, bringing the operation of the coronial system to a standstill.

139 Q115

140 Q158; see also Ev 150–151, paras 2.5 and 2.6

141 BMA submission to Home Office Position Paper

142 Q114

139. We recommend that the class of “interested persons” be substantially restricted and that limits be placed on the decisions of the coroner which are subject to appeal.

6 Death investigation

140. Where a death is referred to the coroner, he may order a post-mortem examination which may, on its own, provide sufficient information for a certificate of cause of death to be issued. In certain cases, a coroner also has a statutory duty to hold an inquest where the deceased:

- has died a violent or an unnatural death;
- has died a sudden death of which the cause is unknown; or
- has died in prison or in certain other circumstances requiring an inquest.¹⁴³

If the coroner decides that the death falls within his jurisdiction, he will proceed to investigate the death in preparation for an inquest. Alternatively, the coroner might decide that the death does not fall within his jurisdiction, in which case he will take no action to investigate the death.¹⁴⁴ The Shipman Inquiry stated that:

... there are grounds for concern about the soundness of the decisions taken by some coroners and coroner's staff as to whether the coroner has jurisdiction... In my view, many decisions on jurisdiction are taken far too informally ... many decisions about jurisdiction are taken by untrained staff without the medical knowledge necessary to equip them to do so and without any proper understanding of the correct statutory tests to be applied. ... In my view, decisions of this kind should be taken by medically qualified coroners or, in the more straightforward cases, by coroner's officers with some medical background and ready access to expert medical advice.¹⁴⁵

141. The draft Bill does not deal specifically with the concern that a coroner may decline jurisdiction on unjustified grounds. However, the decision not to accept jurisdiction would probably be subject to appeal to the Chief Coroner under Clause 60 of the draft Bill. Bereaved people who wish to challenge such a decision would not, therefore, be left without recourse under the new regime and we welcome this.

142. To a certain extent, the draft Bill clarifies the legal framework within which a coroner undertakes a death investigation. A coroner's duty to investigate certain deaths are set out in Part 1, Chapter 1 of the draft Bill. A coroner's duty to investigate arises where:

- the body is situated in his area;
- the deceased died a violent or unnatural death;
- the cause of death is unknown; or
- the deceased died whilst in custody.¹⁴⁶

143 Coroners Act 1988, s8(1)

144 3rd Report of the Shipman Inquiry, Summary, paras 84–86

145 *Ibid*, paras 86–89

146 Draft Coroners Bill, Clause 1

143. There are also different provisions regarding the duty to hold an investigation in cases where there is no body (Clause 2); the death occurred over 50 years ago (Clause 3); the death occurred in Scotland or Northern Ireland (Clause 4); or the deaths occurred outside the UK (Clauses 5 and 6).

144. There is a new concept of a “coroner’s investigation”, with the inquest being only the final part of that investigation. The duty to hold an investigation and the duty to hold an inquest are distinguished, so that the duty to hold an inquest only arises where the investigation has not been discontinued for some reason. An investigation may be discontinued, for example, where the post mortem reveals a natural cause of death, allowing a certificate of cause of death to be issued. The relevant provisions can be outlined as follows:

- Clause 1 of the draft Bill provides that a senior coroner must conduct an investigation into the death of a person who has died in his area where there is reasonable cause to suspect that the death was violent or unnatural, the cause of death is unknown or the deceased died in custody.
- According to Clause 9, the coroner may discontinue this investigation if a post-mortem reveals the cause of death, if there is no reasonable cause to suspect that the deceased died a violent or unnatural death or while in custody, and he thinks it unnecessary to continue the investigation.
- Finally, unless the investigation has been discontinued under Clause 9, Clause 11 imposes a duty on the coroner to hold an inquest.

145. We have not had time to undertake pre-legislative scrutiny of the provisions of the draft Bill on a clause by clause basis. However, the provisions relating to death investigation procedure in Parts 1 and 3 of the draft Bill have generally met with approval from coroners and other stakeholders.¹⁴⁷ Whilst there is certainly concern, even alarm, about what has been left out of the draft Bill, the evidence is that coroners would rather have the reforms they are being offered than no reforms at all.¹⁴⁸

146. We acknowledge that the Government has introduced some sensible reforms with respect to death investigation procedure in Parts 1 and 3 of the draft Bill.

The inquest

147. According to our Specialist Advisers, there are important advantages in the existing system of public inquests. The inquest:

- allows an independent and experienced investigator, the coroner, to call and question witnesses to establish the true facts surrounding an unnatural death;
- compels the witness to attend and answer questions, subject to necessary safeguards on self-incrimination;

¹⁴⁷ Ev 64, para 6; Qq37, 105

¹⁴⁸ Q71

- provides the bereaved and others who have a proper interest with an opportunity to see and hear the witnesses for themselves, giving them an opportunity to ask their own relevant questions or raise issues of concern;
- allows an impartial authority to rule on the disputed factual matters at the heart of the case without seeking to determine liability;
- provides an open and public forum for the structured, but limited, investigation of an unnatural death, so that society as a whole can see what might be of concern and what is being done about it; and
- allows the impartial and experienced investigator to draw attention to issues that need further consideration by those of appropriate experience in order to prevent similar fatalities.

148. Nevertheless, the Luce Review recommended that the public inquest should be used only where there is a public interest in a public process, or there are uncertainties or conflicts of evidence best resolved by a public forensic process. It argued that if this approach was adopted there would be fewer public inquests into traffic deaths, deaths from occupational disease where the diagnosis is clear, and suicides with no suspicion of third party involvement or negligence. Inquests would continue to be held in more complex cases but the overall number of inquests would fall appreciably, although not to the low levels found in some Commonwealth jurisdictions where inquests are now reserved for investigations on the scale of major public inquiries.

149. The 3rd Report of the Shipman Inquiry also questioned the number and conduct of inquests by coroners.

Inquests are held into a far larger proportion of deaths in England and Wales than in other jurisdictions which the Inquiry examined ... In the modern era, the purposes of the public inquest should be to conduct a public investigation into deaths which have or might have resulted from an unlawful act or unlawful acts, to inform interested bodies and the public at large about deaths which give rise to issues relating to public safety, public health and the prevention of avoidable death and injury, and to provide public scrutiny of those deaths that occur in circumstances in which there exists the possibility of an abuse of power.

In many cases, nothing is gained by the hearing of evidence in public. Indeed, in many cases, such exposure amounts to an unwarranted invasion of privacy and only causes increased distress to the bereaved. In my opinion, the public inquest should be limited to those deaths about which there is a real public 'need to know'. In all other cases, the end product of a coroner's investigation would be a written report.¹⁴⁹

150. Michael Burgess questioned whether this suggestion for a more limited provision of inquests was a good idea:

[The Shipman Inquiry's] proposals for the more limited provision of inquests would ... give rise to problems –

149 3rd Report of the Shipman Inquiry, Summary, para 113

(a) case law has now recognised and imposed upon individual coroners' inquests a larger function, namely the discharge of the duty of the State to investigate under Art 2 of the European Convention on Human Rights loss of life in which the State is in any way involved; and

(b) while some reduction in public inquest hearings might well be desirable, a large scale imposed reduction might well be mistrusted and resented by the people most closely affected and by society at large.¹⁵⁰

151. In February 2006, the Government proposed that:

In limited and specific cases, such as some suicides and child deaths, coroners will have a new discretion to complete their investigations and decide on the facts without holding inquests, where no public interest is served by doing so.¹⁵¹

152. This decision was publicly criticised by some coroners, who believed that this flexibility would cause delays and would allow interested parties to exert pressure on the coroner to hold an inquest in private. Aidan Cotter, HM Coroner for Birmingham, has commented:

At the moment we get terrific pressure on us not to hold an inquest ... If I get pressure now, just imagine how much pressure there will be if this goes ahead ... Suppose you have a baby death and the father wants an inquest and the mother doesn't. What do I do? Spin a coin or see who has the loudest MP acting for them?¹⁵²

Several of the written submissions to this Inquiry argued that open scrutiny of the coroner's inquest is an important feature of the current system.¹⁵³ For example, the NSPCC was strongly in favour of inquests into child deaths continuing to be heard in public.

While we recognise that it can be traumatic for families for proceedings to be held in public, such a process arguably serves the public interest more effectively than holding proceedings in private. Where children are concerned, this is perhaps of even greater importance, as they are a very vulnerable group in society with no voice of their own.¹⁵⁴

153. We have heard much debate on the issue of public versus private inquests. However, we are persuaded by the benefits of the public inquest, which will be retained under the draft Bill. Clause 41 provides that inquests will be held in public, subject to certain provisions relating to evidence given by children (Clause 44) and reporting restrictions to protect the identity of the deceased and interested persons (Clause 30).

154. We welcome the Government's decision to keep the public inquest as the standard form of inquest under the draft Bill.

150 Ev 68–69, para 13

151 Department for Constitutional Affairs, Coroners Service Reform: Briefing Note, p 1

152 "Light after Death", Law Gazette, 23 March 2006

153 Ev 151, para 6; Ev 115, para 20; Ev 101, para 24

154 Ev 101, para 24

Medical support for the Coroner

155. The Luce Review concluded that the current system “lacks the medical skills to deal confidently with deaths from natural disease”. It recommended that any reformed system should contain both legal and medical skills and suggested that each coroner should be supported by a Statutory Medical Assessor. The Statutory Medical Assessor would have responsibility for appointing second certificants and auditing the certification process. He would also advise the Coroner more generally on issues of medical investigation.

156. The 3rd Report of the Shipman Inquiry concluded that the coronial system needed a greater involvement of medically trained personnel, but stopped short of proposing a medical examiner system.

Many of the functions currently carried out by coroners (who, in the main, have a legal qualification only) require the exercise of medical judgement. Some of those functions (and others which I am recommending) require legal expertise. In the future, those functions should be carried out respectively by a medical coroner and a judicial coroner. Both the medical and judicial coroners should be independent office-holders under the Crown.¹⁵⁵

157. The Home Office Position Paper proposed that each local coroner’s area would be served by at least one “medical examiner” and his team. This medical examiner would play a very similar role to the Statutory Medical Assessor recommended by the Luce Review.

158. The BMA supported the Home Office proposals for a medical examiner role, arguing that it would serve to bring together the fragmented functions into a single organisational structure and would encourage assessment and audit of death certification. They expressed a view that:

By establishing a coroner’s team with integral medical support rather than the current arrangements, the service provided should improve. However, it is important that the medical audit service is considered as an integral part of the coroner system.¹⁵⁶

159. The Government has now abandoned the Home Office proposals for medical support and proposes instead the appointment of a Chief Medical Advisor to the Chief Coroner. Although it will be the responsibility of the Chief Medical Advisor to “ensure coroners have medical support locally”, it appears that the provision of additional medical assistance to coroners would be on a local basis:

At a local level, funding will be provided to coroners to ensure appropriate independent local medical advice to support their investigation.¹⁵⁷

[Coroners] will have training, including medical training. In addition, they will have their own dedicated health advice, which they do not have at the moment. That will

155 3rd Report of the Shipman Inquiry, Recommendations, para 5

156 BMA submission to Home Office Position Paper

157 Ev 109, para 3.9

be part of a central budget which will be given to each and every coroner so that they have dedicated health support for medical issues.¹⁵⁸

The Government states that these proposals on local medical assistance for coroners are not included in the draft Bill because they do not require primary legislation.¹⁵⁹

160. The DCA has estimated a total figure of £1,300,000 per annum, to be shared amongst all coroners for this purpose.¹⁶⁰ Assuming these funds will be distributed to 60 coroners, this would provide each coroner with an annual budget of under £22,000 each. This budget would not stretch very far.

161. We have heard from the BMA that the proposed ad hoc arrangements for local medical support for coroners will mean that, contrary to the Home Office proposals of 2004, the medical adviser will not now be responsible for assuring the quality of post-mortems in a coroner's jurisdiction.¹⁶¹

162. We recommend that Government change its policy on medical support for coroners and return to the 2004 proposals, with adequate resources being made available to coroners.

Post-mortem examinations

Shortage of pathologists and quality of post-mortem examinations

163. The arrangements for coroners ordering post-mortem examinations would be changed slightly from the current position under the Coroner Act 1988 (Clause 26). In addition, bodies may now be moved to other locations for post-mortem examinations to be carried out, allowing coroners to make use of resources and medical expertise which might not be available in their immediate vicinity.

164. These new arrangements appear to be sensible and we have received no evidence suggesting otherwise. However, concerns about both the chronic shortage of pathologists and the quality and consistency of post-mortem examination remain. The Minister has noted “a dearth of pathologists, which also concerns colleagues in the Department of Health and the Home Office.”¹⁶²

165. We received detailed evidence from the BMA as to the specific reasons for the shortage of pathologists.¹⁶³ In its written submission, the BMA summarises:

There is a shortage of histopathologists and forensic pathologists [who are trained in the detection of signs of foul play], few medical schools require students to pass exams in forensic/medico-legal medicine, and University Departments of Forensic Pathology/Medicine are few in number.¹⁶⁴

158 HC Deb, 6 February 2006, Col 613

159 Draft Coroners Bill, Foreword, p 4

160 Q252

161 Q185

162 HC Deb, 6 Feb 2006, Col 613

163 Q183

164 BMA submission to Home Office Position Paper

166. The Department of Health has assured us that it is addressing this situation, although hospital doctors do not appear to share this optimism.¹⁶⁵ According to Dr Gina Radford, a Department of Health official:

We have been aware for some time of the shortage of pathologists and share the concern expressed earlier. We have invested several million pounds in increasing the number of training posts [in] pathology and recruited quite a considerable number of people into new training posts to increase the sheer numbers and capacity within pathology, but clearly that will take a short time to work through the system so we have people who are then qualified to operate at consultant level. At the moment those people are going through the system.¹⁶⁶

167. In addition to the chronic shortage of pathologists, concerns have also been expressed about the quality and consistency of post-mortem examination. The Luce Review heard from coroners that they had no means of knowing whether post-mortem examinations were being conducted to an acceptable standard, although most were generally happy with the work done for them. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) found in its 2004 report that there were serious concerns with the standards of autopsy reports when judged against the 1993 guidelines of the Royal College of Pathologists. 44% of autopsy reports had a poor, or no, clinico-pathological summary. Depiction of the cause of death sequence (ie the death certificate) by pathologists was not consistent with the clinical and pathological data in one third of cases.

168. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is currently conducting the first audit of coroners' autopsy reports, the results of which will be published in October 2006. Without the benefit of that information, we are unwilling to make any firm recommendations as to the action the Government should be taking to address both the shortage of pathologists and the quality of post-mortem examinations conducted for coroners.

High rate of post-mortem examination

169. The rate of post-mortem examination in England and Wales is high: between double and triple the rate in other jurisdictions.¹⁶⁷ The percentage of cases involving post-mortem examination, as a proportion of all deaths reported to coroners, fell from 50% in 2004 to 37% in 2005, in line with a long-term downward trend.

170. The 3rd Report of the Shipman Inquiry stated that post-mortem examinations should no longer be automatically triggered in the case of referrals to coroners.

At present, once a coroner accepts jurisdiction in respect of a death, a subsequent decision to order an autopsy is almost automatic, without any other preliminary investigation. This immediate resort to autopsy results from the legislation. In my view, it is undesirable. An autopsy should be conducted only when there is a positive reason to do so; the decision should not be taken 'by default'.¹⁶⁸

165 Q183

166 Q208

167 Luce Review, Chapter 2, para 6

168 3rd Report of the Shipman Inquiry, Summary, para 102

171. Dame Janet told us that unnecessary post-mortem examinations created unnecessary stress for the bereaved:

...in quite a number of cases it is not necessary. I can give you as an example a body that was very badly damaged in the course of a road traffic accident or a train accident, you only have to look at it to see that the body is dead and in general terms why. Is there any advantage in detailed dissection of the body parts in order to discover precisely which organs have been damaged in which particular way? The inquest is really about how the train crash happened, how the car accident happened or how the pedestrian was knocked down. It can just be an additional source of distress for the family to think that the body is going to go through an autopsy as well.¹⁶⁹

172. The Luce Review recommended that:

- post-mortem examination should never be automatic, but only ordered where necessary to clarify uncertainty about a death;
- any investigation should be at the lowest level of invasiveness likely to resolve the uncertainty; and
- in cases where the family object to a post-mortem examination, it should not proceed unless there is a positive indication of the need to investigate a possible crime or lack of medical or other care, or a public health risk that requires the cause of an individual death to be established in order to prevent similar fatalities.¹⁷⁰

173. There are two principal reasons why the rate of post-mortem examination in Scotland is lower than that in England and Wales. First, recent changes in general practice and out-of-hours cover make it increasingly unlikely that the death certificate will be signed by a doctor who has seen the patient within the last 14 days. In these circumstances, the Registrar cannot accept the death certificate and must refer the death to the coroner who may then order a post-mortem examination.¹⁷¹ This does not happen in Scotland where there is no 14-day rule.

174. Second, there is a lack of information provided to the coroner and pathologist to assist them with the decision as to whether to perform the examination.

Sometimes in non-suspicious deaths we will receive, if we are lucky, a typed history from the coroner. Usually, it is a handwritten scrawl. I have experience of cases such as road traffic collisions where all the history I get prior to the post-mortem is: “Deceased involved in road traffic accident. Taken to hospital. Died.” That is almost useless and it does not serve the family well to have a post-mortem done for that reason. Neither the coroner nor the pathologist is served by that lack of information.¹⁷²

169 Q51

170 Luce Review, Chapter 13, para 66

171 Births and Death Regulations 1987, Reg 41

172 Q180

In this respect, the BMA argues that the system in England and Wales compares unfavourably with that in Scotland, where sudden death reports typed up by the police are usual and provide a sound basis on which to decide whether or not to perform a post-mortem examination.¹⁷³

175. Following our visit to Scotland, we also noted the potential benefits of the Scottish “view and grant” system. The BMA has also given evidence that the view and grant system might be of advantage in England and Wales:

In approximately 10% of referrals the procurator fiscal will put a note in the letter to us saying, “Would you consider a view and grant in this case?” We would perform an external examination of the body. If we found signs that perhaps were not consistent with the story or slightly suspicious we would phone the procurator fiscal and ask if we could do a full post-mortem. He would say yes. If we found nothing suspicious we would do a view and grant and write out a medical certificate of death. The ability of the pathologist, if you like, to write a certificate of death was helpful in such cases and avoided the need for a post-mortem in, say, 10% of cases in Glasgow. It differed in other jurisdictions in Scotland. Some people used it less and some more.¹⁷⁴

176. Nevertheless, a study has found that the pre-autopsy estimate of the cause of death by experienced pathologists was correct only in a minority of cases, ranging from 39% to 46%. The study finds that accuracy of cause of death pre-autopsy is often dependent on the quality of information available, which may be insufficient. It concludes that the case for view and grant is not made out, as any reduction in the number of autopsies will be accompanied by an increase in the number of errors in diagnosis which, on these findings, were between 54% and 61%. Finally, the study considered why, when the same information was available to both the pathologist and the deceased’s medical practitioner, who might also have had personal knowledge of the patient, that practitioner was not in a position to issue a death certificate, whereas the pathologist felt that there was sufficient information available to determine cause of death in up to 74% of cases. The study concludes that one of the explanations is the operation of the “14 day rule”.¹⁷⁵

177. We recommend that the Government adopt a strategy for reducing the number of post-mortem examinations performed. This may include abolition of the “14-day rule”; provision of detailed information to the coroner and pathologist; adoption of written sudden death reports by the police; and consideration of a system similar to the Scottish “view and grant”.

173 Q180

174 Q173

175 GN Ruddy, RM Duerden, N Carter and JC Clark (2001), *J. Clin. Pathol.* 2001; 54; 279-284

7 The bereaved

178. Although we have heard evidence of good practice in the coronial system, we have received written submissions detailing cases in which the bereaved have received poor treatment and service.

- Victims' Voice cited the experience of a man whose wife was killed in a road accident. The account details a series of episodes in which he was treated insensitively by police, hospital and mortuary staff, although no coroner's staff are mentioned.¹⁷⁶
- The Coroners Services Public Accountability Action Group has made a long submission which reveals a high degree of suspicion about the workings of the coronial system, alleging secrecy, arbitrary decision making, lies and illegality.¹⁷⁷
- Mr Gerald Wright has submitted evidence of inconsistent treatment by the coroner in relation to post-mortem examination of his wife who died suddenly whilst on holiday.¹⁷⁸
- The parents of Nik Morgan have made written submissions detailing their struggles to get an inquest into the sudden death of their son.¹⁷⁹

179. INQUEST, an organisation which works with those bereaved as a result of deaths in custody, has identified a long list of problems with the current coronial system, including:

- lack of information for the bereaved about their rights in relation to inquests and post-mortem examinations;
- lack of understanding and sensitivity in relation to religious and cultural issues;
- insensitivity of coroners and others in relation to post-mortem evidence;
- regional variation in relation to time delays and approach to inquests;
- variable quality of court accommodation;
- variable coronial practice generally;
- variable standards of conduct of coroners' officers; and
- lack of follow-up communication on lessons learned and prevention strategies.¹⁸⁰

180. INQUEST finds that bereaved families have found themselves marginalised by the coronial process and, far from being comforted in their distress, they are left with more questions than answers,¹⁸¹ adding that:

176 Ev 102–106

177 Ev 154–166

178 Unprinted memorandum

179 Unprinted memorandum

180 Ev 113–114, para 10

181 Ev 114, paras 12–15

... far from being the isolated or highly controversial cases or incidents that the system proves incapable of dealing with, it is ill equipped to deal with *most* deaths and *most* families suffer additional distress and grief as a result.

...[The coronial system's] potential role in guaranteeing informed and effective access to appropriate bereavement intervention options for bereaved families must therefore be a central concern in developing a new system.¹⁸²

181. The Foundation for the Study of Infant Death (FSID) has also remarked that:

There are marked inconsistencies between different parts of the country in the official response to unexpected infant deaths. These variations arise mainly from differences in the attitudes and actions of individual coroners, police officers and pathologists. There are also variations in the extent to which paediatricians are prepared (or permitted) to become involved. ... [there is a] lack of central guidance [which] permits wide individual variation of approach, which at times appears idiosyncratic and wayward.¹⁸³

182. Dame Janet Smith agreed that bereaved families are not well served by the existing system:

The evidence about the present post-death procedures shows that the families of deceased persons are little involved in the processes of certification and investigation of a death...the needs and expectations of the bereaved relatives are sometimes not given the consideration they deserve.... the present procedures fail to tap a source of information about the deceased person and the circumstances of his/her death that would be of great value to the process of death certification and investigation...Any changes contemplated for the future must seek to ensure that families are kept informed about, and are consulted and involved at all stages of, the post-death procedures.¹⁸⁴

183. The Luce Review concluded that although individual coroners and their officers were often sympathetic and supportive to bereaved families, the current system had fallen below the standards aimed for in other public services in matters of informed participation.

184. The Government has accepted the recommendation of the Luce Review that the participation of bereaved families in the Coroners service should be secured by a Family Charter. A Draft Charter for Bereaved People Who Come Into Contact With The Coroner Service has been appended to the draft Bill. This sets out:

- the objectives and values of the coroner service;
- details of the standards of service the bereaved should expect;
- the rights of the bereaved to participation in the death investigation process;
- availability of support and bereavement services;

182 Ev 114–115, paras 15 and 16

183 FSID submission to Home Office Position Paper; Luce Review and Shipman inquiry

184 3rd Report of the Shipman Inquiry, Summary, paras 5–7

- information about deaths abroad;
- rights of appeal and review of coroners' judicial decisions;
- procedures for other complaints and comments;
- disability issues; and
- information about monitoring of service standards.

185. We welcome the Government's draft Charter for Bereaved People. However, we note that the raised expectations of the bereaved may lead to severe disappointment in circumstances where serious under-resourcing and, therefore, variable standards in service are likely to persist as a result of inadequate funding for reform of the coronial system.

8 Coroners' officers

The current situation

186. Coroners' officers are, in many respects, the mainstay of the administration of the coronial system and are the primary link between the system and the bereaved.¹⁸⁵

187. Whilst the coroner is funded by local authorities, employment and resourcing of coroners' officers is currently divided between police authorities in some areas and local authorities in others. The tripartite relationship between local authority, police authority and coroner, with coroners' officers in the middle, is often uncomfortable since those resourcing the coroners' officers have no control over how they are deployed. There is no central mechanism for ensuring consistency of standards either in officer training or in the service given.

188. The Coroners' Officers Association (COA) said that, whilst contact with coroners' officers is often beneficial for the bereaved, insufficient staffing levels and inadequate training are hampering them in their work.

More demands by the bereaved and the public at large are being made of the current coroner's service and the service is, in some areas, under considerable strain due to insufficient staffing levels and inadequate training.

Over recent years there has been a considerable diminution of time available for coroner's officers to spend with families and a lot of communication is done over the telephone, this is not ideal, especially in inquest cases. There is no doubt that families benefit from face to face contact with the coroner's officer. It gives an opportunity both for the family to ask questions and raise concerns; and for the coroner's officer to develop a more professional relationship with the bereaved, and become more aware of and more sensitive to their needs.¹⁸⁶

189. The COA was formed by coroners' officers in 1997, partly because of a concern that there was little or no training available for officers at that time. The Association has since developed some training modules which are included in its conferences. It also arranges an annual training symposium. Funding for training was originally sourced from members' subscriptions, although conferences and symposia are now supported with some funding from the DCA.¹⁸⁷

190. Since 2002, the COA has developed some training courses in partnership with the University of Teesside. These are the only accredited courses designed for coroners' officers and other staff working in the coronial system.

Unfortunately most officers are unable to attend the courses, due to the reluctance of employers to provide funding to pay for the courses or lack of available cover to enable them to attend.¹⁸⁸

185 Q127

186 COA submission to the Luce Review; Ev 75–80

187 Ev 75, paras 4 and 5

188 Ev 75, para 6

191. The COA believes that current employers of coroners' officers do not view the coroner system as a priority. Workloads of officers have increased substantially in recent years and the strain is now apparent. There is a lack of acknowledgement of the importance of their role, insufficient investment in staffing and training and, as a result, officers are either leaving the service or considering doing so. The resulting loss of expertise is necessarily detrimental to the standards of service given to the bereaved.¹⁸⁹

192. As a result of long-standing uncertainty over the future arrangements for the coronial system generally and coroners' officers in particular, current employers have been reluctant to invest in coroners' officers and in a service which was already under-funded.¹⁹⁰ The LGA has agreed that:

Uncertainties about the future of the service since 2002 mean that some authorities have been reluctant to invest in service improvements, leading to uneven provision around the country.¹⁹¹

193. ACPO has also admitted that police authorities are reluctant to invest in coroners' officers because of the uncertainty surrounding coroner reform in recent years.

ACPO has long been in favour of transferring employment and management of coroners officers from the Police Service to the local authorities who appoint and pay for the coroners. It clearly does not make sense that police authorities employ and pay for staff when they have no influence on how these members of staff are deployed. It is perhaps not surprising that police authorities have been reluctant to invest in the training and support given to these staff when there has been such a long period of uncertainty over their future status.¹⁹²

The Government's proposals

194. The draft Bill does not alter the present arrangements for employment and resourcing of coroners' officers, although Clause 57 provides that the Chief Coroner must prepare and maintain appropriate arrangements for the training and guidance, not only of coroners themselves, but also of their assistants. 'Assistants' will include coroners' officers.

The intention is that the Chief Coroner will have a strategic overview of the training programme, and a coherent programme of relevant courses will be organised to ensure good induction arrangements and ongoing professional development.¹⁹³

195. The COA has expressed itself extremely disappointed with the lack of recognition of the role of the coroner's officer in the draft Bill.¹⁹⁴ It had hoped for a standardisation of practice under a unified, national system, with appropriate pay and conditions, recruitment strategies and resources to support them.¹⁹⁵ Instead, the COA fears the continued attrition of their experienced members; their replacement by untrained officers;

189 Ev 75

190 Ev 75, para 2

191 Ev 87, para 17

192 Ev 84

193 Explanatory Notes to the Draft Coroners Bill, p 59

194 Q149

195 Q149

and an increasing workload for those remaining.¹⁹⁶ This, in turn, would impact on the standards of service offered to the bereaved.¹⁹⁷ We have heard evidence of low moral amongst coroners' officers which is likely to persist now that it is clear that their circumstances will not be changed by the proposed reforms.¹⁹⁸

196. Those who employ coroners' officers, the local authority or the police according to the area, are in dispute over who should finance them.¹⁹⁹ ACPO has acknowledged the skilled role of the coroners' officers, but has noted that their support structure has only survived in recent years because their employers were repeatedly told by the Government that the issue of coroners' officers would be addressed.²⁰⁰ Both ACPO and the Local Government Association have now stated that police forces and local authorities do not have the resources to increase funding for coroners' officers.²⁰¹

197. Tom Luce argued that Government's failure to reform the current arrangements for the resourcing of coroners' officers was a "very serious error" for two reasons:

First of all, I think that it is hard enough to get [a] consistent attitude towards the development and employment of a group like coroners' officers when they are in local Government employment, but it is at least doubly hard when half of them at any given time are in the employment of police authorities.

The second thing, ... is that particularly under the new service, when the Government ... envisages that there will be a greater emphasis on delivering outcomes and delivering certain quality of interaction with families, the coroner's job is going to become somewhat more managerial than it is at the moment. ... If in some of the coroners' localities, the coroners' officers (in effect the main support staff for the coroners' service) are employed not by the local authority which is supporting the coroner but by a completely different public authority altogether, with different reporting standards and all that kind of thing, there is no way that the coroner can take a responsibility for running his or her service. I think that is a very serious matter and I hope very much that the Government will rethink that aspect of it.²⁰²

198. When we put the plight of coroners' officers to the Minister, asking how the draft Bill could improve the experience of the bereaved without dealing with these fundamental problems, she initially responded with a list of other measures relevant to the bereaved. On the subject of coroners' officers she noted the important rôle they play in relation to the bereaved and added:

That is why we think it is very important that we do not have the situation we have at the moment where somebody can be appointed to be a coroners' officer and, on their

196 Q130

197 Q130

198 Q123

199 Q123

200 Q150

201 Q153

202 Q71; see also Ev 153

first day, they have to do the job without any induction training or any ongoing professional training. The training for coroners' officers is very important indeed.²⁰³

199. Provision of training for coroners' officers by the Chief Coroner, whilst a step forward, does not remotely address the problems they face on a daily basis. We agree with the COA that: "By leaving coroners' officers as they are, we believe that the DCA has lost a real opportunity to modernise, standardise and professionalise death investigation."²⁰⁴ Coroners' officers play the pivotal rôle in the coronial system and we find their neglect by the Government extremely disappointing.

200. We strongly recommend that the Government acknowledges the status and importance of coroners' officers by addressing the serious deficiencies and local inconsistencies in their support structure. We recommend that they be employed by local authorities, that their pay and conditions be standardised and that they be provided with adequate resources and training.

203 Q275

204 Q153

9 Public health and safety

201. Information recorded on death certificates is already collated by the Office for National Statistics and then passed to the Department of Health annually. Information from death certificates may be used for:

- comparing mortality statistics at local, national and international level;
- information about the effectiveness of interventions;
- supporting targeted investigations;
- designing and evaluating public health interventions;
- planning health services;
- research;
- providing information about family medical history.

The Department of Health gives further detail in its submission about its initiatives, based on death certification information, in the areas of suicide prevention and cardiovascular disease.²⁰⁵

202. However, quite apart from this information, coroners are potentially a rich source of other information. Other agencies, commonly in the health field, could benefit from the information gathered at inquest, both from individual cases and trends. Tom Luce identified the need for better use of coronial information for public health.²⁰⁶ However, much of this information remains unused for want of links between the coroner and agencies in the wider community.

203. ACPO has particular concerns about the collection of information about sudden deaths and the circumstances leading up to them which could, if used properly, lead to improvements in public health and safety.

Coroners collect vast amounts of information about sudden deaths and the circumstances leading to them. Coroners are able to summon witnesses and to write to agencies after inquests pointing out failings and calling for action. The powers of Coroners to make sure that this action is actually completed are unclear. Over recent years a whole range of public sector partnerships have been established dealing with matters concerning public health, community safety and general wellbeing. Unfortunately the Coroner is not tied into any of these structures and so local communities do not get the full benefit of their experience in their findings.²⁰⁷

204. ACPO has called for:

²⁰⁵ Ev 90–92, paras 8–19

²⁰⁶ Luce Review, Chapter 3, p 22

²⁰⁷ Ev 85

Detailed work to be carried out to establish the policies and procedures of the Coroners service of the future so that all involved are clear of their roles and the expectations of them. There should also be a strong emphasis on the collection and analysis of data concerning sudden deaths.²⁰⁸

205. The draft Bill makes provision similar to that already established under Rule 43 of the Coroners Rules 1984. Under Clause 12(2), where a coroner believes, as a result of an investigation, that action should be taken to prevent similar fatalities, the coroner *may* report the matter both to a person who has power to take such action and to the Chief Coroner. There is no power for the coroner to compel the person to take action or to report back as to what action, if any, has been taken. The role of the Chief Coroner appears to be to collect this reported information in a central place.

206. During this Inquiry, we have been given considerable assistance by the State Coroner of Victoria, Australia, Mr Graeme Johnstone and the Deputy Director of the Victorian Institute of Forensic Medicine, Professor David Ranson. They have made a number of recommendations:

- There should be a legal framework for a model of death investigation which integrates public health and safety.
- A national Coronial Investigation Data System could be an important tool for the promotion of public health and safety, especially if it were made available to a wide range of public and private agencies. Expert systems software development can also lead to early detection of trends in preventable deaths by monitoring all coroners' death data automatically.
- The legislative framework is only the start of an effective and proactive death investigation process. A long-term strategy for policy development is needed to establish the necessary institutions and recruit and train personnel to support the coroner in the technical and procedural aspects of his work.
- The needs of families should be integrated into the administration and operation of the coronial system, with bereavement support services and services focusing on family health promotion and disease prevention.
- There should be specialist training for coroners and their staff in public health, risk management, therapeutic jurisprudence, investigation management and bereavement. This is necessary for the efficient operation of a coronial death investigation service.²⁰⁹

207. The State Coroner's Office in Victoria operates a death investigation service that is at an advanced stage of integration with other public and private agencies with a stake in public health and safety. The State Coroner said:

Whilst the coroner is not the sole agency working on any particular safety issue, the ability to provide an independent judicial overview of death investigations, to collect timely and detailed data on deaths investigated, to draw together the common threads

208 Ev 85

209 Ev 121–122

of a series of deaths, to make recommendations and provide that information to government and the community, is unique and we believe it saves lives.”²¹⁰

208. The State Coroner gives many examples of coroners’ recommendations leading directly to legislative and policy changes in cases involving: pedestrian safety in the workplace; tractor roll-overs; drowning of children in swimming pools and agricultural dams; accidental child hangings from blind and curtain cords; prison cell design; electrical appliance safety and design; and police use of force. The work of coroners and pathologists in Victoria has also contributed to medical treatment and life enhancement.²¹¹

209. Families often express their wish that something positive might come out of the coroner’s inquiry and desire that relevant agencies will take preventative action so that the death of the family member is not in vain.²¹² This approach also gives the coronial system fresh purpose, raises the morale of coroner and staff, and assists agencies to identify and remedy problems.

210. We consider this to be an excellent model for what can be achieved with an ambitious approach to reform of a coronial system, putting the coroner at the heart of community efforts towards better public health and safety and giving a greater sense of purpose and comfort to the bereaved. We believe that, in taking a timid approach to reform of the coronial system, the Government has missed an opportunity to derive great public benefit and value for money from the death investigation process.

211. We recommend that the Government take a bolder approach to reform of the coronial system, embodying in legislation an enhanced role in relation to public health and safety. This should be backed up with significant additional resources to produce a system which provides greater public benefit and value for money.

210 Ev 122

211 Ev 135–142

212 Ev 143

10 Conclusion

212. The reforms proposed in the Home Office Position Paper of 2004 represented a good model for reform of the death certification and investigation systems, although we received evidence that these reforms could not have been achieved on the revenue-neutral basis claimed by the Home Office.²¹³ In particular, we considered sensible the proposals for reform of death certification, including medical examiner scrutiny of all death certificates. It is disappointing that the Government has, in the draft Bill, retreated from its 2004 proposals, leaving out much of what was good.

213. There are also serious concerns about potential discontinuity when reform takes place, because there is no certainty that serving coroners, particularly part-time coroners, coroners' officers and administrative staff will apply for or be appointed to posts in the new system. **We believe that such complex reforms will require carefully planned transitional arrangements and serious efforts to ensure that skills and experience are not lost to the new system.**

214. Among the issues we raise in this Report, two are pervasive and limit the effectiveness of the entire death investigation system:

- Funding: although the Government has now committed a certain amount of extra funding for the coronial system (£14.5 million start-up costs and additional running costs of £5.8 million per annum) this is likely to fall considerably short of the financial commitment needed to rescue this seriously under resourced service from its current state of neglect
- Death certification, investigation and registration are processes which are inextricably linked. The Government's decision not to reform the death certification system leaves many fundamental problems unaddressed.

215. The reforms proposed in the draft Bill contain much that is praiseworthy but the Government is in danger of wasting a golden opportunity for substantial reform of the coroners system in England and Wales and the death registration system. The draft Bill does little more than tinker on the margins of the current system. Much of the improvement which might come about as a result of the proposals in the draft Bill will be threatened by the paucity of resources which are likely to be devoted to this important area. We believe that this draft Bill falls well short of what is required to reform the system.

213 Ev 62, paras 21 and 32; Ev 96, para 7; Ev 75–77

11 Conclusions and recommendations

Pre-legislative scrutiny and the legislative process

1. [The Minister for Constitutional Affairs asked for the Committee's views on a number of issues at the very end of our oral evidence sessions, leaving us no time to take evidence on these points]. We recommend that, in future, the Government makes known the particular issues with which it requires assistance at the same time as or, preferably, before publication of the draft Bill. (Paragraph 8)
2. The Government cannot claim to be engaging in the pre-legislative scrutiny process when it has published the draft Bill so late that there is insufficient time for scrutiny to be carried out thoroughly and effectively. We recommend that the Department for Constitutional Affairs reviews its procedures for publication of draft legislation so that this Committee may in future have sufficient time to conduct proper pre-legislative scrutiny. (Paragraph 10)

The need for reform: the Shipman Inquiry and the Luce Review

3. Coroners undertake their statutory function in a fragmented and localised system that has remained largely unchanged since the time of Queen Victoria. The current system is ill-equipped to deal with the modern expectations of society and our formal and informal evidence has shown us that coroners are amongst the greatest proponents of change. (Paragraph 21)

Death certification

4. Evidence submitted to us highlights three problems with the death certification system:
 - first, the difference in certification procedures for burial and cremation is anomalous;
 - second, the complexity in the current death certification system and lack of sufficient training for medical practitioners are partially responsible for the very high rate of referral of deaths to coroners; and
 - third, the problem of how Shipman-style abuse of the system might be prevented remains unsolved. (Paragraph 52)

Government proposals for reform

5. We conclude that, because neither the DCA nor the Department of Health is taking responsibility for death certification there is no systematic and coordinated response to the serious issues raised in the 3rd Report of the Shipman Inquiry and in the Luce Review. When asked direct questions about the exact steps being taken to reform death certification, witnesses from both departments have given evasive and vague answers. We can only assume from their evidence that, if anything specific is being done at all, it amounts to tinkering at the edges of a system which has already been deemed unsafe and unsatisfactory by two Government-commissioned reviews. (Paragraph 66)

6. We strongly recommend that the Government revise its policy [not to reform death certification] in order to address reform of death certification in tandem with reform of the coronial system. It should return to the proposals on death certification put forward by the Home Office in 2004, ensuring that they are supported with sufficient resources. (Paragraph 71)
7. As a basic minimum, we recommend that the Government introduce a positive statutory duty for doctors to refer certain categories of death to the coroner and work with the General Medical Council and the General Register Office to establish suitable guidance and training to improve doctors' knowledge of death certification requirements and procedures. (Paragraph 72)

The Coronial System: local service, national framework

8. The Government's proposals lack detail and fail to tackle adequately the resource and structural problems currently facing the existing, outmoded coronial system. The limitations of the local structure of the current system, giving rise to uneven distribution of resources, will remain. It is difficult to see how a Chief Coroner can function effectively as a force for standardisation without being part of a national service. A national service would almost certainly involve significant extra cost, but the failure to introduce one will mean that the current inequalities of resource will continue. (Paragraph 101)
9. It is vital to ensure that changes to the jurisdictional boundaries of the coronial system and to the staff involved in administering it do not inadvertently result in valuable skills and experience being lost. (Paragraph 103)
10. The Government needs to clarify how their proposed system is intended to function in scattered and remote areas. If it is the Government's intention that local authorities responsible for large jurisdictions should provide a coroner with more than one place in which to hold inquests, we recommend that this should be made apparent on the face of the Bill when it is published. (Paragraph 110)

Resources

11. The Government should address the problems of under-resourcing in the existing coronial system in order to create solid foundations on which reforms can be built. This will require a careful assessment of the aggregate costs of the existing system, to include hidden subsidies, together with an assessment of deficits in particular areas. (Paragraph 125)
12. The Government should establish a mechanism for auditing the expenditure of local authorities on the coronial system and ensuring that coroners are given equivalent resources. (Paragraph 126)
13. We further recommend that the Government should reform the structure of the coronial system by creating a national service with centralised and adequate funding so that all coroners are able to work to the same high standards. (Paragraph 127)

The Chief Coroner

14. The Government should reconsider its estimates for resourcing the office of the Chief Coroner on the basis of a detailed analysis of a projected daily workload. In conducting this analysis, the Government should draw on the experience of coroners who will be able to provide greater detail on how they are likely to deal with the Chief Coroner on a daily basis. (Paragraph 133)

Appeals

15. We recommend that the class of “interested persons” [with a right of appeal to the Chief Coroner from any decision] be substantially restricted and that limits be placed on the decisions of the coroner which are subject to appeal. (Paragraph 139)

Death investigation

16. The draft Bill does not deal specifically with the concern that a coroner may decline jurisdiction on unjustified grounds. However, the decision not to accept jurisdiction would probably be subject to appeal to the Chief Coroner under Clause 60 of the draft Bill. Bereaved people who wish to challenge such a decision would not, therefore, be left without recourse under the new regime and we welcome this. (Paragraph 141)
17. We acknowledge that the Government has introduced some sensible reforms with respect to death investigation procedure in Parts 1 and 3 of the draft Bill. (Paragraph 146)

The inquest

18. We welcome the Government’s decision to keep the public inquest as the standard form of inquest under the draft Bill. (Paragraph 154)

Medical support for coroners

19. We recommend that Government change its policy on medical support for coroners and return to the 2004 [Home Office] proposals, with adequate resources being made available to coroners. (Paragraph 162)

Post-mortem examinations

20. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is currently conducting the first audit of coroners’ autopsy reports, the results of which will be published in October 2006. Without the benefit of that information, we are unwilling to make any firm recommendations as to the action the Government should be taking to address both the shortage of pathologists and the quality of post-mortem examinations conducted for coroners. (Paragraph 168)
21. We recommend that the Government adopt a strategy for reducing the number of post-mortem examinations performed. This may include abolition of the “14-day rule”; provision of detailed information to the coroner and pathologist; adoption of written sudden death reports by the police; and consideration of a system similar to the Scottish “view and grant”. (Paragraph 177)

The bereaved

22. We welcome the Government's draft Charter for Bereaved People. However, we note that the raised expectations of the bereaved may lead to severe disappointment in circumstances where serious under-resourcing and, therefore, variable standards in service are likely to persist as a result of inadequate funding for reform of the coronial system. (Paragraph 185)

Coroners officers

23. We strongly recommend that the Government acknowledges the status and importance of coroners' officers by addressing the serious deficiencies and local inconsistencies in their support structure. We recommend that they be employed by local authorities, that their pay and conditions be standardised and that they be provided with adequate resources and training. (Paragraph 200)

Public health and safety

24. We recommend that the Government take a bolder approach to reform of the coronial system, embodying in legislation an enhanced role in relation to public health and safety. This should be backed up with significant additional resources to produce a system which provides greater public benefit and value for money. (Paragraph 211)

Conclusion

25. We believe that [the] complex reforms [contained in the Bill] will require carefully planned transitional arrangements and serious efforts to ensure that skills and experience are not lost to the new system. (Paragraph 213)

Formal minutes

Tuesday 18 July 2006

Members present:

Mr Alan Beith, in the Chair

David Howarth	Keith Vaz
Siân James	Dr Alan Whitehead
Julie Morgan	Jeremy Wright
Mr Andrew Tyrie	

Draft Report [Reform of the coroners' system and death certification], proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 215 read and agreed to.

Summary read and agreed to.

Conclusions and recommendations read and agreed to.

Resolved, That the Report be the Eighth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No 134 (Select Committees (Reports)) be applied to the Report.

Several papers were ordered to be appended to the Minutes of Evidence.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

[Adjourned till Wednesday 19 July at 4.30pm]

Witnesses

Tuesday 7 February 2006

Michael Burgess, HM Coroner for Surrey Ev 1

Rt Hon Dame Janet Smith DBE Ev 6

Tuesday 25 April 2006

Tom Luce CB, Chair, Fundamental Review of Death Certification and Investigation Ev 14

Tuesday 13 June 2006

Victor Round, Honorary Secretary, Coroners' Society of England and Wales; Ev 24

Chief Constable Peter Fahy, Cheshire Constabulary and Association of Chief Police Officers; **Councillor Bryony Rudkin** and **Steve Charteris**, Local Government Association and **Christine Hurst**, Chair, Coroners' Officers Association Ev 30

Tuesday 20 June 2006

Dr Michael Wilks, Chairman, Medical Ethics Committee, **Dr John Grenville**, General Practitioners Committee, **Dr Anne Thorpe**, Chair, Central Consultants and Specialists Committee Pathology Sub-Committee, and **Dr Andrew Davison**, Forensic Medicine Committee, British Medical Association Ev 38

Dr Gina Radford, East of England Regional Director of Public Health, Department of Health Ev 44

Tuesday 27 June 2006

Phillip Noyes, Director of Public Policy, **Lucy Thorpe**, Policy Manager, NSPCC, and **Pip Finucane**, Trustee, Victims Voice Ev 48

Rt Hon Harriet Harman QC MP, Minister of State, Department for Constitutional Affairs Ev 53

List of written evidence

See Volume II

Tom Luce CB, Chair, Fundamental Review of Death Certification and Investigation, 2001–2003

Michael Burgess, HM Coroner, Surrey and Coroner of the Queen’s Household

Coroner’s Officers Association (COA)

Association of Chief Police Officers (ACPO)

Local Government Association (LGA)

Department of Health

British Medical Association (BMA)

NSPCC

Mrs Pip Finucane, Trustee, Victims’ Voice

Department for Constitutional Affairs

INQUEST

Foundation for the Study of Infant Deaths (FSID)

SOLACE

Graeme Johnstone, State Coroner of Victoria and Associate Professor David Ranson, Deputy Director, Victorian Institute of Forensic Medicine

Ian G McCreath MBE, HM Coroner, North Northumberland

Caroline Beasley-Murray, HM Coroner, Essex and Thurrock

The Law Society

Victor Round, Honorary Secretary, The Coroners’ Society of England and Wales

Coroners Services Public Accountability Group

Mrs L H Lewy, Rigorous Analysis of Iatrogenic Death (RAID)

Margaret Lockwood-Croft, Chair, Marchioness Action Group

Independent Police Complaints Commission (IPCC)

The Oak Tree Surgery

National Association of Funeral Directors

Federation of British Cremation Authorities (FBCA)

Health and Safety Executive

City of London Corporation, City Remembrancer’s Office

Brethren Christian Fellowship (The Brethren)

Committee on the Administration of Justice (CAJ)

MRSA Action UK

Judicial Studies Board (JSB)

Royal College of Pathologists

Epilepsy Bereaved

Nigel Meadows, HM Coroner, Plymouth & South Devon

Alan C Crickmore, HM Coroner, Gloucestershire

Unprinted memoranda

Gerald Wright

Mr and Mrs B Morgan

Mrs E Guinee

Ivan Biddle

Reports from the Constitutional Affairs Committee

Session 2005-06

First Report	The courts: small claims <i>Government response</i>	HC 519 <i>Cm 6754</i>
Second Report	The Office of the Judge Advocate General	HC 731
Third Report	Compensation culture <i>Government response</i>	HC 754 <i>Cm 6784</i>
Fourth Report	Legal Services Commission: removal of Specialist Support Services	HC 919
Fifth Report	Compensation culture: <i>NHS Redress Scheme</i> <i>Government response</i>	HC 1009 <i>Cm 6784</i>
First Special Report	Legal Services Commission's response to the Fourth Report on removal of Specialist Support Services	HC 1029
Sixth Report	Family Justice: the operation of the family courts revisited	HC 1086
Seventh Report	Freedom of Information—one year on	HC 991

Session 2004-05

First Report	Freedom of Information Act 2000 — progress towards implementation <i>Government response</i>	HC 79 <i>Cm 6470</i>
Second Report	Work of the Committee in 2004	HC 207
Third Report	Constitutional Reform Bill [<i>Lords</i>]: the Government's proposals <i>Government response</i>	HC 275 <i>Cm 6488</i>
Fourth Report	Family Justice: the operation of the family courts <i>Government response</i>	HC 116 <i>Cm 6507</i>
Fifth Report	Legal aid: asylum appeals <i>Government response</i>	HC 276 <i>Cm 6597</i>
Sixth Report	Electoral Registration (Joint Report with ODPM: Housing, Planning, Local Government and the Regions Committee) <i>Government response</i>	HC 243 <i>Cm 6647</i>
Seventh Report	The operation of the Special Immigration Appeals Commission (SIAC) and the use of Special Advocates <i>Government response</i>	HC 323 <i>Cm 6596</i>