Ministry of JUSTICE

Draft charter for bereaved people who come into contact with a reformed coroner system

18 June 2008

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Introduction

1. The main aim of coroner reform is to deliver a better service for bereaved people. The Charter for Bereaved People who come into contact with the Coroner Service ("the Charter") describes the services they can expect to receive from a reformed service, and sets out the rights of redress if services are not delivered. It additionally explains appeal rights against particular decisions taken by coroners in individual cases.

2. The Charter will be enabled by the Coroners and Death Certification Bill when the Bill gets Royal Assent, and will have therefore the status of statutory guidance. The Charter does not apply to the coroner system as it currently operates.

3. A draft version of the Charter was first published for consultation alongside the draft Coroners Bill in June 2006. The consultation period lasted for three months and we received over 150 written responses. In addition, the Bill and the Charter were discussed at regional seminars involving those directly responsible for delivery of the coroners' service, and numerous meetings with representative bodies and groups from the voluntary sector.

4. The Charter was generally welcomed but the Government undertook to consult further as the reform programme progressed. In 2007, we did so with those with a particular interest (those who work within the current system and the voluntary sector groups which most frequently have contact with it).

5. A revised version of the Charter has been drafted and is attached for comment at **Annex A**. The Coroners and Death Certification Bill is included in the Draft Legislative Programme for 2008-09, which was published on 14 May. This is therefore a final opportunity for further views to be taken into account before the draft Charter is again put before Parliament at the same time the Bill proper is introduced.

Changes made to the previous version of the Charter

6. A number of changes have been made to the draft Charter in response to the feedback we have received since 2006. The main changes are:
   - a new "purpose of the coroner service" section, which has been added to the beginning of the document;
   - a new provision to ensure that families are aware they can report a death to the coroner's office personally, if they believe that a professional agency should have made a report and has failed to do so;
   - a new requirement for coroners or coroner's officers to contact families at least every three months to explain the status of the case and the reason for any delay;
   - clarification that any disclosure of documents made to families should be free of charge;
   - clarification that families will receive copies of any "lessons learned" reports and responses to them;
   - an extension of the time limit for appeals against a coroner's final decision in a case to 60 working days (from 30 days); and
   - clarification that the Chief Coroner is likely to set minimum service standards in relation to specific types of death (e.g. epilepsy, mesothelioma) or to specific types of people who have died (e.g. children, military personnel).

How to Respond

7. We would welcome your comments on the revised draft version of the Charter attached at **Annex A**. The deadline for comments is Wednesday, 10 September 2008.

   Please send responses by email to: geoff.bradshaw@justice.gsi.gov.uk

   Or by post to:

Before 11 July 2008

Geoff Bradshaw
Coroners Unit
Ministry of Justice
11 Tothill Street
London SW1H 9LH

After 11 July 2008

Geoff Bradshaw
Coroners Unit
Ministry of Justice
102 Petty France
London SW1H 9AJ

Annex A Illustrative draft: June 2008

Changes that have been made as a result of feedback to the 2007 version of the Charter have been highlighted in this revised draft to make it easier to see where additions and amendments have been made. Wording that has been added to the Charter is underlined. Any wording that has been deleted is set out in footnotes.

Draft charter for bereaved people who come into contact with the coroner service

NB This is a charter for a reformed service NOT for the service as it is currently structured and currently operates.

General

1. The purposes of the coroner service, when a death is referred to it, are:

   a) to establish the identity of someone who has died, and when, where and by what means the person died

   b) to assist in the prevention of future deaths.

2. HM Coroners are independent judicial office holders operating within the legal framework of the Coroners Act 2009.[1] They are supported by coroner's officers who are employed by either the local police authority or the local authority,[2] and by administrative staff who are employed by the local authority. Together, they comprise the coroner service. This charter sets out the objectives of the service, following reform, and the rights and responsibilities of bereaved people during coronial investigations and inquests.

[1] replaces '2008'

[2] replaces 'local authorities'

Definitions

"Inform", "being provided with information", or "informed" may be by leaflet, letter, e-mail, telephone call, or face to face.

"Working day" means any day between Monday and Friday inclusive, with the exception of Christmas Day, Good Friday or a bank holiday in England and Wales under the Banking and Financial Dealings Act 1971.

"Appropriate next of kin" means the person identified by the coroner or coroner's officer to act as the main contact point to receive information.

"Family member" means other family members who the coroner has determined have an interest in the investigation. These may be: a spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half-brother or half-sister.

Objectives

3. In a reformed coroner service, the coroner or coroner's officer will:
    - help bereaved people understand the cause of the death of the person who has died
    - inform bereaved people about the role and powers of the coroner
    - inform bereaved people of their rights and responsibilities if a coroner's investigation is conducted in relation to the death
    - take account, where possible, of individual, family, and community wishes, feelings and expectations, including family and community preferences, traditions and religious requirements relating to mourning and to funerals, and respect for individual and family privacy
    - enable bereaved people, including children and young people where appropriate, to be informed and consulted during the investigation process, treating them with sensitivity, and helping them to find further help where this is necessary
    - answer bereaved people's questions about coronial procedures as promptly and effectively as possible
    - explain, where relevant and on request, why the coroner intends to take no further action in a particular case[3]
    - provide information about how bereaved people may appeal against or complain about the coroner's decisions, and respond to appeals and complaints within the period and in the form specified by the Chief Coroner.

[3] replaces 'respond to concerns of bereaved people when they are not satisfied about the cause of death given on a death certificate'

When a death is reported

4. When a death is reported to the coroner, the coroner or coroner's officer will contact the most appropriate next of kin, where known, and where possible, within 1 working day of the death being reported to explain why the death has been reported and what steps are likely to follow.

5. The appropriate next of kin will be given information, during first contact, on where they can view the body if they wish to do so and on arrangements for viewing. They will be advised sensitively[4] if the nature of the death may cause the viewing of the body to be particularly distressing.

Right of a family to report a death to the coroner

6. If a family member believes that a doctor, or other relevant professional, has not reported a death to the coroner when they should have done, they will have a right to report the death to the coroner personally. This should normally happen before a funeral takes place.

7. The coroner will inform the family member what action he or she proposes to take when reports are made in this way.

Post-mortems

8. Where a coroner orders a post-mortem, the appropriate next of kin will be told by the coroner why it is necessary, when and where it will be performed, and what they should do if they would like to be represented by a doctor at the post-mortem. If the appropriate next of kin, or any other family member, has queries or is unhappy with the decision to hold a post mortem, they should bring their questions or make known their concerns to the coroner or the coroner's officer as soon as possible. There is no right of appeal to the Chief Coroner against the coroner's final decision.

9. When coroners request additional scientific examinations on specific organs or tissues to assist with establishing the cause of death or the identity of the person who has died, the appropriate next of kin will be informed. Again, if they have queries or concerns, they should be directed to the coroner or the coroner's officer at the earliest opportunity, although the coroner's decision as to whether the examination should take place will be final.

10. In the unusual event of full second post-mortems being commissioned by coroners, and if family members are dissatisfied with a coroner's reason for commissioning such an examination, and they remain dissatisfied after discussion with the coroner or coroner's officer, there will be a right of appeal to the Chief Coroner.

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[4] replaces 'They will be advised as sensitively as possible'

11. This right of appeal also applies to proposed additional scientific examinations on specific organs or tissues arising from the second post-mortem.

12. If the coroner decides **not** to hold a post-mortem, and family members wish to challenge the decision, they should discuss this with the coroner or the coroner's officer[5] and, if they remain of the same view, they may appeal the decision to the Chief Coroner.

13. Family members will have a right, on request, to see reports of any post-mortems carried out.

Keeping in touch

14. If the coroner continues his or her investigation following the post mortem, he or she or another member of the service will contact family members at least every three months to inform them of the status of the case, and explain any reasons for delays.

Inquests

15. When there is to be an inquest, information will be provided to family members of the timing, location, and the facilities available at the place where the inquest will be held, wherever possible, at least four weeks before the date of the inquest.

16. Information will be provided to family members by the coroner or the coroner's officer about the purposes and processes involved at the inquest, who is likely to be present, and on the opportunities for participation in proceedings, including the right to speak or the right to be represented.

17. If the date and/or location of the inquest has to be changed, notification will be provided, wherever possible, within five working days of the decision being taken.

18. Disclosure of all relevant documents to be used in an inquest will take place, on request, free of charge and in advance of an inquest, to those family members whom the coroner has determined have an interest in the investigation.

19. For legal reasons, not all documents that the coroner takes into account during his or her investigation can be disclosed, or disclosed in full. The coroner will explain the reasons why he or she has not disclosed a particular document, or part of a document.

[5] replaces 'the coroner concerned'

20. Where the coroner decides to hold a pre-inquest hearing, those family members known to have an interest will be informed of the time, date and location, the purpose of the hearing and their rights and opportunities during it.

21. Wherever possible, an appropriate private room will be provided for bereaved relatives when they attend an inquest.

22. Some coroners now arrange for Court Support Services to operate on days when they hold inquests. The Support Service will welcome you when you arrive at the inquest, explain the process and answer any queries you have and support you during and immediately after the inquest hearing.

23. If they are approached by the media, coroners or their officers or staff will not release anything other than outline details of specific cases without the consent of the appropriate next of kin. Under no circumstances will photographs be released without the consent of the next of kin.

24. The media is free, however, to report inquest proceedings, although there is a requirement under the Press Complaints Commission code of practice for reporting to be sensitive and sympathetic to the feelings of the bereaved. The relevant section of the Press Complaints Commission code will be made available, on request, to family members.

Reports to prevent future deaths

25. At the end of an inquest, the coroner will decide whether the evidence he or she has heard should lead to a report being made to an organisation which may have power to take action to prevent deaths in the future. The coroner will announce if he or she intends to make such a report.

26. Family members who the coroner has determined have an interest in the investigation will be sent a copy of the coroner's report, and any response, or a summary of the response, which an organisation makes.

27. The coroner will send a copy of the report made to the Chief Coroner who in turn will have a responsibility to provide a summary of reports made by all coroners, and the responses to them, to Parliament.

Other rights to participation[6]

28. Family members will be informed by the coroner, after he or she has consulted with them, of any decision to refer a death for investigation by the coroner for a different area and the reasons for that decision.

29. Once a body is no longer required for the coroner's purposes, coroners will not, other than in exceptional circumstances, retain the body - or organs or tissue - without the consent of the family. In cases where there is a criminal investigation as a result of the death, the requirement is that bodies will be released for funerals within a maximum of 30 days[7] of the death, but normally it will be much sooner than this. The family will be informed, and will have the opportunity to make representations, if an authority (such as the police, or a lawyer representing a defendant in a criminal case) applies to extend the period of retention beyond 30 days.[8]

30. If organs or tissue are retained, the coroner should reach advance agreement with the appropriate next of kin as to what should happen when it is no longer required for coroners' purposes. The coroner should convey the wishes of the next of kin to the relevant pathologist.[9, 10]

Review and appeal rights of coroners' judicial decisions

31. Family members who are designated as interested persons for the purpose of investigations will have the right to appeal the following decisions taken by coroners:
    - if the coroner decides there will NOT be a post-mortem or that there will be a second full post mortem, or any other examination linked to a second post mortem
    - whether there will be an investigation by the coroner
    - whether to resume an investigation suspended by the coroner
    - whether an inquest should be held with a jury.

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6 deleted: 'Family members will have a right, on request, to see reports of any post-mortems, and normally of other investigations, unless the coroner decides that some material needs to remain confidential to him/her permanently or for a period of time, in order to protect the legal rights of third parties.'

7 replaces '40 days'

8 replaces '40 days'

9 deleted: 'Where there is to be an inquest (and in addition to written information about its purposes and processes) family members with a known interest will be provided with a contact point so they are able to ask any questions about what happens at inquests.'

10 deleted: 'The appropriate next of kin will have their views taken into account wherever possible regarding the timing and venue for any inquest.'

32. Additionally, the appropriate next of kin may make representations to the Chief Coroner if he or she is dissatisfied if, in exceptional circumstances, the coroner proposes to retain the body of the person who has died for more than 30 days.[11]

33. In most cases, if there is disagreement between the coroner and the family member about any of the above, it is likely to be resolved through discussion. If however, this is not possible, the family member can appeal to the Chief Coroner, setting out clearly their grounds for appealing the decision, wherever possible within a maximum of 15 working days (within 1 working day if it concerns a post-mortem).

34. In addition, appeals will also be possible against decisions in relation to:
    - a coroner discontinuing an investigation before an inquest
    - the decision given at the end of an inquest.

    The family will have 60 working days[12] to lodge their appeal in these instances, although consideration will be given as to whether appeals can be heard beyond this time limit.

35. Most appeals are likely to be decided on the papers. However, in any case where the Chief Coroner decides that an oral hearing is required, it is likely that additional time will be needed to give a judgment. The family will be kept informed by the Chief Coroner's office of the likely timescale.

36. The Chief Coroner's office will inform the person who has appealed (and others with an interest in the appeal) of the outcome of the appeal.

Deaths Abroad

37. Coroners will investigate deaths abroad if the apparent circumstances of the death would have led them to have done so had the death occurred in England or Wales. The standards of service outlined in this charter, in particular (but not exclusively) in relation to post mortems, may need to be varied because of the additional administrative difficulties in receiving information from overseas Governments.

Disability issues

38. Coroners will, as far as practicable and taking account of their statutory responsibilities, provide appropriate access to coroners' courts and offices. Reasonable adjustments will be made, wherever possible, to meet the needs of those with disabilities.

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[11] replaces '40 working days'

[12] replaces '40 days'

Availability of support and bereavement services

39. Coroners will maintain information on the main local and national voluntary bodies and support groups which offer help or support to people who have been bereaved, including bereavement as a result of particular types of incidents or circumstances. They will make this information available to family members or their representatives unless they request otherwise.

Monitoring service standards

40. The Chief Coroner will require coroners to provide regular reports to him/her on their performance against national standards. The Chief Coroner will give the Lord Chancellor an annual report which will include an assessment of the consistency of standards between coroners' areas.

41. Independent inspections of the service will be carried out and will include consultation with bereaved people. In addition, the Chief Coroner may arrange surveys of service users from time to time.

Other complaints and comments

42. Bereaved people wishing to make a complaint about a failure to deliver other aspects of the service outlined in this charter should do so in the first instance to the coroner. If they are not satisfied with the response they should renew[13] their complaint to the Chief Coroner. The Chief Coroner's address is: [TO BE INSERTED WHEN KNOWN]

43. Coroners are committed to providing a service which meets the needs of bereaved people at a sensitive time, and welcomes general comments from bereaved people about their experiences. They should be directed to the coroner who dealt with the case or the Chief Coroner.

Other responsibilities of the Chief Coroner

44. The Chief Coroner will be responsible for setting national minimum standards across a range of coroner functions. In terms of the services to bereaved families, this could include standards in relation to particular types of deaths or suspected deaths (for example – deaths on active military service, deaths from particular illnesses such as mesothelioma, epilepsy or sudden adult death syndrome). These are matters for the Chief Coroner to determine when he or she is appointed.

45. Similarly, this is a draft charter only, and is intended as a guide - to those with an interest - of the kinds of service it is envisaged will be provided in a reformed service.

[13] replaces 'address'

Annex B Organisations this paper has been sent to

A copy of this paper, which is also available on the Ministry of Justice website, has been sent to:

Association of Chief Police Officers

Adverse Psychiatric Reactions Information Link (APRIL)

Association of Personal Injury Lawyers

Asbestos Group Forum

Assistance and Support in Surviving Trauma

Action against Medical Accidents (AvMA)

British Medical Association

BRAKE

British Lung Foundation

Bromley Bereavement Centre

Centre for Corporate Accountability

Child Bereavement Trust

Childhood Bereavement Network (CBN)

Coroners' Officers Association

Coroners' Society

Coroners Court Support Services

Cruse Bereavement Care

Cardiac Risk in the Young (C-R-Y)

Death after Medical Accidents (DAMN)

Department of Communities and Local Government (DCLG)

Department of Health

Disaster Action

Epilepsy Bereaved

Families against Corporate Killing

Fire Service

Forum for Preventing Deaths in Custody

Foundation for the Study of Infant Death

General Register Office

General Medical Council
Home Office
Health and Safety Executive
Independent Police Complaints Commission
Inquest
JUSTICE
Justice for Victims
Local Authorities Coordinators of Regulatory Services (LACORS)
Local Government Association
Liberty
Marchioness Action Group
Medical Defence Union
Medical Protection Society
Merseyside Asbestos Victim Support Group
MIND
Ministry of Defence
National Association of Funeral Directors
National Concern for Healthcare Infections (NCHI)
National Patient Safety Agency
The National Society for the Prevention of Cruelty to Children (NSPCC)
Police Federation
Prison & Probation Ombudsman's Office
Refuge
Rethink
Road Peace
Royal British Legion
Royal College of General Practitioners
Royal College of Pathologists
Royal College of Physicians
Royal Society for the Prevention of Accidents
SAFE Justice Foundation
Samaritans
Support After Murder And Manslaughter (SAMM)
Stillbirth and Neonatal Death Society

Sudden Adult Death Trust (Sudden Arrhythmic Death Syndrome)
Survivors of Bereavement by Suicide
The Compassionate Friends
Trades Union Congress (TUC)
Victim Support
Victims Voice
Welsh Assembly Government
War Widows Association
Welsh Local Government Association
Youth Justice Board

Produced by the Ministry of Justice
Alternative format versions of this report are available on request
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