



House of Commons
Justice Committee

The Coroner Service

First Report of Session 2021–22



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*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 18 May 2021*

Justice Committee

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Summary

The Coroner Service has improved substantially since the Coroners and Justice Act 2009 was implemented in 2013 but bereaved people are not yet sufficiently at its heart.

The first two Chief Coroners have done a great deal to improve the quality of the Service through leadership, guidance, and training. Much has been done to improve the Coroner Service's response to incidents with mass fatalities, and again we have the Chief Coroners to thank for this. The new third Chief Coroner, His Honour Judge Thomas Teague QC, has our full support as we encourage him to continue their good work. We also thank all those who have kept the Coroner Service going through the very difficult circumstances of the covid-19 pandemic.

We heard from a wide range of sources, not least bereaved people and organisations that help them, that there is still an unacceptable variation in the standard of service between Coroner areas. It is widely accepted that this is due in part to the fact that local authorities are responsible for funding the Coroner Service and they have different assessments of their local priorities and the importance of the Coroner Service within that. We also received evidence that indicates that there are still pockets of behaviour by coroners where bereaved people are not treated with the respect and consideration that they and their deceased loved ones deserve.

Successive governments have failed bereaved people by failing to establish a National Coroner Service for England and Wales. A National Coroner Service is the only way bereaved people can be provided with consistent services at an acceptable standard.

Most people are unaware of the Coroner Service until they first encounter it, often at an extraordinarily difficult time following an unexpected death of a loved one. We found that not enough was being done to provide written information and to direct people often enough and soon enough to specialist support services in the voluntary sector. There is an admirable charity that offers support to bereaved people attending inquests, but it receives no central government funding so is unavailable in around half of Coroners' Courts.

There is a longstanding and significant shortfall in pathology services available to coroners, which leads to delay and distress for bereaved people. Neither any central government department nor the NHS accepts responsibility for the supply of pathology services to the Coroner Service, and the problem has been left unaddressed for many years. Without urgent and effective action by the Ministry of Justice, pathology services for the Coroner Service may disappear.

The Coroner Service has an important role in reporting fatal risks so that action can be taken to prevent future deaths. Coroners vary in how they approach this aspect of their role with some issuing many fewer reports than others. Most concerningly, there is no follow-up to see if coroners' reports have had the desired impact. We call for a new body that will oversee risks to public safety discovered by coroners and inquest juries and monitor and enforce action to reduce these risks, acting in concert with other regulatory bodies such as the Health and Safety Executive and the Quality Care Commission.

Finally, it is unfair that public funding is available for bereaved people to be legally represented at inquests only in exceptional cases and subject to a means test. This is the case even at inquests that involve many public bodies each of which are legally represented at public expense. Non-means tested legal aid should be automatically available at the most complex inquests such as those following public disasters. In all inquests where public bodies are legally represented bereaved people should be entitled to publicly funded legal representation.

1 Introduction

Introduction

1. The subject of this Inquiry is the Coroner Service of England and Wales. The Ministry of Justice is responsible for Coroner Service policy and local authorities for funding 85 local coroner services. Coroners are judicial officers. Senior Coroners in each area are responsible with the relevant local authorities for the local coroner service and are aided by part-time Assistant Coroners. Larger areas may also have one or more full-time Area Coroners. All coroners are appointed by the local authority (with the consent of the Chief Coroner and the Lord Chancellor). Historically, coroners' officers (who investigate deaths on behalf of coroners) have been seconded from local police forces. Other administrative support including accommodation is provided by the local authority.
2. The Coroners and Justice Act 2009 (CJA 2009), which came into effect in July 2013, reformed the Coroner Service, including, most significantly, creating the post of Chief Coroner for England and Wales.

Purpose of the Coroner Service

3. The role of the Service is not well known. Alex Chalk MP, Parliamentary Under Secretary at the Ministry of Justice, told us:

It is to ensure that deaths, where they are violent, unnatural or unknown, are appropriately scrutinised both out of respect for the individual themselves and those who are bereaved, but also so that we, as a society, can have wider public confidence that the facts of those deaths and, in particular, the answers to the four statutory questions [...]—who, how, when and where—are well established.¹

4. The coroner's role is to find facts rather than attribute blame and the CJA 2009 sets out that coroners' and juries' conclusions must "not be framed in such a way as to appear to determine any question of criminal liability on the part of a named person, or civil liability".² This legal limitation on inquest conclusions does not prevent coroners from highlighting where things have gone wrong and should be put right. Indeed, a coroner must make a report where the investigation or inquest he or she has conducted reveals something which raises concern that there is a risk of future deaths. The coroner must make such a report to the person who may have the power to take action that could eliminate or reduce that risk.³ The coroner may recommend that action should be taken, but not what that action should be. Before the CJA 2009, coroners had the power to make such reports but were not under a duty to do so.⁴
5. Deputy Chief Coroner Derek Winter told us about his experience of what bereaved people expect from the Coroner Service:

1 [Q162](#)

2 Coroners and Justice Act 2009, [section 10](#).

3 [Chief Coroner's Guidance Number 5](#), 2013, revised November 2020.

4 [The Chief Coroner's Guide to the Coroners and Justice Act 2009](#), September 2013, paras 172–173

In my experience, most families when they come to the coroner's court tell me that they just don't want this to happen to somebody else. That is what it is about.⁵

Victoria Lebec, Head of Policy, Campaigns and Communications at RoadPeace (which is a national charity for road crash victims in the UK) summed up what we heard from many sources:

families just want to know that their loved one has not died completely in vain and that something is being learned from it.⁶

Statutory functions

6. The CJA 2009 sets out that coroners must investigate deaths that have been reported to them if they think that:

- the death was violent or unnatural;
- the cause of death is unknown; or
- the person died in prison, police custody or another type of state detention (e.g. an immigration removal centre or while detained under the Mental Health Act 1983).⁷

7. The coroner (or jury, where there is one) must answer five questions:

- who the deceased was;
- how, when and where the deceased came by his or her death; and
- the 'particulars' if any required for the death certificate.⁸

8. Where Article 2 of the European Convention on Human Rights (right to life) applies (for example, in cases where the person died an unnatural death in state detention) the scope of the coroner's investigation must be widened to include an investigation of the broad circumstances of the death, including events leading up to the death in question.⁹

9. The then Chief Coroner, His Honour Judge Mark Lucraft QC told us about the legal limits on the role of coroners:

The purpose of the inquest, even when the Article 2 ... is engaged, is not to provide an answer to any sort of 'why' question, in the sense of any deeper societal explanation for a death. Nor can the inquest attribute personal blame in the sense the criminal courts do. In some situations, this means there may be a dissonance between what a participant might want an inquest to deliver, and what is legally possible.¹⁰

5 [Q150](#)

6 [Q70](#)

7 Coroners and Justice Act 2009, [section 10](#).

8 These include sex, date and place of birth, occupation, and usual address.

9 Coroners and Justice Act 2009, [section 5](#) and for further details see [Coroners' investigations and inquests](#), Briefing Paper Number 03981, House of Commons Library, February 2021, p 9

10 Chief Coroner of England and Wales HHJ Mark Lucraft QC ([COR0081](#)), para 96

Coroners' investigations and inquests

Investigations

10. In most deaths there is no need for a coroner's investigation. Instead, the doctor who provided care during the last illness of the deceased person completes a certificate of the medical cause of death. This, in turn, is presented to the local registrar who issues an authority for the disposal of the body. However, some deaths require further investigation and must be reported to the coroner who decides whether to carry out further inquiries.¹¹ Judge Mark Lucraft QC told us:

It is a very small fraction of all the deaths that the coroner is looking at. Their work will be, largely, dealing with very sad situations. The families that they are dealing with are going through grief. They have recently been bereaved. It is an unexplained death.¹²

11. Most deaths reported to coroners are resolved without an inquest. Judge Lucraft told us:

many of the deaths that are investigated by a coroner do not lead to a court hearing with an inquest. It is that part of a coroner's job that, I suspect, goes largely unseen by many members of the public.¹³

Deputy Chief Coroner, Derek Winter, expanded:

One of the greatest effects of the [CJA 2009] was to allow us to discontinue an investigation when we found out, usually after post-mortem examination, that the death was natural. Those cases, otherwise, went through to what seemed to be an unnecessary inquest.¹⁴

12. In 2019, approximately 531,000 deaths were recorded of which 211,000 were reported to coroners. Some 82% (172,000) of deaths referred to coroners were resolved by investigation without an inquest.

Inquests

13. Around 30,000 deaths proceeded to full inquests. Of those, 527 inquests with juries opened in 2019, and 478 of them related to deaths in state detention.¹⁵ Accident/misadventure was the most common conclusion at inquests in 2019.¹⁶

11 [Coroners' investigations and inquests](#), Briefing Paper Number 03981, House of Commons Library, February 2021, p4

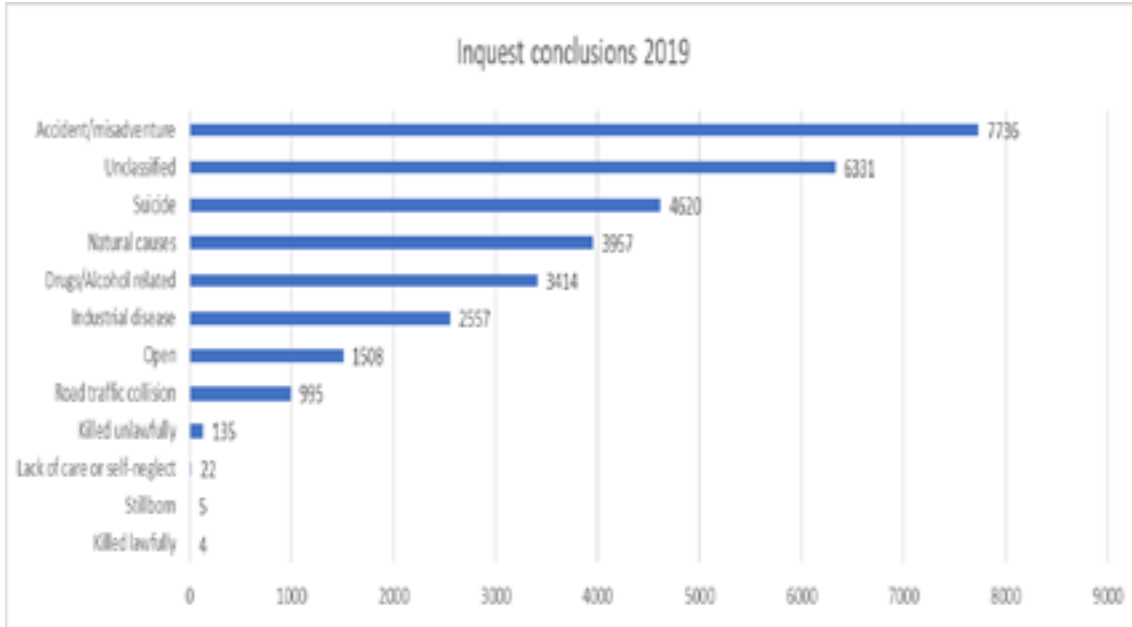
12 [Q122](#)

13 [Q121](#)

14 [Q133](#)

15 Ministry of Justice, [Coroners Statistics 2019: England and Wales](#), May 2020, section 4

16 Ministry of Justice, [Coroners Statistics 2019: England and Wales \(statistical tables\)](#), May 2020, table 7



Coroner Service skills

14. Professor Nicola Padfield (Professor of Criminal and Penal Justice, Cambridge University) described the range of skills needed by coroners and their staff, and the absence of a standard ‘job description’:

Coroners need extraordinary skills: energy and curiosity, determination, integrity, neutrality, empathetic communication skills, excellent understanding of law and medicine, team leadership and case management skills ...

There is also a need to understand the training, skills, role, and performance of coroners’ officers. What happens before an inquest by way of preparation is clearly vital. Some are serving or erstwhile police officers, or civilian police staff. Others have a much broader background. Their terms and conditions are not standard, nor are their job descriptions, roles, and responsibilities.¹⁷

15. André Rebello, Honorary Secretary of the Coroners’ Society of England and Wales, confirmed the importance of the role played by coroners’ staff:

A coroner’s officer works as a family liaison officer as well as a coroner’s officer. The family is contacted by the coroner’s officer who, certainly in my area, gathers all the issues and concerns of the family, and, where we can, we include those issues within the investigation [...] the coroner’s officer is often the mainstay support.¹⁸

¹⁷ Professor Nicola Padfield (Professor of Criminal and Penal Justice at University of Cambridge) ([COR0005](#)), para 1

¹⁸ [Q21](#)

2 The Coroners and Justice Act 2009

16. There have been continued calls for more than 20 years for a national ('national' in this context means England and Wales) coroners' service, including from Dame Janet Smith after the Harold Shipman inquiry and the Luce review, sponsored by the Home Office. The 2009 reforms created a national Chief Coroner, but not a national service. The Ministry of Justice clearly signalled during our inquiry that doing so remains unlikely.

Funding

17. Coroner services are not part of HM Courts and Tribunals Service but are administered and funded by local authorities.¹⁹ Section 24 of the CJA 2009 placed an obligation on local authorities to fund the Coroner Service, while the Ministry of Justice is responsible for providing extra resources for changes imposed through national legislation or centrally determined policy change, and for ensuring that the service is being resourced overall to meet standards centrally recommended by the Chief Coroner.²⁰

The role of the Chief Coroner

18. The CJA 2009 provides for the appointment of a Chief Coroner to give national leadership to the coroner. His Honour Judge Mark Lucraft QC, who served from 1 October 2016 until 30 September 2021 was Chief Coroner during the evidence-taking phase of this inquiry, and he was replaced by His Honour Judge Thomas Teague QC on 24 December 2020. The CJA 2009 also allows for the appointment of Deputy Chief Coroners, the first of whom, Derek Winter, Senior Coroner for the Sunderland coroner area, and Her Honour Judge Alexia Durran, were appointed in January 2019. They support the Chief Coroner while continuing in their respective wider roles.

19. The Chief Coroner must be a senior judge appointed after an open competition by the Lord Chief Justice (after consulting the Lord Chancellor). The Chief Coroner's main responsibilities are to:

- Provide support, leadership and guidance for coroners in England and Wales;
- Set national standards for all coroners, including new inquest rules;
- Oversee the implementation of the new provisions of the Coroners and Justice Act 2009;
- Put in place suitable training arrangements for coroners and their staff;
- Approve coroner appointments;
- Keep a register of coroner investigations lasting more than 12 months and take steps to reduce unnecessary delays;
- Monitor investigations into the deaths of service personnel;

¹⁹ [Q162](#)

²⁰ Tom LUCE ([COR0035](#)) para 25, and see also the Government's [New Burdens Doctrine Guidance](#), June 2011, para 2.1

- Oversee transfers of cases between coroners and direct coroners to conduct investigations;
- Provide an annual report on the coroner system to the Lord Chancellor, to be laid before Parliament; and
- Monitor the system where recommendations from inquests are reported to the appropriate authorities in order to prevent further deaths.²¹

Changes made by the first two Chief Coroners

20. There have been substantial improvements to the Coroner Service since the 2009 Act was implemented in 2013, including guidance and mandatory training for all coroners and coroners’ officers, appraisals for Assistant Coroners, and improved consistency by amalgamation of smaller areas.²² Tom Luce CB, (Chair of the Luce Review) summarised his view of progress since that review:

it was customary to refer to [the Coroner Service] as “quasi-judicial”; I am now confident that the “quasi-” qualification should be dropped. It is developing into a properly judicial service and continues to deepen that essential characteristic of its work to an impressive extent worth public recognition.²³

André Rebello, Honorary Secretary of the Coroners’ Society of England and Wales, agreed:

The coroner service today, generally across the piece, cannot be recognised as the service I joined in 1994.²⁴

Guidance and training for coroners and their staff

21. Mandatory annual two-day training was universally welcomed by those who submitted evidence as an important step forward. Deputy Chief Coroner, Derek Winter, told us about the training introduced since the CJA 2009:

The Chief Coroner, with the Judicial College, will set the course programme for coroners, who get two days’ residential compulsory training every year. Coroners’ officers take advantage of that as well. It is an opportunity for the Chief Coroner, with his training committee, to look at current topics.²⁵

22. We received evidence suggesting that this should be built on in future. Assistant Coroner, Dr Daniel Sharpstone, told us:

Unlike many other public services such as Medicine and the Police, the governance of education and training for all grades is comparatively still in its infancy. There is a yearly mandatory 2 day continuation training course for all coroners. However, there is no formal check on learning, education or keeping up to date.²⁶

21 [The Courts and Tribunals Judiciary website](#), accessed 3 May 2021

22 HHJ Peter Thornton QC and HHJ Mark Lucreft QC. The current Chief Coroner is HHJ Thomas Teague QC who took up the post on 24 December 2020.

23 Tom LUCE ([COR0035](#)), para 10

24 [Q3](#)

25 [Q133](#)

26 Dr Daniel Sharpstone (Assistant Coroner at Suffolk) ([COR0051](#)), p 2

23. André Rebello, Honorary Secretary of the Coroners' Society of England and Wales, identified some problems with training for coroners' officers:

There is a problem in that coroners' officers are short in number in some areas. The Chief Coroner has had a little bit of a battle with some police authorities and local authorities in making sure that coroners' officers are released for training.²⁷

The Coroners' Society also pointed out that some Local Authorities do not pay Assistant Coroners and coroners' officers to attend training.²⁸

24. The Chief Coroner, Judge Lucraft, told us about the importance of learning from the past:

You will know that Bishop James Jones wrote a very searching report about the Hillsborough inquest process [...]²⁹ I invited Bishop Jones to speak to all of the senior and area coroners [...] It seemed to me vital that as coroners we listen to people who are critical of the way in which an inquest has happened, which has not been great, and we learn from that.³⁰

Appointment of coroners

25. Another development is a more open and transparent appointment process for coroners. Giles Adey from Kent County Council told us:

if I remember rightly, assistant coroners and assistant deputy coroners were the personal appointments of coroners... we [now] have a much more robust, open and transparent process uniform to all.³¹

26. The CJA 2009 also required that all new coroners should be legally qualified.³² Before that they could be either doctors or lawyers. As a result, the proportion of coroners who are medically qualified has reduced. No statistics are available on the diversity of coroners.

Appraisal process for coroners

27. Chief Coroner, Judge Lucraft, has recently introduced an annual appraisal process for Assistant Coroners carried out by their Senior Coroners. The emphasis is on improving performance through discussion and identification of training needs. It does not cover judicial conduct or misconduct. Judge Lucraft described how it works:

a large part of the work of a coroner is not in a court setting—it is not at an inquest—but it is dealing with the decisions that are made in the office. It is dealing with how you interact with families. You have to appraise that part of the job as much as you have to appraise what happens in the court setting.

27 [Q6](#)

28 The Coroners' Society of England and Wales ([COR0030](#)), section 5 of the Executive Summary

29 The Right Reverend James Jones KBE, *The patronising disposition of unaccountable power, A report to ensure the pain and suffering of the Hillsborough families is not repeated*, Home Office, HC 511, November 2017

30 [Q141](#)

31 [Q76](#)

32 Coroners and Justice Act 2009, [Schedule 3](#), para 3(b)

The idea, in due course, is that we will roll it out annually for each assistant coroner, to be followed by an appraisal system for the salaried coroners. It has been slightly put back because of Covid.”³³

28. Alex Chalk, the Minister of Justice Minister currently responsible for the service, supported the appraisal scheme:

what we have through the appraisal scheme for coroners is a step change in the ability of coroners to provide that uniformity. It is a far less fragmented system than existed in the past.³⁴

29. **The creation of a Chief Coroner followed by the introduction of guidance, mandatory training and appraisals for the most junior coroners are significant advances towards a more standardised Coroner Service than obtained a decade or so ago, even in the continued absence of a full England and Wales service. We encourage the new Chief Coroner to continue the work begun by his predecessor by extending appraisals to all coroners.**

Merging areas

30. There were more than 127 coroner jurisdictions in England and Wales in 2004 when the Government responded to the Shipman Inquiry and the Luce Review. Since then the Chief Coroners have merged areas so that there are now 85. Merging areas helps to reduce local variations and inconsistencies. John Ellery, Coroner, Shropshire, Telford and Wrekin told us for example that in his area “a considerable amount of historic unevenness has been ironed out.”³⁵

31. There are some technical limitations, however, on how areas can be merged. Giles Adey, coordinator for the four coroner services in the Kent County Council and Medway Council area told us:

In Kent, we have four coroner areas and our plan is to merge those into one, but the way the legislation is written currently means we can merge those four areas only when we have vacancies for senior coroners in three of them.³⁶

The Chief Coroner has proposed a change to the CJA 2009 that would make mergers easier. The details are set out in his most recent annual report.³⁷

32. **Reducing the number of coronial areas has helped increase consistency across the Coroner Service. The Ministry of Justice should amend the Coroners and Justice Act 2009 (as requested by the outgoing Chief Coroner) to make it easier to merge areas.**

Parts of the Coroners and Justice Act 2009 were not implemented

33. Section 40 of the Coroners and Justice Act 2009 (CJA 2009) which introduced a new process for appeals from coroners’ judicial decisions to the Chief Coroner was not brought

33 [Q136](#)

34 [Q184](#)

35 Mr John Ellery ([COR0002](#)), para 1

36 [Q84](#)

37 [The Chief Coroner’s Combined Annual Report 2018 to 2019 and 2019 to 2020](#), November 2020, paras 137–140

into force and has since been repealed.³⁸ The CJA 2009 contained provisions for the Coroner Service to be inspected by the Inspectorate of Courts Administration (excluding inspection of judicial decisions)³⁹ and for a system of appeals to the Chief Coroner from coroners' judicial decisions.⁴⁰ Neither was implemented; each has since been repealed, and the Inspectorate of Courts Administration was abolished in 2011.

Government review of the Coroners and Justice Act 2009

34. The Ministry of Justice reviewed the effectiveness of the CJA 2009 in 2015 but did not publish the result of that review and appears not to intend to. Alex Chalk told us:

for reasons that were a matter for the Minister at the time, that report was not prioritised. The position now is that a great deal has changed [...] Because of that change, the verdicts from that [review], for want of a better expression, will be of very limited import.⁴¹

35. Several witnesses told us, however, that the review was important and relevant. For example, Lisa O'Dwyer from Action Against Medical Accidents (AvMA) told us:

Many of the points that we made in our response to that review are still very live issues. Nothing has changed really. There are still those inconsistencies. Those things [...] such as inconsistency of disclosure [...] are still as pertinent now as they were when we responded in 2015.⁴²

36. Tom Luce told us:

some important reform has occurred but with delay, compromise and significant gaps. This is characteristic of historic governmental lack of interest in and delay over modernising the socially, medically and judicially important regulatory systems concerned with deaths. Contemporary examples of this historic tendency include the serious breach of the Ministry of Justice's undertaking to Parliament to report the outcome of the 2015 consultation on the reformed Coroner service.⁴³

37. Tom Luce, among others, has identified the Ministry of Justice decision not to publish its 2015 review of the operation of the 2009 Act as a serious breach of a commitment to do so. No good reason has been given for the non-publication of that review. The present Minister's argument that it is now out of date is not sufficient reason for continuing to withhold it. At the very least, publication would allow that contention to be tested, and no harm can be done if the report's conclusions truly are obsolete. We recommend that the Ministry of Justice immediately publish its 2015 review of the effectiveness of the Coroners and Justice Act 2009.

38 Coroners and Justice Act 2009, [section 40](#)

39 Coroners and Justice Act 2009, [section 39](#)

40 Coroners and Justice Act 2009, [section 40](#)

41 [Q165](#)

42 [Q43](#)

43 Tom LUCE ([COR0035](#)), para 1

3 Putting bereaved people at the heart of the Coroner Service

The status of bereaved people

38. Bereaved people are referred to as “interested persons” by the Coroner Service. This is defined in section 47 of the Coroners and Justice Act 2009 (CJA 2009) and includes a spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half-brother or half-sister and a personal representative of the deceased. Organisations and other individuals may also have interested person status, such as government departments and hospital trusts.

39. Interested persons are not parties to the inquest as such. However, they have rights to be notified of certain matters including, for example, aspects of the post-mortem and information about the date, time, and place of the inquest. They also have rights to be involved in the inquest procedure, including, for example, by questioning witnesses and seeing written evidence.⁴⁴

The importance of the Coroner’s approach to bereaved people

40. Evidence from the Coroners’ Society and individual coroners shows that many bereaved people are grateful for considerate treatment shown by coroners and their staff. The Coroners’ Society’s written evidence included extracts from the many letters and emails of thanks received by coroners.⁴⁵

41. Other evidence shows, however, that some coroners find it challenging to keep bereaved people at the heart of the process. André Rebello, Honorary Secretary of the Coroners’ Society told us:

I am in a very privileged position as secretary of the Coroners’ Society: all inquiries and telephone calls from the public come through me. I know everything is not perfect. We try our best. Through feedback to the course directors who deliver coroners’ training, we give feedback to the Chief Coroner and try to moderate how coroners behave.⁴⁶

42. Deborah Coles, Director at INQUEST identified an absence of consistent standards across the Coroner Service:

What I will say has been informed by both inquest work with bereaved people and the evidence in our submission that we took from 55 families. Some talked of excellent coroners and coroners’ officers and had very positive experiences of the process, but I am disappointed that far too many talked about being treated very badly by the process, with a lack of dignity, respect and empathy.⁴⁷

44 [Coroners’ investigations and inquests](#), Briefing Paper Number 03981, House of Commons Library, February 2021, p11

45 The Coroners’ Society of England and Wales ([COR0030](#)), Appendix A

46 [Q5](#)

47 [Q28](#)

43. We had evidence that there is good practice in well-funded, well-run areas. Unfortunately, this is not consistently the case. The Coroners Courts Support Service (CCSS) told us:

there are Coroners who will truly enable bereaved families to participate fully in the proceedings and, whilst maintaining their authority within the court, will address the families with empathy and an understanding of the impact the death may have had on them. However, some Coroners may make bereaved families feel unheard, frustrated and angry that the Coroner seems to be dismissing their concerns.⁴⁸

44. We received written evidence from a number of bereaved people and from organisations who are in touch with many more. It would not be possible to repeat all their concerns about variations between areas in this report. An example came from a joint submission from four charities concerned with infant and childhood deaths:

The experience of families can differ greatly based on where they live [...] We received excellent examples of Coroners who kept families informed, gave choices where possible and offered support and referrals. Families who have a negative experience tend to remember this for a long time and openly say that it impacts on their grief.⁴⁹

45. We received submissions directly from bereaved people expressing great distress. Many, but not all, involved a child or close relative who was a vulnerable adult who had committed suicide or met with an accident while being accommodated by a public body or charity or being treated by the NHS in hospital or in the community. They recounted feelings that various coroners brushed aside concerns about the care loved ones had received in the period running up to their death. We also received evidence that a small minority of coroners can be brusque and unsympathetic.

46. Andrew McCulloch, a bereaved parent, gave written and oral evidence to this inquiry. This extract from his written evidence is an example of the Coroner Service at its worst:

[At the pre inquest review] The Coroner arrived late and brusquely stated that he wanted no shouting in the court. He looked at [my wife] Amanda and I aggressively and said only one of us would be allowed to speak and only for two minutes. No mention of sorrow for our bereavement or concern for how we might be feeling.⁵⁰

47. Mr McCulloch told us: “It was like being slammed in the stomach. I can’t tell you the pain, the agony. I’m sorry.”⁵¹ After a Judicial Review (without Legal Aid) and two years, an inquest into his daughter’s death was held by a new coroner. Mr McCulloch told us of the contrast:

The next coroner was a man called Coroner Oldham. I can name him because he was a good guy. He came in and the first thing he said was, “I want to make the victim the centre of this inquest. I want to know who Colette was. I want to read about her. I want to understand her.”⁵²

48 The Coroners’ Courts Support Service ([COR0061](#)), section 1

49 The Lullaby Trust, SUDC UK, Sands - The Stillbirth and Neonatal Death Society, Child Bereavement UK ([COR0070](#)), paras 1.1 and 1.2

50 Andrew McCulloch (screen writer at Freelance) ([COR0029](#)), para 3

51 [Q29](#)

52 [Q29](#)

User-friendly procedures

48. In many deaths, the people who have been bereaved will not be expecting that the Coroner Service will be involved. Many of these are where the death was due to natural causes, but no medical practitioner was in a position to certify that this is the case. As a result, such deaths are referred to the coroner.

49. For the great majority of bereaved people this will be the first time they have had any contact with the Coroner Service, and they are unlikely to know much about it. There are some key areas that are important to helping people when this happens. These include reducing delays so that a funeral may be held, and the body disposed of according to their wishes, and providing bereaved people with information so they understand fully what is going on while the Coroner Service is involved in the death of their loved one.

Reducing delays so a funeral can be held

50. A funeral cannot take place until the coroner releases the body. The time taken for a coroner to release a body for burial or cremation can depend on several factors, including time of death and whether this is outside usual office hours (for example, over a weekend or bank holiday). Sometimes, bereaved families request the coroner to treat a particular death as a matter of urgency. This might be, for example, because the family has a religious or cultural belief that the body should be buried on the day of death or as soon as possible thereafter. Jewish and Muslim families, or their representatives, sometimes make such requests.

51. In May 2018, the Chief Coroner issued new guidance on expedited decision making. This guidance states that coroners should pay appropriate respect to religious and cultural wishes about the treatment of a body and burial following a death. Any policy or practices adopted by coroners must be sufficiently flexible to allow them to give due consideration to expediting decisions where there is good reason to do so. They should seek to strike a fair balance between the interests of those with a well-founded request for expedition (including on religious grounds) and other families who may be affected.⁵³

52. We received written evidence from several faith groups on variations between areas. For example, the Board of Deputies of British Jews told us that individual relationships with Coroners could be more important than systemic factors:

the Jewish community has excellent relations with the vast majority of Coroners, who accommodate the requirements of the Jewish community, especially in regard to early release of bodies and non-invasive autopsy. This is almost entirely due to the building up of individual relationships - there is very little systemic guarantee of such provision. Hence, when a Coroner does not wish to accommodate the needs of a local Jewish community, there appears to be little that can be done.⁵⁴

53. The Chief Coroner's guidance on when and how to expedite a case to meet with the requirements of the beliefs of the deceased is welcome, but whether the needs of faith communities will be met or not depends on how the Coroner Service responds

53 [Chief Coroner Guidance No. 28, Report of death to the coroner: decision making and expedited decisions](#), 17 May 2018, paras 4 and 14–16

54 Board of Deputies of British Jews ([COR0091](#)), paras 4–5

locally. *We encourage the new Chief Coroner to continue the work of his predecessor in liaising with stakeholders, including with faith representatives, so that any problems with expediting cases can be identified and addressed as they arise.*

Written information

54. The Ministry of Justice has published *A Guide to Coroner Services for Bereaved People* (updated January 2020) to provide bereaved people with an explanation of the coroner investigation and inquest process and links to organisations that may provide help and advice.⁵⁵ The Guide to Coroner Services sets out

specific standards of service that you can expect at particular stages of a coroner investigation are set out in ‘Standards you can expect’ boxes throughout this document.⁵⁶

Alex Chalk told us this that the Guide was an important change:

Even since 2009, a lot of attitudes have changed and people recognise that bereaved people and people across the court system, including witnesses, need to be treated sensitively. In terms of what is changing, the single biggest thing that has changed is probably this document, “A Guide to Coroner Services for Bereaved People”, which I would commend to the Committee.⁵⁷

55. The Chief Coroner, Judge Lucraft, told us about a gap in public understanding of the Coroner Service:

In terms of the public understanding, I do not quite know how one can best address that. We have tried in leaflets, which are now provided to people, to explain what the role of the coroner is and how they would carry out that function in a particular set of circumstances.⁵⁸

56. Deborah Coles, of INQUEST, told us about the importance of providing information early:

Post-mortems [are] the critical point at which information could and should be given to families about what an inquest is and about the process, yet families still describe an information vacuum that is often filled by ourselves and other organisations. [...] I fully recognise the importance of the Coroners’ Court Support Service, but we know that is a patchy service. A lot of families simply do not receive information about what an inquest is.

[...] we are contacted routinely by families who are going through an inquest system. They go on to the internet and type in “INQUEST” and we pop up. As an illustration, we sent out 700 of our comprehensive information handbooks and had over 4,000 hits on our advice website. To me, that is indicative of a problem with communicating the purpose of an inquest and what families’ rights are.⁵⁹

55 Ministry of Justice, [Guide to Coroner Services for Bereaved People](#), January 2020

56 Ministry of Justice, [Guide to Coroner Services for Bereaved People](#), January 2020, p6

57 [Q172](#)

58 [Q123](#)

59 [Q28](#)

57. RoadPeace told us that bereaved people had reported to them that in one [coroners] court “the leaflets were so out of date they had gone brown”.⁶⁰

58. **The Ministry of Justice’s Guide to Coroner Services is good first step but more needs to be done to make sure that bereaved people know of its existence. We encourage all Senior Coroners to make sure that the updated Guide to the Coroner Service for Bereaved People is freely available both online and, where requested, in hard copy by post and is offered to people who have been bereaved as soon as it has been decided that a post-mortem is needed.**

Support for bereaved people from other organisations

59. The Chief Coroner, Judge Lucraft, told us how important it is that bereaved people are supported in their interactions with the Coroner Service: “We are dealing with families at a very raw time for them. They are grieving and they find the process very difficult.”⁶¹

60. Lisa O’Dwyer, Legal Director at Action against Medical Accidents, told us about the challenges of helping bereaved people to understand the Coroner Service and the role of independent advice:

I think the Coroner Service does as good a job as it can. It is variable and it will depend on the coroner’s clerk and assistant and so on [...] We have to remember that these are, first of all, grieving people, but also people who do not necessarily have any legal background and have never been exposed to any legal process. It really just goes to the inevitable need for there to be better access to independent advice and information for those. Coroners’ clerks do it as best they can.⁶²

61. Victoria Lebec of RoadPeace agreed about the need for specialist support if there is going to be an inquest:

You have to bear in mind that these people are totally traumatised. They might not have gone to an inquest before or understand what the process will be. [...] It is really about ensuring that the Coroner Service is directing people to specialist support organisations that can explain things to them.⁶³

Coroners’ Courts Support Service

62. The Coroners’ Courts Support Service is a charity whose trained volunteers offer emotional support and practical help to bereaved families, witnesses and others before, during and after an inquest. It operates in around half of coronial areas:

The charity strives to make the inquest process transparent and accessible, and we aim to meet the emotional and practical needs of all those attending. Owing to no financial support from central government, the support of our 400 volunteers is currently only available in half of the coronial areas.⁶⁴

60 RoadPeace ([COR0066](#)), para 6

61 [Q148](#)

62 [Q54](#)

63 [Q54](#)

64 The Coroners’ Courts Support Service ([COR0061](#)), second para

63. The Chief Coroner, Judge Lucraft, told us of the importance of the Coroners' Courts Support Service:

I would urge that every coroner's court be required to have the Coroners' Courts Support Service to greet and meet families and make sure they are not by themselves and induct them into the processes expected in that court. They work regionally and understand how the coroner system works locally and they are an excellent charity that should be encouraged to roll out everywhere.⁶⁵

64. Despite their vital function the Coroners' Courts Support Service receives no central government funding:

We rely on contributions from local authorities which cover a fraction of the cost of the Service and from grant makers who also contribute towards the costs. Although we have been in talks with the Ministry of Justice since 2014 regarding funding for a national expansion, we are no further forward with this [...] Our financial situation is not sustainable and could result in bereaved families going unsupported in the future.⁶⁶

65. The Ministry of Justice told us that the Government had accepted in 2017 that support services for bereaved people need to be improved but this has not yet happened:

Officials are working through a number of commercial and legal issues that have arisen on this. Taking forward a non-legal support service depends on identifying funding.⁶⁷

66. Help and support for bereaved people depends on the priorities, capacity and skills of the local Coroner Service and local volunteers in the Coroners' Courts Support Service. *The Ministry of Justice should as a matter of urgency provide funding for support services for bereaved people at inquests, (such as those provided by the Coroners' Courts Support Service), so that this support is available in every Coroner Area.*

67. *We encourage Senior Coroners to make sure that bereaved people are made aware by their staff of the specialist support organisations that are available to them both locally and nationally.*

Rights for bereaved people

68. Apart from their statutory rights as interested persons (alongside public bodies, insurance companies and so on) bereaved people do not have rights to be treated with special consideration. This is unlike the Criminal Justice System where there is a statutory code on how victims should be treated.⁶⁸ The Coroners' Courts Support Service told us that the:

Guide to Coroner Services outlines what families can expect but as these are not mandatory standards it is difficult for families to know what their rights are as opposed to what they might expect.⁶⁹

65 [Q21](#)

66 The Coroners' Courts Support Service ([COR0061](#)), section 6

67 Ministry of Justice ([COR0096](#)), para 49

68 <https://www.victimsupport.org.uk/help-and-support/your-rights/victims-code>, accessed 3 May 2021

69 The Coroners' Courts Support Service ([COR0061](#)), section 5

JUSTICE, in its report *When Things go Wrong* identified “a stark discrepancy between the rights afforded to victims in the criminal justice system and bereaved people and survivors in inquests and inquiries”.⁷⁰

69. The Criminal Justice Systems’ Victims Code is not directly applicable to the Coroner Service, but the same principles could be applied. Victim Support’s National Homicide Service (based on research carried out in July and August 2020 with staff and caseworkers from the service) told us:

We welcome the updated ‘Guide to Coroner Services for Bereaved People’ published this year, but we feel it must go further. The Code of Practice for Victims of Crime (the Victims’ Code) [...] sets out the minimum level of service that victims should receive from the criminal justice system. Family members bereaved by homicide are entitled to services under the Code, however the coroners process is not currently covered by the Code and remains a gap.⁷¹

70. Bereaved people deserve a charter of rights setting out the standards of service they are entitled to receive from the Coroner Service. Setting out the standards they can ‘expect’ in the Guide to Coroner Services is inadequate. *The Ministry of Justice should implement a statutory Charter of Rights for bereaved people, modelled on the criminal justice system’s victims’ code.*

Disclosing evidence to bereaved people

71. As set out in Chapter 1 only a small proportion of deaths referred to coroners result in an inquest. In the great majority of cases coroners can answer the ‘who’, ‘what’, ‘where’ and ‘how’ questions about the death without hearing evidence in a courtroom. We have outlined in Chapter 3 some of the variations in the consideration given to bereaved people. We also received evidence of lack of consistency in how coroners manage inquests (including preliminary hearings known as pre-inquest reviews). These are centred on disclosure of evidence.

72. Part 3 of the Coroners (Inquests) Rules 2013 require the coroner to disclose copies of relevant documents to an interested person, on request, at any stage of the investigation process (subject to some exceptions).⁷² Most bereaved people are unaware of this rule, however, so do not understand that they need to request documents. Lisa O’Dwyer, Legal Director at Action against Medical Accidents (AvMA), told us:

If you do not have access to the basic documents that the coroner is relying on when you attend a pre-inquest review hearing, you cannot be prepared for that, whether you are represented or not. You need to have access to that information well in advance.⁷³

Victoria Lebec, Head of Policy, Campaigns and Communications at RoadPeace made a similar point:

70 JUSTICE, *When Things go Wrong, the response of the justice system*, Autumn 2020, p2

71 Victim Support (COR0023), para 9

72 *Coroners’ investigations and inquests*, Briefing Paper Number 03981, House of Commons Library, February 2021, p11

73 [Q63](#)

Even though there is the pre-disclosure policy, which is a good thing, the majority of families do not know to ask for the evidence ahead of time and coroners vary in their compassion from that perspective. You cannot be prepared for an inquest without having that information before.⁷⁴

73. Bereaved people are at a disadvantage when they do not have access to the evidence. It is important that the process for obtaining evidence is explained clearly to them as this is important for the fairness of the inquest. We encourage the new Chief Coroner to strengthen guidance and training on disclosure and pre-inquest reviews, emphasising to coroners that bereaved people should be told about their rights to documents early in the process.

Some inquests are adversarial

74. Coroners' inquests are set up to inquire into the facts of a death. They are not trials and do not have the safeguards in place that other courts have when criminal or civil liability is being decided. They are not intended to be adversarial where each side argues against the other. We heard, however, that it can be difficult for coroners to maintain an inquisitorial approach, particularly for complex inquests that involve many people and organisations, some of whom may be seeking to limit their civil (or criminal) liability with the assistance of legal representation. This can leave bereaved people who do not have legal representation feeling lost and unsupported and that their questions are not being considered.

75. In relation to inquests into deaths in state custody Dame Elish Angiolini said in her 2017 report:

The reality is that Inquests into death in police custody are almost always adversarial in nature. This has been the unanimous opinion of coroners, lawyers and families who have given evidence to this review [...] The expectation that the Coroner can meet the family's interests during the inquest is wholly naïve and unrealistic as well as unfair to families and to the Coroner.⁷⁵

The Coroners' Society also referred to an "inequality of arms":

the State in one of its various guises (e.g. a hospital) may be represented but the family may not be. It is clear that when there are multiple advocates inquests can lose their inquisitorial nature.⁷⁶

Institutional defensiveness and a lack of candour

76. Deborah Coles, Director of INQUEST told us of their experience of a culture of defensiveness by public bodies at Article 2 Inquests:

Very often, those lawyers are working as a team to try to reduce the scope of the inquest, to try to limit the number of witnesses or argue against questions

74 [Q63](#)

75 Dame Elish Angiolini [Report of the independent review into deaths and serious incidents in police custody](#), Home Office, October 2017, p 215

76 The Coroners' Society of England and Wales ([COR0030](#)), section 6

being left to a jury, if indeed there is one, or argue against a coroner making a prevention of future death report. [...] There is much more concern for reputation management, rather than a meaningful search for the truth.”⁷⁷

77. The Right Reverend Bishop James Jones KBE drew attention to this institutional defensiveness in his Hillsborough report:

The common thread to the experiences set out in this report is [...] ‘the patronising disposition of unaccountable power’ [...] One of its core features is an instinctive prioritisation of the reputation of an organisation over the citizen’s right to expect people to be held to account for their actions. This represents a barrier to real accountability.⁷⁸

78. In its report “What happened when something goes wrong”, JUSTICE, said:

In both inquests and inquiries, lack of candour and institutional defensiveness on the part of State and corporate interested persons and core participants are invariably cited as a cause of further suffering [for bereaved people] and a barrier to accountability.⁷⁹

Duty of Candour

79. The statutory duty of candour was introduced in November 2014 for NHS bodies in England. It was extended in April 2015 to cover all other care providers registered with the Care Quality Commission (CQC). It is a statutory duty to be open and honest with patients, or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. It applies to all health and social care organisations registered with the regulator, the (CQC) in England. Deputy Chief Coroner, Derek Winter, told us:

The duty of candour is a very helpful development. One of the things that coroners should be doing, in my view, is forming a working and meaningful relationship with the chief executives of the various health trusts and GP communities to get word out about what the coroner’s expectations are at an inquest. It is far better for people to come along and say, “We have fallen into error. Things could have been done better,” than for that admission to be, essentially, extracted out of them. It is better to put hands up, learn lessons and move forward.⁸⁰

80. Lisa O’Dwyer from Action against Medical Accidents (AvMA), said the families of bereaved people were, once more, unaware of their rights here:

Under the statutory duty of candour, there is an ongoing obligation to update families as their investigations progress and to communicate those updates to them. There is an obligation under the statutory duty of candour for what has gone wrong to be written [...] I can say without any hesitation that the families who come to us invariably have not heard of the duty of

77 [Q34](#)

78 Bishop James Jones’ review of the Hillsborough families’ experiences, [The patronising disposition of unaccountable power](#), Home office, November 2017, p 6

79 JUSTICE, [Justice When Things go Wrong, the response of the justice system](#), August 2020, p 56

80 [Q150](#)

candour, or, if they have heard of it, they certainly have not had a duty of candour letter, and they certainly do not get updates. There seems to be a general feeling that once an inquest is called or a similar process, whether it is civil litigation or anything like that, the duty to update families about the progress of internal investigations ceases.⁸¹

81. The failure of health and social care bodies to fulfil their duty of candour to bereaved people during coroners’ investigations and inquests is disappointing. The Ministry of Justice should amend the Coroners’ rules to make it patently clear that the duty of candour extends to the Coroner Service. The Government should consider whether a similar duty to be candid at inquests should be extended to all public bodies.

Legal aid for representation at inquests

82. Provision of publicly funded legal services to bereaved families at inquests is limited. The costs of legal advice and preparation in the run-up to an inquest can be met by legal aid. However, the costs of representation at the inquest itself will be met only in cases deemed exceptional. Applicants for exceptional case funding must also satisfy financial eligibility rules for legal aid. Applicants may still be required to augment a grant of legal aid by making contributions to the costs of funding their representation. There is, however, a discretion to waive both the means-testing and requirement to make financial contributions.⁸²

83. The ‘exceptional funding’ criteria are:

- where it is necessary to carry out an effective investigation into a death, as required by Article 2 of the European Convention on Human Rights; or
- where the Director of Legal Aid Casework has made a wider public interest determination that the provision of advocacy for the bereaved family at the inquest is likely to produce significant benefits for a wider class of people.⁸³

84. Lisa O’Dwyer, Legal Director at AvMA, told us that in her experience: “Exceptional [legal aid] funding is exceptional in name and, quite frankly, exceptional in nature as well. People generally do not access it at all.”⁸⁴

85. The first Chief Coroner, Sir Peter Thornton QC, in his 2015–2016 annual report, set out how many other interested persons may have publicly funded legal representation while the people who have been bereaved do not:

the police, the prison service and ambulance service, may be separately represented. Individual agents of the state such as police officers or prison officers may also be separately represented in the same case. While all of these individuals and agencies may be legally represented with funding from the state, the state may provide no funding for representation for the family.

81 [Q68](#)

82 [Legal aid for representation at an inquest](#), House of Commons Library, briefing paper 04358, April 2019, p3

83 [Coroners’ investigations and inquests](#), House of Commons Library, briefing paper 03981, February 2021, p10

84 [Q64](#)

Sir Peter concluded that “in some cases the inequality of arms may be unfair or may appear to be unfair to the family”⁸⁵ He recommended that “the Lord Chancellor gives consideration to amending his Exceptional Funding Guidance (Inquests) so as to provide exceptional funding for legal representation for the family where the state has agreed to provide separate representation for one or more interested persons.”⁸⁶

86. The Ministry of Justice reviewed Legal Aid for inquests in 2018–19. Its conclusions included:

we have decided that we will not be introducing non-means tested legal aid for inquests where the state is represented. However, going forward, we will be looking into further options for the funding of legal support at inquests where the state has state-funded representation. To do this we will work closely with other Government Departments. [...] Bereaved families need better awareness of when legal aid is available, but whilst we accept that in some cases it is right that they should have legal representation we are mindful that a significant expansion of legal aid could have the unintended consequence of undermining the inquisitorial nature of the inquest system. It could also reinforce the commonly held misconception that an inquest’s role is to apportion blame, as opposed to finding fact and learning lessons. All the work we have done affirms the need to maintain an inquisitorial system and highlights the crucial role of the coroner in achieving this. The measures set out in this document therefore seek to improve the current system rather than revolutionise it.⁸⁷

The Ministry of Justice’s work with other departments has not yet resulted in any funding for legal representation for bereaved people at inquests.

Steps to assist bereaved people other than legal representation

87. Deputy Chief Coroner, Derek Winter told us:

It is really important that we recalibrate the tone of inquests [...] I have been working with the regulators—the Solicitors Regulation Authority and the Bar Standards Board, together with a group of experienced inquest lawyers—to develop a toolkit, a set of competencies and standards. ... because this is a specialist area of advocacy, which requires a certain tone to the proceedings. That should be rolled out in the spring. It complements a protocol that Government lawyers should sign up to, which is in the MOJ guide to coroner services.⁸⁸

88. The Government added the protocol of ‘principles guiding the government’s approach’ to the Ministry of Justice’s Guide to Coroner Services for Bereaved People in January 2020.⁸⁹ These principles apply when a Government Department (or Departments) has interested person status in an inquest.

85 [Chief Coroner, HHJ Peter Thornton QC, Third and final report 2015–16, p44](#)

86 [Chief Coroner, HHJ Peter Thornton QC, Third and final report 2015–16, p44](#)

87 Ministry of Justice, [Final report: Review of legal aid for inquests](#), February 2019, p 11

88 [Q144](#)

89 Ministry of Justice, [Guide to Coroner Services for Bereaved People](#), January 2020, Annex A

89. The principles are that the Government and the lawyers it instructs will:

- Remain committed to supporting the inquisitorial approach and assisting the coroner to find the facts of what happened and learn lessons for the future;
- Approach the inquest with openness and honesty, including supporting the disclosure of all relevant and disclosable information to the coroner;
- Communicate with the bereaved in a sensitive and empathetic way which acknowledges and respects their loss;
- Keep in mind that the bereaved should:
 - Be at the heart of the inquest process;
 - Feel confident that the inquest will get to the facts of what happened;
 - Feel properly involved throughout and listened to;
- Challenge the evidence of other interested persons or witnesses sensitively, where it is necessary to do so;
- Consider a formal acknowledgement to the bereaved to recognise when the death of their loved one happened whilst in the care of the state; and
- Consider the number of lawyers instructed bearing in mind the commitment to support an inquisitorial approach.⁹⁰

90. Alex Chalk told us about some other initiatives:

the MOJ in January of this year [2020] held a conference for people to attend, effectively sending the message out, “This is how we want inquests and inquiries to be carried out. [...] The BSB and the SRA are working together to provide inquest-specific information to lawyers. Also, the MOJ has re-established a stakeholder forum to engage with other Government Departments to see what more can be done to assist bereaved families.”⁹¹

91. Deborah Coles, Director of INQUEST, told us that she did not believe these measures were a reasonable alternative to non-means tested legal aid for bereaved people at inquests where the state is paying for other interested persons to be legally represented:

It involves families being told, “You don’t need lawyers,” and state lawyers being told, “Just be a bit nicer to families, and then everything will be all right,” [...] The lawyer representing a family and asking those questions that that family really need answered not only speaks to the family and recognises how traumatic these processes can be for families but protects the public interest.⁹²

92. The Government’s steps to support the inquisitorial nature of inquests are welcome but are insufficient by themselves to prevent large multi-handed inquests, where individuals’ and organisations’ reputations are at stake, from becoming adversarial.

90 Ministry of Justice, *Guide to Coroner Services for Bereaved People*, January 2020, Annex A, p iii

91 [Q173](#)

92 [Q34](#)

93. Mrs Tracey McCourt submitted evidence about representing her family at the inquest into the death of her brother-in-law without access to legal representation:

We were told that as a family we would not qualify for Legal Aid and that if we wanted to, we could represent ourselves, again we were devastated [...] The Inquest began [...] and was scheduled for three weeks. Nothing could have prepared me for what I was met with on that first day, the amount of people there, mainly police officers left me feeling sick to my stomach. The police force and police officers involved had barristers, they also had members from the Police Federation and Professional Standards, there was me and a 4th year law student with all Leonard's family behind me. The first three days were just terrifying, I felt way out of my depth and just thought that I was letting my family down as they were so desperate for answers to what had happened to their son and brother.⁹³

94. Victoria Lebec of RoadPeace (which is a national charity for road crash victims in the UK) told us that legal representation for some but not others can sway the outcome of the inquest:

In road deaths, the driver is always represented by the insurance company's legal team, and that inevitably sways slightly the way in which the inquest is carried out.⁹⁴

95. A bereaved family member submitted written evidence to us showing how he had to rely on a charity for legal representation in a case of unlawful killing:

In our case, a homicide [abroad], the British perpetrator was given legal aid to appeal against the first Coroner's verdict of "Unlawful killing", by way of a judicial review in the High Court. We, as the bereaved family had no such access to legal representation, either at the High Court, or at the subsequent second inquest [...] Had it not been for the timely intervention by the Charity "Murdered Abroad" [...] we would not have been able to achieve the correct verdict at the second inquest.⁹⁵

Alex Chalk in his evidence paid tribute to lawyers who gave their time for free at the London Bridge tragedy:

That was absolutely in the finest traditions of the legal profession. I know they have the gratitude of the individuals, but they certainly have mine as well.⁹⁶

96. Andrew McCulloch, a bereaved parent, told us how difficult it was to raise money for legal representation by crowd funding:

We had to go down the road of crowdfunding, because taking on a judicial review was an incredibly difficult thing to do. Everyone talks about crowdfunding as if it were a simple panacea. It is incredibly difficult to set it up. It takes a lot of time. You have to make videos and to have events. When

93 Mrs Tracey McCourt ([COR0020](#)), paras 2 and 7

94 [Q53](#)

95 Mr Brian Chandler ([COR0042](#)), para 1

96 [Q173](#)

you are wrecked by the death of your daughter, are in a distressed state, are trying to hold your professional life together—to continue making some sort of living while you are doing that—and are trying to hold the family in one piece, to be expected to do that as well in order to get justice is a disgrace in a country like this.⁹⁷

97. 2017 saw the publication of the Bishop James Hillsborough Report, Dame Elish Angiolini’s report on deaths in police custody, Lord Bach’s final report of his Commission on Access to Justice, and the Chief Coroner’s Third Annual Report, all of which made recommendations that provision of non-means tested legal aid should be provided for bereaved people, in particular where the state provides representation for other interested persons, such as in relation to deaths in police custody or prison or where NHS bodies are legally represented.

98. The Right Reverend Bishop James Jones and the Victims’ Commissioner, Dame Vera Baird QC, submitted written evidence to this inquiry supporting the development of funding outside the legal aid system. One option they are considering is that public authorities that choose to be legally represented at inquests would contribute to funding legal representation for bereaved people too.⁹⁸

99. Deputy Chief Coroner, Derek Winter told us that coroners, themselves, sometimes write to the legal aid agency because they consider the people who have been bereaved should have publicly funded legal representation:

There are occasions where coroners will write letters of support for funding applications. Coroners are trying to level up, to use a popular phrase, not just making sure that the family’s questions are put but, if there is good reason for representation, to support that. Beyond that, there is not much more that coroners can do.⁹⁹

100. Andrew Bridgman, an assistant coroner in Manchester South, submitted evidence rejecting the view that legal aid is not needed because inquests are inquisitorial:

As an independent judicial officer conducting my own inquiry, how can I possibly represent the views of the family? They may have complete[ly] different issues. I invite them to tell me what their issues and concerns are. But they may miss the point. And I find it far easier for me as a coroner to conduct my inquiry more thoroughly and without fear of bias if the family is represented.¹⁰⁰

101. Alex Chalk told us of his support for legal aid for legal representation at inquests for bereaved people in very limited circumstances:

I do not sit here and say that there should never be legal aid for families. [...] of the 420 or so applications for exceptional case funding [last year], 280 were granted. That is something a little over 60%. It is not the case that we

97 [Q35](#)

98 Dame Vera Baird QC (Victims’ Commissioner for England and Wales at Office of the Victims’ Commissioner); The Right Reverend James Jones KBE (Author of the report: ‘The patronising disposition of unaccountable power’ ([COR0074](#)), see 4th para under heading ‘Our approach’

99 [Q147](#)

100 Bar Council, [Running on Empty, Civil Legal Aid Report](#), Bar Council, January 2021, p16

are saying to people as a Government, “There you go,” and fobbing people off by saying that exceptional case funding is in place, knowing fine well that no one is going to get it. That is not the case at all. It is available and people do use it.¹⁰¹

The statistics above do not include those who did not apply for legal aid, either because they were unaware of it or because they did not think they would be eligible.

102. Alex Chalk suggested that representations from coroners supporting legal aid applications should be given great weight¹⁰² and that where state parties are legally represented that should almost always lead to a grant of legal aid for bereaved people.¹⁰³ He also made the point that extending legal aid would use resources that could be spent elsewhere:

blanket legal aid [would] mop up a whole load of resources where they, perhaps, might not be going as far as they could be going in, say, social welfare law or other areas of legal need.¹⁰⁴

103. Bereaved people should not be put through the difficult and time-consuming process of meeting the exceptional cases requirements and the means test for legal aid where public authorities are legally represented at public expense at the inquest into the death of their loved one. *The Ministry of Justice should by 1 October 2021, for all inquests where public authorities are legally represented, make sure that non-means tested legal aid or other public funding for legal representation is also available for the people that have been bereaved.*

Challenging coroners’ decisions

104. The Ministry of Justice’s Guide to Coroner Services sets out what to do if bereaved people have a complaint about a coroner’s personal conduct or the standard of service received.¹⁰⁵ The first are dealt with by the Judicial Conduct Investigations Office and the latter can be directed to the local authority (or police authority) with an option to escalate to the Local Government Ombudsman for those unhappy with the local authority’s response. The Ombudsman cannot review or alter a coroner’s decision, such as one about whether to hold an inquest or what evidence to consider.

105. As with any branch of the judiciary, coroners sometimes make errors. Judge Lucraft acknowledged this: “I am the first to accept that we do not always get everything right, whichever branch of the judiciary we come from ...”¹⁰⁶

106. There is no right of appeal as such from an inquest. However, it is sometimes possible to challenge a coroner’s decision, or the outcome of an inquest, by way of an application under Section 13 of the Coroners Act 1988, or an application for judicial review. Applications to the High Court under Section 13 of the Coroners Act 1988 can be made only with the consent of the Attorney General. The High Court can either order an inquest to be held where a coroner had refused to hold one or quash, (that is cancel), an inquest and order a

101 [Q174](#)

102 [Q175](#)

103 [Q177](#)

104 [Q174](#)

105 Ministry of Justice, [Guide to the Coroner Service for bereaved people](#), updated January 2020, paras 8.3 and 8.4

106 [Q130](#)

new one where that is in the interests of justice.¹⁰⁷ In 2019 the Attorney-General received 16 applications under section 13 and proceeded with four of them.¹⁰⁸

107. Coroners' decisions are also subject to judicial review. The legal test for overturning decisions by way of judicial review is a demanding one. In essence the High Court will not overturn a coroner's decision simply because it is the wrong decision; the decision must meet a higher test of being unlawful or unreasonable, or the product of an unfair procedure.¹⁰⁹ Applicants must apply to the High Court for permission before they can start judicial review proceedings, which is an added barrier.

108. We asked André Rebello, Honorary Secretary of the Coroners' Society, what can be done to speed up the process of remedying coroners' errors:

That is a problem, because section 40 of the Coroners and Justice Act was not enacted [...] The number of judicial reviews and section 13 Coroners Act 1988 challenges are perhaps lower than for any other legal jurisdiction; there are fewer challenges to coroners. That is because there is no real appeal from a coroner's decision. There has to be a judicial review or a section 13 challenge on insufficient inquiry or other defect in the process.¹¹⁰

109. Deborah Coles, Director of INQUEST told us:

As has already been said, there is no appeals process. That was initially in the Act. The reality is that it is very difficult to challenge a coroner. Of course there is a high threshold in terms of judicial review.¹¹¹

110. André Rebello, supported a new appeals process but acknowledged that it would be extensive:

I can see a lot of advantages in having an appellate process, but I can see a very high cost, because how many circuit judges would be involved in reviewing coroners' decisions? Who is an interested person? Is there a preliminary inquiry? Is there an investigation? Should an inquest be opened? Is there a post-mortem? Should that post-mortem be less invasive? Which witnesses should be called? What is the scope of the investigation?¹¹²

111. Judge Lucraft was in favour of staying with the current arrangements, although not completely opposed to an appeals system if it could be funded properly:

my preferred option is that we retain the jurisdiction of the High Court to look at applications for judicial review. If you are going to look at a broader range of appeals from decisions of coroners, that will bring with it quite a requirement of manpower, resource and finance. I am not saying that I am against it—if you were to fund it properly.¹¹³

107 [Challenging Coroners' decisions](#), House of Commons Library, Briefing Paper Number 00525, 5 March 2020, pp 2–3

108 Ministry of Justice (COR0096), para 63

109 [Judicial Review: A short guide to claims in the Administrative Court](#), House of Commons Library, research paper 06/44, September 2006, second para.

110 [Q22](#)

111 [Q33](#)

112 [Q23](#)

113 [Q131](#)

112. Alex Chalk, recognised that the current system was difficult for some but felt it was the workable option:

On the issue of appeal, we think it is about right at present. Arguments could be made either way [...] Not everyone wants to tip off to the High Court to review decisions. I recognise that. It is a hurdle to cross. Equally, we want to make sure that there is not endless either satellite litigation or appellate litigation.¹¹⁴

113. The current arrangements for challenging coroners' decisions are unwieldy and cause unacceptable delays, stress and often expense, for bereaved people. The Ministry of Justice should introduce a system of appeals similar to that in Section 40 of the Coroners and Justice Act 2009 as originally enacted.

Amending Section 13 of the Coroners and Justice Act 2009

114. The Chief Coroner, Judge Lucraft, suggested a change to the Section 13 process in his annual report to give the High Court greater flexibility when it quashes an inquest. In essence it would give the High Court the power to use its own findings about the death instead of ordering a fresh inquest, where it is satisfied that it is neither necessary nor desirable in the interests of justice that a fresh investigation or inquest.¹¹⁵

115. INQUEST were concerned that bereaved people in such a case who had fought either to have an inquest or to have a new inquest might be left feeling that justice had not been served where the High Court decided it had enough information and an inquest was not required.

116. There may be circumstances where with the consent of the bereaved people concerned, it would be sensible for the High Court to be able to direct that the particulars of the Record of the Inquest be amended as appropriate without ordering a fresh inquest. The Government should consider adopting the Chief Coroner's proposed amendment to Section 13 with the caveat that the High Court could use the new power only with the consent of the interested party applying under Section 13.

Stillbirths

117. Stillbirths cannot be referred to coroners.¹¹⁶ The CJA 2009 did not include a provision to change this. There have been repeated calls for stillbirths to be brought within the remit of the Coroner Service.¹¹⁷ The Government consulted on this issue in 2019 with a proposal that deaths after 37th week of pregnancy should be in scope of an inquest.¹¹⁸ It has yet to publish a response.

118. The Government consultation on coronial investigation of stillbirths was welcome but it is disappointing that it appears to have stalled. The Ministry of Justice should revive the consultation on coronial investigation of stillbirths and publish proposals for reform.

114 [Q179](#)

115 [Chief Coroner's Combined Annual Report 2018 to 2019 and 2019 to 2020](#), November 2020, paras 151–155.

116 [The investigation of stillbirth](#), House of Commons Library, Briefing Paper 08167, March 2019, p12

117 [The investigation of stillbirth](#), House of Commons Library, Briefing Paper 08167, March 2019, p17

118 HM Government, [Consultation on coronial investigations of stillbirths](#), March 2019, p6

4 Role of pathology

Responsibility for supply of pathology services to the Coroner Service

119. We heard that there is a serious shortage of pathologists available to carry out post-mortem examinations for coroners which leads to delays in releasing bodies and completing coroners' investigations. Neither any central government department nor the NHS accepts responsibility for the supply of pathology services to the Coroner Service.¹¹⁹ Post-mortem examinations and reports prepared for coroners by pathologists are not covered by NHS contracts. Coronial pathologists are usually NHS consultants working privately outside their normal hours. Their services for coroners are provided for a fee.

120. The standard fees for pathologists' services to the Coroner Service are set by the Lord Chancellor with the agreement of the Lord Chief Justice.¹²⁰ André Rebello, Honorary Secretary of the Coroners' Society of England and Wales, told us:

a pathologist is supposed to be able to do a standard post-mortem for £96.80 and £276.90 for a special examination. I do not know how many of you have recently employed a plumber, bricklayer or joiner, but £96.80 often reflects tens of hours of reading medical records, examining the body, preparing slides, looking down the microscope, deciding what to send off to toxicology and what other special examinations are needed.¹²¹

Shortage of pathologists

121. The shortage of pathologists available to do work for coroners is long-standing and becoming more acute. Dr Mike Osborn, President of the Royal College of Pathologists, told us:

You will run out of pathologists to do post-mortems for you [...] there will be huge delays and problems because pathologists are not taking on post-mortems—it is not part of NHS work. There are already 580 consultant pathology vacancies in this country. There are not enough pathologists to do the diagnostic work in this country, and it has come down to the basic choice of [NHS] trusts supporting cancer diagnosis, inflammatory bowel disease or post-mortems, which is not part of their role.¹²²

The Coroners' Society told us:

The service is essentially being propped up by older and experienced pathologists with fewer younger colleagues coming through the ranks to replace them. The impact on families is delayed investigations and delays in the bodies of their loved ones being released back to them for funerals to take place.¹²³

And that

119 [Chief Coroners' Combined Annual Report 2018 to 2019 and 2019 to 2020](#), November 2020, para 103

120 The Coroners Allowances, Fees and Expenses Regulations 2013 ([SI 2013/1615](#)) para 6 of the Schedule

121 [Q10](#)

122 [Q26](#)

123 The Coroners' Society of England and Wales ([COR0030](#)), section 1(e)

Neither the DHSC nor the MOJ will grasp this nettle. It must be grasped before there is no-one left who can train autopsy pathologist of the future.¹²⁴

Post mortem examinations using scanning

122. Post mortem examinations generally include dissection of the body so that organs and tissues can be examined. The Chief Coroner, Judge Lucraft, told us about the sensitivities relating to post mortem examinations:

Coroners, with their support staff, try to do their very best to explain what the process is. There can be quite difficult conversations, occasionally, where a post-mortem may be required. Not only those with very strong faith concerns about the invasion of the body but most of us do not like the idea of a loved one being examined post death to see what has happened.¹²⁵

123. In more recent times and in some areas less-invasive post-mortem techniques (for example CT scanning) are available in appropriate cases as an alternative to dissection but may have to be paid for by the people who have been bereaved. The Coroners' Society said: "Families in one area should be able to have a less invasive scan by way of post-mortem investigation as any other area, and without any cost."¹²⁶

124. André Rebello, Honorary Secretary of the Coroners' Society made the same point about fairness:

I object most strongly to families and communities being charged for coronial post-mortem investigations. If I order a post-mortem [by dissection], the relevant authority funds it. Relevant authorities do not fund less invasive autopsy, and it is not right that we have this unevenness within the service.¹²⁷

125. Dr Osborn told us more about scanning, and its limitations:

Minimally invasive autopsy is very good but it is not the magical answer to all the questions everybody wants it to be [...] in good centres with well-trained staff you can get the answer to the cause of death in up to 70% of cases. In some studies it is 90%, but realistically it is about 70% of cases.¹²⁸

126. The Chief Coroner, Judge Lucraft, said scanning was increasing and was welcomed by some faith groups:

That can assist many coroners with what might be termed 'relatively straightforward post-mortem investigations'. I know that faith communities, in particular, welcome scanning, which means that there does not need to be a more invasive post mortem.¹²⁹

127. Dr Osborn told us coroners' officers play an important role with respect to post mortem examination as how a post-mortem is done is based on information they provide:

124 The Coroners' Society of England and Wales ([COR0030](#)), section 7 of the executive summary

125 [Q123](#)

126 The Coroners' Society of England and Wales ([COR0030](#)), section 7 of the executive summary

127 [Q10](#)

128 [Q11](#)

129 [Q155](#)

In some areas they are furnished with scene photographs, police statements, statements from coroners' officers and so forth. In other areas you get just two lines written on a piece of A4 saying, "Person found dead in Tesco", or something like that. There is literally that much difference.¹³⁰

Savings from using scanning

128. Giles Adey, from Kent County Council told us that investing in scanning now could save money later:

We are validating the numbers at the moment, but potentially we are looking at a capital investment of £3 million that would be repaid over a period of nine years, after which it would deliver significant annual revenue savings.¹³¹

129. In his recent annual report, the Chief Coroner invited senior coroners and local authorities to consider providing "access to CT scanning facilities as a way (a) to take some pressure from conventional autopsy provision; and (b) to provide a robust form of post-mortem evidence capture including for disaster victim identification (DVI), mass fatality and other special cases."¹³²

Regional centres of excellence for pathology services

130. The Chief Coroner, in his recent annual report refers to the 2015 Hutton review of pathology in England and Wales where Professor Hutton described the immediate future of both forensic and non-forensic pathology services as "fragile, and corrective action needs to be taken now".¹³³ The Chief Coroner has repeatedly called for urgent action to support pathology services in his annual reports. For the longer term he supports Professor Hutton's proposal that pathology services for coroners be organised regionally in 12 to 15 regional centres of excellence.¹³⁴

131. Dr Osborn agreed that a regional model would be the best way forward.¹³⁵ We received evidence from individual coroners, such as Andrew Haigh, Senior Coroner for Staffordshire (South), about the shortage of pathologists and supporting the creation of regional centres.¹³⁶

132. Giles Adey from Kent County Council told us of the difficulties in improving pathology services from a local authority point of view:

The difficulty is that we have never come to a point where regional mortuary provision is at the top of the respective local authorities' priorities [...] Regional provision would make absolute sense, but the question is how it would be funded. I think the challenge would be for Government in funding the capital or set-up costs, because of the difficulties of agreeing it locally, and then for local authorities in a region to collaborate and work together on the revenue consequences."¹³⁷

130 [Q8](#)

131 [Q93](#)

132 [The Chief Coroners Combined Annual Report 2018 to 2019 and 2019 to 2020](#), November 2020, para 63

133 [The Hutton Review](#), A review of forensic pathology in England and Wales, Home Office, March 2015

134 [Chief Coroner's Combined Annual Report 2018 to 2019 and 2019 to 2020](#), November 2020, paras 104–106

135 [Q10](#)

136 Mr Andrew Haigh ([COR0001](#)), para 1

137 [Q108](#)

Lack of progress in addressing the shortage of pathologists

133. Alex Chalk told us that the Ministry of Justice recognises that there is a shortage of pathologists to carry out work for coroners and is working with others to try and fix it:

I entirely accept that this is a pinch point and it is something that the Government are very much aware of, and we are working across Government to see what progress can be made.¹³⁸

134. Pathology services for coroners have been neglected over many years leading to serious problems.

135. The Ministry of Justice should immediately review and increase Coroner Service fees for pathologists, so they are enough to ensure an adequate supply of pathology services to the Coroner Service.

136. In the medium term the Ministry of Justice should work with the Department of Health and Social Care so that pathologists' work for coroners is planned for within pathologists' contracts with NHS trusts.

137. In the longer term, the Ministry of Justice should broker an agreement between relevant government departments and the NHS (in England and Wales) for the establishment and co-funding of 12–15 regional pathology centres of excellence.

5 Local funding, national leadership

Local relationships

138. We were unable to find anyone who was able to provide an overview for us of coroner services from a local authority point of view. We were greatly helped by evidence provided to us by those working as individuals in local authority coroner services both in writing and in person. In 2013, HHJ Peter Thornton QC, the first Chief Coroner (2012–2016), described the complexity of coroner’s working relationships:

A senior coroner is appointed by the local authority but not employed by them, so their line manager is the Chief Coroner, or possibly the Lord Chief Justice. Then you have coroners’ officers, employed by the police. Their line manager is a detective sergeant, or some other officer. Then you have administrative staff, who are employed by the local authority, and line managed by someone there.¹³⁹

139. The Coroners’ Society of England and Wales told us of the fundamental importance of good relationships between Senior Coroners and their local authorities:

In some areas the relationship between the Senior Coroner and Local authority works exceptionally well promoting and funding the service to the benefit of the locally bereaved persons. However, in some areas lack of resources, lack of engagement, reluctance to recognise funding responsibility and poor communication mean the service is not as effective as it should be. Too many Local Authorities do not engage with the coroner’s service nor do they understand their statutory funding responsibilities.¹⁴⁰

140. Debbie Large, Head of the Kent Coroner Service¹⁴¹ explained to us how coroner services operate in practice:

In Kent, all the Coroner Service team are employed by Kent County Council. [...] [we] have very good working relationships with our coroner team. It is a difficult one because coroners direct all judicial activity and it is KCC staff who carry out their instructions, but [coroners] have no line management role.¹⁴²

She told us that the relationships can be difficult because of the complicated employment arrangements:

Because of my work with coroners’ officers, staff associations and years of training coroners’ officers, I am aware that that situation is not mirrored across the country. In practice, some coroners’ officers find it very difficult being employed by either the police or local authority but working under

139 <http://www.prisonreformtrust.org.uk/PressPolicy/Parliament/AllPartyParliamentaryPenalAffairsGroup/Nov2013ReformingtheCoronerService>, accessed 3 May 2021

140 The Coroners’ Society of England and Wales (COR0030), section 1

141 Debbie Large is also Vice Chair of the South East Coroner Managers Regional Group, member of the Chief Coroners Training Group; and was Chair of the Coroners Officer and Staff Association (COASA) from 2010 to 2018, having been a Council Member of COASA since 2001. She started her career in the Coroner Service in 1998 as a Coroners Officer working for the Metropolitan Police Service.

142 [Q86](#)

the direction of the coroner, because [their] employers do not always understand the role or relationship.¹⁴³

141. Judge Lucraft stressed the importance of Senior Coroners building relationships of mutual trust and respect with their local authorities:

It is very important that that relationship is understood; that the coroner is an independent judicial office holder. They very often have to make difficult decisions that may have ramifications for their funding authority. That relationship needs to be one that is respected and regarded both by the senior coroner with the local authority but by the local authority back with the senior coroner.¹⁴⁴

142. Birmingham and Solihull Coroners set out the conflicting pressures on senior coroners and their funding local authorities:

The Senior Coroner has to develop a relationship with their Local Authority for the purposes of planning, managing and running the Coroners service, yet they may have the same Local Authority as an interested person in their court. There is no other judicial office expected to undertake this balancing exercise which is caused by the Coroners service being funded by Local Authorities and not being part of a nationally funded service.¹⁴⁵

They also told us that relationships need to be continually renewed:

Management provided by the Local Authority for the Coroners service changes regularly and this can create difficulties as new staff do not understand the requirements of the service. This creates an additional burden on the Coroner having to educate new staff. A national service would avoid this pressure.¹⁴⁶

Calls for a National Coroner Service

143. As described in Chapter 2 there have been repeated calls for a National Coroner Service. Both the first and second Chief Coroners supported the call for a National Coroner Service. Judge Lucraft, the second Chief Coroner, set out his views in his 2017–18 Annual Report:

There is much to be gained from such a move in terms of standardisation, consistency and implementation of reform. The operational infrastructure provided by a national service would address, over time, many of the issues about inconsistency of experience by bereaved families; that experience can occur in many situations outside the formality of the court room—for example in the interaction with the processes that follow immediately after a death is reported to the coroner.¹⁴⁷

He also set out problems with the current arrangement:

143 [Q86](#)

144 [Q159](#)

145 Birmingham and Solihull Coroners ([COR0048](#)) para 7

146 Birmingham and Solihull Coroners ([COR0048](#)) para 8

147 [The Chief Coroner's Annual Report 201 to 2018](#), December 2018, pp 7–8

the localised nature of the present service produces inevitable inconsistencies between coroner areas. Coroners have to an extent worked in isolation, unsupported by a sound framework and network of coroner resilience [...] There is inconsistency in the provision of resources across coroner areas depending on the approach of individual local authorities. Some areas are well resourced in terms of the provision of coroners' officers and support staff, others are not [...] Shortage of coroners' officers adds to the stress on those staff in post with inevitable knock-on delays.¹⁴⁸

Arguments against creating a National Coroner Service

Local decision making

144. When Alex Chalk gave evidence to us, he argued in favour of keeping the current local system. He suggested that local services were more appropriate due to the way areas vary:

The benefits of devolution are that you allow local autonomy because people know their areas best [...] while one coroner area might be relatively straightforward in so far as there are no particular local institutions, there might be others that have a prison or, for example, a specialist children's hospital. That is relevant because, if there are deaths, you might need specialist medical practitioners, consultant paediatricians or whatever.¹⁴⁹

He also recognised the risks:

There is some serious merit in having a local system, but you have to balance that with avoiding a fragmented system where, in effect, coroners are kings and queens of their own castle, doing their own thing and paddling their own canoe. Plainly, that is not a helpful system.¹⁵⁰

145. Alex Chalk acknowledged that provision of resources varied between local areas: "It is no secret that some local authorities have been more successful in providing local resources and others have been less successful."¹⁵¹ He also suggested that local variations are inevitable and that it could never be guaranteed that nobody would have a bad experience: "even in a centralised system, people will have bad experiences. One should not assume that, therefore, every time someone has a bad experience, the solution is to have a centralised system."¹⁵²

Expense and disruption of a reorganisation

146. Alex Chalk posed the question whether a change to a national system should be avoided due to the expense and disruption involved:

is [it] worth the powder and shot to start sweeping all that aside, recognising that inevitably there will be some advantages for the sake of a centralised

148 [The Chief Coroner's Annual Report 2017 to 2018](#), December 2018, pp 7–8

149 [Q183](#)

150 [Q183](#)

151 [Q165](#)

152 [Q184](#)

system. I think that would throw up new problems of its own. That is to say nothing of the fact—I make no apology for mentioning this—that it would be extraordinarily expensive to do [...] when all the magistrates courts were folded into HMCTS, that caused enormous angst, cost, difficulty, delay and problems [...] you have to be very sure, it seems to me, that it is worth smashing up the existing system to replace it. The case has to be, if not unarguable, absolutely compelling.¹⁵³

147. He argued that the better approach would be to continue to get the most out of the changes introduced by the Coroners and Justice Act 2009 (CJA 2009):

Let us, please, not lose sight of the fact that [...] the coronial service, has moved on enormously since 2010. This piece of legislation has evolved; it has adapted, not simply because of the black letter on the page but because of the skill, dedication and application of coroners. For that, both I and the Government are eternally grateful. [...] The way you strike this balance is through the guidance notes, training and also, frankly, reducing the number of coroner areas [...] If we can get high-quality people into the coronial service, which has been very good and continues to be good, ultimately, that has to be the centre of effort. We do not close our minds, eyes or ears to anything, but I also think we have to be clear-eyed about what makes the biggest difference to court users.¹⁵⁴

Risk of ‘levelling down’

148. We also received evidence raising a note of caution that any new national service needs to be properly funded to avoid a ‘levelling-down’. For example, Ian Arrow, Senior Coroner for Plymouth, Torbay, South Devon argued for retention of a local service:

My concern is that passing responsibility for the organization of the Coroner service to a national body is likely to reduce what have been good locally provided services in currently well-resourced relevant areas. There will be a reduction to the lowest possible service provision [...] In my view the Coroner service’s strength is its local operation and a local knowledge of issues and concerns by both Coroners and Coroners Officers. The service weakness is the varied and sometimes inadequate funding /resourcing.¹⁵⁵

149. The Chief Coroner set out the rationale for a well-funded national coroner service as a means of improving consistency in his written submission to this inquiry. He too was concerned that it should be properly funded:

A properly funded national service may lead to greater consistency—but (as the saying goes) the devil would be in the detail. An underfunded national service may find it hard to make significant improvements.¹⁵⁶

153 [Q190](#)

154 [Q186](#)

155 HM Senior Coroner Plymouth Torbay South Devon Ian Arrow ([COR0013](#)), paras 10 and 14

156 Chief Coroner of England and Wales HHJ Mark Lucraft QC ([COR0081](#)), para 76

Arguments in favour of a National Coroner Service

Inconsistent resources and practices effect bereaved people

150. Evidence from many witnesses emphasised the extent of unevenness of resourcing and how this can affect bereaved people. Birmingham and Solihull Coroners said:

Inevitably the mechanism to fund coronial services through their Local authorities does create a post code lottery. Those Councils with financial challenges will be less able to support their Coronial services and the families involved in those cases.¹⁵⁷

151. Dame Elish Angiolini said in her 2017 report of the independent review into deaths and serious incidents in police custody that:

The overall picture from a number of those who participated in the review meetings and focus groups is one of a coronial system under great pressure of resources, is ‘ad hoc’ and largely dependent on a ‘grace and favour’ relationship with other agencies.¹⁵⁸

152. Witnesses repeatedly told us of a service that is fragmented and under-resourced. Deborah Coles, Director of INQUEST, said that “because it is not a national service there are inconsistencies in resources, standards and practices across the system.”¹⁵⁹ JUSTICE added: “local authority control with little centralisation means that standards and practices can vary greatly.”¹⁶⁰ The Royal College of Pathologists supported the introduction of a National Coroners Service “to help ensure consistency across England and Wales through a single, reliable system.”¹⁶¹ Dr Mike Osborn, President of the Royal College of Pathologists told us:

one of the hospitals in which I work is covered by two coronial jurisdictions. In one I can pick up the phone and call somebody, get an answer in three seconds and everything is sorted out. In the other I have absolutely no idea how I would get in touch with somebody, other than send an email that, if I am lucky, might be answered in three or four days’ time. They are hugely different levels. I am a professional person who is adept at getting what I want and know the secret telephone numbers to which no one else has access. If I am a member of the public without access to the internet, who perhaps is not the most au fait with the system, I have real trouble accessing those things in some areas. In other areas, it is fantastic.¹⁶²

153. Victim Support’s National Homicide Service submitted evidence that draws on the National Homicide Service’s experience and is based on research carried out in July and August 2020 with staff and caseworkers from the service:

In our experience, coroners services can be patchy with bereaved families

157 Birmingham and Solihull Coroners (COR0048), para 5

158 Dame Elish Angiolini, *Report of the independent review into deaths and serious incidents in police custody*, Home Office, October 2017, p.12

159 Q28

160 JUSTICE (COR0085), para 5

161 The Royal College of Pathologists (COR0068), section 1

162 Q9

subjected to a postcode lottery, with different areas providing different levels of services. This can create uncertainty for families and those working with them, and make it difficult for professionals to provide support and advice around the process. [...] In our survey with Homicide Service staff 90% told us that they believed that one National Coroners Service would work better than the current system of 88 different areas operating across England and Wales. One Homicide Service caseworker said that a national service would be beneficial because: “if service was standardised, professionals could be more confident in the processes and what to expect and, in turn, families’ expectations could be managed more easily.”¹⁶³

154. André Rebello, Honorary Secretary of the Coroners’ Society emphasised the importance of consistent high standards across the Coroner Service: “When you work with the bereaved you have to get it right first time.”¹⁶⁴ The Coroners’ Society said:

Some coroner’s services are well staffed ... In others this is not the case and there are acute shortages and pressures on very small teams who have excessive workloads [...] Sickness and stress are common amongst coroners’ staff. Whilst the work can be very rewarding, the constant exposure of coroners and their staff to death, all it brings and those affected by death must not be underestimated. Inadequate staffing levels impact not only on the welfare of the workforce but also on the ability of the service to provide an efficient service to the bereaved.¹⁶⁵

155. André Rebello commented on the local authorities’ statutory obligation to fund the Coroner Service: “There are no teeth to enforce the duties under section 24 of the relevant authority to provide accommodation, staffing and resources to run the coroner service.”¹⁶⁶

156. The Chief Coroner, Judge Lucraft told us that “Some [local authorities] have the latest IT and the latest courts, but others do not. I see a properly funded national service as one way of addressing some of these inequalities on the resourcing that is currently provided.”¹⁶⁷

157. The majority of witnesses to our inquiry, two Chief Coroners, and almost everyone who has been commissioned to review aspects of the Coroner Service sees the need for a unified service for England and Wales. There is unacceptable variation in the standard of service between Coroner areas. The quality of each local coroner service should not have to depend on the local authority and the Senior Coroner having a shared understanding and priorities. *The Ministry of Justice should unite coroner services into a single service for England and Wales.*

The case for a Coroner Service Inspectorate

158. We have also heard calls for the standards of the Coroner service to be policed, in the same way probation, prison and crown prosecution services are, by an independent inspectorate.

163 Victim Support ([COR0023](#)), paras 4, 6 and 7

164 [Q5](#)

165 The Coroners’ Society of England and Wales ([COR0030](#)), section 1(b)

166 [Q5](#)

167 [Q126](#)

159. Alex Chalk highlighted for us the current difficulties in comparing performance between coroner areas:

you have to be careful about comparing apples with pears. Why? Because a local coronial area might have, for the sake of argument, a hospital, a prison or even a specialist hospital or specialist prison; therefore, there are different demands. Other areas may simply not have those pressures.¹⁶⁸

160. We heard evidence that an inspectorate would be a good way of assessing whether areas have the resources they need and that the quality of their performance. However, section 39 of the 2009 Act that had provided that the then Inspectorate of Courts Administration would also inspect and report to the Lord Chancellor on the Coroner System was repealed as this inspectorate was abolished under the Public Bodies Act 2011.

161. André Rebello, Honorary Secretary of the Coroners Association, told us that an inspectorate was needed:

We need a courts inspectorate under the Ministry of Justice. That courts inspectorate could then judge coroner areas by inspection, pretty much like Ofsted, and check that the model coroner area appended to the Chief Coroner's annual report is being met; that resources have been provided to the coroner service; that the accommodation is suitable; that private space is given to bereaved families so they can have time with their loved ones; that coroners are working efficiently; and that the budgets are monitored.¹⁶⁹

162. Kent County Council coroner services manager, Giles Adey, also pressed for an inspectorate as a means of tackling substandard local services:

where things are not going right, either through lack of investment in the service or coroners having a particular way of working that does not necessarily fit with the local authority's ethos, other than taking a complaint to the Judicial Conduct Office, it is very difficult. We have nowhere to go. I would certainly like to see some form of inspectorate, reviewing services and having some teeth in being able to make recommendations that local authorities and coroners would need to adopt.¹⁷⁰

163. Chief Coroner Judge Lucraft also supported an inspectorate: "I am very happy about an inspectorate. I see no difficulty with that and it would bring many positive aspects to it."¹⁷¹

164. The call for an inspectorate is long-standing. JUSTICE, in a recent report recommended "the establishment of a small Coroner Service Inspectorate. This recommendation once again develops a proposal in Luce's 2003 Fundamental Review."¹⁷² It also said that it need not be a large undertaking; Luce recommended that such an Inspectorate would require only six people. Given the moves toward fewer coroner areas and the work already undertaken by the Chief Coroner in producing annual reports for the Lord Chief Justice, the Working Party considers that this number is sufficient. [...] this recommendation

168 [Q166](#)

169 [Q5](#)

170 [Q88](#)

171 [Q156](#)

172 JUSTICE, [When Things go Wrong, the response of the justice system](#), August 2020, pp24–25

would fill a sorely needed gap in quality control.¹⁷³

165. Alex Chalk, however, as the Minister responsible for the service, had reservations about the cost of an inspectorate, and its opportunity cost: “One can see there is a perfectly legitimate argument. Whether it is proportionate is something one has to consider. With endless resources, I can immediately see the point, but we have very difficult judgments to make.”¹⁷⁴

166. As with calls for a national service for England and Wales, there is an overwhelming and long-standing view that the Coroner Service would benefit from the presence of an inspectorate overseeing its work. As with those calls, we are merely repeating what others have repeatedly said by recommending that the Ministry of Justice should establish a Coroner Service Inspectorate to report publicly on how well each area accords with the Chief Coroner’s ‘Model Area’, its readiness in case of mass fatalities and the level of service provided to bereaved people. *The Ministry of Justice should create a Coroner Service Inspectorate.*

167. *Consequent upon the establishment of a national service and an inspectorate, there should be a review of the mechanisms available for handling complaints against Coroners.*

173 JUSTICE, *When Things go Wrong, the response of the justice system*, August 2020, pp24–25

174 [Q185](#)

6 Public disasters

168. There is a particular type of inquest that place significant demands on the Coroner Service—the inquest into public disasters. Public disasters where there have been many fatalities are thankfully rare events but handling them well is an important part of the Coroner Service’s work. Examples of public disasters include the deaths at Hillsborough and the Manchester Arena, and smaller but equally shocking events such as the terrorist attacks on Westminster and London Bridge. These inquests may be required to investigate the broad circumstances of the deaths, including events leading up to the deaths in question, to comply with Article 2 of the European Convention on Human Rights (right to life).¹⁷⁵

169. There has been considerable criticism of how these large-scale inquests have been handled in the past. The most important is that contained in the Hillsborough report.¹⁷⁶ André Rebello, Honorary Secretary of the Coroners’ Society told us about the immense scale of the resources that may be needed for inquests following public disasters, citing for example the infrastructure to support the inquests into the 96 Hillsborough deaths. Under the current arrangements, as with all inquests, a local authority that suffers a public disaster is responsible for covering the costs of what is likely to be a long and complex inquest. This may place a substantial burden on the rest of the local Coroner Service and other local services more generally. The Ministry of Justice has occasionally provided additional funding for these kinds of inquests.

Legal aid

170. These inquests are almost always large and complex with a mass of evidence and many legally represented bodies involved. Yet bereaved people can only get legal aid if they can meet the exceptional funding criteria and pass the means test (or apply for this to be waived). Going through the means tests can be humiliating and distressing. Deborah Coles, Director of INQUEST told us about the barriers bereaved people face when applying for Legal Aid:

They can go through ...[a] very protracted funding processes. Those who fed back to the Ministry of Justice review of legal aid for inquests spoke extremely eloquently about the distress of having to talk about whether you own any expensive jewellery and going through pages and pages. My answer really is, why on earth should families be put through that? Why can we not recognise that non-means tested public funding should be available, particularly in the most complex cases?¹⁷⁷

171. We called in Chapter 3 for public funding for legal representation for bereaved people at inquests where other bodies that are involved are legally represented at public expense. This funding could come from a range of public bodies. For inquests following public disasters, however, we call on MoJ specifically to provide automatic non-means tested legal aid for the people that have been bereaved.

175 [Coroners’ investigations and inquests](#), Briefing Paper Number 03981, House of Commons Library, February 2021, p 9

176 The Right Reverend James Jones KBE, [The patronising disposition of unaccountable power](#), A report to ensure the pain and suffering of the Hillsborough families is not repeated, Home Office, HC 511, November 2017

177 [Q185](#)

Judge-led inquests

172. The Chief Coroners have introduced a range of measures to improve the Coroner Service’s response to public disasters. These include the appointment of judges to conduct some inquests, specialist coroners and the use of pen portraits of the victims to emphasise the individuality and importance of each of the deceased. Chief Coroner, Judge Lucraft, told us that he had himself conducted the inquests in relation to Westminster Bridge and London Bridge and Borough Market.¹⁷⁸

Specialist coroners

173. The Chief Coroner set out the approach of the specialist cadre of coroners in his written evidence including the emphasis on respect for the deceased and bereaved people:

The guiding principles are the provision of honest and, as far as possible, accurate information at all times and at every stage, respect for the deceased and the bereaved, a sympathetic and caring approach throughout and the avoidance of mistaken identification.¹⁷⁹

174. Deputy Chief Coroner, Alexia, Durran, told us, that specialist coroners for public disasters are involved immediately: “There are coroners on call when there is a major incident and they are involved in managing the very beginning, where things have, perhaps, in the past gone wrong.”¹⁸⁰

175. Judge Lucraft described the specialist training:

We have specialist training to make sure that the lessons that were not learned on these incidents before are not missed... We have some of the world leaders, I am pleased to say, in DVI disaster victim identification training, both in Howard Way and in Pete Sparks from the Met police who run that. They help us to keep our coroners up to date.¹⁸¹

176. The Coroners’ Courts Support Service acknowledged the support provided by the cadre of specialist coroners but suggested this level of consideration should be shown to all those who have been bereaved:

bereaved family members of people who have not died due to a mass fatality may feel that the death can be on a sliding scale where someone who dies in a very public or mass situation holds greater importance than those who die when only the family are aware of the death. It is important to recognise and acknowledge these deaths for the individual family as much as the multiple deaths.¹⁸²

178 [Q143](#)

179 Chief Coroner of England and Wales HHJ Mark Lucraft QC ([COR0081](#)), para 100

180 [Q144](#)

181 [Q144](#)

182 The Coroners’ Courts Support Service ([COR0061](#)), section 2

Pen portraits

177. Judge Lucraft told us how useful pen portraits can be in keeping the individuals who have died at the forefront of the inquest, and that he was in the process of drafting guidance¹⁸³ on their use:

In more recent inquests, it [use of pen portraits] has played a key part in the process. We probably all saw some of the pen-portrait material at the beginning of the Manchester Arena inquiry. Pen-portraits now take the form not just of people reading testimonies but often of a video or music being played. It is important in every case, whether it is a high-profile case or not, that the family of that deceased person is treated the same.¹⁸⁴

178. Deborah Coles, Director of INQUEST, also told us how vital pen portraits are: "... to humanise the process and to acknowledge the people who died, so that they are seen in life and not just in death."¹⁸⁵

179. There has been good progress in improving the Coroner Service's response to public disasters. However, a National Coroner Service is needed to ensure that inquests into mass fatalities are properly managed and that the deceased and bereaved people are always given the respect they deserve.

180. It is unacceptable that the people who have been bereaved are not entitled to automatic non-means tested legal aid at inquests into multiple deaths following a public disaster. These inquests are complex and 'equality of arms' is a fundamental requirement to make sure those who have been bereaved can participate fully. *The Ministry of Justice should introduce an automatic entitlement to non-means tested legal aid for legal representation for bereaved people at inquests into mass fatalities.*

183 Not yet published at 3 May 2021

184 [Q142](#)

185 [Q36](#)

7 Prevention of future deaths

Importance of Coroner Service's role in reducing fatal risks

181. Along with answering the questions who, where, when, and how a person came by his or her death, the Coroner Service has an important role in improving public safety. It does this by making 'reports to prevent future deaths' (also known as 'PFDs' or 'Regulation 28' reports). The Coroners and Justice Act 2009 (CJA 2009) requires coroners to make reports where there is a risk that other deaths will occur if action is not taken to eliminate or reduce the risk.¹⁸⁶ The report must be made to the person the coroner believes may have power to take such action. Coroners must not set out specific recommendations.¹⁸⁷ The person or organisation must respond within 56 days (or longer if the coroner grants an extension) setting out the action taken or to be taken, and the timetable for it, or it must explain why no action is proposed.¹⁸⁸ There is no process for following-up the actions proposed or to scrutinise decisions to take no action.

182. In guidance on these reports, the Chief Coroner said they:

are vitally important if society is to learn from deaths. Coroners have a duty to decide how somebody came by their death. They also have a statutory duty (rather than simply a power), where appropriate, to report about deaths with a view to preventing future deaths. And a bereaved family wants to be able to say: His death was tragic and terrible, but at least it's less likely to happen to somebody else.' PFDs are not intended as a punishment; they are made for the benefit of the public.¹⁸⁹

183. The Coroner Service sits within a network of bodies tasked with looking into unnatural deaths. These include

police enquiries, criminal investigations and prosecutions, investigations overseas, Health and Safety Executive (HSE) or Prisons and Probation Ombudsman (PPO) inquiries, Independent Office of Police Complaints (IOPC) inquiries or investigations by one of the specialist [transport] accident investigation bodies, the coroner's inquest is put on 'hold' pending the outcome of those enquiries or investigations.¹⁹⁰

184. There are also internal investigations by public and voluntary sector bodies including health and social care trusts and universities. However, for the occasions where these external and internal investigations do not get to the truth the Coroner Service serves as a final independent arena where attention can be drawn to failings that might result in further deaths if left unaddressed. Lisa O'Dwyer, Legal Director at Action against Medical Accidents, told us:

186 Coroners and Justice Act 2009, [Paragraph 7 of Schedule 5](#). Details of the procedures are set out in Coroners (Investigations) Regulations 2013 ([SI 2013/1629](#))

187 [Chief Coroner, Guidance No 5, Reports to prevent future deaths](#), 16 July 2013, revised 4 November 2020. The Chief Coroner has provided examples of these reports, which must be made in a specific form, in [Annex B](#).

188 Coroners (Investigations) Regulations 2013 ([SI 2013/1629](#)) regulation 29

189 [Chief Coroner, Guidance No 5, Reports to prevent future deaths](#), 16 July 2013, revised 4 November 2020, para 2

190 [Chief Coroner's Combined Annual Reports 2018 to 2019 and 2019 to 2020](#), November 2020, para 22

for a family, very often the inquest is a really important investigation opportunity. Many of them will have gone through the internal processes of trusts. It may be the complaints process, or on occasions they may have gone through a serious incident review process—not always, I hasten to add—and they feel let down very often by those processes, particularly the complaints process, where they feel that the responses are either not answering the questions or are deliberately trying to obfuscate what has happened by using medical terminology and putting families off as to the truth.¹⁹¹

185. PFD reports are often the most important part of the Coroner Service for bereaved people. Lisa O’Dwyer, told us:

They want to know the truth [...] that something has gone wrong and that changes are made so that it does not happen to somebody else. That is the overwhelming driving force for the people whom we represent and whom we see.¹⁹²

Andrew McCulloch, a bereaved parent, confirmed that “The only thing that makes sense of the loss of your loved one is that maybe lessons will be learned and the same thing will not happen to someone else.”¹⁹³

186. Deborah Coles, Director at Inquest, said the reports were valuable for families and for the wider public interest: “An inquest can try to ensure public scrutiny and hold people to account, but also identify false, dangerous and harmful practices, which, if put right, could prevent people from dying or being injured in the future.”¹⁹⁴

Decisions about inquest scope can determine whether issues of concern are discovered

187. How tightly coroners set the scope of their investigations is important as it may determine what is, and is not, revealed during inquests and reported upon. Coroners are individually responsible for deciding which documents should be produced, which evidence will be heard at the inquest, and which witnesses give evidence. This is different from court cases where each of the parties decides what evidence they wish to put before the court. Each coroner is an independent judicial officer with wide discretion. This can lead to different approaches by different coroners. As the Chief Coroner told us the coroner decides:

The scope of inquiry must be sufficient to establish the answers to the four statutory questions, notably how the deceased person came to die. However, the inquiry will very often be wider in scope than strictly necessary to answer those questions. It is a matter of judgment for the coroner to determine the parameters of the inquiry and how far he/she will trace the causal chain leading to the death.¹⁹⁵

191 [Q50](#)

192 [Q67](#)

193 [Q32](#)

194 [Q32](#)

195 Chief Coroner of England and Wales HHJ Mark Lucraft QC ([COR0081](#)), para 38

188. The Coroners' Society told us local variations can affect the depth of coroners' investigations:

local/regional variations in the practice of coroners and in the administration of the coroners service across England and Wales may result in genuine unevenness or at least the perception of unevenness. Inconsistent working practices in respect of the depth of an investigation by a coroner may vary between areas.¹⁹⁶

Independent expert witnesses

189. The matters to be revealed may also depend on the independence of the witnesses that the coroner chooses to call. Lisa O'Dwyer, Legal Director at Action against Medical Accidents (AvMA), raised concerns about conflicts of interest:

We certainly see other coroners who feel that they can rely on evidence given by the trust that is under investigation. That certainly raises issues of conflict on occasions without doubt. [...] You have to recognise that those people very often work in teams and are not independent and impartial. They may well feel the need to protect a colleague or there may be other pressures put to bear on the way in which they give their evidence. It is not appropriate to use it in those circumstances.¹⁹⁷

She raised the impact this may have on bereaved people: "Where families see that a coroner may be relying on evidence that has been given by the trust, they feel hugely let down potentially."¹⁹⁸

190. Lisa O'Dwyer was clear that there was also good practice:

Some coroners will provide experts, and more than one if necessary. It perhaps goes to the issue of training, because not all coroners appreciate the importance that an independent, impartial medical expert witness brings to bear.¹⁹⁹

191. Deputy Chief Coroner, Derek Winter, told us of the practicalities of obtaining independent expert evidence:

Experts, of course, are expensive, so we have to be cautious with public money. If it is required, we tell the local authority of an unusual item of expenditure and they have to fund that. We would get an estimate of costs, write a proper letter of instruction to the expert, agree that with the family and the interested persons, and set the parameters of the expert's report.²⁰⁰

He also pointed out that an independent expert may save time and, therefore, money:

If you get an independent expert who answers all the queries of the family, you may not have to spend two days in court if the family accepts what somebody outside of that trust environment has put forward. There are

196 The Coroners' Society of England and Wales ([COR0030](#)), section 1(c)

197 [Q48](#)

198 [Q50](#)

199 [Q47](#)

200 [Q151](#)

difficult decisions for coroners to make in putting all those things into the balance.²⁰¹

Lawyers to assist coroners at complex inquests

192. The Chief Coroner, Judge Lucraft, told us that he has issued guidance to encourage coroners to appoint lawyers to help them navigate complex inquests:

it may well be that a number of health trusts or doctors are represented before the coroner—very often the coroner has no person to help them through quite a maze of technical terms and legal responsibility.²⁰²

He told us this can help bereaved people as well as the coroner:

Part of the guidance was designed to encourage coroners, in certain types of inquest, to have a counsel or solicitor to help them, partly so that the family can see there is somebody helping the coroner who may ask questions that might otherwise have been difficult for the family to pose to the clinicians or others who had been involved in the case.²⁰³

As with expert witnesses coroners will have to make out a case to their local authority for funding.

Variations in numbers of reports issued by coroners

193. We received evidence that there are wide variations in the numbers of reports issued by different coroners, particularly in relation to deaths on the roads. Some coroners issue many Prevention of Future Deaths reports, some issue fewer. Victoria Lebec of RoadPeace (which is a national charity for road crash victims in the UK) told us that “PFDs are a great initiative, but they need to be used more and they need to be used consistently.”²⁰⁴

194. In April 2020, Chris, and Nicole Taylor, volunteers for RoadPeace analysed published prevention of future death reports for the 7 years from 2013. They found that in relation to highways safety more than 50% of coroners raised less than 3 Preventing Future Death reports over that period and 30% of coroner areas issued more than 50% of the PFD reports in this category.²⁰⁵ The differences are not simply explicable by reference to the numbers of deaths on the roads in each area. For example, the Isle of Wight reported four PFDs for 25 road deaths, while Cambridgeshire and Peterborough reported no PFDs for 253 deaths.²⁰⁶

Insufficient following up

195. There is no process to follow-up whether actions promised at inquests or in responses to prevention of future death reports are put into effect. For example, Coroner Mr Andrew Tweddle, said:

201 [Q152](#)

202 [Q144](#)

203 [Q144](#)

204 [Q70](#)

205 RoadPeace ([COR0066](#)), section 3

206 Mr Christopher Taylor; Mrs Nicole Taylor ([COR0039](#)), section 1

I have written many Prevention of Future Death reports over the years [...] There is a lack of a proper central hub to properly monitor such reports and to follow them up and to try and secure change. It is not the function of the coroner to suggest what improvements to a situation should be, just to highlight shortcomings, and so someone else needs empowering to take matters forward.²⁰⁷

196. Deborah Coles, Director of INQUEST, told us of the importance of following up PFD reports for families:

The very least that families are owed is that, where a report is made, those to whom it is made should make sure that they report back to families on what they have done or not done. I find it simply astonishing that we have a system that thinks it is acceptable not to keep families in the loop.²⁰⁸

197. Lisa O’Dwyer, Legal Director at AvMA, told us that coroners’ investigations may go to waste if they are not followed up:

If you have a good, robust investigation process that the coroners’ courts certainly can deliver on, which produces a prevention of future death report, what happens is that the report is made and you get a response. There is no independent body following that up. There is no independent oversight. There is nobody policing or monitoring it, and that is almost a waste of resources.²⁰⁹

198. Victoria Lebec of RoadPeace thought “too many of them just simply disappear into the ether.”²¹⁰ Several other witnesses including Birmingham and Solihull Coroners,²¹¹ the Coroners’ Court Support Service,²¹² and André Rebello, Honorary Secretary of the Coroners’ Society of England and Wales,²¹³ also expressed frustration at the lack of follow-up to PFD reports.

Action plans and narrative conclusions

199. Lisa O’Dwyer told us that health trusts sometimes put forward action plans for the Coroner, to persuade him or her that a report is not appropriate:

A plan is presented to a coroner saying, “This is what we have done. These are the changes we are going to make,” and the coroner feels that perhaps the need to make the prevention of future death report is not quite so necessary.

She suggested that these action plans should also be followed-up:

207 Tweddle (HM Asst Coroner at Sunderland and Newcastle) ([COR0007](#)), para 3

208 [Q39](#)

209 [Q71](#)

210 [Q32](#)

211 Birmingham and Solihull Coroners ([COR0048](#)), para 17

212 The Coroners’ Courts Support Service ([COR0061](#)), para 3

213 [Q19](#)

Those action plans are as valuable as the prevention of future death reports themselves, and they too should be collated and publicised, and they really do need the same monitoring, policing and follow-up as a prevention of future death report.²¹⁴

200. Deborah Coles, Director of INQUEST, touched upon how to make juries' narrative conclusions more useful too: "The other thing is that jury findings, which are often a very good overview of any systemic failings, are not collated or published anywhere, apart from when we publish them."²¹⁵

Search and analysis of published reports and responses

201. We asked André Rebello what could be done to make reports more effective. He suggested that they should be easier to search and analyse so that coroners "can see what other reports have been issued by other coroners so we can draw the attention of other."²¹⁶ Lisa O'Dwyer made essentially the same point: "Trying to find how many times the same PFD [report] has been made in relation to the same trust is an extremely time-consuming and lengthy process, which for most people, even ourselves, is just not feasible to wade through."²¹⁷ Victoria Lebrec had similar concerns: "It is such a missed opportunity to not be able to go on to the website and search for road deaths by theme and in different local authorities to understand whether there is a particular problem with certain types of crossings on particular roads."²¹⁸

202. The Australian National Coronial Information System is an example of how much better organised information from coroners' investigations can be. It is a fully indexed online repository of coronial data from Australia and New Zealand. The data includes demographic information on the deceased, contextual details on the nature of the fatality and searchable medico-legal case reports including the coronial finding, autopsy and toxicology report and police notification of death which can be used by coroners in future investigations.²¹⁹

203. The Chief Coroner, Judge Lucraft, told us that he has been looking at how to improve the way reports are published but did not yet have a definite plan: "I will not be the Chief Coroner for that much longer. It is one of those jobs that I will leave to my successor."²²⁰

Possible follow-up mechanisms

204. Alex Chalk accepted that getting improvements as a result of PFDs is important but suggested that care would be needed to avoid duplication with other bodies, such as the Health and Safety Executive and the prisons inspectorate:

You want to make sure that the lessons are learnt [...] How one goes about doing that effectively is a subject for legitimate discussion. We have certainly not closed our ears to anything. The only point that I would weigh

214 [Q71](#)

215 [Q39](#)

216 [Q24](#)

217 [Q71](#) [Lisa O'Dwyer]

218 [Q71](#) [Victoria Lebrec]

219 <https://www.ncis.org.au/about-us/> accessed 3 May 2021

220 [Q154](#)

in the balance is that one has to be mindful of avoiding duplication when there are already agencies that will be tasked with the response.²²¹

205. Dame Elish Angiolini, in her report into deaths in state custody recommended that a new office for Article 2 compliance could “oversee a coordinated, methodical and routine process around the dissemination of Coroners’ PFD reports and jury findings to all stakeholders, including (but not limited to) police forces, the College of Policing, the IPCC,²²² and healthcare professionals.²²³

206. The Chief Coroner, Judge Lucraft, told us that such an office could fill the gap after a coroner has issued a report and their role has come to an end. He repeated the point by almost all who provided evidence to this inquiry:

families who go through an inquest process want those lessons to be learned if there are things that can be improved so that other families don’t suffer a similar position to them. I believe that PFD reports are an extremely valuable part of the armoury of coroners. The responses are equally important, but we need to make sure that we don’t let those lessons fall between different stools and that we follow them through. I would suggest, if you wish to do so, that this Committee looks at how we make sure that the lessons flagged in these reports are followed through by Government.²²⁴

207. The system for the Coroner Service to contribute to improvements in public safety is under-developed. The absence of follow up to coroners’ ‘prevention of future deaths reports’ is a missed opportunity. *The Ministry of Justice should consider setting up an independent office to report on emerging issues raised by coroners and juries; and liaise with regulators, (for example the Health and Safety Executive, the Independent Office for Police Conduct, the Prisons and Probation Ombudsman, the Care Quality Commission, Highways Authorities, and Air and Rail safety bodies) and others, to follow up on actions promised to coroners and to report publicly where insufficient action has been promised or implemented. As an alternative a new Coroner Service Inspectorate could be given this role.*

208. The current arrangements for publishing coroners’ reports and responses to those reports require improvement. The information published is the bare minimum and is difficult to search and analyse. *The Ministry of Justice should provide funding so information about the risks to public safety discovered by coroners and inquest juries is freely available online, along with the actions that have been proposed in response. The MoJ should ensure that this information is well-organised and easily searchable.*

221 [Q179](#)

222 Now Known as the IOPC (Independent Office for Police Conduct)

223 Dame Elish Angiolini, [Report of the Independent Review of Deaths and Serious incidents in Police Custody](#), Home Department, January 2017, p246

224 [Q153](#)

8 The Coroner Service's response to covid-19

209. We would like to express our profound gratitude to all those working in and with the Coroner Service for the great efforts they have made to keep the service operating during the pandemic. This effort has included people putting their physical safety at risk where they have needed to attend inquests in person and a range of other pressures on people's well-being.

210. The Coroners' Society told us how difficult it had been to keep up with the pandemic:

Coroners had to work very long days, often seven days a week without respite to ensure that mortuary capacity and funeral capacity was not overrun to collapse. Collaborative working with the police and local authority partners on excess death planning, the mortuary, burial and cremation authorities and doctors in the community and hospitals ensured the infrastructure did not collapse. Public services usually come to notice when things go badly wrong: it should be noted that the coroners' service worked and worked well in these difficult times because of the efforts of all concerned.²²⁵

Remote coroners' hearings

211. Debbie Large, Head of the Kent Coroner Service, told us how they had rolled out remote hearings quickly and of the additional burden of dealing with death while working from home:

At no notice, we went paperless and used [Microsoft] Teams to run inquests. All of our staff worked from home. That has been a challenge. I have been immensely impressed by our staff, who have a really difficult job. They went home and got on with it. Working from home, we dealt with probably a 50% increase in the referral rate over the lockdown period. We have worked very carefully with our team to make sure it keeps work-home boundaries very clear. Our saying is always, "Leave death at the door; don't take it home with you." That has been a challenge for us. Our team continues to work from home.

212. The Coroners' Society of England and Wales also told us about concerns for staff welfare: "Support for coroners and for the staff varies widely from nothing to access to psychologists."²²⁶ The Coroners' Court Support Service (CCSS) raised issues for bereaved people from virtual hearings:

Many Coroners were quick to respond and converted smaller Inquests into virtual hearings. Whilst this did enable bereaved families to get some form of conclusion, it may have put pressure on them to accept the virtual hearing when there was little or no alternative.²²⁷

213. The CCSS also suggested that referrals for support could have been dealt with better:

225 The Coroners' Society of England and Wales ([COR0030](#)), para 4 of the executive summary

226 The Coroners' Society of England and Wales ([COR0030](#)), section 1(f)

227 The Coroners' Courts Support Service ([COR0061](#)), para 4

“The CCSS would have welcomed the opportunity to have bereaved families referred to them for virtual or telephone support via our National Helpline and via our Court volunteer teams.”²²⁸ The CCSS also told us that there were inconsistent approaches by coroners to what hearings can be dealt with remotely or not and who has to attend in person and that is struggling to staff all the courts it used to.²²⁹

214. Debbie Large, Head of Kent Coroner Service, thought it would be helpful to have virtual hearings as an option in future: “I would be very sad to see that everything was virtual, but some people would like to attend an inquest but find it difficult—for example, families overseas.”²³⁰

An increasing backlog of cases

215. Judge Lucraft told us of a growing backlog of inquests and the reasons for them: “Clearly, there will be a backlog of jury inquests simply because finding spaces large enough to hold jury inquests is an issue. There will be a backlog of some other inquests where the key participants in that inquest hearing will themselves be frontline medical workers.”²³¹

216. Head of Kent Coroner Service, Debbie Large, gave examples: “We have estimated, and we are making provision for 220 court days as additional capacity. That is what we are making provision for. It is an estimate. We are working with the senior coroners to identify the number of court days they need.”²³²

217. It is not known how many inquests have been put on hold nationally since March 2020, but it is likely that many jury and other inquests that involve several interested persons will be subject to delays.

Juries

218. André Rebello, Honorary Secretary of the Coroners’ Society, suggested that a temporary suspension of the need for juries could help reduce the backlog: “If we have to sit with juries, many of these cases may go on for another four or five years while we catch up, because death does not stop.”²³³

219. Deborah Coles, Director of INQUEST, raised the importance of juries for some inquests: “Juries actually play an extremely important role at inquests, particularly where you are looking at the conduct of the state and article 2.”²³⁴ Alex Chalk, was also against reducing the role of juries: “juries and pandemics do not go well together [...] we take the view that the single biggest lever that we could pull, which would be to get rid of juries, is not the appropriate policy response, however tempting that might be, because of the read-across to other areas [of the justice system], quite apart from anything else.”²³⁵

228 The Coroners’ Courts Support Service ([COR0061](#)), para 4

229 The Coroners’ Courts Support Service ([COR0061](#)), para 4

230 [Q97](#)

231 [Q160](#)

232 [Q114](#)

233 [Q15](#)

234 [Q33](#)

235 [Q181](#)

Ministry of Justice action to reduce outstanding inquests

220. We asked the Minister, Alex Chalk, what measures the Ministry of Justice was taking to reduce longer waiting times, particularly for jury inquests. He told us:

The guidance is there; the coherence is there. Performance is uneven, but it is uneven in respect of HMCTS as well. The short answer is yes, we are watching; yes, we are observing who is doing well and responding well, and we are seeking to do everything we can to try, with the help of the Chief Coroner, to roll out that best practice and to assist those who are finding it more difficult.²³⁶

221. The Coroner Service responded well to covid-19, and we express our thanks to all those involved under very difficult circumstances. A considerable number of inquests have been delayed because of the pandemic restrictions. We were unconvinced by the Minister's response on how the MoJ will support the Coroner Service to reduce waiting times. *The Ministry of Justice should liaise with the Chief Coroner and consider what central government support may be needed to help the Coroner Service to recover from the pandemic.*

222. *We encourage the Chief Coroner to collect information from each Coroner Service Area on the challenges they face because of the pandemic and communicate the overall picture to the Ministry of Justice.*

Conclusions and recommendations

Improvements since the Coroners and Justice Act 2009 (CJA 2009)

1. The creation of a Chief Coroner followed by the introduction of guidance, mandatory training and appraisals for the most junior coroners are significant advances towards a more standardised Coroner Service than obtained a decade or so ago, even in the continued absence of a full England and Wales service. *We encourage the new Chief Coroner to continue the work begun by his predecessor by extending appraisals to all coroners.* (Paragraph 29)
2. Reducing the number of coronial areas has helped increase consistency across the Coroner Service. *The Ministry of Justice should amend the Coroners and Justice Act 2009 (as requested by the outgoing Chief Coroner) to make it easier to merge areas.* (Paragraph 32)
3. Tom Luce, among others, has identified the Ministry of Justice decision not to publish its 2015 review of the operation of the 2009 Act as a serious breach of a commitment to do so. No good reason has been given for the non-publication of that review. The present Minister's argument that it is now out of date is not sufficient reason for continuing to withhold it. At the very least, publication would allow that contention to be tested, and no harm can be done if the report's conclusions truly are obsolete. *We recommend that the MoJ immediately publish its 2015 review of the effectiveness of the Coroners and Justice Act 2009.* (Paragraph 37)

Putting bereaved people at the heart of the Coroner Service

Reducing delays so the body can be released

4. The Chief Coroner's guidance on when and how to expedite a case to meet with the requirements of the beliefs of the deceased is welcome, but whether the needs of faith communities will be met or not depends on how the Coroner Service responds locally. *We encourage the new Chief Coroner to continue the work of his predecessor in liaising with stakeholders, including with faith representatives, so that any problems with expediting cases can be identified and addressed as they arise.* (Paragraph 53)

Written guidance, advice, and support

5. The Ministry of Justice's Guide to Coroner Services is good first step but more needs to be done to make sure that bereaved people know of its existence. *We encourage all Senior Coroners to make sure that the updated Guide to the Coroner Service for Bereaved People is freely available both online and, where requested, in hard copy by post and is offered to people who have been bereaved as soon as it has been decided that a post-mortem is needed.* (Paragraph 58)
6. Help and support for bereaved people depend on the priorities, capacity and skills of the local Coroner Service and local volunteers in the Coroners' Courts Support Service. *The Ministry of Justice should as a matter of urgency provide funding for*

support services for bereaved people at inquests, (such as those provided by the Coroners' Courts Support Service), so that this support is available in every Coroner Area. (Paragraph 66)

Rights for bereaved people

7. *We encourage Senior Coroners to make sure that bereaved people are made aware by their staff of the specialist support organisations that are available to them both locally and nationally. (Paragraph 67)*
8. *Bereaved people deserve a charter of rights setting out the standards of service they are entitled to receive from the Coroner Service. Setting out the standards they can 'expect' in the Guide to Coroner Services is inadequate. The Ministry of Justice should implement a statutory Charter of Rights for bereaved people, modelled on the criminal justice system's victims' code. (Paragraph 70)*

Access to evidence and openness

9. *Bereaved people are at a disadvantage when they do not have access to the evidence. It is important that the process for obtaining evidence is explained clearly to them as this is important for the fairness of the inquest. We encourage the new Chief Coroner to strengthen guidance and training on disclosure and pre-inquest reviews, emphasising to coroners that bereaved people should be told about their rights to documents early in the process. (Paragraph 73)*
10. *The failure of health and social care bodies to fulfil their duty of candour to bereaved people during coroners' investigations and inquests is disappointing. The Ministry of Justice should amend the Coroners' rules to make it patently clear that the duty of candour extends to the Coroner Service. The Government should consider whether a similar duty to be candid at inquests should be extended to all public bodies. (Paragraph 81)*

Fairness for the bereaved

11. *The Government's steps to support the inquisitorial nature of inquests are welcome but are insufficient by themselves to prevent large multi-handed inquests, where individuals' and organisations' reputations are at stake, from becoming adversarial. (Paragraph 92)*
12. *Bereaved people should not be put through the difficult and time-consuming process of meeting the exceptional cases requirements and the means test for legal aid where public authorities are legally represented at public expense at the inquest into the death of their loved one. The Ministry of Justice should by 1 October 2021, for all inquests where public authorities are legally represented, make sure that non-means tested legal aid or other public funding for legal representation is also available for the people that have been bereaved. (Paragraph 103)*
13. *The current arrangements for challenging coroners' decisions are unwieldy and cause unacceptable delays, stress and often expense, for bereaved people. The*

Ministry of Justice should introduce a system of appeals similar to that in Section 40 of the Coroners and Justice Act 2009 as originally enacted. (Paragraph 113)

14. There may be circumstances where with the consent of the bereaved people concerned, it would be sensible for the High Court to be able to direct that the particulars of the Record of the Inquest be amended as appropriate without ordering a fresh inquest. *The Government should consider adopting the Chief Coroner's proposed amendment to Section 13 with the caveat that the High Court could use the new power only with the consent of the interested party applying under Section 13. (Paragraph 116)*
15. The Government consultation on coronial investigation of stillbirths was welcome but it is disappointing that it appears to have stalled. *The Ministry of Justice should revive the consultation on coronial investigation of stillbirths and publish proposals for reform. (Paragraph 118)*

Shortage of pathology services

16. Pathology services for coroners have been neglected over many years leading to serious problems. (Paragraph 134)
17. *The Ministry of Justice should immediately review and increase Coroner Service fees for pathologists, so they are enough to ensure an adequate supply of pathology services to the Coroner Service. (Paragraph 135)*
18. *In the medium term the Ministry of Justice should work with the Department of Health and Social Care so that pathologists' work for coroners is planned for within pathologists' contracts with NHS trusts. (Paragraph 136)*
19. *In the longer term, the Ministry of Justice should broker an agreement between relevant government departments and the NHS (in England and Wales) for the establishment and co-funding of 12–15 regional pathology centres of excellence. (Paragraph 137)*

A unified national Coroner Service for England and Wales

20. The majority of witnesses to our inquiry, two Chief Coroners, and almost everyone who has been commissioned to review aspects of the Coroner Service sees the need for a unified service for England and Wales. There is unacceptable variation in the standard of service between Coroner areas. The quality of each local coroner service should not have to depend on the local authority and the Senior Coroner having a shared understanding and priorities. *The Ministry of Justice should unite coroner services into a single service for England and Wales. (Paragraph 157)*
21. As with calls for a national service for England and Wales, there is an overwhelming and long-standing view that the Coroner Service would benefit from the presence of an inspectorate overseeing its work. As with those calls, we are merely repeating what others have repeatedly said by recommending that the Ministry of Justice should establish a Coroner Service Inspectorate to report publicly on how well each area accords with the Chief Coroner's 'Model Area', its readiness in case of mass fatalities and the level of service provided to bereaved people. *The Ministry of Justice should create a Coroner Service Inspectorate. (Paragraph 166)*

22. *Consequent upon the establishment of a national service and an inspectorate, there should be a review of the mechanisms available for handling complaints against Coroners. (Paragraph 167)*

Public disasters

23. There has been good progress in improving the Coroner Service's response to public disasters. However, a National Coroner Service is needed to ensure that inquests into mass fatalities are properly managed and that the deceased and bereaved people are always given the respect they deserve. (Paragraph 179)
24. It is unacceptable that the people who have been bereaved are not entitled to automatic non-means tested legal aid at inquests into multiple deaths following a public disaster. These inquests are complex and 'equality of arms' is a fundamental requirement to make sure those who have been bereaved can participate fully. *The Ministry of Justice should introduce an automatic entitlement to non-means tested legal aid for legal representation for bereaved people at inquests into mass fatalities. (Paragraph 180)*

Addressing fatal risks identified by coroners and inquest juries

25. The system for the Coroner Service to contribute to improvements in public safety is under-developed. The absence of follow up to coroners' 'prevention of future deaths reports' is a missed opportunity. *The Ministry of Justice should consider setting up an independent office to report on emerging issues raised by coroners and juries; and liaise with regulators, (for example the Health and Safety Executive, the Independent Office for Police Conduct, the Prisons and Probation Ombudsman, the Care Quality Commission, Highways Authorities, and Air and Rail safety bodies) and others, to follow up on actions promised to coroners and to report publicly where insufficient action has been promised or implemented. As an alternative a new Coroner Service Inspectorate could be given this role. (Paragraph 207)*
26. The current arrangements for publishing coroners' reports and responses to those reports require improvement. The information published is the bare minimum and is difficult to search and analyse. *The Ministry of Justice should provide funding so information about the risks to public safety discovered by coroners and inquest juries is freely available online, along with the actions that have been proposed in response. The MoJ should ensure that this information is well-organised and easily searchable. (Paragraph 208)*

Covid-19

27. The Coroner Service responded well to covid-19, and we express our thanks to all those involved under very difficult circumstances. A considerable number of inquests have been delayed because of the pandemic restrictions. We were unconvinced by the Minister's response on how the MoJ will support the Coroner Service to reduce waiting times. *The Ministry of Justice should liaise with the Chief Coroner and consider what central government support may be needed to help the Coroner Service to recover from the pandemic. (Paragraph 221)*

28. *We encourage the Chief Coroner to collect information from each Coroner Service Area on the challenges they face because of the pandemic and communicate the overall picture to the Ministry of Justice. (Paragraph 222)*

Formal minutes

Tuesday 18 May 2021

Sir Robert Neill, in the Chair

Members present:

Paula Barker Dr Kieran Mullin
Maria Eagle Andy Slaughter
Kenny MacAskill

In the absence of the Chair, Maria Eagle was called to the chair.

Draft Report (*The Coroner Service*), proposed by the Chair, brought up and read.

Sir Robert Neill resumed the chair.

Draft Report (*The Coroner Service*), further read.

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

Paragraphs 1 to 222 read and agreed to.

Summary agreed to.

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

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

[Adjourned till Tuesday 25 May at 1.45 pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 08 September 2020

André Rebello, OBE Senior Coroner Liverpool and Wirral Area, Hon Secretary, The Coroners' Society of England and Wales; **Dr Mike Osborn**, President Elect, Chair of the Death Investigations Committee, Royal College of Pathologists [Q1–26](#)

Deborah Coles, Executive Director, INQUEST; **Andrew McCulloch** [Q27–39](#)

Tuesday 20 October 2020

Lisa O'Dwyer, Director Medico-Legal Services, Action against Medical Accidents; **Victoria Lebrech**, Head of Policy, Campaigns and Communications, Roadpeace [Q40–71](#)

Giles Adey, Lead officer for government consultations, Kent County Council; **Debbie Large**, Head, Kent Coroner Service [Q72–117](#)

Tuesday 17 November 2020

His Honour Judge Mark Lucraft QC, Chief Coroner of England and Wales; **Derek Winter DL**, Deputy Chief Coroner for England and Wales; **Her Honour Judge Alexia Durran**, Deputy Chief Coroner for England and Wales [Q118–160](#)

Alex Chalk MP, Parliamentary Under-Secretary of State, Ministry of Justice; **Judith Bernstein**, Head of coroners, inquests and inquiries policy team, Ministry of Justice [Q161–190](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

COR numbers are generated by the evidence processing system and so may not be complete.

- 1 A family ([COR0046](#))
- 2 A Muslim burial group ([COR0058](#))
- 3 Abrahart, Mrs Margaret (Retired, n/a) ([COR0076](#))
- 4 Action against Medical Accidents ([COR0079](#))
- 5 Adeley, Dr James (Senior Coroner, Lancashire and Blackburn with Darwen) ([COR0008](#))
- 6 Agius, Professor Raymond Martin (Emeritus Professor of Occupational and Environmental Medicine, The University of Manchester) ([COR0064](#))
- 7 Anonymous ([COR0032](#))
- 8 Anonymous ([COR0027](#))
- 9 Beare, Ms Maryanne (Psychotherapist and Coach, Inchkey) ([COR0075](#))
- 10 Birmingham and Solihull Coroners ([COR0048](#))
- 11 Blackham, Mr Derek ([COR0012](#))
- 12 Board of Deputies of British Jews ([COR0091](#))
- 13 Bristol City Council; South Gloucestershire Council; Bath and North East Somerset Council; and North Somerset Council ([COR0028](#))
- 14 British Heart Foundation ([COR0100](#))
- 15 British Medical Association (BMA) ([COR0071](#))
- 16 Brooks, Maggie and Janet ([COR0093](#))
- 17 Campaign for Safer Births ([COR0053](#))
- 18 Chandler, Mr Brian (Retired Engineer, Murdered Abroad) ([COR0042](#))
- 19 Chaplin, Mr Ashley ([COR0041](#))
- 20 Cumbria County Council ([COR0026](#))
- 21 Dame Vera Baird QC (Victims' Commissioner for England and Wales, Office of the Victims' Commissioner); and The Right Reverend James Jones KBE (Author of the report: 'The patronising disposition of unaccountable power', A report to ensure the pain and suffering of the Hillsborough families is not repeated) ([COR0074](#))
- 22 East Suffolk and North Essex Foundation Trust ([COR0021](#))
- 23 Ellery, Mr John ([COR0002](#))
- 24 Ellis, Mrs Laura ([COR0059](#))
- 25 England, Chief Coroner of ([COR0081](#))
- 26 Finer, Louise (Head of Policy, INQUEST) ([COR0103](#))
- 27 Fleming, Professor Peter (Professor of Infant Health and Developmental Physiology, Consultant Paediatrician, University of Bristol); Ian Arrow (Senior Coroner for Plymouth and South Devon, Plymouth City Council); Professor Peter Blair (Professor of Epidemiology and Statistics, University of Bristol); Professor Marta Cohen (Professor of Perinatal and Paediatric Pathology, University of Sheffield); Dr

- Karen Luyt (Reader in Neonatal Medicine, University of Bristol); Dr Tamas Marton (Consultant Perinatal Pathologist, Birmingham Women’s Hospital); Professor Neil Sebire (Professor of Paediatric Pathology, University College, London); Vicky Sleaf (Manager, National Child Mortality Database, University of Bristol); and Dr Jan Till (Consultant Paediatric Cardiologist, Royal Brompton Hospital Trust) ([COR0047](#))
- 28 Fox, Dr Anthony (Consultant, EBD London Ltd) ([COR0006](#))
- 29 Gould, Mrs Mary ([COR0036](#))
- 30 Haigh, Mr Andrew ([COR0001](#))
- 31 Harris, Professor Andrew ([COR0034](#))
- 32 Hindu Forum of Britain ([COR0040](#))
- 33 Howitt, Dr Cordelia (Consultant Histopathologist, University Hosital North Midlands (Royal Stoke University Hospital)); Dr Mark Stephens (Consultant Histopathologist, University Hospital North Midlands (Royal Stoke univeristy hospital)); Dr Louise Edwards (Consultant Histopathologist, University Hospital of North Midlands (Royal Stoke university Hospital)); and Dr Karthik Kalyanasundaram (Consultant Histopathologist, University Hospital North Midlands (Royal Stoke University Hospital)) ([COR0060](#))
- 34 INQUEST ([COR0107](#))
- 35 INQUEST ([COR0097](#))
- 36 Independent Advisory Panel on Deaths in Custody (resubmitting correct version) ([COR0092](#))
- 37 JUSTICE ([COR0085](#))
- 38 James, Dr Ryk (Senior Lecturer in Forensic pathology/ Home Office Pathologist, Cardiff University) ([COR0019](#))
- 39 Julian, Dr George (Knowledge Transfer Consultant, Freelance) ([COR0078](#))
- 40 Kearsley, Ms Joanne (HM Senior Coroner, Greater Manchester North) ([COR0044](#))
- 41 Kent County Council ([COR0069](#))
- 42 Leadbeatter, Dr Stephen (Senior Lecturer in Forensic Pathology, Cardiff University) ([COR0017](#))
- 43 Luce, Tom ([COR0035](#))
- 44 Laskaris, Mrs Fiona ([COR0037](#))
- 45 Lumb, Dr Philip (Home Office Pathologist, British Association of Forensic Medicine) ([COR0072](#))
- 46 Mahajan, Dr Sangeeta (Consultant Anaesthetist / Trustee, Guy’s and St Thomas’ NHS Foundation Trust / PAPYRUS (Charity for Prevention of young suicide)) ([COR0063](#))
- 47 Mason, Professor Catherine (Senior Coroner, Leicester City and South Leicestershire Coroner’s Service) ([COR0073](#))
- 48 McCourt, Mrs Tracey ([COR0020](#))
- 49 McCulloch, Andrew (Screen writer, Freelance) ([COR0029](#))
- 50 McFall, Ms Debra ([COR0065](#))
- 51 McLoughlin, Kevin (Senior Coroner , West Yorkshire (East) Coroners Court) ([COR0011](#))
- 52 Meadows, Mr Nigel (H.M. Senior Coroner for Manchester, H.M. Senior Coroner for Manchester) ([COR0054](#))

- 53 Medical Protection Society ([COR0067](#))
- 54 Ministry of Justice ([COR0096](#))
- 55 Montacute, Dr Rebecca ([COR0038](#))
- 56 Murray, Mr James ([COR0052](#))
- 57 NHS ([COR0104](#))
- 58 Nguyen, Mr Thong (Software Engineering Manager, Facebook Inc.) ([COR0089](#))
- 59 Omer, Mohamed (Co-founder, National Burial Council and Gardens of Peace) ([COR0101](#))
- 60 POhWER ([COR0018](#))
- 61 Padfield, Professor Nicola (Professor of Criminal and Penal Justice, University of Cambridge) ([COR0005](#))
- 62 Parliamentary Advisory Council for Transport Safety (PACTS) ([COR0062](#))
- 63 Pendreich, Ms Eva (Head of Legal Services, South East Coast Ambulance Service NHS Foundation Trust) ([COR0016](#))
- 64 Plymouth, HM Senior Coroner ([COR0013](#))
- 65 Prisons and Probation Ombudsman (PPO) ([COR0088](#))
- 66 Roberts, Mrs Michelle (Director, Retail Motor Sales) ([COR0049](#))
- 67 Richford, Mr Derek ([COR0014](#))
- 68 Roadpeace ([COR0066](#))
- 69 Rowen, Mr Paul ([COR0004](#))
- 70 Royal Statistical Society ([COR0095](#))
- 71 Ruty, Professor Guy (Chief Forensic Pathologist, University of Leicester) ([COR0025](#))
- 72 SUDEP Action ([COR0055](#))
- 73 Sharpstone, Dr Daniel (Assistant Coroner, Suffolk) ([COR0051](#))
- 74 Shaw, Doctor Nicholas (GP locum [retired from full time general practice] and Assistant Coroner for Cumbria, 1953) ([COR0003](#))
- 75 Smith, Miss Rebecca (Clerk/Inquest Manager, North London Coroner's Service) ([COR0077](#))
- 76 Smith, Mr David (Retired Further Education College Vice-Principal, Chichester College) ([COR0087](#))
- 77 Steering Committee of the Registry for unexpected child deaths in England ([COR0050](#))
- 78 Taylor, Mr Christopher; and Mrs Nicole Taylor ([COR0039](#))
- 79 Thacker, Mr Iain (Director, Rosedale Products Europe) ([COR0024](#))
- 80 The City of London Corporation ([COR0102](#))
- 81 The Coroners' Courts Support Service ([COR0061](#))
- 82 The Coroners' Society of England and Wales ([COR0030](#))
- 83 The Lullaby Trust; SUDC UK; Sands - The Stillbirth and Neonatal Death Society; and Child Bereavement UK ([COR0070](#))
- 84 The Royal College of Pathologists ([COR0068](#))
- 85 Tozer, Dr Rosemary (Retired social policy researcher, University of York) ([COR0031](#))

- 86 Tweddle, (HM Asst Coroner, Sunderland and Newcastle) ([COR0007](#))
- 87 United Families and Friends Campaign (UFFC) ([COR0056](#))
- 88 Victim Support ([COR0023](#))
- 89 Vision Zero London ([COR0082](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2021–22

Number	Title	Reference
1st Report	The Coroner Service	HC 68