House of Commons

Justice Committee

The Coroner Service: Government Response to the Committee's First Report

Third Special Report of Session 2021–22

Ordered by the House of Commons to be printed 7 September 2021

HC 675
Published on 10 September 2021
by authority of the House of Commons

Justice Committee

The Justice Committee is appointed by the House of Commons to examine the expenditure, administration and policy of the Ministry of Justice and its associated public bodies (including the work of staff provided for the administrative work of courts and tribunals, but excluding consideration of individual cases and appointments, and excluding the work of the Scotland and Wales Offices and of the Advocate General for Scotland); and administration and expenditure of the Attorney General's Office, the Treasury Solicitor's Department, the Crown Prosecution Service and the Serious Fraud Office (but excluding individual cases and appointments and advice given within government by Law Officers).

Current membership

Sir Robert Neill MP *(Conservative, Bromley and Chislehurst)* (Chair)

Rob Butler MP (*Conservative, Aylesbury*)

Angela Crawley MP (*Scottish National Party, Lanark and Hamilton East*)

Janet Daby MP (*Labour, Lewisham East*)

James Daly MP (*Conservative, Bury North*)

Sarah Dines MP (*Conservative, Derbyshire Dales*)

Maria Eagle MP (*Labour, Garston and Halewood*)

Laura Farris MP (*Conservative, Newbury*)

Kate Hollern MP (*Labour, Blackburn*)

Dr Kieran Mullan MP (*Conservative, Crewe and Nantwich*)

Andy Slaughter MP (*Labour, Hammersmith*)

The following were also Members of the Committee during the 2021–22 Session: Paula Barker MP (*Labour, Liverpool, Wavertree*), Kenny MacAskill MP (*Alba Party, East Lothian*), John Howell MP (*Conservative, Henley*)

Powers

© Parliamentary Copyright House of Commons 2021. This publication may be reproduced under the terms of the Open Parliament Licence, which is published at www.parliament.uk/site-information/copyright-parliament/.

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/justicecttee and in print by Order of the House.

Committee staff

The current staff of the Committee are Chloë Cockett (Senior Specialist), Su Panchanathan (Committee Operations Officer), Tracey Payne (Committee Specialist), George Perry (Committee Media Officer), Christine Randall (Committee Operations Manager), Jack Simson Caird (Assistant Counsel), Ben Street (Second Clerk), Holly Tremain (Committee Specialist), and David Weir (Clerk).

Contacts

All correspondence should be addressed to the Clerk of the Justice Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 8196; the Committee's email address is justicecom@parliament.uk.

You can follow the Committee on Twitter using @CommonsJustice.

Third Special Report

On 27 May 2021 the Justice Committee published its First Report of Session 2021–22, *The Coroner Service* (HC 68). The Government's Response was received on 27 July 2021. The response is appended to this Report.

Appendix: Government Response

Letter from the Rt Hon Robert Buckland QC MP, Lord Chancellor and Secretary of State for Justice

Thank you for providing an advance copy of the Justice Committee's report of its inquiry into the Coroner Service which was published on 27 May.

The Government is grateful to you and your Committee for the time and care you have given and the expertise you have shared in conducting your inquiry and producing your report. The Government's response to the Committee's 25 recommendations is attached.

The Government has accepted six recommendations and there are 11 recommendations where it has committed to undertake further work before coming to a firm decision. There are four recommendations which the Government does not accept as it does not consider that they align with departmental priorities. There are an additional four recommendations which are addressed to the Chief Coroner. I understand that the Chief Coroner will be responding to the Committee on these separately.

The Government is pleased that the Committee has acknowledged the considerable improvement of the overall service provided by the coronial system since the Coroners and Justice Act 2009 was implemented in July 2013. The Government remains committed to its aim of putting bereaved people at the heart of the inquest and to ensure that the inquest process is as sensitive as possible to their needs.

The Government is grateful that the Committee has recognised the tremendous contribution of the previous Chief Coroner, His Honour Judge Mark Lucraft QC and the role of his successor, His Honour Judge Thomas Teague QC, in continuing his predecessors' work. The Government would also like to join the Committee in acknowledging the hard work and dedication of the Chief Coroners, coroners, their officers and their staff in ensuring that coroner services continued despite the challenging circumstances presented by the pandemic.

The Government will continue to work with the Chief Coroner and other key stakeholders to make sure that a high standard of consistency can continue to be delivered across coroner services.

Government Response

Introduction

The Government is grateful to the Justice Committee for its decision to undertake a thorough and wide-ranging inquiry into the Coroner Service and for the painstaking report it has produced, assimilating the many written submissions that it received and evidence provided in the oral sessions.

The coronial system is a vital public service which has a significant impact on many bereaved people when they are at their most vulnerable: each year around 40% of all deaths are reported to coroner services in England and Wales giving rise to some 30,000 inquests. Through its inquiry, the Committee has shone a light on the coroner system and presented the Government with a number of recommendations to build on the reforms contained within the Coroners and Justice Act 2009 and the suite of Rules and Regulations implemented in 2013.

Given the unprecedented challenges presented by Covid-19 on coroner services, the Government would also like to extend its gratitude to the previous Chief Coroner, His Honour Judge Mark Lucraft QC, and the present incumbent, His Honour Judge Thomas Teague QC, for their leadership and support to coroners, as well as to the tireless work of coroners, their officers and administrative staff who have met the everyday pressures on their services, keeping them going throughout the pandemic.

We would also like to thank Judge Lucraft, senior coroners, their officers, charities, faith groups, medical professionals and organisations, bereaved families and other stakeholders who either provided written evidence to the Committee or attended the oral sessions to provide evidence to the inquiry.

The Committee highlighted a number of important areas for our consideration and this response sets out how the Government intends to address the issues identified in the recommendations. We have carefully considered these recommendations and we will be accepting six of them outright. We are working on five measures to simplify processes and bring coroner's courts into line with mainstream courts and tribunals which we have brought forward in the Judicial Review and Courts Bill. We are committing to looking into ten of the recommendations as we consider further work is needed to determine if they can be delivered and fit with department priorities. Five of the recommendations are for the Chief Coroner and he will wish to respond directly to the Committee on them. Finally, there are four recommendations which we will not be taking forward as we do not believe they will achieve the desired objective as intended.

We have provided our responses to the Committee's recommendations in its Report in the order that they have been raised under the headings used by the Committee.

A. Improvements since the Coroners and Justice Act 2009

1. Coroner appraisal

The Committee acknowledged that the creation of a Chief Coroner along with guidance, mandatory training and appraisals for assistant coroners were significant advances towards

a more standardised coroner service, even in the absence of a national coroner service and that the reforms introduced by the previous Chief Coroners had made a significant difference to the delivery of the service. The Committee encouraged the current Chief Coroner to continue the work begun by his predecessor by extending appraisals to all coroners.

We would agree that the creation of Chief Coroner has been a key reform. The office of Chief Coroner was introduced in 2013 to provide judicial leadership, guidance and support to coroners and to promote consistency of standards and practice. The excellent contribution of the first and second Chief Coroners, His Honour Sir Peter Thornton QC and His Honour Judge Mark Lucraft QC, to achieve these objectives has been widely recognised. We are aware of the strategic vision for the coroner service of the current Chief Coroner, His Honour Thomas Teague QC, and his aim to continue to drive forward the reforms initiated by his predecessors.

In his Annual Report to the Lord Chancellor (2018–19, 2019–2020), Judge Lucraft noted that in April 2019, a system of appraisals for assistant coroners had been launched. We understand that Judge Teague will review the scheme in due course.

Appraisal of judicial office holders is, however, a matter for the judiciary, not government ministers. The Chief Coroner will respond directly to the Committee on extending appraisal to all coroners.

2. Coroner area mergers

The Committee acknowledged that reducing the number of coronial areas has helped increase consistency across the Coroner Service. We would agree. It is a longstanding Government policy, and more recently a Chief Coroner policy, to reduce the number of coroner areas so that they are better placed to provide a consistent standard of service to bereaved families and economies of scale for local authorities who will be able to contract for mortuary, pathology and other services across larger areas.

The Committee recommended that, as requested by the outgoing Chief Coroner, the Ministry of Justice amend the Coroners and Justice Act 2009 (the 2009 Act) to make it easier to merge areas. We accept this recommendation and indeed, this is currently in progress as one of the measures in the Judicial Review and Courts Bill.

3. Post implementation review of the Coroners and Justice Act 2009

The Committee was concerned that the Ministry of Justice had not published its 2015 post implementation review of the 2009 Act. It did not accept the argument put forward by the then coroners minister that the work was several years out of date and recommended that the Ministry of Justice immediately publish its post implementation review.

We do not accept this recommendation. We take the view that the analysis carried out at the time is now some six years old and there would be very limited value, or wider public interest, in publishing it now – it would merely be a historic snapshot when the coroner world has moved on immeasurably. In 2015 the coroner reforms introduced in July 2013 had only started to bed in.

There are also concerns regarding the disproportionate resources that we would require to bring the report to a publishable standard. As with all Government Social Research, there are strict quality assurance processes to ensure that the quality of research which is published. This is to avoid misleading or incorrect evidence being put into public domain.

B. Putting Bereaved People at the Heart of the Service

4. Chief Coroner engagement with stakeholders

Following the Administrative Court judgment in the judicial review brought against the Inner North London Senior Coroner by the Adath Yisroel Burial Society in 2018, the then Chief Coroner issued guidance to coroners on handling urgent decisions.[1] The guidance is intended to be a practical guide to assist coroners in situations where a bereaved family has made a request to the coroner for urgent consideration of the death of a loved one and/or early release of the body; or the coroner or coroner's officers otherwise become aware of features of a particular death which may justify treating it as especially urgent. The guidance provides a summary of the guiding principles.

The Committee welcomed the Chief Coroner's guidance but was concerned that whether the needs of faith communities were met depended on how individual coroner services responded. It recommended that the new Chief Coroner should 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.

The Chief Coroner will respond to the Committee on his engagement with stakeholders.

5. Guide to Coroner Services for Bereaved People

In January 2020 the Ministry of Justice refreshed its *Guide to Coroner Services for Bereaved People*[2] to focus it more on the needs of bereaved people – the earlier version, produced shortly before the implementation of the suite of coroner reforms in 2013 was aimed at all users of coroner services, and was rather more legalistic. The Ministry of Justice involved a range of stakeholders in developing the new Guide including coroners and coroner's officers, the Chief Coroner and his office, and the Deputy Chief Coroner. It also worked with those who support bereaved families such as the Coroners' Courts Support Service and INQUEST. This ensured that the information was both accurate and presented in a way that would be useful and helpful for bereaved families.

As part of its work to make inquests more sympathetic to bereaved families, the Ministry of Justice also included at the back of the Guide a protocol of key principles guiding the approach of the Government and the lawyers it instructs when it has interested person status. The principles are to guide behaviour and make sure that bereaved families are at the heart of the inquisitorial process. The protocol applies to government departments but as it states, others may wish to adopt the principles as a model of behaviour.

The Guide has been well received by our stakeholders and we are pleased that the Committee has also acknowledged its value. The Committee's recommendation is that more needs to

1 Chief Coroner's Guidance No.28 - Report of Death to the Coroner: Decision Making and Expedited Decisions (judiciary.uk).

2 Guide to Coroner Services for Bereaved People

be done to make sure that bereaved people are aware of it. It encouraged Senior Coroners to make sure that the revised Guide was freely available both online and, where requested, in hard copy by post and offered to bereaved people as soon as it had been decided that a post-mortem was needed. We accept this recommendation and we will work with the Chief Coroner to make sure that the Guide is available as widely as possible.

The Ministry of Justice informed all coroner's offices when we published the Guide in January 2020 and issued each office with 250 hard copies. However, it explained that as the Guide was available to view online, via mobile phones and tablets, and had been designed with navigable sections, it did not see any reason to continue to supply hard copies. It used to provide hard copies of the previous Guide but that was not easy to view online. The Ministry of Justice also made available a 'print-friendly' version should a coroner office wish to arrange its own printing.

It is our understanding that coroner's offices do provide the Guide to bereaved families at the start of the investigation. Practice varies across the country; some offices send the Guide by link to an electronic copy for both environmental reasons and to save postage; others prefer to send hard copies.

We do accept that there will be some compelling cases for the Ministry of Justice to issue hard copies of the Guide for each area, on their request, for example, to place in waiting areas in coroner's courts or to provide to those who do not have ready access to the internet. For these reasons, the Ministry of Justice will provide hard copies of the Guide in particular cases where there is a sound reason for doing so. It will, however, review this policy on an annual basis to assess the level of demand.

6. Support services

We recognise the important work of support services, in particular the Coroners' Court Support Service (CCSS), in providing non-legal support to bereaved families, as well as witnesses, when they attend inquests. Trained CCSS volunteers provide invaluable emotional and practical support on the day, and sometimes in advance of the hearing, demystifying processes and making a potentially traumatic experience less intimidating. They also operate a telephone hotline and an online contact form for queries.

The Committee also noted the value of support services and recommended that 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 CCSS), so that this support was available in every coroner area.

As part of its commitment to ensure that bereaved families are at the heart of the coroner service, it has long been a Government aim to see a support service in every coroner's court in England and Wales. Indeed, in its Final Report on Legal Aid for Inquests published in February 2019,[3] the Government said that the Ministry of Justice would run a competition to extend support services for coroner's inquests to all coroner's courts. It was made clear then, and since, that this was subject to affordability.

---

3 Final report: Review of legal aid for inquests (publishing.service.gov.uk)

We are currently unable to accept this recommendation as further detailed work needs to be undertaken to understand the affordability, and legal and commercial issues in delivering it.

7. Specialist Support organisations

We are aware of a number of specialist organisations that support bereaved families who come into contact with the coroner system. Indeed section 9 of the Ministry of Justice *Guide to Coroner Services for Bereaved People* provides information on where bereaved people may obtain further general information about coroner investigations and bereavement support, as well as listing a number of organisations who may be able to provide help and advice. The Guide also notes that the coroner’s office will be able to provide information about the main local and national voluntary organisations, support groups and faith groups which help bereaved people including those who have been bereaved as a result of particular types of incidents or circumstances, or specific medical conditions.

The Committee encouraged 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. It will be for the Chief Coroner to provide a response to this recommendation.

8. Charter of Rights

In the report of his review of the experiences of the Hillsborough families,[4] Bishop James Jones proposed a Charter for Families Bereaved through Public Tragedy. This included commitments to be made by public bodies in relation to transparency and acting in the public interest, indicating that the lessons of the Hillsborough disaster had been learned and that the perspective of the families was not lost. Families bereaved by the Grenfell Tower fire also supported such a Charter.

The Committee considered that bereaved people deserved a charter of rights setting out the standards of service that they were entitled to receive from the Coroner Service. They acknowledged that the *Guide to Coroner Services for Bereaved People* sets out the standards they can expect, but they did not consider this went far enough. The Committee recommended that the Ministry of Justice should implement a statutory Charter of Rights for bereaved people, modelled on the criminal justice system’s victims’ code.

We do not agree with the Committee’s views on the Guide which we consider provides detailed information on the standards that bereaved people can expect to receive from the inquest process, and at Section 8 sets out steps that they can take where they feel it has fallen short. The protocol within the Guide also sets out clearly how, when it has interested person status, Government and its lawyers will approach the inquest. It states that it will be sensitive to the needs of the bereaved and guide the behaviour of that department in recognising the need for the bereaved to be properly involved throughout the inquest process. This makes clear to bereaved people what they can expect and provides the opportunity to speak out when they feel standards are not met.

4 Bishop James’ Jones’ report – The patronising disposition of unaccountable power

Further, unlike victims in criminal courts, bereaved families have a special status at inquests as interested persons which gives them certain statutory rights including to receive disclosure as well as to examine witnesses at the inquest. And the coroner can ask questions on their behalf to help ensure interested persons get the answers they need.

Nevertheless, we are considering what more might be provided to bereaved families. This will be set out in the Government's response to Bishop James' report in due course and we are therefore not responding to the recommendation at this stage.

9. Access to evidence

The Committee were concerned that bereaved people were at a disadvantage when they did not have access to the evidence. They considered it important that the process for obtaining evidence was explained clearly to them as this was important for the fairness of the inquest.

It encouraged 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.

We consider that Section 5 of the *Guide to Coroner Services for Bereaved People* goes some way to meeting the Committee's concerns about bereaved people having their rights to disclosure explained to them. This sets out in simple language that as interested persons bereaved people will be given copies of the documents that the coroner or other witnesses will use in the inquest, for example, medical records, witness statements, and expert reports, making the point that they may ask for copies to be sent to them or they may go to the coroner's office to look at a particular document. It explains that bereaved people should speak to the coroner's office as soon as possible if they do not receive documents to which they think they have a right, and that the coroner should explain if they cannot have access to a particular document, or to part of a document. The protocol within the Guide is also clear that Government and its lawyers should support the disclosure of all relevant and disclosable information to the coroner.

The Chief Coroner will however provide a detailed response to this recommendation.

10. Duty of Candour

The Committee considered that health and social care bodies failed to fulfil their duty of candour to bereaved people during coroners' investigations and inquests. It recommended that the Ministry of Justice should amend the Coroners' Rules to make clear that the duty of candour extended to the Coroner Service. It also recommended that the Government should consider whether a similar duty to be candid at inquests should be extended to all public bodies.

The Charter for Families Bereaved through Public Tragedy proposed by Bishop James Jones contains a commitment by public bodies to approach inquests with candour and honesty, making full disclosure of relevant documents, material and facts in the search for truth and learning from past mistakes.

The Government is committed to responding to Bishop James' report, including on the duty of candour, and the relevant departments and organisations are working together to carefully consider this point of learning.

It is, however, important that the Government offers the families an opportunity to share their views before it publishes its full response to the Bishop's report in due course.

The Committee's recommendation will be considered alongside the Government's response to Bishop James' report in due course.

Further, the Government notes that the protocol for lawyers who represent government departments where they have interested person status at inquests within the *Guide to Coroner Services for Bereaved People* includes the principle that such lawyers will approach the inquest with openness and honesty. Whilst the protocol only applies to Government departments, its use is commended to public bodies more widely.

11. Non-means tested legal aid for inquests

Whilst the Committee welcomed the Government's steps to support the inquisitorial nature of inquests, it did not consider that these were enough to prevent large multi-handed inquests, where individuals' and organisations' reputations were at stake, from becoming adversarial.

The Committee did not think that bereaved people should have to go through the process of meeting the Exceptional Case Funding (ECF) requirements and the means test for legal aid where public authorities were legally represented at inquests into the death of their loved one.

It therefore recommended that 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.

The Government remains of the view that the inquest process is intended to be inquisitorial, and that legal representation should not be necessary at all inquests. However, the Government will be considering its approach to legal aid for inquests as part of its response to Bishop James Jones' report of his review of the Hillsborough families' experiences and we will respond to Bishop James' recommendation on legal aid then.

We agree that there are some cases where representation should be granted and these are currently funded through our ECF scheme. We agree that in these cases, access to legal aid should be as simple and easy for bereaved families as possible, which includes limiting the burdens of a financial means assessment. We are therefore pleased to announce that we will be taking forward legislation to remove the means test for applications for ECF in relation to legal representation at inquests. Further, we are proposing to provide non-means tested legal help in relation to an inquest for which ECF has been granted for legal representation. Beyond this, we will consider the wider issue of legal aid at inquests in the Government's response to Bishop James' report.

12. System of appeals

Currently a coroner's decision can be challenged by way of judicial review or in certain circumstances, through an application to the High Court, with the authority of or by the Attorney-General, to have an inquest conclusion quashed under section 13 of the Coroners Act 1988 (as amended) (the 1988 Act). The Government believes that these procedures provide effective and appropriate mechanisms for ensuring that inquests can be held whenever they are required, and that coroners' decisions can be challenged.

The Committee considered that the current arrangements for challenging coroners' decisions were unwieldy and caused unacceptable delays, stress and often expense, for bereaved people. It recommended that 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.

Section 40 of the 2009 Act which was repealed, without ever having been commenced, by section 33 of the Public Bodies Act 2011, made provision for a detailed appeals route to the Chief Coroner, with onward appeal to the Court of Appeal, setting out numerous matters which could be appealed. We understand that there were concerns around the cost of maintaining such an appellate process as well as over whether the Chief Coroner and his office would be able to deal with a potentially high number of appeals on a wide range of decisions in addition to their other work.

Nevertheless, the Government is, however, aware of stakeholders' views and accepts that there is merit in considering the original Section 40 and whether there is a need for an additional mechanism to enable more decisions to be appealed. Any potential appeals mechanism would, however, need to be proportionate and neither make the system more litigious and adversarial nor overwhelm the Chief Coroner's office. We are therefore not responding to the recommendation at this stage.

13. Fresh Inquests

The Committee noted that the High Court's powers following an application under section 13 of the 1988 Act were either to order an inquest to be held where a coroner had refused to hold one or to quash an inquest and order a new one, if that would be in the interests of justice.

It considered that there may be circumstances where 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. This suggestion had been proposed in successive Chief Coroner's reports to the Lord Chancellor, most recently in the then Chief Coroner's combined annual reports for 2018/19 and 2019/20[5]

The Committee recommended that the Government should consider adopting the Chief Coroner's proposed amendment to section 13 with the caveat that the High Court could only use the new power "with the consent of the interested party applying under section 13".

We accept this recommendation; the Government will seek to introduce this measure into legislation when parliamentary time allows.

5 Chief Coroner's combined annual report 2018 to 2019 and 2019 to 2020 - GOV.UK (www.gov.uk)

14. Coronial Investigation of stillbirths

The Ministry of Justice and the Department of Health and Social Care consulted from 26 March to 18 June 2019 on proposals to give coroners new powers to investigate stillbirths.[6] The objectives of the consultation proposals were to bring greater independence to the way stillbirths are investigated; ensure transparency and enhance the involvement of bereaved parents in stillbirth investigation processes, including in the development of recommendations aimed at improving maternity care; and effectively disseminate learning from investigations across the health system to help prevent future avoidable stillbirths.

The consultation attracted over 300 responses from a wide range of stakeholders. Officials have spent time carefully considering the consultation responses, but the Government response has been delayed due to the impact of Covid-19 on work programmes.

The Committee welcomed the Government's consultation on coronial investigation of stillbirths and was disappointed that it appeared to have stalled. It recommended that the Ministry of Justice should revive the consultation on coronial investigation of stillbirths and publish proposals for reform.

The Government accepts the Committee's recommendation. The Department of Health and Social Care have been leading on a range of initiatives to improve maternity reviews and investigations of stillbirths, neonatal and maternal deaths and brain injuries that occur during labour and birth. The Department of Health and Social Care and the Ministry of Justice plan to publish a joint response to the consultation as soon as possible.

15 -17. Pathology Services

i. Raising the fees paid to pathologists

The Committee noted that pathology services for coroners have been neglected over many years leading to serious problems and recommends that the Ministry of Justice should immediately review and increase pathologists' fees to ensure an adequate supply of pathology services to coroner service.

The Government is aware of the increasing challenges coroners face in identifying pathologists to perform post-mortem examinations in their coroner areas. Successive Chief Coroners have also expressed their concern about the shortage of pathologists to carry out post-mortem examinations, most recently the then Chief Coroner in his Annual Report to the Lord Chancellor for 2018/19 and 2020.

The Government accepts that the fee paid to pathologists for carrying out routine post-mortems, which is set by the Ministry of Justice, has not been raised for some years but it does not accept that this is the only reason for the shortage of pathologists. Other reasons include the fact that pathology is no longer part of a medical student's standard training, and post-mortem work no longer seems to be an attractive sub specialism. There is a national as well as international shortage of consultant pathologists. There is no evidence to suggest that raising the fee would of itself address the problem.

6 March 2019 consultation on coronial investigations of stillbirths

We are therefore not accepting this recommendation, but the Ministry of Justice will continue to keep the issue under consideration. We will also continue to engage with the Chief Coroner's office and other government departments to find a sustainable solution to address this issue.

ii. Coronial pathology to become part of pathologists' NHS contract

The Committee also recommended that in the medium term the Ministry of Justice should work with the Department of Health and Social Care so that pathologists' coronial work was planned for within their NHS contracts.

We accept this recommendation on the basis that all these departments and others such as the Chief Coroner's office should work together on this issue. NHS England and Improvement are supportive of working with departments on scheduling coroner commissioned post-mortems into NHS consultant pathologists' job plans.

Currently this work is largely carried out on a voluntary fee earned basis by consultant pathologists outside their NHS contracts which can be unhelpful to both the NHS and coroner services. Given the national and international shortage of a consultant pathologist workforce, however, it will be important not to undermine NHS service delivery in meeting the demands of coronial post-mortems. It is nevertheless recognised that an integrated approach is likely to minimise the impact of shortages on both NHS and coroner services.

iii. Regional pathology centres of excellence

In his Annual Report to the Lord Chancellor for 2018/19 and 2020 the then Chief Coroner suggested a solution to the shortage of pathologists to carry out coronial post-mortems could be the establishment of 12 to 15 regional pathology centres of excellence. The Committee was attracted to this proposal and recommended that in the longer term, the Ministry of Justice should broker an agreement between relevant government departments and the NHS (in England and Wales) to establish and co-fund such centres of excellence.

The Ministry of Justice together with other government departments with a key interest will engage with the NHS to consider this proposal, so we cannot accept this recommendation at this stage. Officials from NHS England and Improvement would in principle support considering the development of an appropriate number of specialist pathology centres of excellence in forensic and post mortem pathology. This would be in line with published NHS England and Improvement aims for pathology.

C. A unified national Coroner Service for England and Wales

18. A unified Coroner Service

The Committee noted that the majority of witnesses to its inquiry, two Chief Coroners, and almost everyone who had been commissioned to review aspects of the Coroner Service saw the need for a unified service for England and Wales. The Committee considered that there was unacceptable variation in the standard of service between coroner areas and did not think that coroner services should have to depend on their local authority and Senior Coroner having a shared understanding and priorities. It recommended that the Ministry of Justice should unite coroner services into a single coroner service for England and Wales.

The Government acknowledges the calls for a national coroner service. However, it does not think that a single service would necessarily address the issues facing the coronial system or be the best solution. It does not accept this recommendation.

Creating a national coroner service would represent a massive change project to bring 85 coroner services into a single service, entailing complex negotiations to bring staff with different salary ranges and job roles into a single entity. Indeed, many local authority staff who work on coroner issues have other roles within the authority, whilst police authorities employ many of coroner's investigating officers. There would need to be negotiations on other issues such as on the ownership of coroner's courts and offices. The project to bring 42 magistrates' courts committees into HM Courts Service took a large team and significant resources over three years to implement.

The cost of the creating a national coroner service could be disproportionate to the benefits it might bring. Nationalised organisations do not necessarily eliminate inconsistencies or postcode lotteries. Further, a national coroner service would only address the funding issues currently experienced by some coroner areas if its funding reflected the true costs of running the service; as the Committee heard, local authorities support many "hidden costs". With increased pressures on public services, in particular as they recover from the impacts of the pandemic, there is no guarantee that funding levels would remain consistent to support a national coroner service.

As a localised service, coroners are familiar with the particular characteristics of their area and use their expertise and knowledge to respond to the needs of local bereaved people. This might be the case, for example, where a coroner has a large faith community in their area.

The Government accepts that there is still a need to address inconsistencies in the delivery of coroner services but it acknowledges the tremendous work of the previous Chief Coroners and present incumbent who have provided judicial leadership and guidance to coroners as well as regular and compulsory training, which has promoted significantly greater consistency of standards and practice in coroner services across England and Wales.

As at recommendation 2 above, it is a long-standing central government and more recently Chief Coroner objective to merge coroner areas when the opportunity arises to improve consistency of coroner provision and standardise practice. The Chief Coroner's Model Coroner Area blueprint (annexed to the then Chief Coroner's Annual Report for 2018/19 and 2019/20) highlights the need for areas with a lower activity to merge, where appropriate, to lead to more jurisdictions of similar size and workload. This also helps to standardise processes and share best practices within the new area.

Working with the local authorities concerned, the number of coroner areas has been reduced from 110 in 2012 to 85 coroner areas today. The aim is to reduce it further to around 75 coroner areas in England and Wales, each with between 3,000 and 5,000 deaths reported annually, when the opportunity presents itself, invariably when a Senior Coroner retires or resigns. The Ministry of Justice will continue to identify opportunities to work with local authorities to achieve this and notes that there a number of potential mergers in train.

19. A Coroner Service Inspectorate

The Committee also noted "an overwhelming and long-standing" view that the Coroner Service would benefit from an inspectorate overseeing its work. It recommended that the Ministry of Justice should create a Coroner Service Inspectorate to report publicly on how well each area was consistent with the Chief Coroner's 'Model Coroner Area', its readiness in case of mass fatalities and the level of service provided to bereaved people.

The purpose of inspection is to provide external and independent assurance about the safe and proper delivery of services and contribute to their improvement and the Government accepts that there could be merit in establishing a Coroner Service Inspectorate to meet these aims. It could also provide a more proportionate means of addressing arguments put forward to justify a national coroner service.

The Government would, however, want the opportunity to look further into this recommendation and will consider the options of taking this recommendation forward alongside other ministerial priorities and taking into account the affordability of establishing a new public body and ongoing running costs. We therefore cannot accept the recommendation at this stage.

20. Handling coroner complaints

The Committee recommended that 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.

The Government's position on the Committee's recommendations on a national service and inspectorate are set out above.

The Government acknowledges the concerns raised by bereaved people and others about the challenges they may face if they seek to make a complaint where a coroner's conduct has fallen short of what is expected of a judicial office holder.

However, coroners are independent judicial office holders and the Judicial Conduct Investigations Office (JCIO) is an independent body which provides a robust mechanism for dealing consistently with complaints about the personal conduct of judicial office holders. The JCIO supports the Lord Chancellor and the Lord Chief Justice in their joint responsibility for judicial conduct and discipline.

The Government considers it would be inappropriate and unhelpful to treat coroners differently from other judicial holders and this could lead to inconsistencies in the way complaints are dealt with. It therefore rejects this recommendation.

21. Non-means tested legal aid for inquests into mass fatalities

The Committee considered it unacceptable that bereaved people were not entitled to automatic non-means tested legal aid at inquests into multiple deaths following a public disaster in light of the complexity of such inquests and felt that 'equality of arms' was a fundamental requirement to ensure the bereaved could participate fully. It recommended that 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.

The Government believes that inquests should remain inquisitorial in nature and that legal representation should not be necessary at all inquests. However, the Government will be considering its approach to legal aid for inquests as part of its response to Bishop James Jones' report of his review of the Hillsborough families' experiences.

We agree that there are some cases where representation should be granted and these are currently funded through our ECF scheme. We agree that in these cases, access to legal aid should be as simple and easy for bereaved families as possible which includes limiting the burdens of a financial means assessment. We are therefore pleased to announce that we will be taking forward legislation to remove the means test for applications for ECF in relation to legal representation at inquests. Further, we are proposing to provide non-means tested legal help in relation to an inquest for which ECF has been granted for legal representation. Beyond this, we will consider the wider issue of legal aid at inquests in the Government's response to Bishop James' report.

On other support for bereaved people following a mass disaster, as part of the previous Government's Victims' Strategy, a 12-week consultation on the role of an Independent Public Advocate (IPA) took place in late 2018.[7] The Government is giving further consideration to what the most appropriate and proportionate response is in relation to the scope of this work going forward and how best to support those affected by such events, building on the work already carried out through the consultation, in a way that is consistent with the necessary and formal investigatory processes that must follow.

The Government remains committed to supporting the bereaved and to make sure that inquests are as sympathetic to their needs as they can be. This is why in January 2020 we published a revised *Guide to Coroner Services for Bereaved People* to make it better focused on the needs of the bereaved and a protocol on the approach government lawyers should take when they have interested person status at an inquest to make sure that bereaved families continue to be at the heart of the inquisitorial system. In January 2020 we also held a conference for lawyers who practise in inquests to hear first-hand the experiences of families and to emphasise the importance of an inquisitorial approach. Building on the protocol, we have been supporting legal service regulators (the Bar Standards Board and the Solicitors Regulation Authority) to address behaviours by legal representatives in the coroner's court.

D. ADDRESSING FATAL RISKS IDENTIFIED BY CORONERS AND INQUEST JURIES

22. Follow up of reports to prevent future deaths

The Committee considered that the system for the Coroner Service to contribute to improvements in public safety was under-developed and that the absence of follow up to coroners' reports to prevent future deaths (PFD) was a missed opportunity. It recommended that the Ministry of Justice should consider setting up an independent office to report on emerging issues raised in PFD reports, to liaise with regulators and others, to follow up on actions promised to coroners and to report publicly where insufficient action had been promised or implemented. As an alternative, the Committee considered that a new Coroner Service Inspectorate could be given this role.

7 September 2018 Consultation on establishing an Independent Panel Advocate

The Government considers that coroners' PFD reports are a vital tool in ensuring that lessons are learnt and that mitigations are put in place to prevent the risk of future harm or deaths. We are also aware that government departments, regulators and others take very seriously what they say in their responses to coroners' PFD reports about the actions they will take.

Nevertheless, the Government recognises that there is more that can be done in this space to ensure that PFD reports actively contribute to improvements in public safety. We will consider options available alongside the Committee's recommendation on an Inspectorate of Coroner Services. We are therefore not in a position to accept the recommendation at this stage.

23. Improving the accessibility of PFD reports

The Chief Coroner's office has published PFD reports and the responses to them on the judiciary website since 2013. However, the Committee considered that the current arrangements for publishing coroners' PFD reports and the responses to them required improvement as the information published was the bare minimum and it was difficult to search and analyse. It recommended that the Ministry of Justice should provide funding so that PFD reports and responses to them was freely available online and the information was well-organised and easily searchable.

We acknowledge that there are some issues in searching for completed reports on the judiciary website and we understand that the Chief Coroner's office has already put in hand work to determine how best to ensure that PFD reports and responses to them are appropriately catalogued and accessible.

We will work with the Chief Coroner's office to consider appropriate resources required to deliver this. We are therefore not in a position to accept the recommendation at this stage.

E. COVID 19

24. Recovery from the pandemic

The Committee considered that the Coroner Service had responded well to Covid-19, and expressed its thanks to all those involved under very difficult circumstances. It noted that a considerable number of inquests had been delayed because of the pandemic restrictions. It recommended that the Ministry of Justice should liaise with the Chief Coroner and consider what central government support may be needed to help the Coroner Service recover from the pandemic. The Government accepts this recommendation.

The Government would also wish to add its own thanks to all coroners, their officers and staff, as well as the Chief Coroner and his staff, for their dedication and diligence in ensuring that death investigations were able to continue, and that many inquests were held, despite the unprecedented challenges presented by the pandemic.

The Chief Coroner has recently issued refreshed guidance to coroners on how their services can best recover from the pandemic and coroners minister Lord David Wolfson QC recently met the Chief Coroner to discuss what additional central government support might be provided to help coroner services recover from the pandemic. Ministry of Justice

officials engage with the Chief Coroner's office on a very regular basis on a range of issues, and they will continue to engage with his office to understand how central Government can further support the coroner service, given that coroner services are funded by individual local authorities.

It is important to note that the Government has provided £6bn in unringfenced grant funding to local authorities to support the costs of Covid-19 pressures, which could be used, amongst other things, to cover any extra costs incurred in the administration of coroner services, including inquest backlogs.

As part of the emergency legislation brought in last year, Section 30 of the Coronavirus Act 2020 removed the requirement to hold an inquest with a jury where the coroner had reason to suspect the cause of death was Covid-19. The requirement for a jury in inquests where Covid-19 was suspected would have disproportionately added to the demand on coroner services, adversely impacting their ability to operate and exacerbating backlogs of jury inquests. Section 30 has supported efforts to keep coroner services functioning. In light of continuing pressures, this provision has been replicated in the Judicial Review and Courts Bill to put a similar provision into the Coroners and Justice Act 2009 once the 2020 Act is sunsetted.

The Police, Crime, Sentencing and Courts Bill includes a measure to extend the use of video and audio hearings to coroner's courts, enabling more participants to attend inquest hearings remotely.

The Government will include four other coroner measures in the Judicial Review and Courts Bill. These are:

- To allow pre-inquest hearings and inquests to take place where all participants including the coroner, participate remotely, bringing coroner's courts in line with other courts.
- To allow inquests to be held without an in-person hearing in non-contentious cases.
- To allow a coroner investigation to be discontinued where the cause of death is natural without a post-mortem examination.
- To allow the merger of coroner areas within a local authority where the new coroner area would not be the entire local authority area.

The Government hopes that these will support coroner services with their recovery from Covid-19.

25. Collecting information from individual coroner services

The Committee encouraged the Chief Coroner to collect information from each coroner area on the challenges they faced because of the pandemic and to communicate the overall picture to the Ministry of Justice.

This recommendation is for the Chief Coroner. However, at his recent meeting with Lord Wolfson, the Chief Coroner set out his strategy for recovery from the pandemic, including

his continued engagement with senior coroners across England and Wales to identify any ongoing issues caused by the pandemic and consider what actions may be necessary to support the post-Covid recovery.

Working with the Chief Coroner's office, Ministry of Justice officials recently made enquiries of all coroner areas asking them how they were scheduling jury and non-jury complex inquests due to the logistical challenges social distancing requirements presented.

The Ministry of Justice will continue to work with the Chief Coroner as he takes forward discussions with individual coroners.