Written evidence from The Coroners' Society of England & Wales

(COR0030)

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Justice Committee Inquiry

The Coroner Service

"Thank you for your time, care and kind words. It was hugely appreciated"
(A family member as the inquest concluded)

The Coroners' Society of England and Wales (CSEW) is the oldest judicial association. It was founded in September, 1846.

The Society has the following objects:

1. the promotion of the usefulness of the office of coroner to the public;
2. the ascertainment in questions of difficulty of the duties which devolve on coroners;
3. the advancement of such amendments to the law as seem desirable;

4. the establishment and maintenance of contact with HM Government and the Chief Coroner; and
5. the protection of the rights and interest of coroners

The Society welcomes the Justice Committee inquiry and provides the following submissions to assist. If the Committee requires further information or explanation the Society will do what it can to help.

The Society has no staff and is run by working coroners. During the Coronavirus pandemic Coroners have been working extended hours to meet the needs of bereaved families. The inquiry timing is unfortunate, in the early stages of recovery from the first wave, as coroners are striving to meet the needs of those we serve in Covid-safety.

The opening quote above is the typical response coroners receive from the families at the centre of our investigations.

Background

The Coroner Service is a judicial service covering England and Wales. The service is led by the Chief Coroner of England and Wales who provides national leadership for coroners, through guidance and training. This sets the tone and consistency for the coroner system whilst using the resources and infrastructure of each coroner area.

The Coroner system operates under statutory provision:

- **Transitional Orders**
- **Coroners and Justice Act 2009 (CJA)**
- **The Coroners (Investigations) Regulations 2013**
- **The Coroners (Inquests) Rules 2013**
- **The Coroners Allowances, Fees and Expenses Regulations 2013**
- The Coroners Act 1988 (CA) (s13 of 1988 Act is needed to fill the lacuna caused by the appeal system not being implemented and s30 is needed because the Treasure reforms were not implemented)

Each coroner area serves its own unique locality. There are 85 coroner areas each of which cover one or more local authorities. In each coroner area there is one local authority which is the "relevant authority". With the agreement of the Chief Coroner and Lord Chancellor the relevant authority is responsible for coroner appointments. The Chief Coroner in agreement with the Lord Chancellor has issued guidance as to the recommended procedure for these appointments.

Each relevant authority, often by historic arrangement with the police force covering a coroner area has a duty to provide resources, staff and accommodation needed for coroners to carry out their function. It is helpful to look at the impact assessment accompanying the 2009 Act to recognize that these resources, staff and accommodation were not recognised as a new burden. It is implausible that Parliament intended the reformed coroner system to operate under the Victorian legislation enshrined in the consolidating Coroners Act 1988; and it was for this reason that the Ministry of Justice undertook a post-implementation Review of the legislation in 2015, which the Coroners' Society understood was primarily to identify unfunded new burdens imposed by the Coroner and Justice Act 2009 so as to ensure the staff, accommodation and resources were available to deliver the intended coroner service.

There was intended to be a Court's inspectorate with the reformed legislations. From the Bill being laid until its enactment the Court's inspectorate was abolished. An inspectorate with sanctions to look at the compliance with s24 CJA - staff, resources and accommodation -would be a proportionate cost effective way to drive up the consistency of service delivery across all areas.

The Ministry of Justice have not thus far published the evidence received nor published the Government's response. This leaves the coroner service underfunded.

The coroner reform project quite rightly raised the bar for public expectations. There was some funding for the Chief Coroner, Training and the Chief Coroner's office however this was inadequate for the aims of the reform and on-the-ground delivery of the service to bereaved people.

Many relevant authorities and police forces resourced the service by taking from other statutory service budgets to fund the coroner areas. Not all relevant authorities have been able to do this given austere parlous financial balance sheets. Most non-statutory local services deteriorated from 2008. By the time the Coroner and Justice Act 2009 was implemented in July 2013 several relevant authorities had nothing other than the existing 1988 Act budget to resource the coroner area, thus perpetuating a post-code lottery.

Post-implementations Review

Overview

When the coroner reforms in the Coroners and Justice Act 2009 ("the 2009 Act") came into effect in July 2013, the last Government made a commitment to review their impact after they had been in place for 18 months.

The aims of the 2009 Act were to put the needs of bereaved people at the heart of the coroner service; for coroner services to be locally delivered within a framework of national standards; and to enable a more efficient system of investigations and inquests.

*This review seeks to **find out whether the coroner reforms are operating as planned and whether there have been any unintended consequences**. We are interested in hearing about people's experiences of aspects of coroner services that were reformed under the 2009 Act. (**Emphasis added**)*

The key areas of change were the following:

- *The publication of statutory guidance, the "Guide to Coroners Services", for bereaved people (available from coroners' offices and on gov.uk)*
- *A requirement that coroners disclose information that bereaved people request during an investigation, free of charge;*
- *A requirement for all inquests to be recorded;*
- *A requirement that coroners are available at all times to address matters which must be dealt with immediately;*
- *A requirement that bereaved people and other interested persons are notified of inquest arrangements and any changes within a week of the arrangements or changes made;*
- *Flexibility of the location for inquests and post-mortem examinations which may now be held anywhere in England and Wales rather than being restricted to the coroner's area.*

This review will run from 15 October 2015 to 10 December 2015. The Government's response will be published in due course…

The Guide to Coroner's services was updated in January 2020

Coroners are judges, judges who investigate deaths which are unexplained, violent or unnatural or in custody or otherwise in state detention.

In every Coroner Area there is a Senior Coroner. The Senior Coroner leads the service and coordinates the relationship between the coronial judiciary and the executive. This is often referred to as the triangle of responsibility between the Coroners, the relevant authority and the police force (where the police employ coroners' officers – note: in some areas coroners' officers are employed by the local authority). It ensures the effectiveness of the coroner service whilst ensuring judicial independence. This is an equivalent relationship, enabling the separation of powers, to that which exists between judges and HMCTS (a body of government within the MOJ).

In some coroner areas there are one or more Area coroner (salaried office holders who work with the Senior Coroner. There is inconsistency across areas as to the use of Area Coroners. Their need is dependent upon workload and capacity to dispense justice efficiently. Some areas

of equivalent size and complexity have two Area Coroners, some have one and others have none.

There has to be at least one fee paid coroner, (Assistant Coroner) in each area. There are often more. Fee paid coroners are part-time judges who are usually also engaged in legal practice. Each fee paid coroner undertakes a minimum of 15 days sitting each year and also commits to the mandatory annual training regime.

A coroner's investigation will usually lead to an inquest. In the coroner's court there are no parties and no-one brings a case to be proved. The inquest is an inquiry with those with an interest being given the status of interested persons. Fairness and equality of arms are essential ingredients in the rule of law, however though the bereaved family are listed first in the definition of interested persons (s47 CJA) it is helpful to consider the bereaved family as the first amongst equals to ensure they are at the centre of the process.

In a Divisional Court hearing in 1982 following the tragic death of 13 young people at a birthday party, in a house fire in New Cross Road, Deptford, London, the late Lord Lane CJ said:

"The coroner's task in a case such as this is a formidable one, and no one would dispute that; that is quite apart from the difficulties which inevitably arise when feelings are running high and the spectators are emotionally involved and vocal. Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the reins whichever metaphor one chooses to use"

Inquest proceedings are inquisitorial. It is an inquiry whereby examination of the evidence with the help of interested persons and other witnesses enables the coroner (or jury) to find fact as to who the deceased person is, when and where that person died and how the death occurred, without determining or appearing to determine criminal liability by a named person or civil liability. The inquest also records a conclusion and the details needed for the Coroner to register the death.

In recent years the MOJ have undertaken work to make inquests less adversarial. Unfortunately most lawyers learn the art of advocacy in the adversarial courts, and that often spills over into the inquest hearing. Fortunately, the vast majority of inquests do not require legal representation. The Coroner's court leads to the registration of deaths and helps society learn lessons to prevent future deaths; but it does not lead to compensation, punishment or findings of liability. Even in complex inquests an inquest makes judgmental findings on central issues

without determining liability. Public bodies need to be represented at inquests by lawyers in some circumstances. This is because bodies corporate need a mouthpiece to speak in court. The lawyers appearing help the court by marshalling evidence which assists all interested persons. The Coroner in most cases can level the playing field.

Coroners have been trained with regard to the Advocacy Gateway with regard to case managing inquests to be less adversarial by using ground rules hearings and recognising vulnerable witnesses.

In the relatively few cases where death occurs in state detention means tested legal aid is available for bereaved families. It is not however available for other interested persons who may not be represented by the public authority.

In recent years there have been several judge-led inquests. These are exceptional cases where the judge sitting as coroner, applying inquest rules is more or less sitting as an Inquiry. The judge has a legal team and vast resources, which the coroner can only look upon with envy. This raises the bar and expectations of the public from the coroner service. On the 10th August 2020 the Chief Coroner issued guidance on coroners' use of solicitor and counsel to the inquest. This was a resource rarely used by coroners but is likely to be an additional burden on "Relevant authorities".

Every death is as important to the bereaved family as every other death is to his or her family. The cost of the judge-led inquests would fund many a coroner area for all reported deaths for a considerable time. It would be helpful to have public inquiries in these cases instead of inquests to avoid comparison, confusion and upset.

Each year the Ministry of Justice publishes an annual statistical analysis of the coroner service, it is evident that the coroner service is very busy, however the figures do not tell of the individual lives affected or the increasing complexity of the workload undertaken by the coroner service.

In 2019, 210.900 deaths were reported to coroners, this is a reducing figure possibly as a result more accurate reporting of relevant deaths which will be further reinforced by the effectiveness of the Notification of deaths Regulations 2019 with effect from October 2019.

There is also likely to be a significant reduction in deaths reported to the Coroner service over the next few years as the Medical Examiner service is established, which should deal with most deaths not requiring a coroner investigation. However the number of inquests may actually rise as Medical Examiners refer cases which might not otherwise have been reported to the coroner.

31,300 inquests were concluded in 2019 with 30,000 inquests being opened, both rising figures on the previous year.

The deaths in custody or otherwise in state detention in 2019 reduced to 478 from 514 in 2018. This is 1.59% of inquests concluded or 0.23% of all deaths reported in 2019. Although relatively small in number such cases are frequently a heavy burden on the corner service especially for those areas with large prison or mental health detainee populations.

Post-mortem examinations were needed in 39% of all deaths reported in 2019. There is a shortage of autopsy pathologists nationally, a problem which has been gradually worsening and leading to delays in the release of bodies for funeral. In some areas coroners have to move bodies out of the coronial area for investigation. There is some availability for post-mortem imaging (less invasive examinations) in some areas for certain types of deaths. These procedures are not suitable for all presentations. The less invasive techniques are particularly helpful for deaths where through faith or belief, bereaved families finds conventional autopsy an anathema. However the landscape is uneven and unfair. By way of example in one part of the West Midlands less invasive investigations are free to local residents and yet for residents of neighbouring boroughs there is a cost to the family or the community of £700.00. Given there are prescribed fee for post-mortem examination (which have not been increased in over a decade) in the Coroner fees regulations etc. and these have not been increased in over a decade leading to many pathologists reducing the number of post-mortem examinations they do or stopping altogether. Allied to this is the limitation on hospital consultant pathologists' time to do non-hospital work since the reorganisation of the NHS consultants' contracts; coroner postmortem examinations are "private" work outside the remit of the NHS. The age profile of pathologists who carry out post-mortem work is rising year on year and those retiring are not being replaced by younger members of the medical profession. Finally the pressure on pathologists to carry out nationally important work, such as cancer diagnosis has rightly significantly increased.

Fee for making a post-mortem examination

6. A suitable practitioner is to be paid a fee of—

For making a post-mortem examination and reporting the result to the coroner	£96.80
For making a post-mortem examination involving additional skills and reporting the result to the coroner	£276.90

A family or community does not pay for a post-mortem examination directed by the coroner. The funding and available resources for post-mortem investigation as to the cause of death needs revision and improving.

A post-mortem report is an expert report by or under the supervision of a consultant pathologist. The investigation requires reading the medical history, examining the body, often involving histology and/or toxicology and writing the report. Expectations on pathologists have increased over the years. The prescribed fees are inadequate and may explain why autopsy pathology is a dwindling resource.

The average time to conclude inquests in 2019 was 27 weeks, however further evidence of the unfunded burdens of the reformed service creating a postcode lottery is that when looking at individual areas the average time varied from 50 weeks in one area to 8 weeks in another area.

Whilst there is always room for continued improvement, the coroner's service in the past few years has gone through a period of considerable evolution and improvement, following the introduction of the Coroners & Justice Act 2009. The Society strongly believes that many of the concerns raised in the areas to be covered are less likely to reflect death investigation now in contrast to that in the 1980's or even a decade ago.

As Coroners we must be careful ourselves not to fall into the trap of being overly content that we always get it right, or are right or of being overly defensive of how we provide the service we provide, however much it has improved. However well we believe we each individually conduct inquests and deal with bereaved families, we should heed the very real experiences of all those families with whom we deal every day.

Just over two years ago now the CSEW responded to a report prepared by Bishop James Jones which primarily focused upon the response to the Hillsborough disaster in 1989 of – amongst others – the police and the coroners' service. The CSEW made the point that since the late 1980's time and practice have moved on and this is a point which we hope this document reinforces.

Coroners aim to deliver a service which places the bereaved family at the heart of the coronial process, whilst remembering at all times that we are independent Judges and that we must treat all individuals and organisations fairly. We do so in a manner which reflects that we are a publicly funded service and we need to be "mindful of the public purse". It is submitted that any significant changes to the service we currently deliver albeit economically ought to be viewed in terms of what additional funding may be necessary and the potential impact upon the Local Authorities (and Police Forces) who provide the necessary funds.

Making this submission to the Parliamentary Committee has provided us with a welcome opportunity to reflect upon and consider how we conduct ourselves (and therefore the service we provide) for bereaved families and those who come into contact with our service.

An Assistant Coroner recently commented that: **“We have to ensure that however many deaths we investigate and however many inquests we hear, each one is treated as an individual and that each and every death is handled with the same sensitivity, sympathy and humanity, whatever the issues, whoever the people.”** This sentence arguably sums up the aims of the coronial service today.

Executive Summary:

1. The extent of unevenness of Coroners services, including local failures, and the case for a National Coroners Service

The Coroners Service has evolved significantly since the Coroner reform project was instituted by the Ministry of Justice in the early noughties. The Service had a long way to go to consistently deliver a service to the bereaved public we serve. At one level the service delivers value added on a shoe-string budget – we are "cheap as chips" as one coroner put it - why would Government want to pay for a national service? Was this really the world class service ministers heralded as the project went through Parliament?

Many local authorities and police forces have stepped up to the plate and have provided staff, resources and accommodation for the coroner area, for which they have responsibility – others have not.

The CSEW is neutral as to whether there is a National Coroner service – that is an executive decision for government – Coroners will serve the needs of bereaved people under any structure, however should there be a National Coroner Service it must be modelled on the best resourced current services rather than being the lowest common denominator service, which loses all that has been developed.

2. The Coroners Service's capacity to deal properly with multiple deaths in public disasters

Coroners have always been involved in mass fatality public disasters. In 2008 after significant planning by the Home Office and the MOJ the CSEW set up a Cadre of Disaster Victim Identification (DVI) trained Coroners. There was residential training and distance learning from the University of Dundee. There were 18 Coroners and two Procurators fiscal appointed. There was a Rota to ensure that a trained cadre coroner was available to support others. In November 2016 HHJ Mark Lucraft QC appreciated the importance of DVI training and mandated that all coroners and coroners' officers should have DVI training awareness. The Chief Coroner took over the DVI Cadre and holds annual training development days.

The DVI Cadre is overseen by the Chief Coroner and consists of a national spread of coroners to ensure expertise across England & Wales. These coroners have more training and expertise in DVI and there is a rota on call for national and international incidents where British nationals (particularly from England and

Wales) may have died. The Coroners service has very close links with coroners in Northern Ireland and the Crown Office in Scotland.

The following principles outlined by Lord Justice Clarke in his report in 2001 form the bedrock of DVI processes:

- *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*
- *the avoidance of mistaken identification.*

The Coroner Service is prepared and ready to work with emergency responders in the eventuality of mass fatality disaster. It is multi-agency working often with several parallel investigations, the role of the coroner being primarily the identification of the deceased person and support of bereaved family by investigation as to how, when and where the death has occurred, in conjunction with the other investigations.

3. Ways to strengthen the Coroners' role in the prevention of avoidable future deaths

Before the Coroner and Justice Act 2009 – coroners wrote reports under rule 43 Coroners Inquest Rules 1984.

"A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly."

The MOJ received copies of all reports and staff within the department wrote annual reports categorizing the reports and drawing out themes. Following the Creation of the Chief Coroner's Office the MOJ department was reduced in size. The CSEW believes that that Chief Coroner was never given the staffing complement needed to continue with this work. Though reports are published by the Chief Coroner it is difficult to identify the themes which could inform Government and public bodies of changes that could prevent future fatalities. It would be helpful for the Chief Coroner's staff levels to be increased.

4. How the Coroners Service has dealt with COVID 19

Coroners have always been involved in excess death management. It is not a statutory duty on coroners but one area where emergency planners look for guidance, advice and support. Coroners deal with unexplained death and unnatural death. COVID-19 is a naturally occurring disease and therefore is capable of being a natural cause of death. The circumstances of a natural death can make it unnatural, so every death reported needs to be considered on its own facts. Coroners had many more deaths reported in March 2020 than in the previous year. Coroners had to adjourn many cases listed for inquest as facilities did not permit social distancing. It is unclear as to when socially distanced Jury cases can resume. The Coroner and the Jury must be in the courtroom. 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.

*Jury inquests required by s7 CJA (for example, but not exclusively, deaths in state detention or where a death is potentially the result of police actions) are often enhanced inquests which need to explore by what means and in what circumstances a death has occurred. This is because the procedural obligation under (**the right to life**) article 2 Human Rights Act 1998 is engaged.*

(i) It must have a sufficient element of public scrutiny of the investigation or its results.
(ii) It must be conducted by a tribunal that is independent of the state agents who may bear some responsibility for the death.
(iii) The relatives of the deceased must be able to play an appropriate part in it.
*(iv) It must be **prompt and effective**. This means that it must perform its essential purposes.*

These are to secure the effective implementation of the domestic laws which protect the right to life and to ensure the accountability of state agents or bodies for deaths occurring under their responsibility.

Inquests can be article 2 compliant where a Jury is not mandated by s7 CJA these cases proceed without delay. No-one can address the court on the facts of a case whether there is a jury or not. When a jury is called there is a greater risk of "grand-standing" when asking questions – which tends to make these inquests

more adversarial. When a coroner sits alone and there is no jury to impress, this is minimised.

In cases where a jury is mandated, there is no margin of judgement afforded to the coroner to proceed without a Jury. Notwithstanding it may be just and reasonable in all the circumstances, so to do.

As a result of the pandemic many coroners have twenty or more outstanding cases where a jury inquest is mandated by law. The numbers in this list are growing as new deaths are reported. These delays have created a problem in meeting with the State's obligations- particularly in being prompt and effective – in effect to learn timely lessons and put things right. Going through the motions of an inquest many years after an organisation and system has changed may bring justice – but it unlikely to have prevented other deaths, in the meantime.

5. Progress with training and guidance for Coroners

All Coroners and Coroners' Officer have mandatory training organized by the Chief Coroner under the auspices of the Judicial College. Before the Coroner and Justice Act 2009 Coroners had access to annual residential training organized by Coroners in the MOJ Coroners Training Group supported by the Judicial Studies Board. This training was not mandatory. Though training is mandatory there are still some relevant authorities who do not pay fee paid coroners (Assistant Coroners) to attend training nor reimburse travel and accommodation expenses.

6. Improvements in services for the bereaved

There have been many improvements to the Coroners Service under the CJA. The Chief Coroner has brought a tone and Consistency through guidance. Up to 50% of coronial areas are supported by the Coroner Court Support Service (CCSS). The main drawback here is funding. Government funding for court support is often directed to Victims. This often prevents the CCSS from competing for funding as they support everyone who attends the inquisitorial inquest hearings, often bereaved family but also witnesses, indeed anyone affected by the unexplained death.

Legal Aid is available for deaths in state detention for the bereaved family on a means tested basis. However it is not available for others affected by the death including witnesses whose acts or omissions may have caused or contributed to the death. Inquests are not adversarial and when advocates appear their role is

to help the coroner and jury (if there is one) unravel the evidence so that the law can be applied to the facts.

Coroners are trained in the advocacy gateway toolkits with regard to using ground rules hearings to level the playing field. Coroners enable participation by all interested persons with or without an advocate. It is often advocates for public authorities who act more as amicus curiae – assisting the court and other interested persons rather than pressing the proving of a case as in the adversarial courts. There is often an inequality of arms: the State in one of its various guise (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 – advocates often need reminding of the wise words of Chief Justice Lane above.

"The coroner's task in a case such as this is a formidable one, and no one would dispute that; that is quite apart from the difficulties which inevitably arise when feelings are running high and the spectators are emotionally involved and vocal. Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the reins whichever metaphor one chooses to use"

7. Fairness in the Coroners system

There is unfairness in the Coroner's system. This stems from lack of resources, staffing, infrastructure and accommodation. Coroner's Courts need to have space for privacy for those affected by death. Municipal buildings and halls may have the space for hearings but not the infrastructure to deliver a world class service to the recently bereaved. The service delivers local justice relying of resources provided by the local authorities covered by the area. And also the pathology and radiology expertise available. There is a post-code lottery. 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.

Coroners should be able to direct post-mortem investigations according to the justice needed in the case not based upon whether pathologists are available.

There is a lack of investment and support for autopsy pathology. Coroners rely not only on forensic pathology but also on general histopathology in the diagnostic laboratories of teaching and district general hospitals. Diagnosis as to the cause of death for coroners usually falls out of a pathologist's contractual hospital duties. This means that only the most dedicated pathologists or those few undertaking training as specialty forensic/autopsy pathologist are available for coroner's work. As senior pathologists retire the resource will become even more remote unless there is government support and intervention. 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. A starting point might be to pay pathologists as the experts they are, quantum meruit rather than the paltry fees prescribed in the regulations.

Forensic toxicology in the United Kingdom is a poor state which more likely than not stems from decisions to close down the Forensic Science services. The Forensic Science Regulator can only regulate what is left – it is for government to plan for the toxicology infrastructure of the future.

Fairness in the coroner system depends upon expectations being met. When expectations are raised beyond the relevant evidence there will be disappointment. The inquisitorial nature of the coroners' investigation and inquest leads to a distillation of the relevant evidence which can be relied upon – this then leads to the findings, determinations and the conclusion. It is important that the people we serve are facilitated in understanding the difference between and inquest and litigation. Specialist advocates in the coroner's court may help; as they have in public law family cases and other jurisdictions.

There should be a whole-time equivalent Chief Coroner, made up of a Chief Coroner with deputy Chief Coroner's making up the rest time of the office. The Chief Coroner's duties need to be matched with a staffing establishment to support the Office as envisaged by Parliament.

Finally though the Chief Coroner and the Lord Chief Justice could not have been more enabling and welcoming to coroners as part of the judicial family of judges the same cannot be said of the judiciary generally. It is not understood by other judges that Coroners are judges and should be referred to and treated as such rather that judicial office holders carrying out a quasi –judicial function. Work is needed in this area.

1. **The extent of unevenness of Coroners services, including local failures, and the case for a National Coroners Service**

Introduction

In responding to the Committee's request for evidence the CSEW would wish to put some context around the work which is done by Coroners on a daily basis. An extremely small proportion of Inquest hearings reach the national and daily news, these are more often than not, the more high profile cases. It is important to recognise the entire spectrum of work undertaken by the Coroner's service. For the general public and media most only see the public inquest the hearing in which relevant evidence is considered to make findings, determinations and a conclusion. The Coroners service is far more than this, it is like an iceberg, and the vast majority of our work goes unseen, in the back office by way of preliminary inquiries and investigation. Not all investigation reaches an inquest. There is also much decision making and planning outside the statutory duties which is expected from Coroners.

Examples of thank you to the Coroners and to the Coroners officers (please see attached exhibit A from just three areas – by way of example of what the public experience from the Coroners service).

1. The Extent of Unevenness of Coroner Services, including local failures

In responding to this question it is important to understand the structure and funding source of the coroner's service. Moreover the importance of the service being a localised service albeit one which should adhere to national standards.

It is recognised by most people including coroners that the coroner's service is, arguably, uneven when looking nationally and comparing each individual area.

Ultimately, whatever the nature of the unevenness, the principle reason will undoubtedly be one of resourcing and finance.

Changes to the work of Coroners since the implementation of the Coroners and Justice Act 2009 in July 2013 has, in some practical ways, resulted in a greater inequality between Areas as they seek to meet the unfunded challenges of the new legislation.

Notwithstanding some of the challenges outlined below, the work undertaken by many Coroner Areas is arguably of an exceptional standard and can make a significant difference to bereaved families as evidenced by the many messages of appreciation received by coroners. It is

acknowledged that some Coroner Areas may not be able to reach the high levels of service which coroners would wish to attain, the reasons for this being multifactorial:

Available national statistics show the variability in certain aspects of the coronial work for example, the percentage of deaths in an area which are reported to a coroner or the number of cases which result in a post mortem. Whilst some variation will undoubtedly come down to the approach/discretion of the individual coroner, much of the variation may well have its roots in resource issues.

In considering the unevenness of the Coroners Service in different Coroner Areas, including local failures, the CSEW considers the following to be crucial aspects;

Relationship with the funding authority

The coroner's relationship with their Local Authority is fundamental in achieving fairness and quality of service. It is imperative that the funding authority understand the work and needs of the service and their statutory responsibility in respect of funding. The importance of the relationship between the Senior Coroner and the Chief Executive of the Local Authority is imperative and should be encouraged.

It is the view of the CSEW that the following are a critical starting point for the coroner's service and the local authority:-

a. Regular Meetings at the correct level of personnel within the local authority
b. Mutual Understanding of Section 24 Coroners and Justice Act 2009
c. Acceptance of the Chief Coroner's Model Coroner Area, including necessary funding. The soon to be published version 2 of this document will hopefully increase consistency across the country
d. An agreed level and standard of service.
e. An agreed understanding of budgets with regular discussions about finance.

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 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.

The Chief Coroner's '*Model Coroner Area v.2*' sets out a reasonable standard of resourcing required to support a local Coroner's Service and should be treated as the foundation for the coroner service in each Coroner Area.

Key areas which are crucial to being able to provide a fully functioning efficient and compassionate service are:

a) <u>Accommodation</u>

Many coroners are trying to deliver a service with wholly inadequate accommodation both in terms of the number of and availability of court rooms – many jurisdictions do not have their own dedicated court room but have shared facilities (with Registrars or other Local Authority Services) often with limited sitting days. Some Coroners areas have limited access to facilities in order to hold the required Jury Inquests. In other areas the office / meeting space is wholly inadequate for coroners' staff and those attending the coroner's court. All of the above feed into the ability to list Inquests in a timely manner.

In order to reduce the unevenness the CSEW would propose;

a) Offices, which need to be adequate to accommodate all staff in an appropriate and safe environment.
b) All Coroner Areas must have ***at least*** one designated separate courtroom and must be able to accommodate a jury inquest. This will include the availability of an appropriate jury retiring room and adequate meeting rooms for families and advocates, and access to court security (most coroners have none at all and they and their staff are vulnerable)
c) A list of necessary/minimum requirements should be agreed between the Coroner and the Local Authority. The aim should be to narrow what are currently huge disparities between different Areas.
d) Sufficient accommodation to allow for timely listing of all hearings.

b) **<u>Staffing</u>**

Coroner's staff are predominantly either local authority or police staff members. There is no national structure for staffing within a coroner's service. Some areas employ all local authority staff to work within the coroner's office in a variety of roles. In other areas the staff are employed by the local police force or a mixture of the two. As well as there being no national staffing structure there is no national guidance as to the roles required within a coroner's office. A coroner's officer in one area may undertake a very different role to a coroner's officer in another area despite the Chief Coroners Guidance issued June 2016 on '*The Function and Duties of Coroners Officers'*.

However the structure is made up, there are huge variations in the staffing levels nationally in coroners' offices. Some coroner's services are well staffed with a variety of administrative staff, court ushers, coroner's officers and managers. In others this is not the case and there are acute shortages and pressures on very small teams who have excessive workloads.

Staffing at an adequate level and in key roles is critical to running an effective Coroner's Service. 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.

Coroners' staff who have responsibility for the management of Inquest cases should not have excessive workloads and adherence should be paid to the recommended case load as set out in the Chief Coroners Model Coroner Area v 2.

c) Coroners

Senior Coroners

As well as discrepancies in relation to the staffing of Coroner's offices there is also variation in the recruitment and appointment of Coroners. All areas will have a Senior Coroner.

Whilst it is a matter for the Senior Coroner to manage their area, most Senior Coroners will have to delegate to an Area or an Assistant Coroner Inquest hearings; the progression of death reports (the back office work) and elements of the strategic management of the Coroner's Service. The importance of the Senior Coroner in delivering localised leadership for example working with the local authority, local resilience forums, presenting and delivering training to key partner agencies is not insignificant. How much of this work a Senior Coroner commits to can vary in each Area.

A coroner's workload can incorporate a wide range of duties and responsibilities and may differ significantly across England & Wales, thereby contributing to unevenness in Coronial Services. Furthermore, since the coming into force of the Coroners and Justice Act 2009 in July 2013 the roles and responsibilities of the coroner are markedly different to those which existed prior to the current legislation, exacerbating (in places) the differences in coronial practices and adding to disparity in coroner services between Areas. It should be noted that the Chief Coroners have sought to lessen such differences through the publication of Chief Coroner Guidance.

It is to be noted that judicial work can be sub-categorized between office work and court work, with inquests in some Coroner Areas accounting for less than one-fifth of the Senior Coroner's judicial work. Inquest work can also vary from straightforward matters to complex lengthy hearings – put simply, there cannot be "one size fits all" for investigations.

There are additional responsibilities and substantial demands upon a Senior Coroners' time for meetings with a variety of stakeholders including (but not limited to) police, hospital trusts, pathologists, mortuary staff, faith and bereavement groups, suicide and child death groups. Furthermore, many coroners are required to have a substantial input into LRFs, the appointment of Medical Examiners as well as contributing to the Coroner Society both at a local and national level.

Some Coroner areas have an increased demand on the out of hour's service provided. All Coroners have to be contacted out of hours for matters such as suspicious deaths or urgent organ donation. However the demand for an out of hour's service can be greater depending on the communities within the Coroners area. In some areas there is a great demand for a 24/7 service for matters which cannot wait until the next working day. This predominately relates to the needs of certain communities to hold funerals very quickly. In these areas there needs to be increased staffing and resources to facilitate this service including the following:

Area Coroners

Some areas have also sought to appoint a full-time Area Coroner as well as fee-paid Assistant Coroners who work when requested, with the understanding they must do a minimum of 15 (likely to increase to 20) days a year.

Ensuring there are sufficient coroners in order to progress the workload efficiently and to be able to hear Inquests is crucial. It is also essential that there is appropriate cover for the Senior Coroner and planning in the event of any period of unexpected absence. There are areas where there is a reluctance on the part of the local authorities to appoint full-time Area Coroners.

This should not be the case and the vast majority of coroner areas should now be seriously considering a full-time area coroner appointment in order to provide full-time support to the Senior Coroner.

Assistant Coroners

Use of Assistant Coroners should be at the discretion of the Senior Coroner albeit communicated to the Local Authority for the purposes of budget planning. Assistant Coroners

are appointed by the Local Authority, albeit the Senior Coroner should be engaged with the recruitment process.

How many Assistant Coroners are required in the area should be a matter for the Senior Coroner in discussion with their local authority. In some areas there is a reluctance to appoint Assistant Coroners due to the perceived cost to a local authority i.e. each Assistant Coroner must receive at least 20 sitting days. In addition Assistant Coroners should be paid to attend mandatory training, as per the Chief Coroner's guidance. This is not currently the case with some local authorities still refusing to pay for such training. There remains unevenness across areas for Assistant coroners in respect of access to the Local Authority pension scheme with some local authorities refusing to offer this to Assistant coroners.

Coroners Remuneration

Despite the efforts of the CSEW and Local Government Association there remains unevenness in the remuneration paid to Coroners. The remuneration of all Coroners should be in accordance with JNC61, 62 & 63.

Judicial Discretion

It is only natural that in the exercise of judicial discretion in there may be what is considered to be, unevenness. This will be perhaps most pronounced when there is discontentment around judicial decision making. There is of course an established process for review of any judicial decision. However any 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, for example when someone dies under the care of Mental Health services some coroners may wait for any internal investigation report before concluding their inquest others may not. Similarly with deaths in an acute trust or prison.

Unlike other judicial offices and courts the Coroners service is unique in that coroners are investigators. Consistency in approach to investigations can be encouraged and assisted through guidance and training.

d) **Office Resources**

In addition to accommodation and staffing, there are national variations which result in some coroners areas having less efficient ways of working. For example not all coroner's offices have

an electronic case management system. Whilst most areas have introduced a case management system there is no national system and often this depends on the costs involved.

Every office now should have a suitable digital case management system which should be web based to allow remote working.

In addition within the courts the quality of IT equipment varies enormously. Some coroners have no means of using video-link for witnesses or for vulnerable witnesses. IT equipment in the Court should allow for the remote taking of evidence and the recording of Inquest hearings.

Every Coroner Area within the office must have an adequate telephony system to allow for the effective and prompt answering of telephone calls from IPs and others involved in an inquest.

e) National Issues which impact on the Coroner's Service

The coroner's service relies heavily on other key partners in order to have the appropriate standard of investigations. In terms of investigating the medical cause of death, particularly where the cause is unknown coroners rely on their local pathologists to undertake a post mortem examination. The current crisis in the coronial pathology service and associate toxicology service are worthy of specific consideration in this paper.

Pathology Services

The post-code lottery in the Coroners' Service is most clearly demonstrated by the shortage of **Histopathologists** able and willing to undertake coronial autopsies. Some areas are relatively well served whilst others have none at all. The effect of this has been that some areas have long turnaround times for autopsies to be undertaken, and have to draft in pathologists from other areas and pay fees in excess of those laid down under the 2013 Coroners Allowances, Fees and Expenses Regulations, which has caused more shortages by taking pathologists from other areas.

The mean time to undertake a post-mortem doubled between 2013-2016, despite the number of autopsies declining.

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.

Those pathologists undertaking this work are frequently under pressure and their reports are often delayed.

The Chief Coroner's Annual Reports have repeatedly highlighted this as an issue.

The cause of this shortage has been repeatedly investigated and Professor Hutton undertook an extensive evaluation of the issues several years ago, making recommendations to establish a national pathology service with regional centres of excellence. None of these have been followed and the service has continued to under more strain than ever.

Some of the causes of the shortage include:

1. The removal of autopsy experience as a compulsory area of training of pathologists.
2. No government department taking responsibility for pathology services, not MOJ which oversees coroners, not HO which oversees forensic pathologists; not DHSC which provides a consented hospital death post-mortem service especially for child and neonatal deaths.
3. The demands of hospital contracts on pathologists making it difficult for them to undertake coronial post-mortem work.
4. The stress of appearing in court, both psychological and due to time pressure.
5. The impact of the HTA making it difficult for pathologists to store and manage histology samples.
6. The derisory payment for pathologists undertaking a routine coronial autopsy and producing a report which has been set at £96.80 for at least 17 years and was not even increased in 2013 when the Coroners Allowances, Fees and Expenses Regulations were enacted with the Coroners and Justice Act 2009. A survey 2 years ago undertaken by the RC Pathologists to investigate why pathologists were withdrawing from coronial autopsy, found the low fee to be the main reason.

Some coroners have had to operate outside these regulations to ensure autopsies are performed, and others have developed lists of cases that the coroner considers to be a post-mortem involving "additional skills" in order to pay £276.90 for undertaking the autopsy and reporting to the coroner. This is in accordance with Chief Coroner Guidance No.32 issued September 2019. Examples of the sorts of cases include: road traffic collisions where the pathologist may even be called to Crown Court; deaths after inpatient hospital admission where notes may have to be considered; deaths in custody where a forensic post mortem examination has not been undertaken; deaths of those detained under the Mental Health Act; decomposed cases; deaths after surgery; deaths were autopsy is considered high infective risk.

There are also shortages of particular specialist pathologists, for example neonatal, neuropathologists, bone specialist etc. All of these impact on the speed of service delivery and delay release of the deceased person back to their family.

Forensic pathologists are mainly self-employed and are managed in regional practices through the Pathology Delivery Board part of the Home Office (HO). The HO which oversees their training and recruitment and agrees their fees which by comparison to Histopathologist is approaching £3000 per case. There are still however delays, often of more than a year in a coroner receiving the post-mortem examination report which is a cause of significant delay in case management and thus to the family of the deceased person. Though managed by the Pathology Delivery Board the Forensic Pathologists in a practice appear to have autonomy as to whether there is work for additional pathologists and who can join the practice. This is in spite of delays in Post-mortem reporting and increasing complexity to cases.

Post-mortem imaging. (PMI)

CT scanning in adults and MRIs in children supported by techniques such as angiography and lung inflation and limited histology is again very variably available across England and Wales It is the examination of choice in Preston and Blackburn, but only available to families who can pay in London.

This is despite the strong evidential basis for it being the examination of choice along with toxicology for many causes of death for example trauma, and the advances in diagnosis seen during the current Covid 19 pandemic when there are typical lung lesions that allow the cause of death to be identified without the infective risk of autopsy.

The field is developing constantly with extensive use internationally. Research has shown that post-mortem imaging plus toxicology can establish the cause of death in around 80 % of cases. Even if a subsequent autopsy is required this can be limited to areas of likely pathology.

The use of PMI in DVI is invaluable, charting injuries and assisting with cause of death but also images of facial features, teeth, body habitus, old trauma, implants, chronic disease, age, sex and ethnicity.

Images produced by PMI are excellent for presenting evidence in court and help reduce the requirement for second post-mortem examination, capturing evidence of fact that can be shared and analysed by multiple experts.

The PMI scene is not all rosy though. Some areas which have adopted PMI have found it even more difficult to find pathologists to undertake autopsy when required, and there are concerns

about causes of death being given by radiologists unsupported by pathologists who are expert in the field of death analysis and consider scene and other evidence not just image findings. In some areas pathologists are not involved at all, and body visual examination, toxicology etc. carried out by anatomical pathology technicians without expert support from pathologists.

The RC Pathologists and RC Radiologists have recently reissued their joint guidance on PMI and how and when it should be undertaken.

The Hutton report attempted to address all of these issues and more and the MLC considers that government should look again at implementing its findings.

Summary

The correct approach would be have PMI and autopsy available and the examination chosen according to the particulars of the case. Increased use of PMI would reduce the pressure on pathologists, increase turnaround times, move pathology forward and most importantly present a less distressing alternative to families where the case would suitable to autopsy. This is especially important to those whose faith precludes autopsy.

It is highly unfair that access to such services is determined by where the death occurred.

Coronial toxicology.

There have been the well-publicised failures in forensic toxicology since the Forensic Science Service was disbanded.

Toxicology is central to the coronial investigation of unnatural death and death of unknown cause. In 2019 24% of all deaths investigated by a post mortem ordered by a coroner included toxicological analysis to a total of 19,219 cases. The proportion of cases involving toxicology has risen since 2011.[1] The complexity of the toxicology requested varies considerably, from a simple request for a blood alcohol estimation through to the very full toxicology required to investigate a possible "Chemsex" death. No figures for the total cost of coroners' toxicology are available, but assuming a reasonable estimate of the average cost per case is £ 400, the total annual cost for England and Wales would be approximately £7,700,000.00.

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[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/888314/Coroners_Statistics_Annual_2019_.pdf

Toxicology may be required not only to investigate the direct cause of death, as in. for example, an apparent drug overdose, but also the circumstances of the death, as in a death in a road traffic collision or where an assessment of the deceased's ability to form an intention is central to the Coroner's conclusion.

Good toxicology is a three legged stool. In order to obtain helpful results, the samples have to be collected properly, analysed appropriately and interpreted competently. If any one of those legs is deficient, then the toxicology may mislead rather than assist. Obtaining timely results is also very important.

Sample Collection

Sample collection will normally be carried out by or under the direction of the pathologist. After death changes in the concentration of drugs within the body take place and in order to obtain results that can support appropriate interpretation samples have to be collected from the correct site in the body, placed in the correct sample containers, properly documented and sent promptly to the right laboratory. This implies proper training in autopsy practice for pathologists. A survey by the Royal College of Pathologists indicated that a majority of trainees in histopathology either had attained the Certificate of Higher Autopsy Training (CHAT) or intended to pass the necessary examination by the end of their training. [2] Despite this, sub-optimally collected or labelled samples are still received by most toxicology laboratories from time to time. Home Office registered forensic pathologists are uniformly excellent in avoiding these problems.

A particular problem is when patients die of a cause requiring coronial investigation, such as overdose or as a result of injury, after several days of hospital care. In such circumstances toxicological analysis of samples collected at autopsy may be of little or no value. What is of value in the investigation of such deaths is analysis of the blood samples collected as part of the patient's care in the first few hours of the hospital admission. The coroner has no right of access to such samples before the patient's death and, in most cases will have no knowledge of the patient. Many such samples are disposed of within 48 to 72 hours of collection as refrigerated storage space in clinical laboratories is limited. There is no obvious way of addressing this problem within the framework of current legislation

The selection of cases requiring toxicological analysis is a matter for the Coroner and depends on the information available at the time of the autopsy. One source of such information may be the use of screening tests based on analysis of sweat from the deceased's fingers. This is of

[2] https://www.rcpath.org/profession/publications/college-bulletin/july-2015/the-future-of-the-coronial-autopsy-service.html

limited utility as the range of substances that can be screened for is limited and there are practical issues relating to the sensitivity and specificity of the test in operational use.

Sample Analysis.

This is particularly problematic in England and Wales as there is no uniformity in the laboratory services available to coroners. Smaller jurisdictions such as Northern Ireland and the Nordic Countries do not have this problem. They have the benefit of centralised forensic laboratory services.

In England and Wales, Local Authorities pay for coroners' toxicology and have limited funding as with every other service they provide. Not all toxicology services are equal in the range of analyses offered and in their costs. Contract Specifications for toxicology services may be written by Local Authorities with little input from coroners or their pathologists.

A rough classification of those who provide analytical services for coroners is set out below:

NHS District Hospitals; may offer pricings in the range of £100 to £250 for a panel of tests. The cost may be cross subsidised by the clinical service. The technology available may not support the range of analytes or the analytical sensitivity available to deal drugs that are now commonly encountered, such as fentanyl analogues, Novel Psychoactive Substances or the gabapentinoids. By the time the ongoing coronial investigation has disclosed the need for more detailed analyses the samples may have been disposed of, despite the requirement of coronial law to retain samples until the inquest has been completed and the coroner is *functus officio*.

Tertiary level NHS Hospitals, Public Analysts, University Departments (sometimes associated with NHS Labs in tertiary level Hospitals); they may charge prices in the £250 to £450 range. They generally have access to more advanced analytical techniques, and, if prompted, will be able to look for the more exotic intoxicants and usually have more expertise in the interpretation of results.

Large Commercial Laboratories, some with a global business, tend to be more expensive with costings in the £350 - £600 range. They may be known to local authority purchasing departments as a result of their outsourcing of statutory public analyst functions. Many do contract work for the police with the work product being a Streamlined Forensic Report, the spectrum of analyses reported being dictated by the contract with the particular police force. This leads to a standardised approach to cases, rather than the more bespoke one that is often appropriate for coronial investigation. Their large "customer service" departments may not facilitate discussion of individual cases between the toxicologist and the coroner, pathologist and/or the coroner's officer.

Interpretation of the Results.

There is much more to the interpretation of post mortem toxicology results than simply presenting the results alongside a table of therapeutic concentrations of the drugs of interest in life. Pathologists very often simply cut and paste the toxicologists report into their own report. Thus, the ability of the reporting toxicologist to add value to the analytical results obtained by providing an interpretive report is useful in most cases and essential in many. Appropriate training and experience are required and it is noteworthy that there is no UK professional exit qualification exclusively in forensic toxicology. This can be compared to the situation in the United States where Fellowship of the American Board of Forensic Toxicology is a requirement for directors of forensic toxicology laboratories.[3]

The drugs and poisons of coronial interest constantly change and evolve. This means that the analytical methods used by toxicologists have to evolve, often with a significant capital cost involved, and the toxicologist will require documented continuing professional education.

The timeliness of results is very important. The pathologist's report will often depend on the availability of the toxicologist's report. If a rapid turn round of toxicology results is required there has to be a concomitant investment in capital equipment and in staffing to carry out the analyses and report the results. It is simply not possible to have both cheap results and rapid results that are reliable and fit for purpose.

Accreditation

It should go without saying that any laboratory providing results for the Court system should be accredited to ISO 17025, or to have an accreditation that maps to that. ISO 17025 is the standard for analytical laboratories. When interpretation of the results is also a consideration, in the context of human pathology ISO 15189 accreditation, the standard for clinical laboratories providing interpretation of results, is also highly desirable.

Summary

The provision of forensic toxicology services for Coroners in England and Wales is currently fragmented and of variable cost and quality. Improving the quality of the service will benefit the bereaved by leading to quicker inquests and benefit public health by the rapid

[3] http://abft.org

identification of novel drugs of abuse. The currently fragmented market for coronial toxicology services is neither efficient nor providing a service of uniformly high quality.

Inter-action with other agencies

In addition to the bereaved families the majority of the evidence for the Inquest is required from other public sector agencies such as the NHS, Acute and mental health trusts, police forces, fire services, ambulance services and other private organisations such as care / nursing homes, drug and alcohol services etc. Delays encountered by the coroners' service can often be in the receiving of information and evidence from such organisations albeit sometimes for reasons which are understandable due to their own pressures.

It is in these circumstances that the locality of the service, the local knowledge of the Senior Coroner and the multi-agency relationship working can be of paramount importance. But to allow the time for the Senior Coroner to facilitate these discussions there has to be the appropriate coroners to assist with the day to day running of the courts and office (see above).

f) Coroner and Staff Welfare

An area of unevenness which is increasing is in respect of the welfare of both coroners and the staff who work within the coroner's office. It need not be repeated here the nature of the work undertaken every day by the staff and coroners. Aside from the public disasters and the very real impact these can have on the local communities, possibly directly on those who work in the coroners service, the daily nature of the job, dealing with death, speaking to the bereaved, having difficult conversations around post mortems, tissue and organ retentions, explaining the process, dealing with traumatic and child deaths, can have and regularly does have an impact on staff and coroners welfare.

Whilst coroners do not employ or manage the staff working within the Coroner Service for their Area, their position of leadership of the Service frequently results in staff welfare falling within their remit.

Welfare has been recognised even more so as a key issue for Coroners and the staff during the recent pandemic. Working at home when dealing with this traumatic subject will bring its own challenges and concerns.

Support for coroners and for the staff varies widely from nothing to access to psychologists. Those who employ staff in this area should have a structured and funded form of regular support.

Case for a National Coroner Service

The Coroner's Service is and always has been a 'local service' in that it is funded locally and serves the local community:

- Coroners are appointed and paid locally;
- The Service is funded locally, including the provision of Courts and other accommodation;
- Coroners Officers and other support staff are employed locally either by the Local Authority or by the local police force.

In providing a local service, Coroners are able to maintain their independence and are able to be agile and flexible in providing a service that adapts to local demands.

The communities that coroners serve in their individual Coroner Areas differ greatly in many ways. The nature of different Areas varies considerably, some are metropolitan with large inner-city areas, others are largely industrial, whilst others are primarily rural. Demographics very considerably, some with older retired populations and others with much younger ones. Areas have varying levels of deprivation, some being very poor others being extremely affluent. Some are very ethnically diverse, with large minority ethnic populations, others have very little diversity. Some are home to a significant number of different acute NHS trusts with numerous specialist departments, others may have only a small number of community hospitals. Some Areas house a large number of prisons, others have no prisons at all. Some may need to conduct a significant number of Article 2 compliant and jury inquests; others may have very few. What is absolutely clear is that one size will not fit all.

As already seen in this response, the differences in the nature of different Coroner's Areas is matched only by the different levels of resourcing provided to individual coroners by their Local Authorities.

Whilst a National Coroner's Service may have its supporters amongst those coroners who strive to deliver a service with insufficient resources, be it in terms of staffing levels and / or facilities because they are badly resourced by their Local Authorities, it might be said that the real question is how can Coroners retain all the benefits of being a local Service whilst being resourced to a national standard.

With the introduction of the Chief Coroner, the Chief Coroner's Guidance and Law Sheets together with the work conducted by the Coroner's Society of England and Wales, it can properly be argued that we already have a local service with national leadership.

In recent years the trend has been to move towards the merger of coronial areas and many senior coroners now serve whole county regions. Even this relatively mild expansion of Areas has been seen by some to be detrimental to the Service with the suggestions that a bereaved family is arguably better served when they know that the coroner and his or her coroner's officer are very familiar with the location of the fatal road traffic collision or with the NHS trust or care home where their loved one died etc., some of which can be lost even in some of the current larger Coroner Areas, in larger areas. Such problems may be significantly compounded by a move towards a national service and there is a real apprehension that a national service would result in a Coroner Service of the 'lowest common denominator' with many Local Authorities failing to meet their funding obligations under the CJA 2009 (S24). The 'postcode lottery' problem, therefore, is often the result of local government not funding the service properly after the CJA 2009 was introduced.

As might be expected, there are both positives and negatives from creating a National Service:

Pros

- Greater consistency in decisions, resources and service
- Funding would come from Central Government, which would lead to greater consistency, whether that be bad or good.
- Coroners would be entitled to have the same terms and conditions of office as other members of the judiciary, including the terms of a judicial pension.
- Senior Coroners, Area Coroners and Assistant Coroners should be called Judge, HM Coroner
- Would allow for Coroners to work across areas

Cons

- Would cease to be a local service with all the benefits derived from that position.
- Coroners will lose control to adapt to local requirements
- Loss of Independence
- *Big Brother* – Controlled by Civil Servants without knowledge or experience of Coroner Service
- May involve sitting in Magistrates Courts, Crown Courts with loss of identity and lack of access to courtrooms – bereaved families mixing with other court users e.g. criminal defendants
- Lose ability to recognise local variations suit local needs and recognise the differences between areas

- It is possible Government would aim to deliver the Coroners Service on a shoe-string pulling down the high standard of service delivery the bereaved people we serve.

Conclusion

It might be argued that the main advantages listed above either already are or could be enjoyed without the need for a National Service.

The leadership of the Chief Coroner, the Chief Coroner's guidance / law notes together with the training provided by the Judicial College and the work done by the CSEW have already led to a greater consistency of approach on the part of coroners in England and Wales.

Recognising and treating the Chief Coroner's '*Model Coroner Area v.2*', as setting a nationally recognised level of resourcing necessary to support a local Coroner's Service. Thereby supporting Senior Coroners and Local Authorities to reach agreement over the level of resourcing required for a specific Area. This would go a long way in reducing what are currently huge disparities in resourcing between different Coroner Areas.

The ultimate aim being to support the concept of a local Service, capable of adapting to local needs, which is resourced to a minimum national standard.

2. The Coroners Service's capacity to deal properly with multiple deaths in public disasters

(i) Summary of the role of the coroner in deaths following a public disaster.

Coroners all over England and Wales regularly deal with scenarios in which multiple deaths have occurred, from for example road traffic collisions, fatal fires, the current pandemic, plane crashes and terrorism related incidents.

The coroner's role is fundamental given their statutory responsibility to investigate violent or unnatural deaths, deaths of cause unknown, and deaths in state detention, and to establish who was the person who has died and how, when and where the death came about and the medical cause of death. In appropriate cases, the inquiry extends to the circumstances in which the death occurred. Coroners are also under a duty to report matters from the circumstances of particular deaths that if changed may prevent future deaths occurring to an agency with the authority to effect such change.

It is clear that public expectation on coroners is heightened in deaths resulting from a "public disaster".

Once a death has occurred in which the coroner's statutory interest is engaged, the legal control of the body of the deceased person passes to the coroner. It is on the coroner's authority that the body or remains are recovered from the scene and taken to the mortuary of the coroner's choosing and examined in order to establish identification, the medical cause of death and collect evidence that may assist with investigation of the death. For criminal cases this will occur in conjunction with the police.

The role of the coroner evolves at different stages of the investigation, with early stages being centred on body recovery, identification, pathology and forensics, then moving to releasing the body back to their family, and the opening of the inquest. The next phase concentrates on gathering of evidence, and finally the inquest itself.

Many public disasters have occurred and the role of the coroner in their investigation has been subject to proper scrutiny by public inquiries. Of particular note is the inquiry following the Marchioness disaster and the recommendations made by Lord Justice Clarke during this inquiry which clarified the role of the coroner in such investigations, was the instigation of disaster victim identification (DVI) and laid down the guiding principles that coroners now follow:

1. honest and accurate information at all times and at every stage;
2. respect for the deceased and the bereaved;
3. a sympathetic and caring approach;

4. the avoidance of mistaken identity.

The overarching role of the coroner in the early stages of any mass fatality incident is managed by the coroner chairing a Mass Fatalities Coordination Group (MFCG), through which the coroner works closely with partner agencies and in particular with the police to ensure the best possible recovery, identification and examination procedures are followed, and wider investigation of the incident facilitated. The coroner chairs this committee of partners and experts and requests support and resources to support the coronial aims, taking advice as appropriate. The coroner will also liaise with families, communities, central and local government agencies and link to the Strategic Co-ordinating Group (SCG). At all times the principles of LJ Clarke should be applied.

Even for the largest incidents it is usual for coroners to manage the first stages of the investigation to the opening of the inquest. However, in public disasters, this is only achievable with the appropriate support of partner agencies and resources and training. As investigations evolve for larger public disasters and those especially involving evidence that may be secret and thus a coroner not able to hear it, the middle and final stages of the inquiry may be passed to a judge with the appropriate clearance to hear secret evidence or become a public inquiry.

(ii) Background to training and planning.

Following the appalling disasters in the 1980s and the terrorist incident in London on 7th July 2005, there was initiated training for a cadre of coroners to provide and improve expertise in the management of mass fatality incidents. Since then this has been expanded and evolved and close communications and connections formed between coroners, their local resilience fora and the Home Office's UKDVI, such that coroners now plan and train with their partner agencies. This includes being trained on the Senior Identification Manager's course with senior police officers run by the college of policing which provides training in management of mass fatalities and disaster victim identification.

Since all incidents have been managed in the initial stages by a coroner, even if the investigation is later passed to a judge supported by resources to manage a big investigation, it has been deemed essential by the Chief Coroner (HHJ Mark Lucraft QC) that all coroners and their staff receive appropriate training in DVI. The Chief Coroner has overseen appointment to the DVI cadre of coroners and ensured that there is a geographic spread of expertise across England and Wales, and that all coroners and their staff are trained in DVI principles. Coroners and their officers have been trained through mandatory continuation training through the judicial college and about 400 coroners and 600 officers have been trained. Further information on these aspects is provided below.

(iii) <u>Service deaths overseas</u>

The Chief Coroner has a statutory responsibility for the monitoring of investigations and inquests into deaths of service personnel on active service overseas. In 2013 a special cadre of some 20 coroners was created to conduct such cases and special training arranged. There is guidance on the use and function of the cadre. Service deaths are often complex and involve multiple fatalities. These cases are retained by the Oxfordshire coroner by virtue of the fact that the bodies are usually repatriated to RAF Brize Norton in Oxfordshire. Cases involving single fatalities are usually dealt with by the coroner for the area where the deceased lived or his/her family live.

Oxfordshire County Council has received additional funding from the MOJ for several years to pay for an additional coroner's officer so that the Oxfordshire Senior Coroner can respond very effectively to service deaths. Thankfully, there have not been many deaths in recent years. The MOJ have withdrawn the additional funding this year to save costs but this will mean there will be difficulties responding as effectively as before should there be an increase in the number of service deaths.

(iv) Mass Fatality Incidents Dealt with by Coroners in recent years

It is important to recognise that coroners have dealt with a significant number of mass fatality incidents in the last five years. Many of which have been high profile and tantamount to a public disaster. Coroners recognise the impact of all deaths to those who are bereaved. This report acknowledges there are many more incidents which have resulted in a number of fatalities, however this response focuses on those incidents which the writers consider are tantamount to a public disaster.

Such incidents which have been dealt with by coroners include:

Plane / Helicopter Crashes
- 2014 - Malaysian Airlines Flight MH17
- 2015 - Germanwings Flight 4U 9525
- Shoreham Air Crash
- 2018 – Leicester City Helicopter
- 2019 - English Channel Piper PA46
  - Ethiopian Airlines Flight ET302
  - Dubai Diamond DA62 aircraft
- 2020 – Ukrainian Airlines Flight PS 752, Iran

Terrorist Incidents
- 2015 – Sousse
- 2017 - Westminster Bridge
- Manchester Arena
- London Bridge

Finsbury Park

2019 – Sri Lanka Easter Bombings
Fishmongers Hall

2020 – Reading Park Attack

Other

2015 – Bosley Mill Explosion

2016 – Birmingham Recycling Plant Wall Collapse

2017 – Llangammarch Wells Farmhouse Fire, Powys,
Grenfell Tower Fire

2018 – Hinckley Road Explosion, Leicester

2019 – Essex Container Lorry Deaths

Other significant incidents which are arguably public disasters requiring coroner involvement may not involve mass fatalities, such as the Salisbury poisoning incident, which led to one fatality.

(v) Knowledge and Training

In 2016 the Chief Coroner and the Coroners Training Committee agreed that the focus for the 2017 training for coroners would focus on mass fatality incidents and Disaster Victim Identification (DVI). The training is mandatory for all coroners (Senior, Area and Assistant Coroners) and runs several times throughout the year. The first session took place in January 2017, subsequent incidents throughout 2017 informed the remaining training and featured significantly to advise and inform coroners.

As well as training for coroners, coroner's officers also have mandatory annual training. In 2016 and 2018 training on mass fatality incidents was a key theme at the training delivered to them.

Mass Fatality incidents in particular those from public disasters, are a recurring topic on training for all involved in the Coroners Service.

In addition to the national training provided to coroners and coroners officers each local area will themselves or as part of the region hold regular training or table-top exercises to which Coroners are invited and encouraged to participate. These will generally be arranged through the Local Resilience Forum or key stakeholder agencies. Such exercises cover a wide range of topics from widespread flooding with fatalities, terrorist incidents, or more specific focused areas such as body recovery and the DVI processes within the mortuary.

In addition to the annual cadre training UK DVI hosts a bi-annual international DVI conference which is well attended by coroners and again provides an opportunity to discuss learning from both international and national incidents as well as smaller multiple fatality incidents.

Coroners are often asked to provide training on dealing with public disasters. Many coroners work with partner agencies to provide training on a local, regional and national level. Coroners work closely with UK DVI and the National College of Policing to provide input into the Senior Identification Managers (SIM) course.

As indicated coroner's officers have also received training on DVI incidents and on a local level in some areas they have taken part in specific training such as specialist logistics training through the LRF, should so they can be called upon to assist in the event of an incident. A number of Local Authorities have trained other staff in the role of a coroners officer should the impact of any such incident adversely affect staffing levels in the coroner's office, particularly in the event of a pandemic or natural disaster.

(vi) Coroner Capacity and support

All senior, area and assistant Coroners in each coroner area have now received training to manage a mass fatality incident in their area. In addition senior coroners have the ability to call upon assistant coroners to support the office should they be called away to deal with a specific incident, allowing the normal daily referrals to continue.

In 2017 the Chief Coroner established a Cadre of DVI Coroners with two national coroner leads. The purpose of which was to have a smaller, highly trained, skilled and informed body of coroners who would be able to support and assist coroners nationally in the event of a mass fatality incident, particularly if this was following a public disaster. DVI Cadre Coroners attend enhanced annual training. In 2019 and 2020 this training has included:

Inputs from the Home Office Resilience Unit, the National Policing Lead for DVI and Casualty Bureau, Pathology input relating to DVI and updates from UK DVI together with presentations from Coroners and Police involved in the following specific incidents:

Gas Explosion in Leicester – Senior Coroner Leicester and Dr Mike Biggs
King Power Helicopter Crash – Senior Coroner Leicester
Update on the Visiting Forces Act following the Helicopter Crash in Norfolk – Senior Coroner Norfolk
Ethiopian Airlines Flight ET 302 – international incident assisted by Senior Coroner from West Sussex
Dubai Air Crash - Senior Coroner for Somerset
New Zealand Mosque Attack – Chief Coroner of New Zealand
Sri Lanka Terrorist Attacks – Senior Coroner for Essex
Essex Lorry Container Deaths – Senior Coroner for Essex and Detective Superintendent Pasmore

Fishmongers Hall – Senior Coroner for Westminster and Detective Superintendent Detective Superintendent McHugh
Academic update on DVI and learning from incidents – Senior Coroner for Manchester North

Membership of the cadre comes with a number of responsibilities. The main responsibilities, over and above those of all senior coroners, are:

- A willingness to act as an incident coroner, for an incident in another coroner area, if called on by the Chief Coroner to do so. This is obviously subject to individual discussion and agreement in such circumstances.
- In the event that advice or assistance is required by another coroner or the Chief Coroner, to be available and contactable.
- Participation in the on-call rota (currently only for international deaths and incidents) which is organised by the cadre chairs.
- Attendance, unless good reason given, at the annual (or otherwise) cadre training
- To lead by example in terms of their own preparedness, locally, for a DVI, mass fatality or other serious incident.

(vii) Coroner role and engagement with Local Resilience Forums and stakeholders in preparation for public disaster

Many coroners sit on the LRFs and dependant on the structure in the local area, may chair the relevant group associated with Mass Fatality Planning. In addition, there are regional meetings of the LRFs, which are attended by designated coroners who will disseminate any shared learning or key information in terms of planning. As part of their daily role coroners engage regularly with other key agencies such as pathologists, mortuary staff, funeral directors and key strategic agencies. The foundations and relationships required to deal with any public disaster are built through the coroner's engagement all year round.

(viii) Challenges for Future Incidents

The nature and scale of any future incident will give rise to its own specific challenges. Coroners are well placed, experienced and highly trained to respond and handle any public disaster. Although it is acknowledged across all agencies that the threat of an open chemical, biological, radiological, nuclear (CBRN) incident would present challenges on an unprecedented scale.

Following the immediate recovery and identification response to any mass fatality incident the coroner will have to conduct an investigation and open the inquests. Resumption of the inquest hearings can currently present difficulties if some of the material which is required to

be considered is considered sensitive. At present no coroners have access and clearance to view or hear such evidence. This does not only present difficulties in mass fatality incidents but may also be relevant following deaths involving the police. It would be our proposal that in order to prevent delay and increased costs that consideration should be given to allowing a small number of experienced, specialist coroners to be enhanced vetted and security cleared.

3. Ways to strengthen the Coroners' role in the prevention of avoidable future deaths

The preventative role of the coroner is a really important aspect of our work. It is a fundamental part of the death investigation / inquest process and all coroners will be familiar with family members stating "we know this process will not bring XXX back, but we do not want this to happen to anyone else'.

When investigating a death, Coroners have a duty to make a report to an individual or organisation able to take action aimed at minimising the risk of a recurrence of the circumstances which appear to have contributed to that death.

The Coroner's and Justice Act 2009 paragraph 7, Schedule 5 and Regulations 28 and 29 of the Coroner's Investigation Regulations 2013 sets out a Coroner's duties in relation to the prevention of future death reports (PFD). There is also relevant Chief Coroner's Guidance [Number 5].

The significance of such reports was reinforced when the 2009 Act made it a duty rather than a discretionary power to make such a report when a concern has been identified.

These reports are welcomed by organisations such as the Care Quality Commission which actively encourages coroners to ensure their reports are brought to the attention of the CQC. Such agencies can introduce positive change.

The number of reports has increased from 207 in 2008 – 09 (when the Ministry of Justice last produced an annual summary) to 235 in 2012 – 13 and to 505 in 2018 – 19.

The Chief Coroner's guidance suggests:

1. Coroners may hear evidence on and representations regarding the contents of a report, although an inquest is not a public enquiry and lengthy additional evidence should be avoided
2. Reports should be based on clear evidence and expressed plainly and simply
3. The intention should be to improve public health and safety. Reports should be brief, clear, focused, and meaningful and designed to have practical effect.
4. A report should not apportion blame or make observations of any kind
5. Where possible, reports should be addressed to an individual sufficiently senior to have the power to take action
6. Reports are provided on a template to promote consistency.
7. Reports and responses may be sent to other interested bodies.

This Society feels that there are ways in which the role of the coroner can be strengthened including:

- **Improving the standard of responses to reports made by coroners:** the standard is very variable. Not infrequently, coroners may encounter the recurrence of deaths arising from similar circumstances where a previous report has clearly not resulted in any remedial action being taken, or where steps have been taken they were ineffective. On occasions no response is received at all. This is an issue which needs addressing. Coroners have no power to compel a response, as they have no jurisdiction once they have concluded their investigation. They have no power to take any action on a response which they consider inadequate to address the issue.
- **Improving how these reports and responses to them are publicised / evaluated:** the Chief Coroner lacks resources to do much more than publish the reports and responses. Some years ago a summary of such reports [then referred to as Rule 43 reports] was produced by the Ministry of Justice and made available although not since 2009 and coroners feel there are benefits in resurrecting this. It could result in improved awareness of important preventative issues; it would promote awareness of recurring themes; it would minimise the chances of duplication and inconsistency amongst different coroners. Although the Chief Coroner's Office maintains a database of all reports and responses, if such documents could be accessed more easily the a coroner thinking of writing a report to an organisation may be more easily able to learn that the issue he / she is raising has already been raised elsewhere in the country.
- **Better funding:** the effectiveness of coroners' work in this area could be achieved by making resources available. Although funding may allow someone within the Ministry of Justice or the Chief Coroner's office to be assigned to work on this subject, and alternative suggestion is for some funds be made available to finance the appointment of a small number of Assistant Coroners who could then perform some much needed work on this topic. Assistant Coroners do not work as Coroners on a full time basis – the majority "sit" a minimum of 15 days annually. Many have experience within health and safety, risk management and other relevant fields and may be well suited to perform such a task. The Chief Coroner could identify appropriate candidates.
- **Facilitating greater analysis of the information provided by the reports and responses:** improvements could be made either by a group of selected Assistant Coroners with relevant experience as mentioned above, or alternatively by commissioning an annual academic study of the reports and responses provided each year leading to an analysis of the nature, extent, type and recurrence of issues involved. Such study could assess the extent to which coroners' reports led to effective remedial action being taken, and would enable the information made available by the reports nationally to be better understood, and acted upon. Such an academic analysis might usefully include the provision of recommendations as to how circumstances giving rise to a recurrence of deaths might be:

(a) more widely shared and collated to reduce the risk of recurrence
(b) more effectively lead to monitoring, regulation and enforcement action by existing enforcement agencies (such as the Health & Safety Executive. Care Quality Commission)

- Another suggestion made was that a model similar to the one which currently operates in Australia be adopted where coroners are assisted by a **panel** consisting of staff appointed to collate such reports and then co-ordinate subsequent action. It was mooted that this could be a piece of work performed by appointed Assistant Coroners or by way of university research bodies [this occurs in other fields – for example there is currently some work being performed on behalf of the Government in relation to the deaths of former Veterans.]
- Although coroners will identify areas of concern, it is not for the coroner currently to make recommendations as regards what if any changes should be made or to be prescriptive about the action an individual / organisation ought to put in place. However, providing coroners with the option to do so may be worthy of consideration. An organisation which decides to ignore a coroner's report runs the risk of a similar death occurring in the future and any lack of action further to the earlier report being exposed. Were it to be the case that a Coroner had specifically recommended certain steps be taken, then organisations may be more reluctant to take no action for fear of future criticism.
- The committee has considered if compliance with reports would improve were the coroner to be able to impose sanctions / financial penalties. Some coroners would favour this, but others are very much aware that one of the great benefits of the coronial service is the non – adversarial approach we adopt. Inquests are not about apportioning blame in any direction. However it is the view of many coroners that being afforded the power to impose sanctions / introducing any financial element to the coroner's process would fall foul of our non – adversarial system which must be preserved. One alternative approach may be for coroners to consider issuing a notice of non – compliance in the event no meaningful response is forthcoming, with such a notice being served upon relevant organisations such as the CQC / HSE/ NHS England and relevant senior personnel within a relevant Local Authority.
- Finally, this committee is mindful that coroners are not obliged to wait until an inquest is concluded before writing a report to prevent future deaths. Such a report can be written during the coroner's investigation and many coroners do so. One example is that the Senior Coroner for Inner West London wrote such a report during the early stages of her investigation following the fatalities at Grenfell Tower in June 2017. Having reflected upon this issue this committee will now raise this point with coroners nationally in order to promote greater consistency of use of this option.

4. How the Coroners Service has dealt with COVID 19

(i) Emergency Legislation

The introduction of the Coronavirus Act 2020 was initially difficult for the Coroners' Service as there was confusion about how it should be applied. This improved after the Chief Coroner's Office and Registration Service issued guidance. The main difficulty concerned the legislative provisions themselves in relation to the completion of Medical Certificates of the Cause of Death (MCCD) and cremation forms by doctors.

The legislation provides that a doctor who has not seen or treated the patient in life or after death can issue a medical certificate of the cause of death (MCCD), providing they are satisfied as to the medical cause of death and that it is a natural death. However if that patient has not been seen by them or any other doctor in person or by video link in the last 28 days of that patient's life or after death in person by a doctor, then the death has to be referred to the coroner for consideration before the MCCD can be completed and the death registered.

If referred to the coroner, the coroner will consider the circumstances surrounding the death and if satisfied that the cause of death is known and it is natural, the coroner will issue a Form 100A in support of the doctors MCCD, which will enable a death to be registered. The registrar will also issue the "green form" to allow funerals to take place. Without issuing the green form, the deceased person cannot be buried or cremated.

For hospital deaths, the patient would have been seen by a doctor before death, and the emergency legislation was greatly assistive, allowing non front-line doctors to issue MCCDs based upon the patient's records, and so release time for front-line staff to care for the living.

However, as the death rates increased and more people die in the community, increasing numbers of deceased persons have not been seen in the last 28 days of their lives nor after death by doctors. In some coronial areas, this resulted in an increase in deaths being referred to already over-stretched coronial service.

In relation to cremation regulations, the emergency legislation provides that a deceased person can be cremated with a doctor completing cremation form 4 only. The need for a second doctor to scrutinise cremation form 4 and complete cremation form 5, has been suspended (the cremation referee will still complete cremation form 10). Cremation form 4 can again, like MCCDs be completed by a doctor who has not seen or treated the deceased person themselves, as long as the deceased has been seen by another doctor in person or via video-link in last 28 days of their life or after death by a doctor. If the deceased was not seen in life or after death, a

cremation form 4 can be issued allowing cremation by the doctor, if the coroner has considered the circumstances surrounding the death and issued a Form 100A to the registrar.

Again in some areas confusion over the new legislation in particular changes in relation to the cremation form increased pressure on coronial and registration services and put a delaying step in the death management process. There was also considerable confusion at times for families, registrars and especially funeral directors. This resulted in many coroners' services issuing local guidance on the new statutory process.

During pandemic surges there is also an increased risk of referrals to coroners as the medical cause of death is unknown. This in turn requires the coroner to order examination of the deceased person's body to help determine the cause of death and exclude unnatural deaths, increasing pressure on pathology services which are already over stretched.

(ii) <u>Impact on Coroners Service</u>

a) Pre-Planning

In the vast majority of areas, the Coroner's service adapted very quickly following the outbreak of the COVID 19 pandemic. Business continuity plans were activated, and Coroners and Coroner's staff were able to work from home. In some areas business continuity planning was very advanced and had been regularly tested. As key workers, some areas had staff remain in the office for the parts of the work which could not be carried out remotely. This varied in each Coroner area and was adapted to the needs of that area.

b) Workload/Death Reporting

Despite COVID-19 deaths being a natural cause of death, the pandemic resulted in a significant rise in the numbers of deaths referred to coroners across England and Wales, for the reasons outlined above. In some areas there was a significant increase (200-300% increase) in the number of deaths reported to the Coroner's Service for several weeks. In addition the introduction of the Coronavirus Act 2020 and the emergency legislative changes led to increased enquiries from GPs and hospital Doctors who were unsure of the new provisions and whether deaths needed to be reported to Coroners or whether they could certify the death with a Medical Certificate as to Cause of Death (MCCD). As a result, deaths were being referred to the coroner (and continue to be referred) where COVID-19 does not appear to be involved.

Where there was a demand Coroners and the staff increased their working hours with many offices opening over the bank holidays and Easter weekend in order to ensure deaths were able to be progressed and registered to enable funerals to be held.

c) Inquest Hearings

The main impact initially was on the cases listed for Inquest which had to be adjourned. The Coroner's service was able to react effectively and efficiently in notifying the bereaved, all Interested Persons and witnesses and dealing with any concerns or upset which the enforced adjournments caused. In line with other Courts there is now a backlog of Inquest hearings in particular Jury Inquests. In some Coroner areas the outstanding Jury Inquests to date total more than 30 weeks' worth of Court time.

d) Technology and Accommodation requirements

In some areas the impact on the Coroner's service was not understood, for example the requirement for Inquests to be opened in Court and the necessity for all hearings to be in public. Some Coroners had access to their buildings and Court restricted as they were simply closed down. The pandemic highlighted the importance of appropriate resources both in terms of accommodation and also technology, particularly suitable IT equipment for home working. Courts have had to adapt quickly to adapt to the use and requirements of remote Court hearings. The Chief Coroner has issued guidance to assist with the holding of remote hearings, but there will be some inquests where participants will need to be present. Whilst social distancing is required, adjustments will be needed in the Coroner's service.

e) Welfare

The British Psychological Society recently published an article specifically referencing amongst other professions Coroners (and their staff) and the potential impact of trauma through home working due to the subject matter. The impact on Coroners staff in particular is something which is yet to be considered in any detail but remains of importance to Coroners.

f) Ongoing Engagement and planning with stakeholders

Coroners continue to contribute to the management of the effects of the pandemic, working closely with other agencies to prepare for any second wave as well as actively engaging in winter planning which may be critical this year, to ensuring the death management process is effective and there is capacity in the system to cope with excess deaths.

(iii) How Coroners responded

As experts in death management coroners have a key role in emergency planning both for mass disasters and excess death scenarios. Most coroners in England and Wales sit on or chair LRFs and subgroups such as excess death management. During the pandemic coroners have acted as strategic advisers at all levels: cabinet office committees, LRFs, SCGs, Excess Death Management Groups, and Local Authority groups etc. They have advised on body movement, storage, transport, legislation, guidelines, interaction with death registration etc. In many areas

the coroner, with their oversight and understanding of the death management process has been seen as the lynchpin of death related services.

Coroners have also met and continue to meet regularly at regional and national levels in conjunction with the Chief Coroner, sharing experience and learning and keeping up to date with guidance and legislative change.
All of this work has been undertaken by coroners in addition to their day to day role of investigating the increased number of deaths referred to their services, and the adaption of the coronial services themselves to the pandemic situation.

Relationships with partner agencies from local authorities, mortuaries, registrars, police, funeral directors etc. have all been maintained and built upon. Changes in practice encouraged by the pandemic for example the response by partner agencies to unexpected death in the community and electronic communications, may well continue on and improve services going forward.

(iv) Impact Going Forward on Coroners Service

The impact of the coronavirus pandemic on the work of coroners has been significant and now presents a further area of challenge in relation to the investigation of COVID-19 related deaths.

The Notification of Deaths Regulations 2019 oblige a medical practitioner to report a death to the coroner if the cause of death is unknown (and an MCCD cannot be issued), or if it is suspected that it falls within any of the circumstances set out in reg.3; these include the disease causing death being “attributable to any employment” and the death being “unnatural”.

In Guidance No. 37, the Chief Coroner, emphasised that decision in COVID-19 referrals must be reached by applying the usual legal principles. These provide that a death from a naturally occurring disease may be unnatural if it resulted from (i) some culpable human failing or error, (ii) neglect, or (iii) failure to meet a positive obligation arising under Art. 2. One can see that an Inquest may therefore be required if the individual death in question may have resulted from, for example, exposure to the virus at work and in the absence of sufficient protective measures, or the lack of, delayed access to, or inadequacies of medical treatment (whether from GP, 111 or emergency services or in hospital).

It is not yet apparent from publicly available statistics how any COVID-19 deaths which have been reported to coroners are proceeding to investigation and inquest.

Suicide is also likely to become a more pressing concern as the pandemic spreads and has longer-term effects on the general population, the economy and vulnerable groups. The

pandemic is expected to have a knock-on effect on people's mental health. Although there are no figures yet for the UK to suggest whether the suicide rate has increased, decreased or remained the same there is concern about the impact of the COVID pandemic on the mental health and wellbeing of people of all ages and, as a result, about the possibility of a rise in suicide. Child suicides are rare and there is a worrying signal in some areas that child suicide deaths may have increased.

What is clear is that COVID-19 related deaths attributable to employment and increased suicides will result in increased investigations for coroners.
Delays in inquests being heard are foreseeable due to the impact of COVID-19 on healthcare professionals. Providing statements and attending inquests (in person or remotely) will have to be balanced against the recovery of the health service.

Local authorities will need to provide the resources required as by Coroners to help them fulfil their statutory duty. Coroners have highlighted the financial impact of COVID-19 to their Local Authority who are likely to have added them to their risk register.

(v) Recovery of the Coroners' Service

The main impact on the Coroners' Service has been the adjournment of the majority of Inquest hearings. The key focus of the recovery strategy for the coroner in conjunction with their local authorities has been the resumption of safe courts to include Jury Inquests and the return of staff into work, where required. Each coroner area will be different, and some local authorities have been more proactive than others in terms of conducting the necessary COVID health and safety assessments. To a great extent recovery is dependent on the coroner's office and court facilities. For example, some coroners have unsuitable Court premises before COVID which are now not functional. Some coroner's offices are co-located in buildings used by other services such as health which has implications for the required safety measures. Some local authorities have closed their buildings and are not re-opening them with little thought to where or how the Coroner's service will function especially in terms of Courts.

However, as of the end of July 2020 a number of coroner areas have resumed Inquest hearings in approved Courts and have utilised the technology available to adapt the way Court hearings are being conducted. Many coroners have quickly familiarised themselves with, and adapted to using Microsoft Teams and other such platforms in order to limit the number of witnesses required to attend Court. This is likely to require financial commitment from local authorities to increase IT facilities in Coroners Courts.
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The inability to hear Inquests for effectively 4 months will mean there is a backlog of Inquest hearings in most areas which are likely, in many areas, to require the increased use of Assistant Coroners.

The requirement for certain Inquests to be heard with a Jury remains problematic and coroners will have to work with their local authorities to find and fit out suitable premises. Some areas such as in the North East, coroners are exploring the financing and adaption of a regional jury facility. The impact on jury cases is likely to be significant and lead to delays in many cases. This is also going to lead to increased expenditure for local authorities who may have to look at solutions out of their own local areas.

Finally, the welfare of the staff and the potential impact of working from home, particularly if this continues, requires consideration.

5. Progress with training and guidance for Coroners

Coroners have always recognised the importance of training however prior to the 2009 Act. The Home Office, Department for Constitutional Affairs and the successor department the Ministry of Justice funded this training which was delivered by the Coroners' Study Group, later the Coroners' Training Group with the support of the Judicial Studies Board (the body replaced by the Judicial College) with induction training, day courses and annual residential training being delivered by the Coroners Society of England and Wales. The training was well attended but was not mandatory.

Following the introduction of the 2009 Act, Coroner training was identified as an essential requirement for the provision of a better service for bereaved families. The Chief Coroner has established a mandatory training provision which is now delivered in conjunction with the Judicial College. The progress made since 2013 in respect of Coroner training and guidance is set out below:

Coroners and Justice Act 2009 – Regional Training 2013

- National training was scheduled across England and Wales for all Coroners on the 2009 Act, and on the new Rules and Regulations when the CJA 2009 came into force on 25th July 2013.
- Training was delivered regionally and was attended by full and part time Coroners.
- To supplement the training, the Chief Coroner produced a guide to the Coroners and Justice Act 2009. This is currently available on the judiciary website and can be downloaded.

Chief Coroners Training Committee and Introduction of Course Directors

- Following on from the implementation of the 2009 Act, the Chief Coroner established a Training Committee.
- Expressions of Interests were sought from all Coroners (Senior/Area and Assistants) who were interested in an appointment as a Course Director. After an open selection process which included an interview with the Director of Judicial Training and the Chief Coroner, a number of Course Directors were appointed by the Judicial College to assist the Chief Coroner in the content design, delivery of all aspects of Coroners and Coroners Officers Training.
- There are currently nine Course Directors – all Coroners.
- Course Directors are appointed on a 3 year (renewable) term. An appointment as a Course Director cannot exceed more than nine years.
- The Chief Coroner and Course Directors meet quarterly at the Chief Coroner's Training Committee to discuss and review ongoing training needs, and plan for future training needs.

- All Coroner and Coroners Officers Training is now delivered on behalf of the Chief Coroner under the auspices of the Judicial College which provides training to all judicial office holders in England and Wales.
- The Chief Coroner is involved in all aspects of training, including identifying training needs and topics.
- The Chief Coroner also attends and delivers a session at all training events.
- Working in teams of three, Course Directors have been allocated responsibility to deliver the following training which takes place every year:
    - Assistant Coroner Induction Training
    - Continuation Training
    - Coroners Officers Training
    - One Day Medical Training.
- The majority of the preparatory work undertaken by Course Directors is completed in their own time.

Assistant Coroner Induction Training

- In 2014, a new two day residential induction training course was introduced for newly appointed Assistant Coroners.
- This course is skills based and is scheduled twice a year (April and December) and covers all aspects of coronial law, practice and procedure. It also provides delegates with a basic understanding of medicine and human anatomy.
- This course has been run by Course Directors for the past six years and is updated regularly to reflect any changes in legislation, case law and practice.
- Approximately 25 – 30 newly appointed Assistant Coroners attend each residential training, which must be completed within the first year of their appointment.
- In April 2020, Assistant Coroner Induction Training was cancelled due to the Coronavirus pandemic.
- A new online course has been developed for delegates who were scheduled to attend. The remote induction training is planned to take place in October 2020 and will accommodate a larger group of delegates than the number generally permitted at residential training.

Continuation Courses

- In 2014, compulsory residential training was introduced for all Coroners in England and Wales. Since then, a two day residential continuation training has been taking place.
- The training cycle commences in April and concludes the following year in January.
- During this period, five 2 day training sessions are scheduled throughout the training year (April, June, October, November and January).

- Dates are circulated in advance and Coroners are encouraged to book onto a course based on their availability.
- Coroners who fail to book and attend compulsory training can be identified by the Judicial College. It is not uncommon for the Chief Coroner to contact individual Coroners to ascertain the reason for their failure to attend, and notify the relevant Local Authority.
- Attendance at Continuation training (and other training) has also been incorporated into the annual Appraisal Scheme for Assistant Coroners which was introduced in 2019.
- Coroners (Assistants/Area and Senior Coroners) who have expressed an interest and have been appointed as syndicate leaders by the Judicial College, will assist at the training with syndicate group discussions.
- Continuation training has a different training 'theme' each year as identified by the Chief Coroner and Course Directors.
- The following topics have been covered during Continuation training to date:
    - 2014/2015: Judge/court craft, Article 2 of the ECHR, writing judgments and giving reasoned /structured rulings, summing up and avoiding the appearance of bias.
    - 2015/2016: Conclusions (short form and narrative) completing the Record of Inquest/Deprivation of Liberty Orders and jury questionnaires
    - 2016/2017: Mental Health investigations and Inquests
    - 2017/2018: Mass Fatalities and Disaster Victim Identification
    - 2018/2019: Hospital Deaths
    - 2019/2020: The Inquest process

- Guest speakers such as Judges, Barristers, both Leading and Junior and specialists in medicine/surgery are invited to attend the residential training and deliver training on complex and new emerging areas of law/medicine.
- In April 2020, all residential training was cancelled by the Judicial College until November 2020 due to the Coronavirus pandemic.

Coroners Officers Training

- In 2015, a two day compulsory and residential training course was introduced for all Coroners Officers. This two day residential training consolidated Police and Local Authority Coroner Officer's training in England and Wales for the first time.
- The training cycle for Coroner Officers training commences in May and concludes in December. During this period, seven 2 days training events are scheduled.
- The programme and content for training varies each year, but generally reflects similar training themes to that of Coroner Continuation Training, focussing on a mixture of law,

medicine and good practice, with greater emphasis on investigation and case management of deaths.

- Experienced Coroner Officers who have been appointed as syndicate leaders assist at the training with syndicate discussion.
- **Chief's Annual Conference for Senior and Area Coroners**
- Each year, the Chief Coroner holds an Annual Conference for Senior and Area Coroners. This also provides a further opportunity for Coroner training and development.
- In 2015, the Chief's Annual conference focussed on a number of topics including the statutory meaning of 'un-natural death', the investigation of deaths subject to Deprivation of Liberty Orders and pathology services. The Chief Coroner also held a one-day conference in 2015 which focussed on prison deaths.
- In 2016, the Annual Conference focussed on ethical issues arising out of investigations and inquest and leadership challenges.
- In 2017, the Annual Conference focussed on Coroners appraisal, recruitment, mentoring, ethics and the Judicial Code of Conduct
- In 2018, the Annual Conference focussed on the report of the Independent Review of Deaths and Serious Incidents in Police Custody and the 'Hillsborough report'.–
- In 2019, the Annual Conference focused on the Deepcut inquest, the role of Counsel to the Inquest, Judicial Review and mental health issues
- The Chief's Annual Conference Scheduled in March 2020 was cancelled due to Covid 19

One Day Medical Training

- In addition to the above compulsory training, Coroners can also attend one day medical (non-compulsory) training to further develop their understanding of medicine and human anatomy. The one day medical training is arranged by Course Directors and the 'theme' varies each year and is identified by Course Directors. In the past the training has covered:
    - The Head and the Brain - 2015
    - The Respiratory System - 2016
    - The Cardiovascular System - 2017
    - Abdominal Organs - 2018
    - Care of the Elderly – 2019

A one day medical training event had been scheduled for September 2020 but this has been cancelled in line with all other training.

Joint Coroner and Medical Examiner Training

- But for the Coronavirus outbreak and pandemic in early 2020, all Coroners and Medical Examiners in England and Wales were expected to attend joint regional training following the introduction of the long overdue Medical Examiner Scheme.

- Reforms as to how deaths are certified were originally proposed decades ago following various independent reviews and reports stemming from the Harold Shipman murders.
- With the appointment of a National Medical Examiner and regional Medical Examiners in 2019, implementation of the new medical examiner system across England and Wales has been slowly taking place.
- Implementation of the ME System in the first instance, will be in hospitals and then rolled out to community deaths.
- The non-statutory system introduced in April 2020 will bring a new level of scrutiny whereby all Medical Certificates of Cause of Deaths (MCCDS) completed by medical practitioners will be scrutinised by a Medical Examiner.
- A statutory ME system will be introduced in April 2021.
- Medical Examiners will be supported by Medical Examiners Officers who will manage cases from initial notification of death through to completion of the MCCD. This will include communication with bereaved families.
- As of June 2020, more than 570 medical practitioners across England and Wales had completed a 26 module e-learning online course and face to face training on the role of the ME system as part of the appointment process.
- Joint training for Coroners and Medical Examiners has been developed by the Chief Coroner's Course Directors together with the Royal College of Pathologists.
- Eight regional training days across England and Wales were identified, to commence from March through to June 2020. Each event had a minimum of 100 delegates attending. Coroners and medical practitioners were strongly encouraged to take advantage of this opportunity to network and establish relationships with fellow Medical Examiners and Coroners in their respective region.
- The aim of the joint Coroner and ME course is to assist all Coroners and Medical Examiners to understand each other's respective roles and responsibilities, understand how and when a death must be referred to a Coroner, and to identify/ resolve issues and concerns that the bereaved family may have that do not necessarily come within the Coroners remit.
- However, due the Covid-19 pandemic, all face to face training has been postponed.
- Course Directors are considering how this course can be delivered before the statutory scheme comes into force in 2021 assuming the current restrictions on face-to-face training remains in place.

Cross Jurisdictional training available to Coroners

In addition to the above training, Coroners can attend cross jurisdictional training offered by the Judicial College to all members of the judiciary to further develop their skills and abilities. The Judicial College offers training on in a number of areas such as:

- Business of Judging

- Judge as communicator
- Leadership
- Appraisal
- Mentoring

Seminars for fee-paid Coroners aspiring to be Senior and Area Coroners and Seminars for Lawyers aspiring to be Coroners

The Chief Coroner has recognised that it is important that the judiciary reflects the public we serve. To increase opportunity and to ensure diversity periodic courses are offered by the Chief Coroner to encourage applications for Coroner appointments. These courses are very popular and have increased the open competition for vacancies.

Local Society Training

- In addition to the formal training organised by the Chief Coroner via his Training Committee, training also takes place regionally on an informal basis and locally in each coronial jurisdiction.
- There are 10 local societies across England and Wales:
    - East Anglia
    - Southern Eastern
    - Southern Society
    - Southern Western
    - East Midlands
    - West Midlands
    - Wales
    - Northern Society
    - North West and North Wales
    - Yorkshire
- All Coroners will be members of at least one local society.
- Local societies will generally meet 2 – 3 times a year to discuss national/local (regional) issues and concerns.
- Each local society is encouraged to take advantage of opportunities at the meeting for further training and development.
- This is achieved by encouraging local guest speakers to attend and deliver training.
- The training will vary on the training needs identified locally and will be a combination of medical and legal training.

- Local society meetings not only strengthen relationships between Coroners, but also amongst various (local) service providers and organisations who also benefit from having a greater understanding of the Coroners role and remit.
- On a more local basis, Coroners and their staff will provide training to GPs/Hospital Trusts, Care Homes, Police and various faith groups in their own coronial jurisdiction.
- Again training will be dependent on local needs, but most Coroners will have provided some form of local training in their jurisdiction, on for example:
    - The role of the Coroner and the inquest process, and attending court to give evidence,
    - The death referral process following the introduction of the Death Notification Regulations on 1st October 2019,
    - And the legislative changes introduced by the Coronavirus Act 2020 which expanded the MCCD 'window' from 14 to 28 days, and now allows for a medical practitioner who did not attend the deceased during their last illness, to sign a MCCD.

Unfunded New Burdens

- The above illustrates that substantial changes have been made in relation to Coroner training which now aims to ensure consistency in approach between all Coroner areas. Irrespective of the geographical location in which a death occurs, bereaved families can expect the same level of investigation from Coroners.
- However, the major changes in Coroner training has placed significant new unexpected financial burdens upon Local Authorities who fund Coroner Services.
- Local Authorities are now required to fund travel and attendance of *all* Coroners and Coroner Officers at training which is compulsory.
- In some coronial areas, the extra costs associated with training has resulted in some Local Authorities refusing to fund travel and attendance for Coroners and staff despite the cost of accommodation being paid for by the Judicial College.
- This has resulted in some Coroners officers (Police and Local Authority appointed) not being able to attend training.
- Assistant Coroners have been particularly dis-advantaged, who have either been unable to attend for the same reason, or have travelled at their own expense, but are not paid the daily fee for their attendance. Many Assistant Coroners are self-employed and a loss of income for two days is often an influencing factor resulting in some Coroners unable to attend training.

Advice and Guidance

- To support and add to Coroner training, and with a view to enhanced national standards, the Chief Coroner provides written guidance, advice and law sheets to Coroners to assist Coroners with the law and their legal duties.
- Formal guidance is circulated to all Coroners and published on the Chief Coroner's website which can also be accessed by the public.
- There are now 39 Guidance notes issued by the Chief Coroner and five law sheets as set out below, covering a wide range of coronial issues.

Guidance notes:

• **Guidance No.1 The use of post-mortem imaging (adults)**
• **Guidance No.2 Location of Inquests**
• **Guidance No.3 Oaths and Robes**
• **Guidance No.4 Recordings**
• **Guidance No.5 Reports to Prevent Future Deaths**
• **Annex A: Forms – Reports to Prevent Future Deaths**
• **Guidance No 6 The Appointment of Coroners (Revised March 2020)**
• **Guidance No.7 A Cadre of Coroners for Service Deaths**
• **Guidance No.8 Pre-Signed Forms**
• **Guidance No.9 Opening Inquests**
• **Guidance No.10 Warnings to Juries**
• **Guidance No.11 Juries in Railway Cases (Suicides and Accidents)**
• **Guidance No.12 The Inquest Checklist**
• **Guidance No.13 Family Court Proceedings**
• **Guidance No.14 Mergers of Coroner Areas**
• **Guidance No.15 Apparent Bias**
• **Guidance No.16 Deprivation of Liberty Safeguards (DoLS)**
• **Guidance No.16A Deprivation of Liberty Safeguards (DoLS) 3 April 2017 onwards**
• **Guidance No.17 Conclusions: Short-form and narrative**
• **Guidance No.18 Section 1(4) Reports: Investigation Without a Body**
• **Guidance No. 19 Mentors**
• **Guidance No. 20 Key Skills for Assistant Coroners**
• **Guidance No. 20 Key Skills Form**
• **Guidance No.21 Translators and Interpreters**
• **Guidance No.22 Pre-Inquest Review Hearings**
• **Details of when the guidance was revised**
• **Chief Coroner Joint Guidance on Sudden Cardiac Death – Inherited Heart Conditions**

• **Guidance No. 24 Transfers**
• **Guidance No.25 Coroners and the media**
• **Guidance No. 26 Organ Donation**
• **Guidance No. 27 Jury Irregularities**
• **Guidance No.28 Report of Death to the Coroner: Decision Making and Expedited Decisions**
• **Guidance No. 29 Documentary inquests**
• **Guidance No. 30 Judge-led inquests**
• **Guidance No. 31 Death Referrals and Medical Examiners**
• **Guidance No. 32 Post-Mortem Examinations including Second Post Mortem Examinations**
• **Guidance No. 33 Suspension, Adjournment and Resumption of Investigations and Inquests**
• **Guidance No 34 Chief Coroner's Guidance for coroners on Covid-19**
• **Guidance No. 35 Hearings during the pandemic**
• **Guidance No 36 Summary of the Coronavirus Act 2020, provisions relevant to coroners**
• **Guidance No 37 COVID-19 deaths and possible exposure in the workplace – (amended)**
• **Guidance No 38 Remote participation**
• **Guidance No 39 Recovery from the COVID-19 pandemic**
• **<u>Guidance No 40 Counsel to the inquest</u>**

Law Sheets:

• **Law Sheet No.1: Unlawful killing**
• **Law Sheet No.2: Galbraith plus**
• **Law Sheet No.3: The Worcestershire Case**
• **Law Sheet No.4: Hearsay Evidence**
• **Law Sheet No.5: The Discretion of the Coroner**

- The Guidance above includes guidance issued by the Chief Coroner following the legislative changes introduced by the Coronavirus Act 2020 into death certification.

- Coroners also receive guidance from the Chief Coroner (when appropriate) on cases dealt with in the High Court where he has sat on applications for judicial review and applications for a fresh inquest under section 13 of the Coroners Act 1988 (as amended), which remains in force.
- Coroners are actively involved in drafting guidance on the Chief Coroners behalf at his request. As and when the needs arises, earlier guidance issued by the Chief Coroner is also reviewed and re-issued.
- Where possible, guidance issued by the Chief Coroner, and any new case law, is linked to Continuation Training.
- The guidance and training is aimed at providing a thorough and consistent approach to coronial work so that the outcome of all inquests will be clear to bereaved families, and the wider public, irrespective of the geographical location of the Coroner dealing with the case.

Conclusion

- There is a huge demand for Coroners and Coroners Officers training which plays a key part in providing an effective and efficient local Coroner's service.
- With the support of Course Directors and Syndicate leaders, the Chief Coroner and Judicial College provides training to approximately 1000 people which includes Senior, Area and Assistant Coroners and Police and Local Authority Coroners Officers.
- Whilst face to face training has been temporarily suspended and remote/digital training options are actively being considered, this is not a substitute for the other benefits attributable to residential training. Such as the opportunity for engagement, networking, sharing of experiences and ideas, and most importantly, the discussion/learning that occurs in small syndicates groups, which over the years has proved to be very beneficial.
- Coroner training needs to be instructive, practical, skills and knowledge based and is best delivered face to face particularly if complex/new areas of law are to be understood.
- Ultimately, Coroners and bereaved families benefit from this training as it ensures consistency in approach, and consistency in service, to bereaved families across England and Wales.

6. Improvements in services for the bereaved.

Funding and provision of legal aid for representation at inquests.

Coroners place the bereaved at the very centre of the death investigation process. Last year coroners dealt with over 200,000 deaths which resulted in over 30,000 inquests. For the vast majority, Interested Persons were not legally represented, and nor did they need to be so. Whilst it is always open to families to seek representation in the overwhelming majority of situations it would be a waste of their money to do so and it would similarly be a poor use of public funds to finance representation in substantially greater numbers than is currently the case. The provision of funding for legal representation for families at Inquests will not provide an overall improvement for the bereaved or for the Coroner service.

For coroners the non-adversarial process we operate is sacrosanct and is the real strength of our service. It places coroners in a unique position whereby we can be fair to all Interested Persons, aim to address any relevant issues that the bereaved family may have, and to lawfully answer the statutory questions we must answer including of course how the Deceased came to die.

Many legal representatives are helpful – the best ones are those who manage to represent their clients appropriately whilst assisting the Coroner with the inquest process and in a way which avoids hostility. In too many cases the presence of lawyers is unhelpful. Some lawyers do not like the non-adversarial process and wish to curtail it, attempting to limit the open questioning style and investigation of the coroner. Proceedings can be delayed due to numerous requests from legal representatives for additional documents, witness statements and exhibits that turn out to be of marginal or no significance to the ultimate conclusion. Inquests can be lengthened due to the presence of additional witnesses not central to the issues to be canvassed at the inquest. Many legal representatives have difficulty with the coroner's statutory duty to answer specific questions in relation to the death, and thus the requirement of the coroner to concentrate evidence in relation to these questions. Representatives instead often wish to divert proceedings into arguable but not relevant matters and raise expectations of their clients that the coroner's court is a place for quasi civil or criminal proceedings.

Some applications to resume inquests (particularly following Crown Court convictions) appear to be opportunistic from some firms and even possibly exploitative of some families when one considers what, if anything, the families themselves might have to gain (and what the law firms have to gain).

However, there is some debate amongst coroners as regards funding and not all are in agreement. Many feel that if a Coroner is doing his or her job properly then there is actually

little need for legal representation within the inquest process. The Coroner is there to ensure fairness to any and all interested persons. From the biggest and most powerful corporations to the most modest of families.

Some Coroners feel that as regards the often-raised argument that a basis for extending legal aid is that there should be parity between the family and large organizations who are able to – and often do - pay for legal representation is not borne out by their day to day experience. They feel that with the introduction in recent years of the Coroners & Justice Act 209 and developing guidance from the Chief Coroner leading to greater consistency in approach, it seems to some coroners that if fewer families engaged legal representatives, so fewer organizations (Hospitals, Prisons) would routinely engage legal representatives too. A virtuous circle. This would allow better use of funds in those services.

Other coroners view this unrealistic and do not feel that if there is no legal representation for the family that this will lead to Trusts and other Public Authorities no longer instructing Counsel. They feel that there are some inquests where despite a Coroners best endeavours to look after the family throughout the proceedings if others are represented families do feel disadvantaged and often leave feeling there has been an imbalance.

One suggestion advanced is that a legal helpline, properly funded, may help. In the event that a family seeks some guidance on the coronial process and the law they contact the coroner's officer dealing with the investigation and [possibly after that officer liaises with the coroner] and are provided with the guidance they need. However, it is acknowledged that certain families may prefer to seek guidance elsewhere and some coroners feel the opportunity to contact a legal helpline could be of benefit in the same way that people can contact a helpline for advice on for example housing repossession proceedings.

Another suggestion is that more use be made of Counsel to the Inquest - rather than face the prospect of an unduly adversarial approach that can arise in inquests involving numerous lawyers, a central fund for Coroners to apply for Counsel to the inquest would be better and more constructive. It is also submitted that this would be a far cheaper alternative.

Families at the heart of the inquest.

Coroners have always placed families at the heart of their inquiries, with wide spread use by coroners of "pen-portraits" from families to remind the court that the inquest is touching the life of a person who has lived, loved and been lost going back 20 years or more. However, the

reports Bishop James Jones and that of Dame Elish Angiolini show that coroners haven't always got it right and the service can always be improved.
The CSEW responses to these reports have demonstrated the coroners' service's ability to reflect and learn, assisted with leadership from the Chief Coroner.

Disclosure is now greatly improved; for equality of arms see the discussion above; Bishop Jones came to address the Chief Coroner's Training Day for Senior and Area Coroners in 2018, and coroners have received training on vulnerable witnesses, discrimination and unconscious bias. All of these have improved services for the bereaved.

The review of the Grenfell Tower fire by Inquest was complimentary of the coroner. This was also seen after the Manchester Bombing, and in other public disasters, bereaved families have been unhappy with investigation being taken away from the responsible coroner and passed to a judge.

The Chief Coroner.

The positive impact of the role of Chief Coroner in improving services for the bereaved has been considerable and is laid out in many parts of this response. He provides leadership, training and guidance for coroners and their staff. This has improved consistency of approach across different jurisdictions, improving services for the bereaved. The Model Coroner Area has helped set standards, encouraging LAs to respect their obligations under Section 24 C&J. He has raised the profile of coroners, helping them to integrate better with the wider judiciary and access services such as welfare. He has encouraged engagement between LAs, police forces and coroners, with increases in some areas of resources from court facilities to staff. He has introduced appraisal and mentoring for coroners. He has provided leadership and support for coroners during public disasters, including during the current pandemic, and liaises with government and partner agencies on the coroners' service's behalf. His annual report paints a yearly picture of the service, improvements and concerns. All of these trickle down to improved services for the bereaved

The current Chief Coroner is part-time supported by two deputies. Coroners support this role becoming full-time, and eligibility criteria being extended to enable a senior coroner to apply for the position (there is currently a glass ceiling preventing a coroner from becoming a Chief Coroner).There are however negative consequences, such that the Chief Coroner position may become a sinecure at the end of a judicial career, given the interruption of career progression and the inability to have a mixed judicial diet. It may be preferable to encourage the best of candidates to apply for the office as a way of demonstrating and developing leadership which could then result in elevated office in the senior courts. One way of doing this would be to have a whole time equivalent Chief Coroner; with the Chief Coroner in role for half the time and the

deputy Chief Coroners time making up the other half. This has the advantage of flexibility as in a year of several terrorist fatal incidents or a pandemic, the Chief coroner is not only available but working at all hours. In other times the work may only be a half-time position.

Improved IT.

Electronic disclosure, has facilitated earlier and fuller disclosure of evidence to families, improving the service to them.

Moving to electronic case management systems has improved efficiency in many areas and allowed staff to work from home during the pandemic in these areas.

IT facilitation of semi-remote hearings has allowed access to hearings by families during the pandemic, has reduced in some cases anxiety about attendance at the inquest, and positively improved access for disabled people and those living abroad. This likely to become the new normal for many hearings.

Partnership engagement.

Most coroners actively engage and train with partner agencies from mortality planning, faith and community leaders, MEs, registration services, embassies, hospitals, police and GPS to funeral directors. This improves inter-agency working, and understanding of the needs of communities, for example timely body release for some faith deaths and encourages a locally responsive service improving services for the bereaved at all levels.

Some suggested improvements:

1. The **Coroner Court Service support** being available in every Court and funded centrally. CCS is an invaluable service, providing support to families and other witnesses when they attend court, and providing bereavement sign posting. Their assistance relieves the pressure on court staff and officers, and their calm empathic approach has positive benefits for all the staff, up to and including the coroner. Helping to diffuse witness, family and staff anxiety and manage expectations of the proceedings in this way encourages less adversary and more investigative consideration in the court room.

2. Particularly with the recent trend for **larger geographical coroner areas** there is a concern that the local aspect of the service is declining. Bereaved families often face long trips to court for the inquest. Coroners having the resources to serve the community by conducting inquests in local court centres - with proper provisions for families including a designated Family room – would be welcome.

3. If **CT Scanners** are made available in any coronial areas, then they should be made available uniformly across the country. Further, if such post-mortem imaging is being funded by the local authority in some areas then again this should be the case everywhere. This will reduce the number of invasive PMs – a process which does cause unnecessary upset for some families.

4. The introduction of the **Medical Examiner** [ME] scheme across Hospitals and the community throughout the Country will be a welcome development. The hope is that the quality of referrals to coroners will improve, with fewer cases that need consideration of form 100A from the coroner. However, there is likely to be an increase in the number of complex cases referred which will require more resource for coroners to investigate and pay for experts and increased work for officers and court time and space. Some areas have also seen an increase in the number of post-mortem examinations required.

   Some MEs are already working very closely with coroners to mutual benefit of both organisations, with hospitals learning lessons and inquests increasingly focussed, improving services for the bereaved.

   However, real concern remains that with the ME being part of the NHS and DHSC, there is the risk that the scrutiny of deaths by them will not be independent as envisaged following the Shipman Report and the Coroner's and Justice Act. MEs accountable to their medical directors and employed by organisations who pay them, appraise them and write their references may cause difficulty for individual MEs looking at deaths within their own organisation, especially if placed in a whistle blowing situation. Management structures that require concerns to passed to the regional and Chief ME may diffuse this concern but cannot negate it, and does not deal with the fundamental issue of their lack of independence.

   Potential solutions to this would be to make MEs properly independent of the NHS (they were to be aligned with LAs), bring them closer to coroners' services, aligning them with the coroner and the registrar, or require that MEs scrutinise deaths of neighbouring hospitals and communities, and not those that fall within their employing organisation.

   Another concern has been the recruiting of coroner's officers in some areas by MEs.

5. The Society would welcome the introduction of all of the elements of the **Coroners & Justice Act 2009 not yet implemented**. For example, in relation to the seizure of documents and exhibits. The acquisition of appropriate evidence by the coroner is

fundamental to their ability to investigate a death and thus improve services for the bereaved. The Courts inspectorate to monitor compliance with s24 CJA and the Chief Coroner's Model Area.

6. **Pathology** – changes should be made to ensure that the urgent action so clearly needed and for so long now in relation to pathology happens.

These include:

- There is a scarcity of pathologists and more are needed. Families are waiting longer in some cases for the Deceased to be released to them because of delays in the post-mortem taking place due to limited numbers of pathologists. Genuine work be done to ensure that the role is an attractive one which will encourage doctors to want to train as a pathologist;
- There needs to be an increase in the statutory fee payable to Pathologists.
- Paediatric pathology: the number of hospitals now performing such work is minimal. Recently bereaved families are facing long and often distressing trips to such locations to view their children. More regional hospital mortuaries should be able to perform paediatric post-mortem examinations. A paediatric pathologist travelling to such mortuaries will avoid the family having to travel large distances.
- Care proceedings: one coroner expressed the view that when pathologists are asked to perform a paediatric post mortem on a child, and that the child has a sibling who may be the subject of ongoing care proceedings in the family courts, it should be possible to instruct that pathologist to expedite the post mortem examination. It is vital that those care proceedings can conclude in a timely manner so that the family court Judges can make determinations in the nest interests of the sibling. However too often those hearings are being held up as we wait far too long for the conclusion of the post-mortem examination report.

7. **Bereavement Support Nurses attached to Coroner's offices.**
An excellent initiative in Manchester has seen a joint funded post of bereavement nurse being attached to the coroner's office allowing access to bereavement support for those families that may need it. This has immense benefits for families and the service, allowing officers to end difficult conversations with families about the death of the loved with some positive support to offer. This must have positive mental health benefits for families, but also improves their relationships with the service and their understanding and experience of their interactions with it. Time will tell whether it may even reduce suicide rates in the bereaved. The expansion of such initiatives has obvious benefits.

8. **Medical Coroners.**

The CJA 2009 when introduced in 2013 removed the eligibility of medical practitioners to become coroners, with those already in post not being allowed to apply for other appointments.
This means that some jurisdictions now have no assistance from medical practitioners. MEs cannot fulfil this role for several reasons: firstly they do not work within the coronial service and so cannot consider referrals nor set investigations, they look only at whether a case is reportable to the coroner and have limited experience of what then occurs and their experience is with natural deaths in a medical context, unlike the wide range of deaths reportable to the coroner.

Medical coroners bring inherent expertise that allows them to focus inquests and understand medical and forensic evidence from a back ground of investigative analysis, and empathic communication with patients. They tend to instruct fewer experts and are no more likely than legal coroners to be subject to judicial review or conduct complaints. They tend to work in a cost effective and time efficient manner.

Many of the initial decisions taken in relation to reported deaths are based upon legal tests applied to a medical context.

One solution would be to allow those medical coroners in post, who are often highly experienced, to apply for other assistant coroner positions.

Another would be to change the eligibility criteria for coronial appointments to extend to medical practitioners with 5 years medical experience and a recognised and specified legal qualification, but not to require also 5 years legal practice.

7. Fairness in the Coroners system

***Do those who come into contact with the Coroner's service receive a fair hearing*?**

It ought to be borne in mind that coroners are conducting investigations and not trials which conclude with a guilty / not guilty verdict. At the conclusion of an inquest coroners are expected to complete a document known as the Record of Inquest and all of that document is regarded as the inquest conclusion. In completing that document we often have a number of issues to determine: in addition to answering the "statutory questions" we can make critical findings and write reports aimed at preventing future deaths. We aim to do so in a way which means appropriate decisions are made whilst at the same time ensuring the bereaved are at the heart of the process and we can provide them with answers to the issues they may have. The vast majority of bereaved families attend an inquest and leave having understood the process, the issues that have been aired, and – even if they do not agree on occasions with the conclusions reached – feeling as thought they had a fair hearing. This is borne out by the countless "thank you" cards and messages received by coroners and their officers annually [see Appendix A attached] but also by the negligible amount of complaints that are received.

The fairness of the process was boosted with the introduction of the Coroners and Justice Act 2009 ('CJA 2009') and associated secondary legislation. These provide a statutory scheme, building on previous legislation and significant decisions of the senior courts, designed to promote fairness to all involved at every stage of the coronial process, from an initial report of a death to an inquest where required.

The introduction of the office of Chief Coroner was in part aimed at promoting consistency. This has been successful, assisted by the national guidance and law sheets introduced since 2013 on an increasing range of issues. This is supplemented with comprehensive induction and annual training that is mandatory for all sitting coroners and is provided by the Judicial College in conjunction with the Chief Coroner.

The Coroners' Society of England and Wales, particularly via its website, disseminates the latest relevant judgments from the senior courts and offers a safe-space for coroners working in different locations to exchange ideas and views as to agreed best practice.

Coroners are firmly of the view that the service is fair. We are able to achieve this aim due to the over-whelming benefits of our non-adversarial process. For this to change in any way would do bereaved families a great dis-service.

It is often cited that the very existence of 85 separate Coroner areas can lead to unfairness, for example, due to different approaches taken by different coroners in different areas to a

particular matter, or in terms of what different levels of resourcing made available by different local authorities and Chief Constables may mean a particular coroner is able to offer a bereaved family. Some coroners have dedicated court facilities, others do not. This may mean one bereaved family can access a private room before and after a hearing, while another family may have to make do with a public landing.

The CSEW is of the view that it is important to bear in mind that those who may seek to level criticism at the coronial service are often only familiar with one aspect of our service, the inquest, and only the larger inquests which involve State agencies. The vast majority of the work of coronial staff goes largely unseen – the "back office " work – which involves coroners making countless decisions every day such as determining if a post mortem examination is needed, or if a death investigation should be discontinued now it is known the death was due to natural causes. Very little of this work is criticised.

Is the system transparent?
Yes – all of our hearings, including the opening of an inquest process, pre inquest review hearings, and the inquests themselves are heard in open court. Families and other Interested Persons receive disclosure of the evidence a Coroner will consider at an inquest and be afforded the opportunity to make representations on the evidence they receive prior to the inquest taking place. This is important and a beneficial exercise although in some inquests it can be a costly process especially if families do not able to receive evidence electronically due to a lack of IT. All of the court hearings are recorded.

Do families know what to expect from the service?
Yes – an improved and updated Guide to Coroners Services has recently been issued and coroners routinely distribute this document to families at the start of their investigations. Coroners will explain to a family at the start of the hearing what the inquest is trying to achieve and the process to be followed;

Are the wishes of bereaved families respected?
Yes. Examples may include the following:

- Coroner's Officers asking the family if they want to see the evidence or not? Some do not – albeit advanced disclosure is always offered.
- Checking if the family want to view the post mortem report. Some do not.
- Explaining to the family that if they do not feel able to attend the inquest in person then an audio recording of the inquest can be provided to them so they can one day listen to the hearing for themselves once ready to do so.
- Prioritising requests; these may include aiming to respect the wishes of family who seek the early release of their loved ones for funeral; aiming where appropriate to conduct only essential post mortem examinations;

- Working hard to facilitate organ donation when it is the express preference of a family that donation proceed (as these decision are made before jurisdiction falls to the coroner this is an additional duty outside the statutory duty and often out of usual court hours) ;

Do families understand the evidence and issues involved?
Largely yes. Coroners aim to explain medical terminology to unrepresented families for example. They will encourage medical professionals and pathologists to set out their evidence in witness statements and also in court in clear and understandable terms although more could be done.

Are the issues a bereaved family may have considered at an inquest and put to witnesses during evidence?
Yes. Coroners ensure that a family has the opportunity to put their questions to witnesses at an inquest. All coroners' officers speak to families when deaths are reported to ensure that all concerns and issues are understood. Many of these can be dealt with by the investigation although not all will fall within the relevant evidence that is permissible at the inquest. Even if no inquest is required material obtained within the investigation is shared with families so they can take the matters up with patient liaison services and others.

Is there unfairness?
There is arguably unfairness through inconsistency - whilst differences of approach are inevitable between individual judicial officers who are, on occasions, required to exercise discretion, a greater consistency in approach was one of the stated aims of the CJA 2009. The legislation itself introduced important requirements, for example, in relation to advance disclosure of documentary and other evidence and in standardising fees for access to documents. One example may arise in relation to the depth of a particular coroner's investigation – there is no guidance available to coroners as regards how detailed their investigation needs to be and it is very much a matter for their individual coronial discretion.

Timeliness –
…when inquest proceedings are not concluded in a timely manner this can cause unfairness: one of the Chief Coroner's Key Performance Indicators requires coroners to complete hearings within an average of 26 weeks. Despite an overall improvement in performance nationally, there remains a wide variation in performance across different coroner areas. This is an area for improvement. However, delay can be due to factors outside a coroner's control, for example, local funding arrangements, how long it often takes for the Crown Prosecution Service to decide whether to prosecute a crime. There is also delays in deaths in state detention whilst awaiting for reports from the Prison and Probation Ombudsman or the Independent Office for

Police Conduct. Coroners cannot control how government funds and resources these important bodies, but it is likely that both receive inadequate funding for what is asked of them. Coroners do involve the family in decisions relating to when an inquest is heard and if a family is just not ready to deal with an inquest then most coroners will try to respect this.

Funding –
CSEW has addressed the issue of publicly funded representation for families above in relation to the criteria "improvements if the services for the bereaved". However, it is the source of potential unfairness, notably where State agencies are involved. It continues to be the case, for example, where a deceased was under the care of a Mental Health Trust that the Trust and individual doctor(s) will be professionally represented at an inquest whereas the family will not. Similar situations arise in prison deaths. Public funding may be available through Exceptional Case Funding but that is subject to both means and merits testing. While inquests are inquisitorial rather than adversarial in approach, there is little doubt that hearings have become increasingly adversarial. Most lawyers for public bodies take the role of Amicus when a family is not represented, however the public may not always appreciate this and may feel "outgunned". While a coroner can try to 'level the playing field' at the same time s/he has to retain judicial independence. The Society understands and welcomes that consideration is ongoing as regards ways in which the non – adversarial process can be reinforced thereby minimising any perceived unfairness stemming from a lack of public funding.

Inspectorate –
…there is some support for the view that any perceived unfairness arising from coronial performance could be addressed were coroners to be scrutinised by way of an inspectorate as opposed to what would inevitably be a much more expensive shift towards additional public funding of representation at inquests. An Inspectorate could operate under the auspices of the Chief Coroner in order to achieve consistency. This would be mainly with regard to ensuring that s24 CJA is being complied with and that the model coroner area is replicated across all areas.

CT scanners / non – invasive post mortem facilities:
…if such scanners are made available in any coronial areas then they should be made available uniformly across the country. In addition, some local authorities will fund such scans. It is unfair if some have access to this but others do not and inevitably this results in lower numbers taking up the option of a scan if they have to pay.

Independent Public Advocate –
…the government has stated its intention that the IPA will act for bereaved families after a public disaster and support them at public inquests. A consultation period closed in December 2018 yet IPAs have yet to be introduced.

Coroners must be live to the possibility of unfairness not only to the family but other Interested Persons. It is suggested that often stakeholders are unwilling to challenge poor coronial performance/practice directly because organisations such as local hospital trusts need to maintain a positive relationship with their local coroner's service and may be reluctant to "rock the boat".

Appointments –

…the fairness of the system has been improved significantly in recent years through the fact that all coronial appointments are held by way of an open and transparent competition. Local Authorities make appointments subject to Chief Coroner and Lord Chancellor approval.
In addition, as Judges, Coroners' personal conduct can be referred to the Judicial Conduct Investigations Office [JCIO] for investigation and appropriate action/sanction.

The Office of Coroner

The Coroners' Society would wish to put on record that Lord Burnett the Chief Justice and HHJ Mark Lucraft QC, the Chief Coroner could not have been more enabling and welcoming to Coroners as judges. However the same cannot be said of the judiciary as a whole, whom we come across in cross-jurisdictional training and when there are other proceedings arising out of fatalities the subject of our investigation. Coroners are told they are a full part of the judicial family of judges. This is easy to state but is not borne out by the evidence. Coroners have been given access to ejudiciary – a platform which provides judges with information and enables communication. Most resources are not available to coroners. Coroners have ejudiciary–lite basically a Microsoft 365 email system. Legal resources are turned off. Presumably the MOJ have not funded the Judicial Office for this resource for coroners nor is judicial HR readily available for coroners as it is for judges. It is very awkward and difficult for coroners to use HR resources of funding relevant authorities given that the relevant authority often are interested persons in investigations. Perhaps the most telling evidence as to the judiciary as a whole not embracing coroner's as judges is that notwithstanding the Coroners' Society is the oldest of all judicial associations it is the only association not represented on the Judicial Council.

By far and away most interactions between the coroners' service and families are positive, with compliments and thanks not being routinely collated as they are the norm, not the exception!

The final word should come from the bereaved public we serve

Appendix A

> "I would like to thank X for his kindness today at the inquest of my grandson. I hope you will pass on to him how much his closing words meant to my son, my husband and myself. With kind regards,"

> "Thank you so much for your compassionate and wise words which I will pass on. It is thoughtfulness such as yours that is helping us to withstand the pain of our grief."

"Thank you for all the help and support you have gave me over the months. You have the ability to put people at ease. Also thank you for being so kind when we attended court on 4th May."

"We would like to thank you for everything you have done since the death of our Dad. We wouldn't have been able to manage it as well as we did without your help. You were so professional and empathetic and went through everything we needed to know and made sure we received our letter before we had to catch our flight back to Ireland. We are all so grateful and you will forever be in our thoughts for your kindness."

"I wanted to thank you both again for the professionalism, care and attention in my Dad's case."

"Thank you for the quick reply. The family would also like to express our gratitude for all the help you gave us at such a difficult time. You and your colleagues were fantastic with us and showed real compassion and understanding which gave us a great deal of comfort for which we will always be grateful."

"Thank you for the help that you gave us at a very stressful time of our life with the death of our Mum. Thank you for being so understanding at such an emotional time."

"I would like to thank you for the care, guidance and, most of all your compassion, in dealing with my wife's death."

"Many thanks for your kindness and professionalism. It was a great help through what could have been a daunting process."

"Thank you so much for all the help and support you gave us after the death of our son. You helped us through a most difficult time and were are really grateful to you."

"Thanks for all your help as well as your team's. The family really appreciated it. Having dealt with several courts yours is by far the most efficient and helpful not only from our perspective but importantly the family's."

"Thank you so much for the way you handled dealing with mine and my family's request over my mum's inquest. You went above what I expected. You made dealing with this difficult time a little easier."

"Many thanks for your kindness and professionalism. It was a great help through what could have been a very daunting process."

"Thank you for all the help and support you gave me over the months. You have the ability to put people at ease. Also thank you for being so kind when we attended Court."

"A really big thank you from us all, you made such a sad time bearable by looking after us fantastically."

"I am writing to thank you for helping me through my journey as a jury member. The friendly advice, and gentle instruction was very welcome, in what was an unknown experience for me. I learnt a lot and found it all fascinating, if not a little daunting at times."

"*I just wanted to say thank you for your help in obtaining the documents that I needed. You showed a lot of compassion and that really made a difference to me."*

"Can I extend thanks to you and your team, for inviting us to court last week. It was a very informative visit and we appreciate the time given to us from your very busy schedules!"

"I would like to take this opportunity to thank you for your support during dealings with my late father at his inquest. At the court you were all very compassionate and reassuring thank you once again it is wonderful to know that there are such people working within our local government."

"I am sure you will recall your hard work arranging for the Coroner to accelerate the process for my Mothers burial, when we spoke on 23rd. I can confirm she was buried the next day and all went well. My family and I wish to thank you for facilitating the procedures at

a difficult time. Your empathy and compassion were much appreciated. You are a credit to your force and the team."

"Thank you very much for your help over the past year. You have already been an immense help to me. Now that the inquest has happened I will find closure and I can only again pass on my thanks to you from me and my family."

"Can I take this opportunity to again compliment you on behalf of my family and myself for the very professional and caring way in which you have dealt with this case. I appreciate that I have thanked you before and that this is your job. Nonetheless I too work in public service and I am sure you encounter more complex cases than my mother's and that perhaps your interactions with bereaved families are not always easy. Therefore I think it must help to know how the work that you and your colleagues do, when done well and with compassion, can help families so much at what are obviously difficult periods in their lives."

"Thank you so much for your help and support yesterday, you were so caring and understanding."

"*Could you also pass on my thanks to the Coroner for making the inquest personal to my mum. It made such a difference at this difficult time."*

"I would like to personally thank you for your time and management of our father's case. You have dealt with us in a very supportive and sensitive way and we are very appreciative of that."

"Thank you. May I place on record how grateful I am to you and your team for the efficient and effective way this inquest was managed by you and your office. Rapid responses and updates with proper and timely disclosure. When this happens it is so very helpful and promotes confidence in the service and that the matter will be properly and effectively concluded."

"You have shown empathy and sincerity at the most difficult time in my life. I would like to thank you from the bottom of my heart."

"*Just wanted to thank you for all you did for us over the last 4 months; you made a terrible situation that little bit easier to cope with." "For all your guidance and help on our difficult journey, I cannot thank you enough*."

"Thank you all so much for getting the answers about my dad's death. Now my family and myself can grieve and move forward knowing the reason for his passing which has given me comfort just knowing."

"*Words cannot express my gratitude for your sensitive handling of my late husband's death and post mortem. It was a horrendous ordeal for my family and you made such a difficult situation bearable. Your professionalism, and gentle manner was so appreciated."*

"Thank you for all your help & support during, what I can only describe as the most traumatic and life changing event that has ever happened in my life. Thank you."

"Thank you again for helping us through the post mortem/inquest process. Your knowledge and compassion made the unbearable, bearable. You really do make a difference to people's lives."

"I feel compelled to email regarding the exceptionally positive experience today from the staff of the Liverpool Coroner's Office during what has been a very sad time for our family.

My mother died and I was advised to contact the Coroner's office this morning. From my initial conversation with a member of your admin team then being passed onto the Coroner's Officer, the whole process was most positive. Your admin team member promptly escalated my query and was most approachable.

The Coroner's Officer clearly demonstrated excellent interpersonal skills and was professional yet friendly in her approach. She put my concerns to rest. As I am having surgery on Fri and the funeral was planned for Thurs this week there was an urgency in getting all the necessary paperwork in order. I felt supported along the whole journey by her. She replied well within the timescale promised and advanced the paperwork as I was assured she would do.

This made what was a very upsetting process bearable and I cannot thank her enough for her gentle yet professional approach. In turn the coroner completed the inquest almost straight away.

Please do pass on my most grateful thanks to all these staff. Whilst this work is "everyday" to you all it is one of the most upsetting conversations which families will ever have. How it is handled will live with family members for a long time.

Thank you so much, on behalf of all our family, for the way in which you dealt with our case."

"This is a quick note to thank you for your help with the whole process. You have a lovely, reassuring manner and guided us through a system that nobody would wish to navigate."

"I would also be grateful if you could pass our thanks to the Coroner. He was kind and compassionate, keen to arrive at a fair conclusion and do good by my brother. At the same time, he had the interests of my brother and me at heart, listening carefully to our concerns and addressing them with clarity."

"I just wanted to thank you for all your help sorting things out and getting our relative home to us so quickly."

"I wanted to pass on praise and thanks to all Officers who dealt with this case but in particular gratitude to yourself.
At what was such a stressful time for our family I wanted to let you know how important the compassionate, empathetic and professional way you dealt with the sudden death was, and how this positively impacted on how well I am managing to cope with the loss of my son.
The way you dealt with the inquest, preparing paperwork and generally ensuring all ran smoothly, in addition to keeping our family informed of the process was a great relief to us."

"Please would you pass on my heartfelt thanks to the staff who have both been a tremendous help after the sudden death of my aunt. Their help, support and advice have been invaluable to me. Many thanks"

"I just wanted to say thank you so much for all your hard work and the assistance you gave to both the family and me on the matter of the funeral papers for my son. You certainly pulled all the stops out and thanks to you and all the efforts of the team in the Coroner's office, his funeral can go ahead as scheduled. Thank you once again."

"I'd just like to say a great big thank you to you all in the Coroner's office for your help and kindness when dealing with me about my Daddy's passing. You made an extremely distressing time bearable and were so helpful in dealing with the process."

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