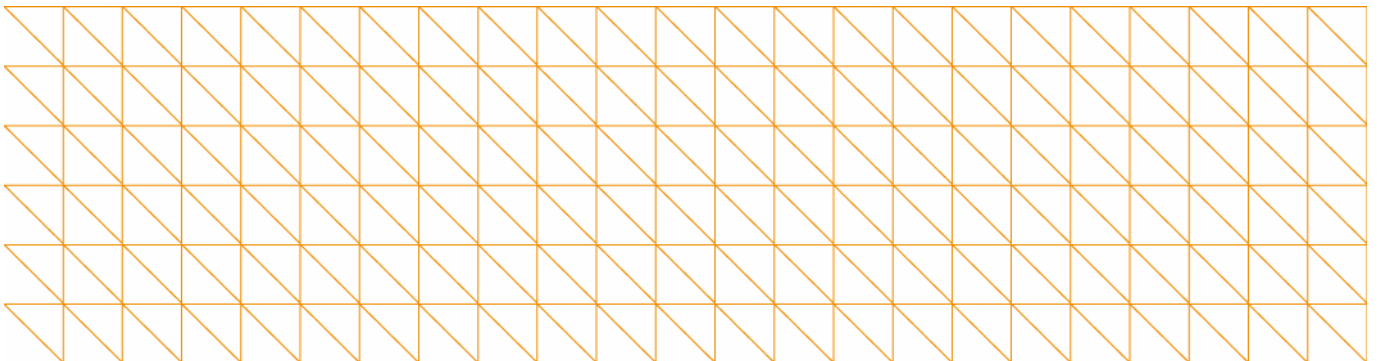




Ministry of
JUSTICE

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

Revised draft Charter and response to 2008 discussion paper
January 2009





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**This information is also available on the Ministry of Justice website:
www.justice.gov.uk**

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Foreword

By Bridget Prentice MP, Parliamentary Under Secretary of State for Justice

The Government's plans to reform the coroner system were first set out in detail in the draft Coroners Bill which was published in June 2006. Alongside the Bill we published the first draft of the *Charter for bereaved people who come into contact with a reformed coroner system*.

The inquest process can undoubtedly be a very distressing time for bereaved families, my primary aim for reform is to see *real* improvement in the service provided to families and for the highest standards to be maintained nationwide. The Charter will set out the services that they can expect to receive in a reformed coroner system, and what they can do if these standards are not met.

The initial consultation on the draft Charter took place in 2006. We were pleased at the general welcome it received, and in particular the support for what we were seeking to achieve.

We issued another discussion paper last year, and this document comprises our revised draft Charter, plus a short summary of the comments and views we received. The new Chief Coroner, which the legislation creates, will probably want to consult again before the reforms are implemented in full in two or three years' time.

I am extremely grateful to everyone who responded to the discussion paper for their suggestions, or for their further suggestions in some instances. I am especially grateful to those bereaved families who responded, some of whom I have had the benefit of meeting. I am impressed by the collective determination to get things right, a determination I intend to match as I take the coroners' legislation through Parliament.

Once again thank you to everyone who took the time to respond.

Introduction and contact details

This document is the response report for the discussion paper *Draft Charter for bereaved people who come into contact with a reformed coroner system*.

It will cover:

- the background to the report
- a summary of the responses to the report
- a detailed response to the specific questions raised in the report
- the next steps following this discussion paper.

Further copies of this document can be obtained by contacting the address below:

Coroners and Burials Division
Ministry of Justice
2nd Floor, 102 Petty France
London
SW1H 9AJ

Telephone: 020 3334 6399
Email: Elizabeth.Knapp@justice.gsi.gov.uk

This document is also available on the Ministry's website: www.justice.gov.uk.

Alternative format versions of this publication can be requested from the Coroners and Burials Division.

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

Revised draft: January 2009

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

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

1. NB This is a charter for a reformed service, NOT for the service as it is currently structured and currently operates. It is a charter for family members of a person who has died and who a coroner has decided is a "properly interested person". At the earliest stages of an investigation - the post-mortem in particular - it will not always be possible for the coroner to have made such a decision, and it will be for the coroner to decide who is to receive information at these stages. Separate information will be prepared for those who are also given interested person status by the coroner, but who are not related to the person who has died.

General

2. A coroner's investigation is required if the death is violent, unnatural, of unknown cause, or occurred while the person is detained by the State.
3. The purposes of the coroner service, when a death is reported to it, are:
 - to establish whether a coroner's investigation is required
 - if so, to establish the identity of someone who has died, and how, when, and where¹ the person died
 - to assist in the prevention of future deaths
 - to provide public reassurance.
4. HM Coroners are independent judicial office holders operating within the legal framework of the Coroners and Justice Act 2009. They are supported by coroner's officers who are employed by either the local police authority or the local authority, and by administrative staff who are employed by the local police authority or the local authority. Together, they comprise the coroner service. This charter sets out the objectives of the service,

¹ Deleted: and by what means

following reform, and the rights and responsibilities of bereaved people during coronial investigations, including inquests.

5. Most full investigations take between 6 and 12 months to complete, but a small number will take less than this, and an even smaller number of complex cases will take longer.

Definitions

6. “Inform”, or “informed” means the giving of information by² ³leaflet, letter, e-mail, telephone call, via a website or face to face.
7. “Working day” means any day between Monday and Friday inclusive, with the exception of Christmas Day, Good Friday or a bank holiday in England and Wales under the Banking and Financial Dealings Act 1971.
8. “Appropriate next of kin” means the person identified by the coroner or coroner’s officer to act as the main contact point to receive information.
9. “Family member” means⁴ a spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half-brother or half-sister of the deceased.

Objectives

10. In a reformed coroner service, the coroner’s⁵ office will:
 - help bereaved people understand the cause of the death of the person who has died
 - inform bereaved people about the role and powers of the coroner
 - inform bereaved people of their rights and responsibilities if a coroner’s investigation is conducted in relation to the death
 - take account, where possible, of individual, family, and community wishes, feelings and expectations, including family and community preferences, traditions and religious requirements relating to mourning and to funerals, and respect for individual and family privacy
 - enable bereaved people, including children and young people where appropriate, to be informed and consulted during the investigation process, treating them with sensitivity, and helping them to find further help where this is necessary

² Replaces ‘may be’

³ Deleted: being provided with information

⁴ Deleted: other family members who the coroner has determined have an interest in the investigation. These may be but are not restricted to

⁵ Deleted: or coroner’s

- answer bereaved people's questions about coronial procedures as promptly and effectively as possible
- explain, where relevant and on request, why the coroner intends to take no further action in a particular case
- provide information about how bereaved people may appeal against or complain about the coroner's decisions, and respond to appeals and complaints within the period and in the form specified by the Chief Coroner.

When a death is reported

11. When a death is reported to the coroner, the coroner's office will contact the most appropriate next of kin, where known, and where possible, within 1 working day of the death being reported to explain why the death has been reported and what steps are likely to follow.
12. The appropriate next of kin will be given information as soon as possible⁶, on where they can view the body if they wish to do so and on arrangements for viewing. They will be advised sensitively if the nature of the death may cause the viewing of the body to be particularly distressing.

Right of a family to report a death to the coroner

13. If a family member believes that a doctor, or other relevant professional, has not reported a death to the coroner when they should have done, they may⁷ report the death to the coroner personally. This should normally happen before a funeral takes place.
14. The coroner will inform the family member what action he or she proposes to take when reports are made in this way.

Post-mortems

15. Where a coroner orders a post-mortem, the appropriate next of kin will be told by the coroner why it is necessary, when and where it will be performed, and what they should do if they would like to be represented by a doctor at the post-mortem. If the appropriate next of kin, or any other family member, has queries or is unhappy with the decision to hold a post-mortem, they should bring their questions or make known their concerns to the coroner's office as soon as possible. There is no right of appeal to the Chief Coroner against the coroner's final decision.
16. When coroners request additional scientific examinations on specific organs or tissues to assist with establishing the cause of death or the identity of the person who has died, the appropriate next of kin will be informed. Again, if they have queries or concerns, they should be directed

⁶ Replaces 'during first contact'

⁷ Replaces 'will have a right to'

to the coroner's office at the earliest opportunity, although the coroner's decision as to whether the examination should take place will be final.

17. In the unusual event of a⁸ second post-mortem being commissioned by coroners which is of the same type as one previously commissioned, and if family members are dissatisfied with a coroner's reason for commissioning such an examination, and they remain dissatisfied after discussion with the coroner's office, there will be a right of appeal to the Chief Coroner.
18. ⁹If the coroner decides **not** to hold a post-mortem, and family members wish to challenge the decision, they should discuss this with the¹⁰ coroner's office and, if they remain of the same view, they may appeal the decision to the Chief Coroner.
19. Family members will have a right, on request, to see reports of any post-mortems carried out although they should be aware they may find the details distressing.
20. These provisions may need to be varied in respect of post-mortems resulting from criminal or suspected criminal offences. The coroner's office or the Police Family Liaison Officer will discuss this with you in respect of those cases.

Keeping in touch

21. If the coroner continues his or her investigation following the post-mortem, the coroner's office¹¹ will contact family members at least every three months to inform them of the status of the case, and explain any reasons for delays. This will not apply if family members have indicated that they only wish to be contacted when there is progress to report.

Inquests

22. When there is to be an inquest, information will be provided to family members of the timing, location, and the facilities available at its venue¹², wherever possible, at least four weeks before the start¹³ of the inquest.
23. Family members' views will be taken into account about the timing of the inquest and information will be provided to them¹⁴ by the coroner's office¹⁵

⁸ Deleted: full

⁹ Deleted: This right of appeal also applies to proposed additional scientific examinations on specific organs or tissues arising from the second post-mortem.

¹⁰ Deleted: coroner or

¹¹ Deleted: he or she or another member of the service

¹² Deleted: the place where the inquest will be held

¹³ Replaces 'date'

¹⁴ Replaces 'family members'

¹⁵ Deleted: or the coroner

about, for example, the purpose of of¹⁶ the inquest, who is likely to be present, and on the opportunities for participation in proceedings by addressing the coroner directly or through a legal representative¹⁷. Information will also be provided about when legal aid may be available.

24. If the date and/or location of the inquest has to be changed, information¹⁸ will be provided, wherever possible, within five working days of the decision being taken.
25. Disclosure of all relevant documents to be used in an inquest will take place, on request, free of charge and in advance of an inquest, to those family members whom the coroner has determined have an interest in the investigation.
26. It is possible, for legal reasons, that not all documents that the coroner intends to use at an inquest¹⁹ will be able to be disclosed, or disclosed in full. On request, the coroner will explain the reasons why he or she has not disclosed a particular document, or part of a document.
27. Where the coroner decides to hold a pre-inquest hearing, those family members known to have an interest will be informed of the time, date and location, the purpose of the hearing and their rights and opportunities during it.
28. Wherever possible, an appropriate private room will be provided for bereaved relatives when they attend an inquest.
29. Some coroners now arrange for Court Support Services to operate on days when they hold inquests. The Support Service will welcome you when you arrive at the inquest, explain the process – working jointly with the coroner's office -²⁰and answer any queries you have before and immediately after the inquest²¹. Where there is no Support Service, the coroner's office will fulfil this role.
30. With one or two exceptions, the media is free to report inquest proceedings, although there is a requirement under the Press Complaints Commission code of practice for reporting to be sensitive and sympathetic to the feelings of the bereaved. The relevant section of the Press Complaints Commission code will be made available, on request, to family members.

¹⁶ Replaces 'and processes involved at'

¹⁷ Replaces 'including the right to speak or the right to be represented'

¹⁸ Replaces 'notification'

¹⁹ Replaces 'takes into account during his or her investigation'

²⁰ Replaces: and support you during and

²¹ Deleted: hearing

31. If they are approached by the media, the coroner's office will not release anything other than outline details of specific current cases without the consent of the appropriate next of kin. Under no circumstances will photographs be released without the consent of the next of kin.

Reports to prevent future deaths

32. At the end of an inquest, the coroner will decide whether the evidence he or she has heard should lead to a report being made to an organisation which may have power to take action to prevent deaths in the future. The coroner will announce if he or she intends to make such a report.
33. Family members who the coroner has determined have an interest in the investigation will be sent a copy of the coroner's report, and any response, or a summary of the response, which an organisation makes.
34. The coroner will send a copy of the report made to the Chief Coroner who in turn will have a responsibility to provide a summary of reports made by all coroners, and the responses to them, to Parliament.

Other rights to participation

35. Family members will be informed by the coroner, after he or she has consulted with them, of any decision to refer a death for investigation by the coroner for a different area and the reasons for that decision. The same consultation will take place if the Chief Coroner directs that an investigation is carried out by a coroner for a different area. In that case, the responsibility for informing family members rests with the Chief Coroner.
36. Once a body is no longer required for the coroner's purposes, coroners will not, other than in exceptional circumstances, retain the body²² without the consent of the family. Exceptional circumstances may include when there is a dispute about whom the body should be released to. In cases where there is a criminal investigation as a result of the death, the requirement is that bodies will be released for funerals within a maximum of 30 days of the death, but normally it will be much sooner than this.²³
37. Sometimes, organs or tissues are retained for additional examination. In this instance²⁴, the coroner should reach advance agreement with the appropriate next of kin as to what should happen when they are²⁵ no

²² Deleted: or organs or tissue

²³ Deleted: The family will be informed, and will have the opportunity to make representations, if an authority (such as the police, or a lawyer representing a defendant in a criminal case) applies to extend the period of retention beyond 30 days.

²⁴ Replaces 'If organs or tissue are retained'

²⁵ Replaces 'it is'

longer required for coroners' purposes. The coroner should convey the wishes of the next of kin to the relevant pathologist.

Review and appeal rights of coroners' judicial decisions

38. Family members who the coroner has²⁶ designated as interested persons²⁷ will have the right to appeal the following decisions²⁸:
- if the coroner decides there will NOT be a post-mortem or that there will be a second ²⁹post-mortem³⁰ of the same type as previously requested
 - whether there will be an investigation by the coroner
 - whether to resume an investigation suspended by the coroner
 - whether an inquest should be held with a jury.
39. Additionally, the appropriate next of kin may make representations to the Chief Coroner if he or she is dissatisfied if, in exceptional circumstances, the coroner proposes to retain the body of the person who has died for more than 30 days after the death.
40. In most cases, if there is disagreement between the coroner and the family member about any of the above, it is likely to be resolved through discussion. If however, this is not possible, the family member can appeal to the Chief Coroner, setting out clearly their grounds for appealing the decision, wherever possible within a maximum of 15 working days (within 1 working day if it concerns a post-mortem) of the decision being taken.
41. In addition, appeals will also be possible against decisions in relation to:
- a coroner discontinuing an investigation before an inquest
 - the decision given at the end of an inquest.
42. The family will have 60 working days from the day the decision is taken to lodge their appeal in these instances, although consideration will be given as to whether appeals can be heard beyond this time limit.
43. Most appeals are likely to be decided on the papers. However, in any case where the Chief Coroner decides that an oral hearing is required, it is likely that additional time will be needed to give a judgment. The family will be kept informed by the Chief Coroner's office of the likely timescale.
44. The Chief Coroner's office will inform the person who has appealed (and others with an interest in the appeal) of the outcome of the appeal.

²⁶ Replaces 'are'

²⁷ Deleted: for the purpose of investigations

²⁸ Deleted: taken by coroners

²⁹ Deleted: full

³⁰ Deleted: or any other examination linked to a second post-mortem

Deaths Abroad

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

Responsibilities of family members

46. Family members of the person who has died have a responsibility to provide all information to the coroner's office that is relevant to the investigation.
47. Family members, when requested, should treat with confidence any information or documents they have disclosed to them.
48. Family members should inform the coroner's office of any details, such as change of address, so they can be contacted promptly.
49. Family members should treat the coroner and his or her staff with courtesy and respect at all stages of the investigation.

Disability issues

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

Availability of support and bereavement services

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

Monitoring service standards

52. The Chief Coroner will require coroners to provide regular reports to him/her on their performance against national standards. The Chief Coroner will give the Lord Chancellor an annual report which will include an assessment of the consistency of standards between coroners' areas.
53. Independent inspections of the service will be carried out and will include consultation with bereaved people. In addition, the Chief Coroner may arrange surveys of service users from time to time.

Other complaints and feedback³¹

54. Bereaved people wishing to make a complaint about a failure to deliver other aspects of the service outlined in this charter should do so in the first instance to the coroner. If they are not satisfied with the response they should renew their complaint to the Chief Coroner. The Chief Coroner's address is: [TO BE INSERTED WHEN KNOWN]
55. Coroners are committed to providing a service which meets the needs of bereaved people at a sensitive time, and welcomes general feedback³² from bereaved people about their experiences, including feedback on where the service has performed well. They should be directed to the coroner who dealt with the case or the Chief Coroner.

Other responsibilities of the Chief Coroner

56. The Chief Coroner will be responsible for setting national minimum standards across a range of coroner functions. In terms of the services to bereaved families, this could include standards in relation to particular types of deaths or suspected deaths (for example – deaths on active military service, deaths as a result of atrocities or other disasters, deaths from particular illnesses such as mesothelioma, epilepsy or sudden adult death syndrome, and deaths apparently resulting from suicide). These are matters for the Chief Coroner to determine when he or she is appointed.
57. Similarly, this is a draft charter only, and is intended as a guide - to those with an interest - of the kinds of service it is envisaged will be provided in a reformed service.

³¹ Replaces 'comments'

³² Replaces 'comments'

Charter for bereaved people who come into contact with a reformed coroner system – response to 2008 discussion paper

Background

1. The Charter will be enabled by coroners' legislation and will have the status of statutory guidance. It details the services that bereaved people who come into contact with the reformed coroner service can expect to receive, and sets out their rights of redress if these services are not delivered. Additionally, the Charter sets out appeal rights against particular decisions taken by coroners in individual cases.
2. A draft version of the Charter was first published alongside the draft Coroners Bill in June 2006. In 2007 we consulted those with a particular interest (those who work within the current system and the voluntary sector groups which most frequently have contact with it). The subsequent draft of the Charter incorporated the feedback we received from both the 2006 and 2007 consultations.
3. The Charter was issued for discussion again between 18 June and 10 September 2008. A list of respondents is at **Annex A**.
4. This report summarises the responses received to the discussion paper. The report also highlights how the responses have influenced the redrafting of the revised Charter.

Summary of responses

5. A total of 84 responses were received. Responses came from a wide variety of organisations and individuals, including coroners themselves, medical professionals, local authorities, voluntary organisations and bereaved family members. During the consultation period, we have also had a number of meetings with coroners and interested voluntary groups about the Charter.
6. In general, respondents supported the wider aims of the Charter. Inevitably some respondents expressed concerns about specific aspects of the draft. In summarising the responses, we identified the following key issues:

Support for the Charter

7. Many respondents expressed their support, subject to minor alterations, and applauded the Charter for the likelihood that it would improve nationwide consistency.
8. Voluntary organisations generally welcomed the Charter, especially the paragraphs ensuring that bereaved families who come into contact with the coroners' service will be better informed, more closely involved, and treated more sensitively. For example, the voluntary organisation INQUEST welcomed the proposed changes and noted that they hoped that the Charter would become a reality.
9. Support for the draft Charter was not limited to voluntary groups. Martin Alford, HM Coroner for Kent, described the Charter as providing a more transparent and open service for the bereaved, and Andrew Tweddle, HM Coroner for Darlington and South Durham/North Durham districts, described it as "laudable". Caroline Beasley-Murray, HM Coroner for Essex and Thurrock, noted that the draft Charter was complementary to the draft Bill.
10. Other organisations also articulated their support. For example, the Royal College of General Practitioners considered the draft Charter a comprehensive document and found the emphasis on communication with bereaved families both timely and appropriate.
11. **We are pleased that the Charter has received this level of support.**

Resources

12. Some coroners raised concerns about the resources required for the Charter's implementation, and argued that without increased resources they would be unable to meet their obligations.

13. For example, HM Coroner for Kent Martin Alford argued that unless the reformed service brought with it a large increase in financial resources it would be impossible to deliver a reformed service as envisaged in the draft Charter. HM Coroner for the Black Country, Robin Balmain, was concerned that the draft Charter introduced a number of new obligations that coroners were not currently resourced for, and that there was no mechanism to compel local authorities to provide appropriate resources.
14. Victim Support, a voluntary organisation that works closely with some bereaved families, was concerned about whether the necessary funding and resources would be made available to effectively implement the reforms and ensure that appropriate support was given to the bereaved.
15. **We understand concerns about resources, but have no plans to alter current local authority funding arrangements for individual coroners. However, firstly the new Chief Coroner will have oversight of the performance of all coroners and will be able to press local authorities if he or she believes there is under-funding in a particular coroner area, particularly if there have been complaints from bereaved families about a lack of service provision. Secondly, the new and parallel changes in death certification arrangements should mean that at least 10% (and probably more) of the current referrals made to coroners by doctors will be dealt with instead by the new medical examiners who will be appointed. This will release coroners' officers and other staff in the coroner's office to deliver the services outlined in the Charter which they are not delivering already.**

Elevating the bereaved over others

16. Some respondents felt that the draft Charter focused on bereaved family members to the detriment of other interested parties such as paramedics, insurance companies, and NHS trusts. As a result, these respondents felt that the Charter risked being unfair and unbalanced.
17. For example, the Coroners' Society argued that it was wrong to favour one set of people, and that a charter should cover all interested persons. The Royal Liverpool and Broadgreen University Hospital Trust commented that interested persons such as NHS trusts should not be excluded from the Charter, and that it would give bereaved families an unfair advantage above other parties in their preparation for an inquest.
18. There were some respondents who felt that the concept of "bereaved" was too wide as it could include everyone connected to the deceased and would therefore give too many people rights under the Charter. Some respondents articulated concerns that this would cause delays and increase costs.
19. **To mitigate these concerns, we have clarified that this Charter is for the bereaved and have reiterated that it is our intention that guidance will be provided to other interested persons at inquests at a later stage. It is not our intention that families receive a preferential**

service, but having their own Charter recognises the different and specific needs they have in comparison with others with an interest in coroners' investigations.

Unrealistically raising expectations

20. Some respondents expressed concerns that the draft Charter would raise unrealistic expectations given that time and resources were in practice limited.
21. For example, the draft Charter states that wherever possible a private room will be provided for bereaved relatives for use during the inquest. Some respondents said that this would raise unrealistic expectations of the services the bereaved could expect to receive as not all coroners had such rooms available.
22. Andre Rebello, Secretary of the Coroner's Society and HM Coroner for Liverpool, argued that the Charter gives rise to undeliverable expectations and considerable resource implications. Gordon Ryall, HM Coroner for Peterborough and Stamford, claimed that this could be "a pointless exercise" because if the draft Bill was not included in the legislative programme, then the Charter would fall with it. He was concerned that it would build up expectations that would not be realised.
23. **The Charter makes it clear that it describes the level of service under a reformed coroner system. We have also drafted the Charter to differentiate between what 'will', 'should' and 'may' be done under the reformed service – i.e. between what will be mandatory and what will be desirable. More generally, we believe the service will be equipped to meet the expectations families should have of a modern public service.**

Legal advice

24. Some respondents argued that the rights of the bereaved to seek legal advice ought to be stressed in the Charter as this would make the bereaved aware of their rights to have legal representation at an inquest.
25. For example, Leigh Day & Co Solicitors would like to see reference made to legal representation in the Charter so that the bereaved are not disadvantaged in the coroner's court.
26. **We have included a reference in the revised Charter to legal representation, although the likelihood is that the vast majority of inquests will continue to take place without lawyers representing any of the parties with an interest.**

Responsibilities of the bereaved

27. A few respondents felt that the draft Charter focused too heavily on the coroner's obligations and in doing so failed to identify how bereaved families could help to ensure the investigation is effective.
28. For example, David Horsley, HM Coroner for Portsmouth and South East Hampshire, thought that the Charter should impose obligations on the bereaved family such as cooperating with the coroner.
29. **We agree and have included new provisions in the revised Charter detailing the responsibilities of the bereaved. The new provision notes what the bereaved may do to assist the process, for example provide documents in a timely manner and keep the coroner's office up to date with contact details.**

Method of contact with bereaved people of Charter

30. A few respondents sought clarification on the recommended method of contact with the bereaved. For instance, Derek Winter, HM Coroner for Sunderland, suggested that where "contact" was mentioned in the Charter, it should be clear whether this contact was intended to be in writing or simply verbal.
31. **We have taken these comments into account when drafting the revised Charter.**

Timeframe

32. Some respondents felt that the draft Charter failed to address what the maximum timeframe should be for completing an investigation (including the inquest). They were concerned, that without a clear timeframe it is difficult for bereaved families to come to terms with their loved one's death and to move on.
33. For example, bereaved family members affiliated to INQUEST commented on the long delays before inquests took place. Leigh Day & Co solicitors believed that the Charter should contain a maximum time for holding an inquest, and suggested that inquests be held within 12 months of the death.
34. **We agree that clarification is required around the issue of timeframes. However it would be unfair to expect coroners to comply with hard and fast rules because, as part of their investigations, they are often reliant on information from independent organisations over which they have no authority. This will be a matter to which the new Chief Coroner is likely to give some thought.**

The purpose of the coroner's service

35. Some coroners, such as Dr Roy Palmer, HM Coroner for Southern District of London, argued that the draft Charter did not sufficiently explain the function of the coroner's service.
36. Similarly, Geoffrey Fell, HM Coroner of Western District of North Yorkshire, did not feel that the Charter explained what the full purpose of an inquest was, as it stated only the statutory purpose.
37. **We agree with the comments raised, and have expanded paragraphs 1 and 2 to provide more detail on coroners' functions.**

Clarification of the relationship between coroners and the police Family Liaison Officers

38. A few respondents, particularly voluntary organisations and bereaved individuals, noted that there is currently confusion around the respective roles of the Family Liaison Officers and coroners in terms of providing information and updates to the bereaved.
39. For example, Mrs R. S. Mayes, a bereaved family member, would like to see more clarification on the role of the police and the coroner in the providing of information about what is occurring at any given time.
40. Disaster Action, a voluntary organisation, noted the need for clarifying the respective roles of the coroners and police Family Liaison Officers with regard to distributing information. They argued that lack of clarity over responsibility for communicating and receiving such information on the part of the coroners' officers and police Family Liaison Officers, meant the possibility of duplication of effort, or of material information not being passed on at all. This was an issue that they became aware of in relation to delays to the inquests of the victims of the 7 July London bombings.
41. **We agree this relationship needs to be clarified. However it is a complex issue, with different effective arrangements in different areas which we would not want to disrupt. We believe therefore that this is best dealt with outside of the drafting of the Charter.**

Consistency of language

42. A few respondents identified that the Charter was not consistent in its use of language. The following comments were raised by respondents:

Family

43. There were some comments on the consistency of terms used. Ian Smith, HM Coroner for South and East Cumbria, suggested there should be more consistency when referring to family, next of kin, bereaved people etc. Similarly, Dr Roy Palmer, HM Coroner for Southern District of London, noted the need for consistency regarding use of "family member" and "appropriate next of kin".

44. David Horsley, HM Coroner for Portsmouth and South East Hampshire, thought that the wordings “the family” and “family members” needed to be tightened as the document is currently unclear around who the coroner owes a duty to. He suggested the next of kin could appoint a family representative at an early stage of the process who would then be the point of contact.

Coroners/coroners’ officers

45. There were a number of comments about the varying use of “coroner”/“coroner’s officer”/“another member of the service” etc throughout the Charter. Dr Roy Palmer suggested that “*coroner or another member of the service...*” could be used throughout the Charter.
46. Edward Thomas, HM Coroner for District of Herefordshire, felt that the Charter implied that families would have direct access to the coroner, which would not necessarily be the case.

Other

47. Roger Whittaker, HM Coroner for Bradford, noted that present legislation refers to “reported deaths” rather than “referred deaths”. He commented that there needed to be more consistency in the use of the terms reported and referred throughout the Charter.
48. Victim’s Voice, the voluntary organisation, felt that repetitive phrases such as “where possible” and “information will be provided by the coroner” could be made as a general statement at the beginning of the Charter, unless otherwise stated.
49. **We have taken these comments into account when drafting our revised draft Charter.**

Simplification of the Charter

50. A few respondents would have liked to see the document simplified.
51. For example, the Coroners Officers’ Association argued that the Charter was too wordy and needed to be more generic and simple. Action Against Medical Accidents, a voluntary organisation, recommended that the Charter be accompanied by a series of booklets that would explain the Charter in more “user friendly detail”.
52. A bereaved family member affiliated with INQUEST commented, “I have read through the Charter word for word but being a layman on these matters most of it was over my head”.
53. The Royal College of General Practitioners believed there was scope to make the language of the document more accessible.
54. **We have taken these comments into account where possible when drafting our revised Charter.**

Conclusion and next steps

55. The government is grateful for the diverse and informed responses it has received about the draft Charter. We have considered all the responses we have received, and a revised version is included within this document.
56. We are publishing the revised draft Charter alongside the formal Parliamentary introduction of coroners' legislation.

Annex A – List of respondents

Coroners

Andre Rebello (Liverpool)

Christopher Dorries (Sheffield)

Alan Crickmore (Gloucestershire)

Dr Nigel Chapman (Nottingham)

M J H Singleton (Blackburn)

Ian Smith LLB (South and East Cumbria)

Derek Winter (Sunderland)

R D Atkinson (Lincolnshire)

Michael D Oakley (North East Yorkshire)

G U Williams (Worcestershire)

Ms M E Hassell (Cardiff and the Vale of Glamorgan)

R J Allen (Wolverhampton)

R H G Corner (Milton Keynes)

Dr Paul Knapman (Westminster)

John Matthews (Isle of Wight)

R J Balmain (Blackwell)

Ian Stewart Smith (Stoke-on-Trent and North Staffordshire)

David C Horsley (Portsmouth and South East Hampshire) – also on behalf of three fellow coroners in Hampshire and the County Council's Assistant Head of Regulatory Service

I M Arrow (Torbay and South Devon)

Geoffrey Saul (East Riding and Kingston Upon Hull)

Edward G Thomas (Hertfordshire)

Chris Johnson (West Kirby)

R. LI. Whittaker (Bradford)

John Pollard (Manchester South)

Dr Roy Palmer (Southern District of London)

Caroline Beasley-Murray (Essex and Thurrock)

Dr Elizabeth Earland (Exeter and Greater Devon District)

Andrew Tweddle (Darlington and South Durham/North Durham Districts)

Geoffrey L Fell (Western District of North Yorkshire)

Roger Sykes (Mid Kent and Medway)
Mike Howells (Pembrokeshire)
Martin Alford (Kent)
Ian McCreath (North Northumberland (retired))
Tony Brown (North Northumberland (acting))
Gordon Ryall (Peterborough and Stamford)
Dr Andrew Reid (St Pancras, Camden)
Rebecca Cobb (North East Kent)
Michael Rose (Western District of Somersetshire)
Andrew Haigh (South Staffordshire)

Coroners' Officers

The Coroner's Officers Association
Christine Hurst (Cheshire)
Peter Church (City of Plymouth and South West Devon)

Voluntary Organisations

Comments made at the Coroner Reform Voluntary Stakeholder meeting
26 June 2008

National End of Life Care Programme
British Lung Foundation
The Coroners Courts Support Service
Victim Support
Disaster Action
Action against Medical Accidents
MRSA Action
Foundation for the Studies of Infant Deaths
Families Against Corporate Killers (FACK)
Dignity in Dying
Epilepsy Bereaved
INQUEST
Victims Voice
Cruse Bereavement Care

Medical professionals

Emily Parry-Harries (Children's Commissioning Team, Bradford and Airedale PCT)

Charles Naylor (Chief Forensic Pathologist, Queensland Health Department)

Dr Philip Allan (MD Stockport PCT)

Gary Pugh (ACPO lead on forensic pathology)

Dr Jeff Adams (Forensic Science Regulation Unit, Home Office)

Francesca Maloney (Royal Broadgreen and University Hospitals Trust)

Priya Goyal (Human Tissue Authority)

Alison Hall (Research Association in Law and Genetics)

Mat Lawson (Royal College of General Practitioners)

David Agbamu (UK Cardiac Pathology Network)

Lawyers

Emmalene Bushnell (Leigh Day & Co Solicitors)

Association of Personal Injuries Lawyers

Local Authorities

Council of the Isles of Scilly

Manchester City Council

North Yorkshire County Council

Alison Prestwood (Superintendent Registrar, North Lincolnshire)

Bereaved Family Members

Ian Holyland

Alice Beaven

R S Mayes

Barry Mizen

Lilly Lewy

Elaine Isaacs

Tony and Yvonne Brown

Other

James Bethel (Senior Lecturer, Emergency Care, University of Wolverhampton)

Santha Rasaiah (Newspaper Society)

Su Lewis (National Association of Funeral Directors)

The Board of Deputies of British Jews

Augene Nanning, Bereavement and Loss Therapist

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