



**Draft Coroners Bill:
Analysis of Scrutiny by Bereaved People's Panel
9 November 2006**

**Prepared for the Department for Constitutional Affairs
by Opinion Leader Research**

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Foreword by Rt Hon Harriet Harman QC MP Minister of State for Constitutional Affairs

To feed into our plans to reform the coroners' system in England and Wales, I arranged an innovative strand of scrutiny, by families, to inform discussion on the legislation underpinning the reform process.

In June, I published a draft Coroners Bill which sets out the framework for the reform plans. Published with the Bill was a draft Charter for Bereaved People, which lays out proposals for standards of service the public might expect when they come into contact with a reformed coroners service. One of the key objectives of these reforms is to make the investigation and inquest process better for bereaved relatives.

Participants were brought together in the Houses of Parliament on 9 November to look at the Bill and the Charter. The men and women invited to take part in the scrutiny had all recently been through the inquest process and were uniquely positioned to say whether the changes in the Bill would have made a difference to them.

I was impressed by the enthusiasm, commitment, and public spiritedness of those who attended, particularly as all had suffered bereavement recently, and many in devastating circumstances. I listened to their comments throughout the day, and was particularly pleased that fellow MPs took the opportunity to drop in on the discussion at different stages.

I will be considering how to take forward all of the points raised by participants - some as part of the coroner reform programme, others to pave the way for, or to complement, reform.

As one of the participants said in her feedback after the event, this was democracy in action, with the Government consulting people about public services in the very building where Parliament sits.

I thank everyone who helped to make the event a success, the participants above all, and commend the process to all of my Ministerial colleagues who are preparing legislation which will have a direct impact on the public.

Harriet Harman

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1. Introduction

1.1 Background

The Department for Constitutional Affairs (DCA) commissioned Opinion Leader to conduct a workshop with people who have had recent experience of the Coroners' Service to scrutinise the Draft Coroners' Bill.

The objectives of this event were:

1. To enable members of the public with recent experience of the coroner service to give feedback to the Government on measures in the draft Coroners Bill (and the draft Charter for the Bereaved) which impact on bereaved people
2. To enable Parliamentarians and others with an interest to observe the discussion

Opinion Leader recruited 14 people to take part in this event. All participants had taken part in a telephone survey conducted, by Ipsos MORI, for the DCA in June 2006 and had contact with the Coroners' Service in the previous 12 months. Participants were selected on the basis of:

- Their willingness to participate in the event
- Their location – ensuring a good geographic spread
- Their overall satisfaction level with the Coroners' Service – reflecting different satisfaction levels revealed in the survey
- Their gender – reflecting the proportions of males/females who participated in the survey

The event took place between 11am and 4pm on Thursday 9th November.

1.2 Approach

The event focussed on 5 key areas of the Bill, including the Draft Charter for Bereaved People.

Participants had been given a brief overview of the changes in these areas in advance of the event.

The day commenced with an introduction by Opinion Leader and Constitutional Affairs Minister Rt Hon Harriet Harman MP.

Participants were then split into two smaller breakout sessions (6-7 people) to discuss contents of the Bill in detail. Two Opinion Leader facilitators moderated these sessions.

In the morning, participants talked about their experiences of the Coroners' Service. They then examined the Draft Charter for Bereaved People, which they had been sent in advance of the event. After lunch participants looked at four key sections of the Bill. These were:

- Changes to Post-Mortems
- Reporting Restrictions
- Appeals
- Complaints

The event was run according to an agenda which was drafted by Opinion Leader in consultation with the DCA. The agenda included key topics and question areas that framed discussions, and it is appended to this report. Participants were given handouts which summarised key changes in the Bill and illustrated the impact of these changes with scenarios. These handouts are also appended.

The workshop was overseen by Rt Hon Harriet Harman MP. It was viewed by some MPs, civil servants and other observers who had the opportunity wanted to hear people's opinions on the Bill first hand. Moreover, there was interest in witnessing what is a new way of developing legislation. This consultation was the first time that members of the public have been actively involved in scrutinising draft legislation in this way in Parliament.

2. Executive summary

2.1 General views on the Coroners Service

The survey conducted for the DCA earlier this year found that half (50%) of users of the Coroners' Service were 'very satisfied' and a further quarter (27%) were 'fairly satisfied' with the service they received.

The research identified the key factors relating to satisfaction with the coroners' system. Those people who were well prepared for what to expect from the process were most satisfied, as were those who received regular updates of the progress of inquiries. The fact that 90% of people were satisfied with the way they were treated by those who currently work within the system is a tribute to coroners, coroner's officers, and support staff and volunteers.

Participants to this workshop were deliberately selected to represent different levels of satisfaction with the Coroners' Service. As such, a number of common issues were identified with the service, reflective of the survey. It was inevitable, in an event like this, that the focus was on the less positive aspects of the service received, even from those who were generally satisfied, and this report focuses on the constructive criticisms which were made.

The time taken for the process was a key concern, with complaints about the length of time relatives needed to wait for an inquest to be held. Delays had a direct impact on some people with reports of insurance companies not accepting interim death certificates. A corollary issue is that relatives felt they were not always being adequately informed of progress or given sufficient notice of inquest dates.

The other main theme was around relatives not being placed at the centre of the process. This included not being told what to expect or what rights they had, and lack of sensitivity to their wishes and needs in some cases. Specific examples ranged from not having suitable facilities at inquest venues, not considering relatives' wishes on post-mortems, not disclosing evidence or disclosing it very late, to not providing a record of the inquest or a verdict statement at the end of the process.

There were also specific comments about differences in the level of service received from Coroners' staff compared to from Coroners themselves. Families felt that more training and service standards may be required to ensure a consistently high level of service is provided from all Coroners' Service personnel.

In addition, there was a particular point of view that the scope of inquests is currently too narrow and that there should be a requirement for Coroners to make recommendations which then need to be acted upon.

Another specific point made was that there is currently an imbalance between relatives and other parties in inquests as relatives may not be able to access legal representation while other parties can. This may be because they are not informed of the option or because they cannot afford this and are not entitled to legal aid.

Nonetheless, some people did not have particular issues with the Coroners' Service but may have had complaints about other agencies such as the Police, CPS or health services. This highlights the complexity of the experience and also the sensitivity as many had only very recently been bereaved.

2.2 Draft Charter for Bereaved People

The Charter for Bereaved People was welcomed by participants, who valued the creation of a document which enshrines their rights and clearly outlines what they can expect of the service.

"It's good that there is a Charter, I suppose that shouldn't be underestimated, the fact that there is one."

The principles of more information, more involvement of relatives and more standardisation of processes were each endorsed. Overall, participants felt that such a document could help achieve more consistency across the Coroners' Service.

There were also a number of specific points that participants were favourable about:

- Opportunity to be represented by a doctor at a post mortem
- Opportunity to raise objections and make appeals
- Relatives' involvement prior to the inquest enhanced
- A more professional service with the Coroner being a full time position and introduction of a Chief Coroner

However, participants felt that in places the language of the draft Charter should be more explicit. This particularly applied to clarifying who has responsibility (Coroner, Coroner's officers etc.), and what particular actions mean (e.g. what does 'reconsidering' a decision involve).

The density of the document was also an issue for some people. This meant that some of the points were not obvious to participants, even though they had the document to read in advance. We would recommend that the organisation of content in the Charter be reviewed, with more sub-headings and signposting to aid navigation.

One option to consider would be to reorganise the content by stage in the Coroners' process. This will reinforce how the process works and enable users to hone in on the most directly relevant parts.

2.3 Changes outlined in the Bill

Post-mortems

The provisions of the Bill which state that the family should receive information and be consulted on the scope of post-mortems were fully endorsed by participants.

Participants were less positive about the provisions to move the body to any suitable place in the country as they could not envisage what the rationale for this would be. Similarly, there were concerns about withholding information from the family in certain circumstances, as again participants did not fully understand under which circumstances these restrictions would be necessary.

Reporting restrictions

Participants broadly endorsed changes in reporting restrictions, believing that information should be withheld in cases where there is no public interest, and some also believed that names should be withheld under all circumstances.

There was discussion about what constitutes 'public interest' and participants felt there should be greater clarity on this. Participants also wanted to know if they could appeal the Coroner's decision on reporting.

In discussion, participants also felt that if the press was likely to be present at an inquest the family should be told so that they would be prepared. Whilst alluded to in the Charter (point 11), this obligation could be more clearly specified.

Appeals and complaints

Participants greatly valued the inclusion of a provision for appeals and complaints. They particularly welcomed that they can appeal the scope of the inquest, because many had not been satisfied with the scope in their case. They felt that these provisions would help, not only to redress problems, but to ensure better decisions are made in the first place.

Participants requested greater clarity on what they can appeal or complain about, and also on how the process works. This includes how long it is likely to take and if it would incur a cost to the bereaved. The process outlined in the Charter therefore could benefit from some more detail.

There was a mixed reaction to the role of Chief Coroner. Whilst participants felt it was important to have someone clearly identified to oversee appeals and complaints they were concerned that the Chief Coroner may not be sufficiently independent.

Overall

The points of concern above primarily relate to users not sufficiently understanding the rationale for changes. This is something that could potentially be addressed by providing more supplementary explanations in the Charter.

2.4 Broader feedback

Juries were not on the agenda for discussion (as almost all participants did not have juries in their inquests). However, a couple of participants had noticed the provision to reduce mandatory juries and were concerned by this. This element may therefore require further explanation.

Participants also raised a number of issues that they felt had not been covered in the draft Charter or Bill. Of particular concern was the issue of legal representation - participants wanted measures that would ensure a more 'even contest', with relatives having the same measures available to them as other parties.

Another point that some participants wanted to make is that, in their view, the Coroners' Service had a broader responsibility than solely ascertaining reasons for individual deaths – this being to improve society by preventing this type of death happening again.

In terms of feedback on the day, analysis of post-workshop questionnaires showed that all participants enjoyed the workshop, believing it to be a good way of involving the public in drafting law. They particularly valued meeting and talking to other bereaved people, being listened to and feeling that they were contributing to law that would benefit others.

“(The best thing about the workshop was) hearing other people’s views and ideas and being able to speak openly about the problems we faced.”

“(The best thing about the workshop was) meeting other people with similar experiences, hearing their point of view and sharing in the debate.”

“(The best thing about the workshop was) the hope that we may have helped.”

3. Main findings

3.1 General views on the Coroners Service

The survey conducted for the DCA earlier this year found that half (50%) of users of the Coroners' Service were 'very satisfied' and a further quarter (27%) were 'fairly satisfied' with the service they received. However, close to one in five (18%) were dissatisfied with their experience.

Participants to this workshop were deliberately selected to represent different levels of satisfaction with the Coroners' Service. As such, a number of common issues were identified with the service, reflective of the survey.

3.1.1. Concern with time taken

The time taken for the process was a key concern. There were complaints about the length of time it had taken for the inquest to be held. Delays can also have direct impact on some people, as a few participants reported that insurance companies did not accept interim death certificates, causing financial hardship.

"The interim death certificate is not accepted by some companies that pay out - well they ought to be paying out and (not doing so) can leave people in hardship."

However it did appear that the wait was often due to other involved agencies (e.g. the police, health and safety executive) delaying the inquest process while they completed their sometimes lengthy investigations.

A number were dissatisfied by the notice that they had been given of the inquest. This caused distress as the bereaved felt they had insufficient time to prepare for the inquest. One participant commented that she was not able to get the legal representation which she felt she needed, as she was given only four hours notice of the preliminary hearing.

"The Coroners clerk gave me four hours notice of the preliminary hearing which was absolutely disgraceful, I was livid. I didn't have a chance to get legal representation so I did it myself."

3.1.2. Relatives not at the centre of the process

Another main theme was around relatives not being placed at the centre of the process.

Many of the bereaved felt that their wishes had not been sufficiently accounted for. Some had wanted to input on the post mortem (e.g. they would have preferred no post mortem, or a limited post mortem), or the scope of the inquiry (a number wanted broader parameters).

There was also some dissatisfaction with the communications that had been received from the Coroners' Service. For example, some participants had only received phone calls while they wanted something in writing and/or have a face to face meeting.

"We were told over the phone, nothing more than that, nothing in writing, no face to face meeting at all to see what the procedure is or how it is going to be carried out and all the rest of it."

Some participants felt they had not been made aware of what to expect at the inquest, and did not feel sufficiently prepared. Some were also not told that the press might be present.

Another complaint from some was that they had not been made aware of their rights to have legal or, at the post-mortem, medical representation.

There was also a view expressed that inquest facilities were not always appropriate for families (not sufficiently private etc.)

"It was in a council chamber a fantastic building, some great architecture, not really appropriate for a Coroners Court I think, the facilities weren't great, there was no place to get a coffee or anything, you were left standing around, kind of on the lunch break, and you were talking to your barrister while the doctors and their legal teams were on the other side of the room, so that wasn't great."

3.1.3. Lack of consistency

Discussions highlighted some inconsistency in the quality of Coroners' Services across the country. Some participants experienced elements of service that were lacking in other people's experience.

"Unlike my friend here they followed everything up in writing, she wrote to me saying what was happening as well as a telephone conversation andabout the inquest and what would be expected at the inquest, who would be there and how it would be conducted... I had nothing but praise for the people I dealt with."

There was specific comment about the lack of consistency in the ability to get a record of the inquest, with inquests recorded in some cases but not in others. Recording an inquest is believed to be crucial so that an accurate record is available.

There was also apparent inconsistency in whether or not families received a verdict statement.

“You didn’t even get a copy of what the final verdict was. All you received was a death certificate and that was it, and some of you were left frantically trying to get down key points from the inquest and...I expected to get a formal letter ...at least giving the verdict, giving the coroners summation of what had gone on and I never did, I never got anything.”

There were also specific comments about differences in the level of service received from Coroners’ staff compared to from Coroners themselves. This point highlights a perceived lack of consistency in service delivery, and possibly also in level of skills across Coroners’ Service personnel.

3.1.4. Further specific points

There was a particular point of view expressed in the consultation that the scope of inquests is currently too narrow. More specifically, some people felt that it was not sufficient for inquests to purely determine the cause of death in the individual case, but rather that the Coroner should be required to make broader recommendations to prevent the same sort of death from happening again. It was also seen as important that there is some obligation for these recommendations to be acted on by relevant authorities.

“There should be something in there that requires recommendations that come from the Coroner to be acted upon.”

“If somebody comes to a conclusion, makes recommendations and what happens then, you know, what happens?”

In addition, an imbalance in legal representation between relatives and other parties in inquests was perceived. Relatives may not be able to access legal representation while other parties can, either because they are not informed of the option or cannot afford representation and are not entitled to legal aid. This issue was seen to require immediate redress.

3.1.5. Contact with multiple agencies

Some people did not have particular issues with the Coroners’ Service, but had complaints about other agencies, such as the Police or the CPS. In some cases this dissatisfaction impacts negatively on how they feel about the Coroners’ Service.

They had experienced confusion about what information to expect from the police and what information to expect from the Coroners' Service and sometimes did not know who to approach with queries, e.g. release of the body.

Having a single point of contact throughout the process, who could help families negotiate different agencies, would have made a real difference in many cases and this was a direct suggestion to emerge from the consultation.

3.2 Draft Charter for Bereaved People

Participants had all received the Draft Charter for Bereaved People in advance of the workshop so that they were familiar with the document on the day.

They identified a number of positives about the document, which they thought went some way to solving the problems that they had encountered and the overall feeling about the document was positive. However there were a number of points that would benefit from clarification. There was also an issue in the format and language of the document.

3.2.1. Positives

Participants considered the main strength of the Charter to be the very fact that it was a document drafted to outline what bereaved people can expect from the Coroners' Service.

"It's good that there is a Charter, I suppose that shouldn't be underestimated, the fact that there is one."

They felt that the document recognised the due importance of the bereaved in the process.

"I think that we felt, that we are, we're just part of a process, of somebody else's process when we'd suffered the loss, that the process should be about us and about us getting to the right conclusion about what has occurred. So we felt that the Charter recognised that and that was a good thing."

They believed that the Charter would go a long way in ensuring consistency in service across regions. Those who were satisfied with the service that they had received felt that much of what is outlined they already experienced, but this document will try to ensure that others will share their positive experience.

"We had different experiences of the Coroners Court, and some were better than others, so having the very fact that there was a Charter would be good if everybody could more or less go through and have the same standard of service, that would be a very good thing."

All participants welcomed the provision for informing and consulting the bereaved throughout the process, and this stood out as possibly the most important of the objectives and values of the document. This is something that many had felt had been lacking in their case.

The provision to consult with the bereaved was a significant strength of the document as many felt this is what had been lacking in their experience. In many cases the bereaved felt that they had a better understanding of the case than anyone else and the obligation to consult would be important in ensuring that this understanding is not wasted.

Participants commented that they particularly welcomed the provision to consult with families on the release of the body and that families can request early release for personal, cultural or religious reasons.

“The opportunity to make the quest such as for early release of the body for people, again to take into account our wishes, our needs, we felt that the Charter reflected that, and that was a good thing.”

There was confusion about who the Coroner should and should not consult (e.g. what if there was a partner who was not family) and also what if the Coroner ignored what the bereaved had said in consultation – was this something they could appeal immediately?

In terms of information, participants particularly liked both the provision of information on what to expect of the inquest process and also the support information.

“A big plus was about information, the obligation to provide information, because we all felt that the process didn't really result in us getting the information that we should have had. It would have made a big difference if requisite information had been provided”

They also welcomed the fact that decisions made by the Coroner, such as not ordering a post-mortem, would be explained to the bereaved. They also felt that the document explained their rights, e.g. having medical representation.

There was positive comment on both the appeals and complaints provision outlined in the Charter. Participants believed that the opportunity to raise objections and make appeals was crucial and that it was important to ensure that the bereaved know that these options are available.

They particularly appreciate that bereaved can appeal the scope of an inquest. Participants even comment that the fact that the scope can be appealed may ensure that the Coroner specifies a wider scope of inquiry initially.

Moderator: "What would your expectation be as to what effect that would have? Would you expecta marked increase in appeals?"

Participant: "Better decision making I think, anything that checks ...is likely to produce decisions... hopefully a wider inquiry, wider scope of inquiry."

The reference that the Coroner would not release additional details of the case (which had not been aired in open court) to the media without consent of the family was another plus point, and people welcomed this control over the media.

The point which outlined the aim to ensure a private room is provided for bereaved relatives was also welcomed; this is something that participants had commented that they had wanted.

Participants also believed that the Coroner being a full time position, and the introduction of a Chief Coroner, would ensure a more professional service.

3.2.2. Suggested improvements

Participants felt that in places the language of the draft Charter should be more explicit. There were a number of areas of confusion.

One group felt that the wording around consulting the bereaved did not sufficiently convey the importance that this process should carry. They believed that the charter should express an *obligation* for the Coroner to take into account the feelings of the bereaved. The other group had concerns along similar lines, stating that they were unhappy that the family could ask for a decision to be 'reconsidered'. They wanted to know what this really meant and what they could expect in these circumstances.

"It mentioned that certain decisions will be reconsidered. That needs to be stronger, more explicit – what does that mean? What can people expect by the term reconsidered? It needs to specify."

One group also felt that the section on information provision needed to be more explicit, specifying a requirement for face to face meetings, as well as contact in writing.

There was confusion around the perceived interchangeable wording of the Coroner and Coroner's staff or Coroner's Officer. Participants want to know who is responsible for what and they need clarity on what they can expect from each person that they may come in contact with.

"The language of the Charter should be more explicit. There are some inconsistencies. For example, it says the Coroner will notify the public, rarely does it ever happen that the Coroners' office will do it. And sometimes it says

the Coroner's staff and sometimes it says the Coroner's officer; so that's not standardised and people find it unclear."

Participants in one group were unhappy about the language of the title. They felt that the word Charter was overused and did not sufficiently convey what it is aiming to achieve.

"It was also suggested that, regarding the word Charter, people may have a cynical perception of that word now... 'Standards of Service' was one example that was put forward."

Another area of confusion was around how long the bereaved should expect the process to take. Participants discussed having a maximum limit on the timing of an inquest.

"There should be an obligation on the Charter, it should mention that there should be an obligation on the timing of the inquest. And there should be a maximum limit."

Participants wanted more information on appeals. They were not clear exactly when they could appeal and they wanted more information about how this might work, e.g. who should they appeal to?

Whilst the position of Chief Coroner was welcomed for ensuring consistency of service, there was concern that the Chief Coroner would not be sufficiently independent and this was a consistent concern in the afternoon session.

The density of the document was also an issue for some people. This meant that some of the points were not obvious to participants, even though they had the document to read in advance. We would recommend that the organisation of content in the Charter be reviewed, with more sub-headings and signposting to aid navigation.

One option to consider would be to reorganise the content by stage in the Coroners' process. This will reinforce how the process works and enable users to home in on the most directly relevant parts.

3.3 Changes to Post-Mortems

Participants were given a handout (appended) which explained the changes to post-mortems, as explained in both the Charter and the main body of the Bill.

Consistent with the Charter session, participants endorse the provisions in the Charter which ensure that the family is given information about decisions to hold a post-mortem together with the opportunity to object and appeal the decision. They

do however want clarity on who is responsible for information provision and who they should appeal to.

Other changes which receive a positive response include the provision for more limited post-mortems, which participants believe are always preferable if possible and the easing of restrictions on requesting any pathologist, including specialist pathologists, to examine a body where necessary. Both these changes are not believed to have any downsides.

“We welcomed as well the role of including a specialist pathologist. We felt that would be good and would be helpful to the situation and also that shouldn’t be so restricted from a geographical point of view as well. So obviously get the best person in the right area.”

The new power to order that a body be moved to any suitable place in the country receives a less positive response because participants are unclear why this might be necessary. They do not like the idea of the body of their loved one being moved and they would need to be clearly told why this was necessary and where the body was being moved to, to ease this concern.

“I don’t want my child traipsed all round Britain for someone else to poke at her.”

In addition to confusion about why a body would need to be moved, participants are unclear about why they might need representation from a doctor and would like this explained.

“That isn’t clear and I think the Charter should include what the parameters are for any GP being there.”

They are also unclear about why the Coroner might decide that some material needs to remain confidential and so cannot be disclosed to families. Some feel strongly that this should never be the case and that all evidence should be disclosed to families. Again this concern would be eased if there was a more full explanation as to why this might be the case.

“Why should any information be permanently excluded from any of us? These are our next of kin and loved ones when all is said and done.”

More broadly, participants believe that the changes in the Charter and the Bill on post-mortems seem to emphasise the right to appeal decisions on post-mortems, rather than consult with families before the decisions are made. Participants would like clarity on this, as they believe consultation in advance is a more constructive and positive approach. They do welcome the right to appeal, but realise that this might cause a delay in post-mortems which is far from ideal.

3.4 Reporting Restrictions

Participants broadly endorsed the changes in reporting restrictions. They thought it was correct that the Coroner should have the power to ban the publication of the name when there is no public interest in naming them, particularly as outlined in cases such as suicide or child deaths.

“For instance, if somebody committed suicide it’s of no relevance to the public to hear about that person, what happened. The family have suffered enough anyway and it’s just bringing added trauma to their lives really. It’s of no benefit to anybody to know about somebody committing suicide.”

Participants did not always believe that restricting information from the press was a good thing. In a few cases they had welcomed the involvement of the press in their case as they wanted their case to receive publicity, for reasons of public interest.

There was discussion about what constitutes public interest and participants believe that this needs to be more clearly defined.

“These words, public interest, needed to be defined more clearly as to what that actually meant.”

There is also recognition of the possible tension between being sensitive to families and reporting for the sake of public interest.

“There is a tension between reporting and sensitivity to the bereaved and public interest”.

“I am a great believer in the freedom of the press but there are people as we know that are left there afterwards and for me it didn’t allow us to mourn because ...the following morning it was on the television, we had a camera stuck outside the front door.”

For this reason participants not only believe that the term ‘public interest’ needs to be more clearly defined, but also that families should be consulted about press involvement.

“We feel that families should be consulted when the press is in the court.”

Participants also want to know if families can appeal the Coroner’s decision to impose or not impose reporting restrictions.

If the Coroner does anticipate that the press will be present at an inquest the family should be warned. One participant had had a press liaison officer in their case and felt this would be valuable for other people.

"We were given a press liaison officer and that was done through the Coroner's office which was quite helpful"

Whilst alluded to in the Charter (point 11), the obligation to inform the family about press presence could be more clearly specified.

3.5 Appeals and Complaints

As mentioned above, participants greatly value the inclusion of provision for appeals and complaints.

"...The right to appeal we think is crucial, people need to know what they can appeal against."

They believe that these provisions will actually lead to better decision making by the Coroner, who will be more cautious if their decision can more easily be scrutinised and reversed. So whilst there might be more appeals and complaints under this new system in the short term, in the longer term this may not be the case. Even if the number of appeals and complaints remain higher under this new system, participants believe that the extra use of resource is acceptable in order to ensure the system is fair and robust.

Participants request greater clarity on exactly what they can appeal or complain against.

"As far as appeals and complaints, again we felt there needed to be clarity"

They also want clarity on the detail of the process itself. They do not believe that point 30 of the Charter gives sufficient detail of how the process works. In particular they want to know how long the process will take, especially because they don't want the process to take any longer than necessary, and what costs it might incur.

"...there's going to be an issue here on timing then... that needs to be sorted out because if there's an appeal and it's holding up processes then obviously that's not to be welcomed."

"The concern at the moment in any law appeal process is cost on the individual."

There is a mixed reaction to the role of Chief Coroner. Participants believe it is important to have someone clearly identified to oversee appeals and complaints. However, there is concern that the Chief Coroner is not sufficiently independent and separate from the coroners under scrutiny to be able to review these cases in an impartial way.

"...It needed to be clear about this Chief Coroner...that there would also be able to be appeals to an independent adjudicator so that would be important that he would then be able to work in an independent capacity."

"I would like the appeal process to go before a Circuit Judge, or someone of that ilk rather than the Chief Coroner."

3.6 Broader feedback on the Draft Bill

The points of concern outlined above primarily relate to users not sufficiently understanding the rationale for changes. This is something that could potentially be addressed by providing more supplementary explanations in the Charter.

Juries were not on the agenda for discussion (as almost all participants did not have juries in their inquests). However, a couple of participants had noticed the provision to reduce mandatory juries and were concerned by this. This element may therefore require further explanation.

"There's proposals to reduce mandatory juries... some of us felt that if those were reduced then the rigour of the whole system could be lost"

Participants also raised a number of issues that they believed had not been covered in the Charter or Bill but should be. The issue of legal representation for the bereaved was considered important in both breakout groups. They believed that the bereaved should have legal representation in cases where another party is represented. This should not be a cost burden on the bereaved, so legal aid should be provided. Another option might be that neither side is allowed legal representation. Either way it needs to be an 'even contest.'

"The requirement for there to be legal aid...what chance do you have of representing yourself ...it's an uneven contest in a way."

A couple of participants believed that the Bill did not address their perception of a lack of scrutiny of evidence, such as witness statements.

"Witnesses statements should be checked if possible... if they stand out as being particularly weak, you know, weak and not substantial then they should be investigated sufficiently."

More broadly participants believed that the Coroners' Service had a broader responsibility than solely ascertaining reasons for individual deaths. Preventing the next death should be the key aim of an inquest.

"The key, the main focus, the key end should be to prevent the next death."

It is for this reason that the scope of the enquiry should not be too narrow and, furthermore, recommendations must be made and acted upon. Whilst there is room in the bill to appeal the scope of enquiry, there is no requirement to make recommendations at all and in addition no requirement for recommendations to be acted upon. Participants would like to see this included in the Bill.

3.7 Feedback on the process

At the end of the day participants were asked to complete a questionnaire, in order for us to assess how they had found the process.

Results showed that all of the participants enjoyed the workshop; the majority enjoyed it a lot and found it interesting, important and informative.

All participants believed that this kind of workshop a good way of involving the public in drafting a law.

They particularly valued meeting and talking to other bereaved people, being listened to and feeling that they were contributing to law that would benefit others.

“(the best thing about the workshop was) hearing other people’s views and ideas and being able to speak openly about the problems we faced.”

“(the best thing about the workshop was) meeting other people with similar experiences, hearing their point of view and sharing in the debate.”

“(the best thing about the workshop was) the hope that we may have helped.”

4. Appendix

4.1 Agenda



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DCA DRAFT CORONERS BILL – SCRUTINY BY BEREAVED PEOPLE WORKSHOP

9.11.06

AGENDA

SESSION ONE: (10.30 for) 11AM-1PM	
<i>Aim of session:</i>	
<i>Participants to give brief background on their own stories and park burning issues</i>	
<i>Participants to scrutinise Draft Charter for the Bereaved</i>	

10.30- 11.00am (30 mins)	ARRIVE AND GET SETTLED <ul style="list-style-type: none"> ● Registration, name badges, table allocation ● Tea/coffee
11.00- 11.10am (10 mins)	INTRODUCTION (PLENARY) <ul style="list-style-type: none"> ● Harriet Harman MP welcome – explain context and aim of workshop ● Opinion Leader Chair (Deborah Mattinson) welcome – OLR's role, ground rules (including message to observers), housekeeping, outline agenda for the day
11.10- 11.30am (20 mins)	PARTICIPANT BACKGROUNDS & BURNING ISSUES (GROUPS) <ul style="list-style-type: none"> ● Participant paired introductions – name, a little bit about you / your story ● Rating of the Coroners Service – scale of 1-10 and reasons ● Park any burning issues or gripes about the Coroners Service <ul style="list-style-type: none"> ➤ Participants asked to write down any 'burning issues' about the Coroners Service on post-it notes for moderators to post on the burning issues board

<p>11.30-11.35am (5 mins)</p>	<p>CHARTER FOR THE BEREAVED (PLENARY)</p> <ul style="list-style-type: none"> • Geoff Bradshaw (DCA) to introduce the charter <ul style="list-style-type: none"> ➤ What it is designed to do ➤ How it would be used • Geoff to also refer to chief coroner post
<p>11.35-11.40pm (5 mins)</p>	<p>CHARTER FOR THE BEREAVED (GROUPS)</p> <ul style="list-style-type: none"> • Refer to Draft Charter for Bereaved People – all to have read previously • Before looking at the detail, what are their overall / first impressions of the document? <ul style="list-style-type: none"> ➤ How would it help someone in their situation?
<p>11.40-11.50pm (10 mins)</p>	<p>CHARTER FOR THE BEREAVED (GROUPS): DETAIL</p> <ul style="list-style-type: none"> • Objectives and values (point 2): <ul style="list-style-type: none"> ➤ What do they think of the objectives and values of the charter? ➤ Likes / dislikes? ➤ What is the overarching message? ➤ Any surprises? ➤ Anything missing? ➤ Is it clear / easy to understand? ➤ How would it help people in their situation?
<p>11.50-12.05pm (15 mins)</p>	<p>CHARTER FOR THE BEREAVED (GROUPS): DETAIL</p> <ul style="list-style-type: none"> • Standards of service (points 4 – 13): <ul style="list-style-type: none"> ➤ What do they think of this section overall? ➤ Likes / dislikes? ➤ Any surprises? ➤ Anything missing? ➤ Would it have been relevant / useful in their case? ➤ Is it clear / easy to understand?
<p>12.05-12.20pm (15 mins)</p>	<p>CHARTER FOR THE BEREAVED (GROUPS): DETAIL</p> <ul style="list-style-type: none"> • Rights to participation (points 14 - 24): <ul style="list-style-type: none"> ➤ What do they think of this section overall? ➤ Likes / dislikes? ➤ Any surprises? ➤ Anything missing? ➤ Would it have been relevant / useful in their case? ➤ Is it clear / easy to understand?
<p>12.20-12.25pm (5 mins)</p>	<p>CHARTER FOR THE BEREAVED (GROUPS): DETAIL</p> <ul style="list-style-type: none"> • Availability of support and bereavement services (point 25): <ul style="list-style-type: none"> ➤ What do they think of this section overall? ➤ Likes / dislikes? ➤ Any surprises? ➤ Anything missing? ➤ Would it have been relevant / useful in their case? ➤ Is it clear / easy to understand?

<p>12.25-12.30pm (5 mins)</p>	<p>CHARTER FOR THE BEREAVED (GROUPS): DETAIL</p> <ul style="list-style-type: none"> ● Deaths abroad (points 26 & 27): <ul style="list-style-type: none"> ➤ What do they think of this section overall? ➤ Likes / dislikes? ➤ Any surprises? ➤ Anything missing? ➤ Would it have been relevant / useful in their case? ➤ Is it clear / easy to understand?
<p>12.30-12.40pm (10 mins)</p>	<p>CHARTER FOR THE BEREAVED (GROUPS): DETAIL</p> <ul style="list-style-type: none"> ● Review & appeal, other complaints and comments (this will be examined in more detail in afternoon) (points 28 – 32): <ul style="list-style-type: none"> ➤ What do they think of these sections overall? ➤ Likes / dislikes? ➤ Any surprises? ➤ Anything missing? ➤ Would it have been relevant / useful in their case? ➤ Is it clear / easy to understand?
<p>12.40-12.50pm (10 mins)</p>	<p>CHARTER FOR THE BEREAVED (GROUPS): OVERVIEW</p> <ul style="list-style-type: none"> ● Now looking at the Charter overall: <ul style="list-style-type: none"> ➤ If put into place with no amends would it be an improvement on the service? ➤ Is there anything missing? What else would they like to see in the charter? ➤ For those who gave the coroners service a low rating – would it take into account the problems they experienced? ● Facilitator to flipchart 3 likes and 3 recommendations for improvement of the charter ● Nominate one participant to feedback in plenary
<p>12.50-1.00pm (10mins)</p>	<p>FEEDBACK (PLENARY)</p> <ul style="list-style-type: none"> ● Participant in each group to feedback 3 likes and 3 recommendations ● Response from Harriet Harman
<p>1.00- 2.00pm</p>	<p>LUNCH</p>

SESSION TWO: 2PM- 4PM

Aim of session:

Participants to scrutinise 4 provisions of the Bill – Post Mortem, Reporting Restrictions, Appeals and Complaints

<p>2.00 – 2.20pm (20 mins)</p>	<p>SCRUTINY OF BILL – POST MORTEM (GROUPS) Look at the <i>Draft Charter</i> specifically in light of Post Mortems – points 6, 7, 14 & 16</p> <ul style="list-style-type: none"> • What do they think about the obligation for the Coroner to consult with families about post-mortems? (points 6 & 7) <ul style="list-style-type: none"> ➤ How do they think this should work? • How should the coroner deal with a post-mortem in cases where family members disagree with the best way to proceed? <ul style="list-style-type: none"> ➤ Especially given the time constraints of the process? • Should bereaved people have the right to appeal the coroner’s decision on post-mortems? (point 16) <ul style="list-style-type: none"> ➤ What are the pros and cons of this? <p>Give <i>handout on bill</i></p> <ul style="list-style-type: none"> • What do they think about the coroner asking any pathologist to examine a body? (change 1) • What do they think about the new power for the coroner to specify the type and extent of the post mortem? (change 2) • Do they think it is best to avoid a full post mortem where possible? (change 2 – in handout, I've put 2 + 3 together as they are the same thing & example) • How do they feel about moving bodies to different areas of the country where there is specialist equipment available? (change 3)
<p>2.20-2.35pm (15 mins)</p>	<p>SCRUTINY OF BILL – REPORTING RESTRICTIONS (GROUPS) Give <i>handout on bill</i> (includes examples)</p> <ul style="list-style-type: none"> • Thoughts on each change (3 in total) – like/dislike, why? • What do they think of the principle of reporting restrictions? • What would be the reasons for having or not having reporting restrictions? • Does the principle vary according to the type of case? • What about the principle of open justice (ie. not doing this behind closed doors?) • In what way will this policy help bereaved families? • Do they think they should be able to appeal the coroner’s decision to impose reporting restrictions, or not impose restrictions?

<p>2.35-2.50pm (15 mins)</p>	<p>SCRUTINY OF BILL – APPEALS (GROUPS) Give <i>handout on bill</i> (includes examples & point 30 of Charter)</p> <ul style="list-style-type: none"> • What do they think of the new appeals system (point 1 handout and point 30 of draft charter)? <ul style="list-style-type: none"> ➤ Do they think the new system is clear, easy to understand and use? ➤ Would they have been more likely to have appealed during their case if this system was in place at the time? • Do they agree that appeals should be dealt with by a Chief Coroner (point 2)? • Do they think that this system will lead to a sharp increase in appeals? (with families appealing every stage of a case) <ul style="list-style-type: none"> ➤ If so is this acceptable? • What if it places strain on the system?
<p>2.50-3.05pm (15 mins)</p>	<p>SCRUTINY OF BILL – COMPLAINTS (GROUPS) Give <i>handout</i> (includes examples & point 31 Charter)</p> <ul style="list-style-type: none"> • What do they think of the complaints system (point 2 & points 31 & 32 of Charter) <ul style="list-style-type: none"> ➤ is it an improvement? • Do they agree that complaints should be dealt with by a Chief Coroner (point 1)? • What powers should the Chief Coroner have to deal with complaints – eg. Compensation to complainant? Discipline coroner? • Do they think the coroner in the example was wrong to proceed with the post-mortem given the time consideration and the fact that he needed to ascertain cause of death?
<p>3.05-3.15pm (10 mins)</p>	<p>PREPARATION TO FEEDBACK (GROUPS)</p> <ul style="list-style-type: none"> ▪ Participants to identify the 5 key points that they want to raise on the bill ▪ Moderator to flipchart the top 5 key points ▪ One participant to feedback in plenary
<p>3.15-4pm (45 mins)</p>	<p>FEEDBACK (PLENARY)</p> <ul style="list-style-type: none"> • Participant in each group to feedback 5 key points (as above) they want to raise on the bill • Response from Harriet Harman <ul style="list-style-type: none"> ➤ To the important things identified ➤ To participants input over the course of the day • Harriet Harman to float any ideas of additional changes with panel members for their feedback (e.g. idea of support for families during inquests) • Questions and answer session with participants and Harriet Harman • Deborah Mattinson to thank and close • Panelists to complete a post workshop questionnaire and a few to be interviewed on camera

4.2 Handouts

Changes to Post-Mortems

Changes in the Draft Charter for the Bereaved

6. Where a coroner orders a post-mortem, the family will be told by the coroner and his/her staff why it is necessary and 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. These standards will also apply in the event of second post mortems being commissioned by coroners.
7. If the coroner decides *not* to hold a post mortem, the family can make representations and ask for the decision to be reconsidered.
14. The family will have a right to see reports of any post-mortems, and normally of other investigations, unless the coroner decides that some material needs to remain confidential to him/her permanently or for a period of time, in order to protect the legal rights of third parties.
16. Where there is a decision to hold a post-mortem, a family will be told within 24 hours of their right to raise objections and to appeal the decision. If they disagree with a decision *not* to hold a post-mortem, they will also have a right to appeal. When a post-mortem is held, families will be informed of their right to be represented at the post mortem by a doctor of their choice.

Changes in the Bill

1. A Senior Coroner, who is responsible for conducting an investigation, now has the power to ask any pathologist, including a specialist pathologist where the death appears to demand it, to examine a body. At the moment, a coroner has to use a pathologist within his or her area.
2. The coroner will have the power to specify the type and extent of post-mortems that they will require pathologists to make. The coroner will be able to order an external examination or a limited internal examination, meaning that full post-mortems can be avoided where possible.
3. The coroner now has the power to order that a body be moved to any suitable place in the country for a post-mortem examination. Before the body could only be moved within a coroner's area or to a neighbouring area.

Example

Mr Jackman lives with his son and daughter-in-law and died in his sleep aged 72. He is known to have a history of high blood pressure and has been in hospital before for heart treatment. It is very likely that he died of heart failure, however the coroner has ordered a full post-mortem to determine the exact cause of death. Mr Jackman's son would have liked to have been consulted before the decision was made about the type of post-mortem that was carried out and would have liked to have known what other options were available.

Reporting Restrictions

1. Coroners have a new power to ban the publication of the name of the deceased or any information that might identify that person, where there is no public interest in naming them. This is designed to protect bereaved relatives from an invasion of their privacy.

It is thought that this might be particularly appropriate in cases of apparent suicide or child deaths where there is no question of any other person being implicated in the death or, in either type of death, if there is no public interest in the facts of the case being known.

2. The coroner can decide how long the ban on the publication of a name can last.
3. The coroner can punish anyone who does keep this with being in contempt of court.

Example

John Mills and his wife of 14 years had been undergoing marriage counselling for a number of months. On discovering that his wife was about to leave him for another man and wanted to take their two children with her, Mr Mills wrote a suicide note, took an overdose of paracetamols and subsequently died. Again, after investigation and given the distressing and personally sensitive nature of this case and the fact that there was no public interest in naming the parties, the coroner decided to impose reporting restrictions in this case, where a suicide verdict was given.

Appeals

1. There is currently no proper appeals system against a coroner's decision. Applications against a decision can only be made through the limited, and expensive, route of the Judicial Review process or by asking the Attorney General to refer an inquest verdict to the High Court. A new, easy to use appeals system will be created, allowing bereaved people and other interested parties the right to challenge a coroner's decision at the investigation, post mortem and inquest stage. This is explained in point 30 of the Charter for the Bereaved.

Point 30, Charter for the Bereaved

In most cases, if there is disagreement between the coroner and the family member about any of the above, it will 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 two working days if it concerns a post-mortem).

In addition, appeals will also be possible against decisions in relation to:

- the cause of death given by the coroner following an investigation, but no inquest
- the decision given at the end of an inquest.

2. Appeals will be dealt with by the Chief Coroner.

Example

A 45 year old lady, Yasmeen Khan, dies suddenly in Ealing Hospital after complaining of pains in her arms and chest the previous day. She had a reasonable complex history of some illness, but the death was sudden and unexpected. The local coroner decides that a post-mortem is required to determine the exact cause of death. The husband and family are anxious to have the funeral as soon as possible, in line with their religious beliefs and find the idea of a post mortem upsetting.

Under the current system, though they can register their feelings with the coroner, there is no accessible and quick way they can effectively challenge the coroners decision.

Complaints

1. The Chief Coroner has a duty to set up and maintain a scheme of investigating complaints against coroners.
2. This complaints system is set out in the Charter for Bereaved People – point 31.

Point 31, Charter for the Bereaved

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 address their complaint to the Chief Coroner.

Example

Using the same scenario of Mrs Khan, the coroner has held a post mortem on Mrs Khan against the family's wishes and before they have been able to appeal. The family think the coroner has been unhelpful and insensitive and want to complain against him.

Currently, complaints against coroners made on the grounds of misconduct (for example, if the family think the coroner made inappropriate remarks during the inquest) are referred to the new Office for Judicial Complaints. Other complaints (for example, if the family were not informed of the time of the inquest) are referred to the Coroners Unit in DCA.

Under the new proposal, all complaints will be brought to the attention of the Chief Coroner who will investigate the complaint - referring cases about professional misconduct to the Office for Judicial Complaints – and decide on what action can be taken.