Reform of the Coroners' System and Death Certification

Government Response to the Constitutional Affairs Select Committee's Report

Cm 6943

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Presented to Parliament
by the Secretary of State for Constitutional Affairs and Lord Chancellor

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Introduction

The Government is grateful to the Constitutional Affairs Select Committee (CASC) - and all those who made submissions and gave evidence - for the time and effort they gave to exploring the proposed reform of the coroners' system and death certification, including scrutiny of the draft Coroners Bill. We welcome the report and the contribution it makes to the consultation on the draft Bill, and are grateful for the areas it highlights where more work should be carried out.

The Select Committee focused its inquiry on the systems of death certification and coroner reform. It considered the problems arising within the existing system of death certification and investigation, the proposals for reform in the draft Coroners Bill and alternatives to a coronial system as practised in other jurisdictions. We are grateful for the Committee's recognition that some areas of reform are welcome. At the same time, we acknowledge that the Committee has fundamental concerns about the Government's approach to these matters.

We should like to repeat the apology for the lateness with which the Committee received the draft Bill, and we have noted that the Committee may be returning to consider coroners' policy at some stage in the future.

Summary

The Government welcomes the Committee's report on the coroners' system and death certification. The Government notes the commendation of some of the proposals in the draft Coroners' Bill. The purpose of the Bill is to make improvements to the coroner system, by giving it a national framework and leadership, by modernising investigative processes and giving a new focus to bereaved people, whilst retaining broadly the present scope and purpose of coroners, and their local operational base. As we announced in February 2006, it is not the intention of the Bill to reform the death certification system.

The Government has given careful consideration to the Committee's recommendations. We have also noted the criticisms that the draft Bill does not go as far as to establish a nationally employed coroner service, although it does introduce national leadership through the establishment of the post of Chief Coroner and establish national standards, and that it does not change death certification by introducing a new independent scrutiny of every death by a coroner. We have looked again at the policy framework we intend for coroner reform. While respecting the strength of the Committee's reservations, and the thoroughness of its enquiries, we have concluded that our approach is most likely to achieve the aims we set out when we published the draft Bill.

A wider consultation has been taking place since the draft Bill was published, with the full range of professional stakeholders and others with an interest, including the voluntary sector. Analysis of the responses is under way, and we will publish the results shortly. We have also conducted a survey of 150 people with recent experience of the inquest system to get their views on how the process works and the impact on bereaved families.

All of this valuable feedback will be taken into account as we prepare the Coroners Bill for Parliamentary introduction, as soon as time allows.

Response to the Specific Recommendations

Pre-legislative scrutiny and the legislative process

Recommendation 1: **The Minister for Constitutional Affairs asked for the Committee's views on a number of issues at the very end of the oral evidence sessions, leaving us no time to take evidence on these points. We recommend that, in future, the Government makes known the particular issues with which it requires assistance at the same time as or, preferably, before publication of the draft Bill (*paragraph 8*).**

The Government agrees with the Committee's recommendation. It was regrettable that these matters were not made known to the Committee earlier.

Recommendation 2: **The Government cannot claim to be engaging in the pre-legislative scrutiny process when it has published the draft Bill so late that there is insufficient time for scrutiny to be carried out thoroughly and effectively. We recommend that the Department for Constitutional Affairs (DCA) reviews its procedures for publication of draft legislation so that this Committee may in future have sufficient time to conduct proper pre-legislative scrutiny (*paragraph 10*).**

The Government agrees with the Committee's recommendation, and the DCA apologises that insufficient time was given for proper pre-legislative scrutiny to be carried out. Preparation of Bills is a complex administrative process, with substantial consultation required across Government and demanding deadlines to be met. The team, including Parliamentary Counsel, who worked on the Bill produced a high quality product which has drawn praise for its clarity of lay out, but we regret that it was not delivered to the Committee in May, as originally undertaken. We shall use the lessons learned from the production of this Bill to ensure timely delivery of future draft legislation.

Death Certification

<u>Recommendation 5</u>: We conclude that, because neither the DCA nor the Department of Health (DH) is taking responsibility for death certification there is no systematic and coordinated response to the serious issues raised in the 3rd report of the Shipman Inquiry and in the Luce Review. When asked direct questions about the exact steps being taken to reform death certification, witnesses from both departments have given evasive and vague answers. We can only assume from their evidence that, if anything specific is being done at all, it amounts to tinkering at the edges of a system which has already been deemed unsafe and unsatisfactory by two Government-commissioned reviews (*paragraph 66*).

The DCA, the DH and the Office for National Statistics (ONS) work closely together to ensure that the death certification process safeguards patients. There are a number of processes that contribute to the satisfactory completion of a death certificate and a body being able to be released to be either cremated or buried. The legislative framework is clear that cremation certification lies with the DCA, and responsibility for providing doctors with medical certificates of cause of death (MCCD) and for the registration of deaths lies with the Registrar General (Births and Deaths Registration Act). These responsibilities complement the Registrar General's remit, which is to record life events and compile statistics, including those for mortality and morbidity. The DH has an interest in the professional regulation of, and training for, doctors. The Government therefore rejects this conclusion.

Officials from all three departments (ONS, DCA, and the DH) are working closely to ensure that the death certification process helps to safeguard patients and provides the important information needed for public health and clinical governance purposes. The Government is exploring what else might be done to strengthen the overall system within which deaths are certified and investigated to drive up the quality and accuracy of certification and to ensure that information on death certificates can be used as part of local governance arrangements. Our response to recommendation 6 below indicates what action the Government is taking to improve the current policy and practice.

Recommendation 6: **We strongly recommend that the Government revise its policy not to reform death certification in order to address reform of death certification in tandem with reform of the coronial system. It should return to the proposals on death certification put forward by the Home Office in 2004 ensuring they are supported with sufficient resources (*paragraph 71).***

The Government is not convinced that to have all deaths reported to the coroner service would be effective in terms of targeting resource where the risk is greatest. Such a system could bring unnecessary delay to families wishing to proceed quickly with funeral arrangements. The improved focus of the coroner service under the proposals in the Bill, the changes the DH has made on controlled drugs, and the changes it is consulting on in relation to professional regulation (e.g. doctor revalidation every 5 years, an independent tribunal to adjudicate on fitness to practice) will, we believe, reduce the likelihood of a Shipman type figure operating undetected in the future, and will curb or deter other potential abuses. The structural changes we are proposing to the Coroner Service do not preclude further changes to the processes for validating and using death certificate information in the future and we are exploring the options as set out in our response to recommendation 5.

In the interim, as part of the implementation of the Bill, we will look further at how coroners can better interact with registrars. In most areas there are good working relationships between local offices. Plans are for registrars to become local government employees in the future, when legislation allows, and a number of shire counties are looking at local organisation of offices. There may be opportunities to look at more instances of co-location, and the sharing of administration facilities. In the longer term, it may be possible to introduce electronic exchanges of information to further enhance co-operation and to facilitate more efficient working relationships. The Government rejects this recommendation.

Recommendation 7: **As a basic minimum, we recommend that the Government introduce a positive statutory duty for doctors to refer certain categories of death to the coroner and work with the General Medical Council (GMC) and the General Register Office (GRO) to establish suitable guidance and training to improve doctors' knowledge of death certification requirements and procedures (*paragraph 72).***

The Government accepts this recommendation. We propose to add a provision to the Bill requiring doctors to refer deaths to coroners providing certain conditions are met. We will work with all interested parties, including the GMC and the GRO to set out in secondary legislation what these conditions will be.

At present, the certifying doctor indicates on the MCCD where he has reported a death and the registrar does not register in these cases until authorised to do so by the coroner. Advice and guidance to doctors on reporting deaths is included with the instructions for completing the MCCD. Revised guidance was placed on the GRO website last year. Provision for registrars to report a death is contained in regulations. The DCA work with the GRO on death certification guidance and will continue to see how this can be improved. Likewise the department is, and will continue to be, in close contact with the DH and other medical stakeholders on doctor training in death certification.

The Coronial System: local service, national framework

Recommendation 8: **The Government's proposals lack detail and fail to tackle adequately the resource and structural problems currently facing the existing, outmoded coronial system. The limitations of the local structure of the current system, giving rise to uneven distribution of resources, will remain. It is difficult to see how a Chief Coroner can function effectively as a force for standardisation without being part of a national service. A national service would almost certainly involve significant extra cost, but the failure to introduce one will mean that the current inequalities of resource will continue (*paragraph 101*).**

The Government's aim is to have the best features of a national structure, headed by a Chief Coroner, with the best features of local service delivery. We believe we can successfully create a partnership between the police, local authorities, their local coroners and the Chief Coroner so that the service is embedded as an adequately funded local service, with national leadership and standards on key matters. As with the police force, the education system, and many other services which come within the remit of local authorities, we believe this structure will ensure responsiveness to local circumstances and help to build strong local partnerships with other services, while at the same time providing national leadership and national standards. The Government rejects this recommendation.

<u>Recommendation 9</u>: It is vital to ensure that changes to jurisdictional boundaries of the coronial system and to the staff involved in administering it do not inadvertently result in valuable skills and experience being lost (*paragraph 103*).

The Government agrees with this recommendation. We recognise its significance and aim to move as quickly as possible, engaging stakeholders fully and resolving key policy areas. Transitional plans will be worked through thoroughly.

<u>Recommendation 10</u>: The Government needs to clarify how their proposed system is intended to function in scattered and remote areas. If it is the Government's intention that local authorities responsible for large jurisdictions should provide a coroner with more than one place in which to hold inquests, we recommend that this should be made apparent on the face of the Bill when it is published (*paragraph 110*).

The Government partly accepts this recommendation. We are aware of the need to ensure that the coroner service can operate effectively in rural areas, in terms of both the conduct of investigations and the holding of inquests. This will be taken into account when new boundaries are drawn and will be made clear during the passage of the Bill. We do not, however, consider that this is a matter for the face of the Bill.

Resources

<u>Recommendation 11</u>: The Government should address the problems of under-resourcing in the existing coronial system in order to create solid foundations on which reforms can be built. This will require a careful assessment of the aggregate costs of the existing system, to include hidden subsidies, together with an assessment of deficits in particular areas (*paragraph 125*).

The Government's position is that there is sufficient resource within local authorities' existing budgets to adequately fund the service. We acknowledge that funding levels vary between local authorities, which can lead to a difference in the level of service provided, however we believe that the Bill makes provision to tackle this variation. The national

standards and leadership that we are creating in the Bill through the office of Chief Coroner, as well as the work that we are doing with the Local Government Association (LGA) and others on these issues, will ensure that local authorities afford a priority to the coroners service and help to promote consistency, while still allowing local authorities autonomy in spending according to their local circumstances. Removal of the uncertainty over reform will improve matters – in evidence to the Committee, a LGA representative acknowledged (Q107) that there have been deficits in funding by some local and police authorities because they have been "waiting for something else to happen" and that "we (local authorities) must take responsibility for that (deficit in funding)". The Government rejects this recommendation.

Recommendation 12: The Government should establish a mechanism for auditing the expenditure of local authorities on the coronial system and ensuring that coroners are given equivalent resources (*paragraph 126*).

The Government partly accepts this recommendation. The Chief Coroner will have responsibility for looking at the service at a national level and comparing expenditure across areas. However while guidance will be given on service levels, the Chief Coroner could be neither prescriptive nor directive about how much a local authority spends on this local service. As we have indicated, the Bill proper will include provision for an inspection function which will look broadly at inputs to and outcomes from the service. In addition, the Audit Commission has a general power to inspect the Coroner Service as part of Local Authority expenditure but, in practice, has not looked at the service.

Recommendation 13: We further recommend that the Government should reform the structure of the Coronial system by creating a national service with centralised and adequate funding so that all coroners are able to work to the same high standards (*paragraph 127).*

As in Recommendation 6 above, the Government does not agree that the only way to ensure adequate resourcing and standards is to create a national service.

Chief Coroner

Recommendation 14: The Government should reconsider its estimates for resourcing the office of the Chief Coroner on the basis of a detailed analysis of a projected daily workload. In conducting this analysis, the Government should draw on the experience of coroners who will be able to provide greater detail on how they are likely to deal with the Chief Coroner on a daily basis (*paragraph 133*).

The Government partly accepts this recommendation. Whilst costing invariably needs to be refined and more analysis carried out, we believe our figures are broadly correct. There has been some confusion about the costs for additional deputies to hear appeals. This has been accounted for within the £1.1m running costs for appeals and therefore is not included in the £1m for the Chief Coroners office.

Appeals

Recommendation 15: We recommend that the class of "interested persons" [with a right of appeal to the Chief Coroner from any decision] be substantially restricted and that limits be placed on the decisions of the coroner which are subject to appeal (*paragraph 139*).

The Government accepts these recommendations, and intends to amend the Bill accordingly before introduction. We intend to replicate the hierarchy of “people in a qualifying relationship” which is listed in the Human Tissue Act 2005, and list the decisions made by coroners which will be subject to appeal. And we will also ring fence the court proceedings, so that appeals cannot be made while the inquest is in progress.

Medical support for Coroners

Recommendation 19: We recommend that the Government change its policy on medical support for coroners and return to the 2004 [Home Office] proposals, with adequate resources being made available to coroners (*paragraph 162)*.

The proposals for medical support outlined in the 2004 paper were based on the premise that all deaths would be scrutinised by the coroner service. As stated above (recommendation 6) we believe that such a system would be overly bureaucratic and could lead to unnecessary delays for families in making funeral arrangements. We propose to create the office of Chief Medical Adviser, to support the new Chief Coroner, and the service more generally, on medical policy and practice. The Chief Medical Adviser will liaise with the medical professions and professional bodies at a national level, and advise on exceptional cases, or appeals which impact on the medical dimension of a case.

At a local level, we will make available a grant to all coroners to buy in medical advice, as best suits their particular area and way of working. Again, this is an issue on which further detailed work and consultation is required. The Government rejects this recommendation.

Post-mortem examinations

Recommendation 21: We recommend that the Government adopt a strategy for reducing the number of post-mortem examinations performed. This may include abolition of the "14-day rule"; provision of detailed information to the coroner and pathologist; adoption of written sudden death reports by the police; and consideration of a system similar to the Scottish "view and grant" (*paragraph 177)*.

The Government partly accepts this recommendation. We agree it is likely that too many unnecessary post mortems are being carried out. However the evidence is not conclusive enough at this stage to have an immediate explicit target for reduction. There is a need to have a strategy to ensure that the right criteria and alternatives are in place so that, as far as possible, post mortems are carried out only when strictly necessary. We will look further at ways of achieving this, including whether the extension of the “14 day” rule may be justified in light of current medical practice. We will prepare secondary legislation to deal with the detailed interaction between coroners, pathologists and the police. We do not think that the ‘view and grant’ system is the way forward - as the Scottish representative of the British Medical Association said in his evidence to the Committee, Scotland probably has too few post mortems - but we are watching developments in new technology carefully to assess whether pathologists may be recommended to make more use of non-invasive techniques.

Coroners' officers

<u>Recommendation 23</u>: We strongly recommend that the Government acknowledges the status and importance of coroners' officers by addressing the serious deficiencies and local inconsistencies in their support structure. We recommend that they be employed by local authorities, that their pay and conditions be standardised and that they be provided with adequate resources and training (*paragraph 200)*.

The Government partly accepts this recommendation. We agree that coroners' officers are vitally important and will continue to do all we can to acknowledge this. However, we do not intend to be prescriptive about a transfer of all coroners' officers from the Police to Local Authorities as this may not be the right solution in all cases. This must be a local decision although the DCA will encourage and facilitate discussions at a local level. Having established the right employer locally, the Government's view is that the employer should be responsible for pay, training and support so that local needs are taken into account, but within a national framework set out by the Chief Coroner.

Public health and safety

<u>Recommendation 24</u>: We recommend that the Government take a bolder approach to reform of the coronial system, embodying in legislation an enhanced role in relation to public health and safety. This should be backed up with significant additional resources to produce a system which provides greater public benefit and value for money (*paragraph 211*).

The Government rejects this recommendation. We believe that the current proposals will give significant benefit and the best value for money and that the most vital role in relation to public health and safety will be provided by local coroners engaged in local partnerships and by the Chief Coroner taking a national view on these issues. On the face of the Bill (for the first time), coroners have a power to issue a report to a public organisation on matters raised by a particular death. The Chief Coroner will have an important role in monitoring the impact of these reports, and drawing them to the attention of Parliament in a section of his or her annual report.

Conclusion

Recommendation 25: We believe that the complex reforms contained in the bill will require carefully planned transitional arrangements and serious efforts to ensure that skills and experience are not lost to the new system (*paragraph 213).*

The Government agrees with the Committee's advice. We will engage all stakeholders to work through transitional arrangements (see also Recommendation 9 above).

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