Justice Committee

Mike Freer MP
Minister for Courts and Legal Services

By email only

23 May 2024

Dear Mike,

As you know the Justice Committee has been working on a follow-up inquiry into the Coroner's Court Service for England and Wales. The announcement yesterday of a General Election in July unfortunately means that we will not be able to report our findings over the Summer as we had planned. To pay tribute to the assistance we have been given by the many people passionately engaged in this area, I am writing to you now to set out our findings in so far as I am able to do so.

Most importantly I offer both my sincere thanks and apologies to those who wrote to us, met us, or came to give oral evidence to the Committee. We received 69 submissions, held three oral evidence sessions, and visited multiple Coroners' Courts. I would like to thank in particular the many bereaved people who wrote to us, and the group of bereaved families who came to Westminster to meet us and tell us about their concerns. We are extremely grateful to them.

A Service in Crisis?

The primary message I want to emphasise to you is what the Chief Coroner told us:

> In my view, the coroner service in England and Wales is, with very few exceptions, chronically under-resourced and underfunded.[1]
>
> …
>
> There comes a point at which underfunding imperils the rule of law. That is not an exaggerated statement. A judge in whatever jurisdiction has to know that he or she can decide the case on the merits of the case—on the justice of it. If as a result of chronic underfunding you get to a situation where a coroner's decisions are

[1] Q3

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> partly dictated by economic necessity, judicial independence no longer exists, and that imperils the rule of law. That, I am afraid, is a point which we have already reached in some areas.[2]

The evidence we saw - in particular the worsening delays to the completion of inquests - has persuaded us that the Chief Coroner's concerns are grave and pressing. We encourage the new Government to shake off what seems to us a worrying complacency and enact change with far more urgency than has been the case up to now.

Provision of Pathology Services

The crisis in the provision of pathology in the Coroners' Service has been well known and understood for years. The Committee is extremely pleased that the Government is taking this problem seriously, and hopes to see that continue. We welcome the consultation on fees for pathologists and look forward to seeing what we hope will be a swift resolution to this issue.

However, it is clear that this will not be enough to solve the wider problem. We heard from every coroner we spoke to that they are already routinely paying pathologists well above the basic rate. It is to be hoped that the changes the Government make will not merely bring the law into line with reality, but also materially improve the situation. However, even this will not produce new, fully trained pathologists ready and qualified for Coronial work. For that I cannot do better than to repeat our recommendations from 2021 and, again, urge prompt action from the Government:

> 134. Pathology services for coroners have been neglected over many years leading to serious problems.

> 135. The Ministry of Justice should immediately review and increase Coroner Service fees for pathologists, so they are enough to ensure an adequate supply of pathology services to the Coroner Service.

[2] Q47

136. In the medium term the Ministry of Justice should work with the Department of Health and Social Care so that pathologists' work for coroners is planned for within pathologists' contracts with NHS trusts.

137. In the longer term, the Ministry of Justice should broker an agreement between relevant government departments and the NHS (in England and Wales) for the establishment and co-funding of 12–15 regional pathology centres of excellence.

In the interests of transparency and accountability it would be very welcome if the Ministry of Justice were to publish a strategy for improving coronial pathology, with at least an indication of when Coroners can expect to see improvements.

A National Coroner Service for England and Wales

I also take the opportunity to reiterate our recommendation from 2021 that the Ministry of Justice should unite coroner services into a single service for England and Wales.

Although it is hard to make a definitive statement given the lack of data, we remain of the view that the advantages of a national service would far outweigh its costs. While it would undoubtedly not be a panacea, it would afford an opportunity to standardise the service, allowing scope for national minimum service levels, and more consistency across England and Wales. It would also allow economies of scale, smooth out regional resourcing and accommodation issues, and facilitate more efficient processes (like calling a jury, and nationwide IT provision).

However, we were realistic about the Government's attitude to this proposal and are aware that there is no current intention to make such a change. We therefore asked for evidence on other possible reforms to improve consistency and accountability across the coroner service.

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Enhancing the Chief Coroner's Capacity

The Chief Coroner providing compelling evidence that where he and his office are able to focus on a particular Coroner Area they can help reduce delays within that Area. I would strongly encourage the Ministry of Justice and the Chief Coroner's Office to collaborate on putting together a business case to increase the size of the Chief Coroner's office to allow them to provide more support to Coroner Areas.

A National Inspectorate for Coroners

In the absence of a national service, the case for a national inspectorate for coroners is very strong. We heard many times about unacceptable variations in service, with no mechanism for meaningfully addressing those differences. I would encourage your successor in the Ministry of Justice to seriously consider putting a national inspectorate in place as soon as possible.

The Triangle of Responsibility

Having heard from both the National Police Chiefs' Council, and the Metropolitan Police Service, I am also confident in endorsing the Chief Coroner's view that the so-called "triangle of responsibility" is archaic and needs to change. The sharing of responsibility between the Senior Coroner, the relevant local authority and the police causes more problems than it solves. I urge you and your officials to actively assist the Chief Coroner in helping each Coroner Area to move to a simpler model where all staff and funding are provided by the Local Authority.

Improving Regional Cooperation

We would also encourage the Ministry of Justice and the Chief Coroner to look at ways to improve regional cooperation. Small changes on regional cooperation could provide a relatively low cost and high impact way to promote consistency and smooth out local capacity issues. One way to help (and which could form part of the business case I describe above) could be to appoint more Deputy Chief Coroners with a regional focus. Another might be to look at amending the law as it applies to Coroners Areas in England to reflect the situation in Wales. This would remove some of the bureaucratic obstacles to sharing resources between Coroner Areas.

Provision of information

The Committee was pleased to hear that the Ministry of Justice plans to review their Guide to Coroners Services. I strongly suggest that they consult widely when doing so, in particular with bereaved people who have already been through the system.

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I also encourage them to look beyond the standard model of a written guide and consider the benefit of a well-maintained central website with links to other sites, video explainers, virtual tours and other alternative means of conveying information.

The Coroners' Court Support Service

The Coroners' Court Support Service is a charity which was set up to address the absence of any formal provision of support for bereaved people during the coronial process. They describe themselves:

> … as the only organisation dedicated to supporting bereaved families attending a Coroner's Court for an Inquest that is required into the sudden, unexplained, or violent death of a loved one…
>
> The CCSS [volunteers] support families, witnesses and others attending, explaining the remit of the Inquest process, what to expect, who might be in court, their role and responsibilities, and to inform people of their rights within this environment.

We heard first-hand how relatively inexpensive the CCSS is both to set up and run, and how much it is valued by Coroners, Coroners' staff and, most importantly, bereaved people. The Committee recommended in 2021 that the Service should be offered support from Central Government to allow it to function in every Coroner's Court in the country. I continue to believe that this could make an enormous difference to bereaved people who are currently forced to navigate the coronial process without support.

Legal aid

One major theme of the 2020/21 inquiry was inequality of arms between families and other interested parties, and the benefits of legal representation for bereaved families during some inquests. The problems we identified then remain today. The inquisitorial nature of an inquest is essential and should be preserved. However, it should not blind us to the reality that some inquests are invariably contentious and should be understood as such from the outset. In those cases, an unrepresented family is, while contributing to a process conducted by the state of its own volition,

at an enormous and unfair disadvantage. They should be entitled to legal advice at the expense of the state.

Preventing Future Deaths

Along with answering the questions who, where, when, and how a person came by his or her death, the Coroner Service has an important role in improving public safety. It does this by making 'reports to prevent future deaths' (also known as 'PFDs' or 'Regulation 28' reports). The Coroners and Justice Act 2009 requires coroners to make reports where there is a risk that other deaths will occur if action is not taken to eliminate or reduce the risk.[3] While it can be highly effective, there are problems of capacity and consistency with nearly every aspect of the current system which need to be addressed centrally.

It would be extremely helpful if the underlying IT better supported the system. I leave it to the experts to work out how this would best be done, but ideas we have heard are that it should:

- be a unified cloud-based system, removing the need for emails between organisations which inevitably introduce error
- revolve around a standard template which also ensures that demographic data about the deceased be routinely recorded
- allow deaths to be categorised according to a nationally standardised taxonomy.

It would be helpful too if the Chief Coroner maintained an up-to-date list of stakeholders to which relevant PFDs could as a matter of routine be sent.

I can also see great merit in Dr Georgia Richards suggestion that the Government should either conduct or commission research into the drivers for the use or non-use of Prevention of Future Death Reports.

It is also worth considering whether Coroners could be granted further powers to follow up on responses to PFDs which they have issued. This could include power to publish the names of non-responders, to report non-responders to the relevant regulators and, in some cases, to issue fines to non-responders. There is force,

[3] Coroners and Justice Act 2009, Sch 5 para 7. Details of the procedure are set out in the Coroners (Investigations) Regulations 2013, SI 2013/1629.

however, in the argument that a Coroner is not and should not be used as a regulator, and these powers should not be enacted without first consulting all Coroners on both the substantive merits of the proposal and its practicalities.

There is a wider "accountability gap". No person or body is responsible for judging the adequacy of a response to an individual PFD, or for the thematic assessment and analysis of all relevant PFDs to identify patterns of preventable death. In their campaign for a "National Oversight Mechanism" INQUEST have sought to provide a solution to a real and pressing problem, which may well be leading to unnecessary loss of life. However, there already exists a network of national regulators with sector specific expertise. It would be worth exploring their capacity to take responsibility for this function before creating a new body tasked with oversight of all relevant sectors.

Dr Richards suggested that all of the regulators covering the sectors where most relevant deaths occur should publish their strategy and approach to PFDs, considering in particular their value as a regulatory tool. I agree. I would also like to see a cross-sector board within each sector overseen by the relevant Department of State, tasked with oversight and analysis of all relevant PFDs and responses.

Finally, I would like to comment on the use of coronial data as a tool to analyse and understand preventable deaths and, ultimately, stop more of them happening. Dr Richards "Preventable Deaths Tracker" website has shown what is possible for a relatively small cost. It seems extraordinary that such an important national service is reliant on the initiative and energy of a single academic working without reliable funding. The Tracker should be placed on a secure footing and used as the basis for further work – whether this means it is brought within Government or central funding is found for it should be the subject of further consideration.

Looking further afield, I am also very concerned that the UK is falling behind other jurisdictions in the efficient and effective use of coronial data. The Government should scope the creation and maintenance of a Coronial Information Service, similar to that already provided in Australia and New Zealand.

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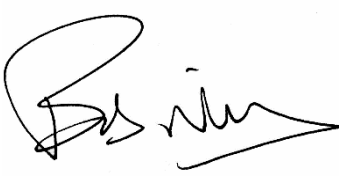
The Coroners Service for England and Wales is a remarkable one, staffed with highly skilled and dedicated people performing a difficult but essential service. I am extremely grateful for the work they do, and it is the responsibility of Government and Parliament to give them the resources and systems they need to continue to serve the people of this country.

Yours sincerely,



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