

ILLUSTRATIVE DRAFT: JUNE 2006

DRAFT CHARTER FOR BEREAVED PEOPLE WHO COME INTO CONTACT WITH THE CORONER SERVICE

NB This is a charter for a reformed service NOT for the service as it currently operates.

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General

1. Coroners will operate independently within the legal framework of the Coroners Act 2007. This charter sets out guidance for bereaved people, including their rights and roles, during coroner investigations and inquests.

Objectives and values

2. The coroner service will:-
- help bereaved people understand the cause of the death of the person who has died
 - inform bereaved people about the roles of the coroner service and the powers of the coroner
 - inform bereaved people of their rights and responsibilities if an investigation or inquest is conducted in relation to the death
 - comply, where possible, with individual, family, and community wishes, feelings and expectations, including family and community preferences, traditions and religious requirements relating to mourning and to funerals, and respect for individual and family privacy
 - enable bereaved people, including children and young people where appropriate, to be informed and consulted during the process of investigating violent, unnatural or unexplained deaths, or deaths of those in prison or other state custody, treating them with

sensitivity and with dignity, and helping them to find further help where this is necessary

- answer bereaved people's questions as promptly and effectively as possible
- respond to concerns of bereaved people when they are not satisfied about the cause of death given on a death certificate
- provide information about how bereaved people may appeal against or complain about the service's decisions, and respond to appeals and complaints within the period specified by the Chief Coroner.

Standards of service

4. When a death is reported to the coroner, the coroner or his/her staff will aim to contact the most appropriate next of kin, where known, within 24 hours to explain why the death has been reported and what steps are likely to follow.

5. The family will be given information, within 24 hours of confirmation of the identity of the person who has died, by the coroner or his/her staff on where they can view the body if they wish to do so and on appropriate arrangements for viewing. They will be advised, as sensitively as possible, if the nature of the death may cause the viewing of the body to be particularly distressing. Wherever possible, the family may be offered a photograph of the body first.

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.

8. Where there is an investigation but no inquest, the coroner or his/her staff will, within ten working days of its completion, offer the family a copy of the coroner's investigation report and will offer to explain any parts they do not understand.

9. The family will be sent, by the coroner or his/her staff and within two working days of its completion, a copy of the confirmation of the cause of death and the details of the person who has died. This will enable the family to bring any errors to the attention of the registrar or the coroner.

10. When there is to be a full inquest, information will be provided by the coroner and his/her staff, of the timing, location, and the facilities available at

the place where the inquest will be held, wherever possible, four weeks before the date of the inquest.

11. Information will be provided by the coroner and his/her staff about the purposes and processes involved at the inquest, who is likely to be present, what evidence is likely to be given and on the opportunities for the family to participate in proceedings, including the right to speak or the right to be represented. If the date and/or location of the inquest has to be changed, bereaved people will be informed within five working days.

12. Wherever possible, an appropriate private room will be provided for bereaved relatives when they attend an inquest.

13. Coroners or their staff will not release details, including photographs, of specific cases to the media without the consent of the family.

Rights to participation

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.

15. The family will be informed, by the coroner or his/her staff of any decision to refer a death for investigation by a different coroner's area and the reasons for that decision. The family may appeal against this decision. Similarly, the family may make representations that a different coroner's area should handle the case.

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.

17. Where the coroner decides to hold a pre-inquest hearing, the family will be informed of the time, date and location, the purpose of the hearing and their rights and responsibilities during it.

18. In cases where there is an investigation, but no inquest is planned, the family will have a right to meet the person conducting the investigation and to give information.

19. Where there is to be a full inquest (and in addition to information about its purposes and processes) the family will have the right to meet in advance the coroner's officer and any other staff helping the coroner's preparations. This will provide an opportunity to explain what happens at inquests and to familiarise families with the layout of the court.

20. The family will have their views taken into account regarding the timing and venue for any inquest.

21. Coroners will release the body of the person who has died at the earliest opportunity once the medical cause of death has been confirmed. But families may request early release for personal, cultural or religious reasons.

22. In cases where there is a criminal investigation as a result of the death, the coroner will take account of the rights of the family as well as the right of a suspect to a fair trial. The normal expectation is that bodies will be released for funerals within a maximum of 40 days of the death. The coroner or his staff will inform families if this timescale will not be met, and will update them regularly on the situation subsequently.

23. Once the body is no longer required for the coroner's purposes, coroners will not, other than in exceptional circumstances, retain human organs or tissue without the consent of the family. The family will be informed, and will have the opportunity to make representations, if an authority (such as the police, or a lawyer representing a defendant in a criminal case) applies to extend the period of retention beyond 40 days.

24. If organs or tissue are retained, the coroner should reach advance agreement with the family as to what should happen when they are no longer required for scientific or possible evidential purposes.

Availability of support and bereavement services

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

Deaths Abroad

26. Coroners will investigate deaths abroad when the following circumstances apply:

- where there is a connection between the death and circumstances arising in England and Wales (for example medical errors or malpractice, or an accident, in this country) or
- where action might reasonably be taken in England and Wales to avoid deaths in similar circumstances in future (for example planning of overseas school trips) or
- where the coroner has reasonable cause to suspect that the death was caused as a result of a criminal act and if no equivalent of either a criminal investigation, a coroner's investigation or an inquiry is taking place, or has taken place, in the country in which the death occurred or

- where the person who has died was a member of the armed forces and died while on duty abroad.

27. In addition, there may be special circumstances where a death overseas ought to be investigated even though none of the above criteria apply. The Lord Chancellor has power to require an investigation into a death which occurred abroad, where it appears to be in the public interest to do so. If the coroner decides that there will not be an investigation and the family disagree with this decision, they may appeal to the Chief Coroner or they may write to the Lord Chancellor to ask him to report the death to the Chief Coroner on the ground that it would be in the public interest to conduct an investigation into the death of the deceased. Coroners will also have power to report a death to the Chief Coroner if they believe the death should be investigated and they do not have power to do so.

Review and appeal rights of coroners' judicial decisions

28. Family members who are designated as interested parties for the purpose of investigations will be consulted by coroners about the following decisions they take in individual cases (when they have indicated a wish to be consulted):

- whether or not there will be a post-mortem (this is subject to the identity of the dead person being known)
- when the body of the person who has died will be released (this is also subject to the identity of the dead person being known)
- whether there will be an investigation by the coroner
- whether or not reporting restrictions should be imposed on inquest proceedings
- the scope of an inquest
- whether there should be a jury
- which witnesses to be called at the inquest, including expert witnesses

29. If the family member is dissatisfied with how the coroner intends to proceed, he or she will be able to ask the coroner to review their decision.

30. 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.

Other Complaints and comments

31. 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.

32. The coroner system is committed to providing a service which meets the needs of bereaved people at a sensitive time, and welcomes comments from bereaved people about their experiences. They should be directed to the coroner who dealt with the case or the Chief Coroner.

Disability issues

33. The coroner service will, as far as practicable, provide appropriate access to coroners' courts and offices. Reasonable adjustments will be made, wherever possible, to meet the needs of people with sight, hearing and physical or mental impairments.

Monitoring service standards

34. The Chief Coroner will require coroners to provide regular reports to him/her. The Chief Coroner will give the Lord Chancellor an annual report which will include an assessment of the consistency of standards between coroners' areas. The Lord Chancellor will publish any report given to him and lay a copy before Parliament.

35. Inspections of the service will be commissioned by the Secretary of State. This will involve consultation with bereaved people. In addition, the Chief Coroner will arrange surveys of service users from time to time.