# Summary: Intervention & Options

| Department /Agency: | Title: | |
|---|---|---|
| **Ministry of Justice** | **Impact Assessment of the coroner sections of the Coroners and Justice Bill** | |
| **Stage:** Final proposal | **Version:** 1 | **Date:** **December 2008** |
| **Related Publications:** Coroners and Justice Bill | | |

**Available to view or download at:**

http://www.

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## What is the problem under consideration? Why is government intervention necessary?

The Shipman Inquiry (2003) and the Fundamental Review of Death Certification and Investigation (2003) found the level of service provided to bereaved people was inconsistent; family and friends were not always involved in coroners' investigations; there was a lack of leadership and training for coroners; and insufficient medical knowledge in the system as a whole.

The Government also recognises that improvements are required to make the process of death certification simpler for all concerned and intends to put into practice a new death certification system in England and Wales. The Department of Health is producing a separate Impact Assessment on their proposals to improve the process of death certification which are also included in the forthcoming Coroners and Justice Bill.

## What are the policy objectives and the intended effects?

The policy objectives of the coroners sections of the Coroners and Justice Bill are to introduce a national coroner service for England and Wales, headed by a new Chief Coroner; to improve the experience of bereaved people coming into contact with the coroner system, giving them rights of appeal against coroners' decisions and setting out the general standards of service they can expect to receive; and to reduce delays and improve the quality and outcomes of investigations and inquests through improved powers and guidance for coroners, and the publication of statistics and reports to prevent future deaths.

The outcomes of reform will result in a coroner service that meets both the interests of bereaved families and the wider public interest in terms of the quality and effectiveness of investigations and reaches the optimum level of understanding about the causes of unexpected deaths. The system will ensure that the knowledge gained from death investigation is applied for the prevention of avoidable death and injury in the future, consequently meeting the requirements and expectations of a public service in a multi-cultural twenty-first century society.

What policy options have been considered? Please justify any preferred option.

Option 1: no legislative change.

Option 2: limited improvements to the current service and the creation of whole time coroner districts.

Option 3: enhanced service, locally based.

Option 4: unified national service.

Option 3 is the preferred option, as this will make the best use of resources to improve service delivery.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

Projected costs and benefits are set out below and will be reviewed at key stages during the implementation process and 12 - 18 months after implementation.

**Ministerial Sign-off** For final proposal/implementation stage Impact Assessments:

***I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.***

Signed by the responsible Minister:

Bridget Prentice

..... Date: 16 December 2008

# Summary: Analysis & Evidence

| Policy Option: | Description: Enhanced service, still locally based (Option 3) |
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**COSTS**

| ANNUAL COSTS | Description and scale of **key monetised costs** by 'main affected groups' |
|---|---|
| **One-off** (Transition) **Yrs** | Both the transition costs and additional annual costs of the new coroner service will be met by the Ministry of Justice. (See paragraph 42 of the evidence base.) |
| **£ 10m** | |
| **Average Annual Cost** (excluding one-off) | **Total Cost** (PV) **£64m over 10 yrs** |
| **£ 6.5m** | |

Other **key non-monetised costs** by 'main affected groups' Coroners, coroner's officers, local authorities, police, pathologists, funeral industry and voluntary groups will need to adapt to new legislative framework, charter for bereaved people, new appeals system and local changes to coroner area boundaries. Ministry of Justice to provide information and training.

**BENEFITS**

| ANNUAL BENEFITS | Description and scale of **key monetised benefits** by 'main affected groups' |
|---|---|
| **One-off** **Yrs** | Reforming the coroner system will deliver non-financial benefits by improving the service provided to bereaved people. It may also allow coroners and local authorities to reprioritise existing resources (see paragraph 53 of the evidence base). |
| **£ n/a** | |
| **Average Annual Benefit** (excluding one-off) | **Total Benefit** (PV) **£ n/a** |
| **£ n/a** | |

Other **key non-monetised benefits** by 'main affected groups' A more consistent service that better meets the requirements and expectations of bereaved people and that serves the public interest by preventing future deaths.

Key Assumptions/Sensitivities/Risks We will continue to refine the estimated cost of implementation as our plans are developed in more detail. A key risk is the operation of the appeals system. We have estimated the volume of cases likely to be appealed and this will be tested by pilots in advance of implementation.

| Price Base Year 2008 | Time Period Years 10 | **Net Benefit Range** (NPV) **£ -£57.6m to -£83.2m** | **NET BENEFIT** (NPV Best estimate) **£ -£64m** |
|---|---|---|---|

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|---|---|
| What is the geographic coverage of the policy/option? | England and Wales |
| On what date will the policy be implemented? | Plans are phase implementation between 2010-12 |
| Which organisation(s) will enforce the policy? | MoJ & GMC |
| What is the total annual cost of enforcement for these organisations? | £ Negligible |
| Does enforcement comply with Hampton principles? | Yes |
| Will implementation go beyond minimum EU requirements? | No |
| What is the value of the proposed offsetting measure per year? | £ Negligible |
| What is the value of changes in greenhouse gas emissions? | £ Negligible |
| Will the proposal have a significant impact on competition? | No |

| Annual cost (£-£) per organisation (excluding one-off) | Micro **0** | Small **0** | Medium **0** | Lar ge |
|---|---|---|---|---|
| Are any of these organisations exempt? | No | No | N/A | N/ |

**Impact on Admin Burdens Baseline** (2005 Prices)

| Increase of | £ 375K | Decrease of | £ 0 | **Net Impact** | (Increase - Decrease) **£** 375K |
|---|---|---|---|---|---|

(Current estimate, but will be tested with pilots in 2011/12)

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

# Evidence Base (for summary sheets)

## Background

*The coroner system*

1. When someone dies the death should be referred to the coroner when there is reasonable cause to suspect that it was violent or unnatural, or if the cause is unknown. Deaths that fall within certain public interest categories (e.g. deaths in custody or other forms of state detention, or from industrial disease) should also be referred automatically to the coroner.

2. The coroner has jurisdiction over deaths reported to him / her when the body is lying within their district. The role of the coroner is to establish who the deceased was, how, when and where they came by their death and the particulars required for death to be registered. In order to help with this the coroner may commission a post-mortem and in some cases hold a full inquest i.e. a public hearing.

3. In 2007 there were 504,100 deaths in England and Wales, of which 234,500 (46.5 per cent) were reported to coroners. These reported deaths led to 110,400 post-mortem examinations being conducted (47.1 per cent of all deaths reported to coroners) and 30,800 inquests opened (13.2 per cent of deaths reported). The proportion of deaths reported to coroners in England and Wales has increased by around 10 percentage points since 1995[1]. It is considerably higher than the percentage dealt with in many other jurisdictions[2].

4. Central Government (the Ministry of Justice) has responsibility for the legislative framework in which coroners operate. It does not have any operational responsibility. Local authorities are responsible for funding the coroner system and appointing the coroner. There are currently 32 full-time and 78 part-time coroners. Many of those working part-time are also employed as solicitors or doctors. The coroner is generally supported by a deputy coroner and one or more assistant deputy coroners, all of whom he or she appoints personally.

5. The coroner also works with coroner's officers who manage investigations and liaise with bereaved people. The majority of coroner's officers (90%) are employed and funded by the relevant police authority. The coroner may also be supported by staff provided by the local authority.

[1] Statistics on deaths reported to coroners, produced by the Ministry of Justice: www.justice.gov.uk/docs/coroners-stats-2007.pdf

[2] See page 19 of the Fundamental Review into Death Certification and Investigation in England, Wales and Northern Ireland: www.archive2.official-document.co.uk\document\cm58\5831\5831.pdf

## The need for reform

6. Following the murders committed by Harold Shipman, a doctor in general practice in Hyde, Cheshire, the death certification system and the coroner system came under increased public scrutiny. In 2003 the Third Report of the Shipman Inquiry[3] and the Fundamental Review of Death Certification and Investigation (the Luce Review)[4] found:
   - Inconsistent levels of service provided to bereaved people.
   - Bereaved people not always involved in coroners' investigations.
   - An absence of quality controls and independent safeguards.
   - A lack of leadership and training for coroners.
   - The unnecessary use of public inquests in some cases.
   - Insufficient medical knowledge

7. There are a number of weaknesses in the current arrangements for death certification, particularly the difference in the level of certification required for cremation rather than burial. The Department of Health's proposals to reform the system (also included in the Bill) will introduce a unified process of death certification for both burials and cremations in which a medical examiner, provides an independent and consistent medical scrutiny of all deaths (other than deaths which are reported to the coroner) before they can be officially registered.

8. The Department of Health have produced a separate impact assessment dealing specifically with these proposals.

## Summary of Consultation on the coroner sections of the Bill

9. The Ministry of Justice published a draft Coroners Bill in June 2006. We received around 150 responses from a range of interested parties including: coroners; coroners' officers; administrative staff; voluntary organisations; local authorities; medical organisations; the legal profession; press organisations; the police; unions and other representative bodies; government departments and committees; as well as numerous individual responses.

10. The Government's response [5] addressed concerns raised by consultees about: the appointment of coroners to the new service; changes to coroner area boundaries; the role of local authorities; resources; the appeals system; death certification; deaths abroad; the use of juries and deaths at work; and the provision of medical advice. It confirmed that alternative proposals would be considered further.

11. As part of the extensive consultation process, the Ministry of Justice held regional events for around 350 people in London, Birmingham, Leeds and Cardiff. Coroners, coroners' officers, police and local authorities were given the opportunity to hear about the proposed changes in more detail and to question Ministers and policy officials.

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[3] The Shipman Inquiry. Third Report. Death Certification and the Investigation of Deaths by Coroners. See: www.the-shipman-inquiry.org.uk/thirdreport.asp
[4] See www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf
[5] www.dca.gov.uk/consult/coroners/cb684907b.pdf

12. The draft Bill was subject to pre-legislative scrutiny by the Constitutional Affairs Select Committee (CASC). The CASC report[6] was published on 1 August 2006 and the Government's response[7], published on 7 November 2006, gave careful consideration to the Committee's recommendations. It was acknowledged that the draft Bill did not establish a nationally employed coroner service (although it introduced national functions and standards), or introduce an independent check on every death certificate. However, while respecting the strength of the Committee's reservations and the thoroughness of its enquiries, the Government concluded that the approach in the draft Bill (subject to some amendment) was the most proportionate way of achieving its policy objectives.

**Consultation on Statutory Duty for Doctors and other Public Service Personnel to report Deaths to the Coroner**

13. A separate consultation paper on the statutory duty to report deaths was published on 26 July 2007. This considered who should have a duty to report deaths, which types of deaths should be reported, and what the sanction should be for not reporting deaths appropriately. Responses were received from people working in the coroner system, voluntary groups working with bereaved people, registrars, GPs and medical practitioners working in NHS Trusts as well as individuals with experience of using the coroner system. A summary of responses was published on 21 May 2008. We concluded that the most proportionate approach was to place a duty to report deaths on registered medical practitioners only and not on other public service personnel. The sanction against non-referral would be a complaint to the General Medical Council.

**MORI survey**

14. In June and July of 2006 Ipsos MORI carried out a survey to gather information regarding recent users' experiences of the coroner system and their level of satisfaction. The survey usefully informed further work, in particular the development of the draft charter for bereaved people, which is being published alongside the Bill.

**Bereavement Panel**

15. In November 2006 a cross-section of people who had taken part in the MORI survey attended a workshop in Parliament to scrutinise parts of the Bill which would impact directly on bereaved families. The discussion focused on individuals' personal experiences as well as examining four key sections of the Bill: changes to post-mortems;

[6] Reform of the coroners' system and death certification. See: www.publications.parliament.uk/pa/cm200506/cmselect/cmconst/902/902i.pdf
Volume I contains a full list of contributors and volume II sets out the oral and written evidence.
[7] See www.official-documents.gov.uk/document/cm69/6943/6943.pdf

reporting restrictions; appeals and complaints, and the draft charter for bereaved people.

## Ongoing Consultation with Coroners and other Stakeholders

16. Following on from the initial consultation work described above, officials from the Ministry of Justice have continued to meet regularly with representatives from the Coroners' Society, the voluntary sector and other interested stakeholders to discuss policy and operational reform issues.

## Cross Government consultation

17. A cross-Government programme board oversaw the development of coroner reform proposals, up until the publication of the draft Coroners Bill. The board comprised:
    - Department for Constitutional Affairs (now Ministry of Justice).
    - Cabinet Office.
    - H M Treasury.
    - Office for National Statistics.
    - Department of Health.
    - Department for Communities and Local Government.
    - Home Office.
    - Northern Ireland Court Service.
    - Welsh Assembly Government.

In addition other departments have been consulted on specific issues, including:

- the Foreign and Commonwealth Office on inquests into deaths abroad;
- the Department for Culture, Media and Sport on treasure;
- the Attorney General's Office on appeals policy;
- the Lord Chief Justice's Office on appointment of the Chief Coroner;
- the Department for Education and Skills (now the Department for Children, Schools and Families) on safeguarding children issues;
- the Department for Transport on the link between coroners' investigations and inquiries into transport crashes; and
- the Ministry of Defence on inquests into service personnel killed on operational duty in Iraq and Afghanistan.

## Policy Options

### 18. Option 1: no legislative change

19. The system would continue as at present, with a lack of accountability, limited and inconsistent focus on bereaved people, and experiencing difficulty with the demands placed on it by modern society.

| Summary of costs/disadvantages | Summary of savings/benefits |
|---|---|
| No costs involved.<br>Signals lack of interest from the Government<br>Present poor level of service continues<br>Present variability across the country continues<br>Risk of further high profile incidents. | Affordable<br>No disruption to present service |

20. This option would not address any of the concerns raised in the Shipman Inquiry (2003) and the Luce Review (2003) that found the systems for the certification and investigation of deaths in England and Wales needed fundamental review.

**21. Option 2: limited improvements to the current service and the creation of full time coroner districts**

22. This option would improve investigation/inquest process and effectiveness, and comprehensive boundary reshaping to enable whole time coroner jurisdictions. It would continue to develop training, work with bereaved people and performance monitoring. This shifts the service from a pre-dominantly part-time basis to a system with a cadre of professional, full-time coroners, all of whom will be fully focused on their coronial work. A Chief Coroner would be appointed (by statute) and a national advisory Coronial Council established. The Secretary of State would have new powers to determine the size and boundaries of coroner districts creating up to 42 whole-time coroner districts linked to court boundaries. These coroners would continue to be appointed and funded by local authorities, and there would be no basic changes to current resourcing and accountability. National inspection arrangements would be introduced with power for the Lord Chancellor to direct action in accordance with recommendations.

| Summary of costs/disadvantages | Summary of savings/benefits |
|---|---|
| Start up costs of £12m and running costs of £3m p.a.<br>o Full time (FTE) coroners<br>o Procedural improvements<br>o Chief Coroner and Coronial Advisory Council<br>o Training<br>Future efficiency savings difficult to drive through.<br>Coroner/district changes consume resources.<br>Ability of many coroners to challenge medical establishments remains low | Greater efficiency and more focus on bereaved people.<br>Some central leadership.<br>Minimum disruption to the system.<br>Improved all round performance through a system made up of whole time coroners.<br>Greater accountability through inspection arrangements. |

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| due to insufficient medical expertise.<br><br>Coroners still dependent on a mix of police authority and local authority support. | |

23. This option was rejected on the grounds it did not go far enough in providing the level of central leadership, accountability and governance that the system requires. Further the Government consider that bereaved people needed to be served by an appeal procedure and that the general low level of medical knowledge in the service required attention.

**24. Option 3: enhanced service, still locally based**

25. This option would provide full time coroners, procedural improvements and a Chief Coroner. In addition a national medical adviser and team are established and local mechanisms are set up to give coroners access to independent doctors for advice. Coroners would continue to be appointed and funded by local authorities, with no basic change to current resourcing and accountability. An appeals process to enable coroners' decisions to be challenged other than through expensive Judicial Review is also put in place.

| Summary of costs/disadvantages | Summary of savings/benefits |
|---|---|
| £10m start up costs<br>• Programme staff costs<br>• Publicity and launch<br>• IT<br>• Recruitment costs<br>• Costs to operate a full shadow year before implementation<br>• Training.<br><br>and £6.5m annual running costs.<br><br>• Chief Coroner and National Medical Adviser offices<br>• Appeals system<br>• Inspection<br>• Provision of specialist medical advice<br>Additional investment of central funding and other resourcing, major service-business change.<br>Challenge to develop and implement a model that allows adequate central guidance and control whilst funding remains with local authorities and police.<br><br>Implementation inevitably more difficult than for single organisation as needs to be done in partnership with local authorities and police. | Greater rights for bereaved people through introduction of appeals process.<br><br>Improvements to case handling<br>• Greater medical input to investigations.<br>• Fewer unnecessary post-mortems.<br>• Greater consistency across coroner jurisdictions from introduction of national standards and leadership.<br><br>Co-operative working with coroners to develop training, charter and other initiatives for bereaved people supported by strong positive central lead.<br><br>More effective handling of cross-districts major emergencies<br><br>Greater accountability through inspection arrangements. |

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| Future efficiency savings still a challenge to drive through. | |

26. Local authorities will continue to fund the day-to-day running costs of the coroner service including coroner and staff costs, the removal of bodies, mortuary fees, post-mortems and the costs associated with holding inquests. Similarly police authorities will continue to cover the costs of the coroner's officers whom they employ. It will be for the coroner and their team to review ways of working and to prioritise resources in response to guidelines and standards issued by the Chief Coroner.

27. This option was deemed to be the most cost effective and one where the limited resources available would directly improve front-line performance. Although the administration and funding would still be at a local level, there will be national leadership and a national framework to ensure better consistency of service. This option was therefore accepted based on these criteria.

**28.** The parallel reform of the death certification system and the appointment of Medical Examiners will also provide greater medical input at a local level and should result in reductions in referrals and post mortems.

**29. Option 4: unified national service**

30. This option would create a single national service organisation, possibly as part of a MoJ agency. It would make Ministers accountable for providing effective means for a consistent, flexible, responsive, efficient public service, with common standards for the public, an enforceable charter for bereaved people, leadership, accountability, inspection and internal appeals processes for the public. It centralises forward planning and efficiency savings. It has a national career structure for its coroners (whole-time) and staff. However, it has the highest cost of the four options and will need a major change programme and upheaval for the service.

| Summary of costs/disadvantages | Summary of savings/benefits |
|---|---|
| Start up costs of at least £31m and £17m running costs p.a.<br>• Set up new national organisation.<br>Highest cost option; use of additional resources that could be allocated in another area of MoJ business or invested for greater benefit.<br>High overhead cost for relatively small organisation.<br>National organisation no guarantee of best possible service.<br>Risk of losing the benefits of a locally delivered service and integration with other local services. | Effective introduction and enforcement of good practice, common standards for public, charter for bereaved people, complaints/appeals process.<br>Leadership and public accountability.<br>Enables comprehensive co-ordinated forward planning, resource management, efficiency savings.<br>Single career structure for coroners and staff, management of personnel.<br>Single system of medical expertise to support service.<br>Streamlining, modernising investigation and inquests for greater efficiency and |

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|---|---|
| Money invested in reorganisation rather than improved benefits.<br><br>No direct involvement for local government and police; staff and funding (totalling approximately £66m-£70m) transferred over. | with more focus on bereaved people. |

31. This option was rejected because it was unaffordable. The additional costs incurred in setting up a separate organisation did not represent good use of resources or value for money. The Government is not convinced there is evidence to show that a step change in performance can only be achieved by creating a separate national coroner organisation.

**Final Policy Proposals**

32. Amongst the four options outlined, option 3 is considered affordable, provides best value for money and addresses weaknesses found in the current coroners system. It provides a higher level of central leadership, support and investment in terms of inspection, training and development, and performance monitoring and management. This option is now being taken forward in the Bill and forms the basis of discussion in the remaining sections of this document. The key policy proposals are;

- Introduction of a Chief Coroner
- Relaxation of rigid boundary restrictions (but services remain based within local authorities)
- Appeals system
- Independent inspection
- New coroner areas
- New appointment system for coroners
- Powers to secure information and evidence
- Charter for Bereaved Families

33. The Bill will also include the Department of Health's proposals to reform the death certification system. The impact of these proposals has been considered in a separate document that will be published in parallel with this assessment.

**Sectors and groups affected by the final policy proposals**

34. The measures in the coroner sections of the Bill will have an impact on the following groups in England and Wales:
    - Bereaved people.
    - Coroners and coroner's officers.
    - Local authorities.
    - Police authorities.
    - Voluntary organisations working with bereaved people.
    - Funeral industry and crematoria.
    - Professionals involved in death certification.

35. The different ways in which these groups are likely to be affected are outlined below. A range of specific impact tests (including competition and small businesses) have been completed and are attached at Annex A. It is

recognised that people of different faiths may have different expectations and needs from the service. These will continue to be taken into account.

*Bereaved people*

36. In 2007 nearly a quarter of a million deaths were reported to coroners, bringing a substantial number of bereaved people into contact with the coroner system. Under the reformed service national leadership and standards will mean that bereaved people will benefit from an improved and more consistent level of service; more involvement in investigations and inquests; and an opportunity to appeal certain decisions. Furthermore, a new public charter will ensure that bereaved people have a better understanding of the coroner's role and of their own rights and responsibilities.

37. Powers to redraw coroner area boundaries will enable a gradual move to a largely full-time coroner service. National standards, established and monitored by the Chief Coroner, will help put an end to the uneven provisions within the current system, while at the same time encouraging local authorities to augment the service according to local need.

*Coroners*

38. Powers to redraw current area boundaries would enable a gradual move to predominately full time (FTE) coroners, which would mean fewer coroner areas. The Ministry of Justice will work with coroners, local authorities and other interested groups (coroner's officers, police authorities) to agree where the area boundaries might be drawn in future. Actual changes would be made over time to suit local needs and generally when the existing coroner resigns or retires. The area boundaries will be consistent with existing local authority boundaries, although some areas will consist of more than one local authority.

39. Upon implementation of the coroner sections of the Bill, newly appointed coroners must retire when they reach 70 and must be legally qualified. Existing coroners, deputy coroners and assistant deputy coroners will be exempt from the statutory retirement age.

40. Coroners, coroner's officers and support staff will play a key role in the successful implementation of the new service e.g. adapting to the new legislative framework, operating the new appeals system, engaging with the Chief Coroner and providing him/her with management information. The Chief Coroner will provide coroners with national leadership, guidance on best practice, and appropriate arrangements for training. The parallel reform of the death certification system and the appointment of Medical Examiners will also help coroners to carry out investigations and inquests more effectively.

*Coroners' officers and support staff*

41. There are currently around 430 coroner's officers in England and Wales who manage investigations and liaise with bereaved people. Around 90% are employed by the police and the remaining 10% by the local authority. In addition, some coroners are supported by administrative staff who are

employed by the local authority. Neither coroner's officer/staff numbers nor their employment status is expected to change as a result of the proposed reforms. Where relocation is an issue, as now, decisions will be made locally.

42. As with coroners, the new processes will enable coroner's officers to carry out their work more effectively. Once the Chief Coroner is in post he/she will have a strategic role in the provision of training and guidance to coroners' officers and support staff.

*Local authorities*

43. Local authorities will continue to fund the day-to-day running costs of the coroner service including coroner and staff costs, the removal of bodies, mortuary fees, post-mortems and the costs associated with holding inquests.

44. It is recognised that the new appeals system could create a new burden because of additional resources required by coroners and their offices to respond to appeals. Local costs are estimated at £375k per year across England and Wales. However the system will be piloted in a number of areas in 2011/12, to test the new system and quantify the additional burden more accurately.

45. As mentioned above, powers to redraw current area boundaries would enable a gradual move to predominately full time (FTE) coroners, which would mean fewer coroner areas. The Ministry of Justice will work local authorities, coroners and other interested groups (coroner's officers, police authorities) to agree where the area boundaries might be drawn in future. Actual changes would be made over time to suit local needs and generally when the existing coroner resigns or retires. The area boundaries will be consistent with existing local authority boundaries, although some areas will consist of more than one local authority.

46. New inspection arrangements will help the Government, Chief Coroner and local authorities to assess the effectiveness of the coroner service. We will work with the Audit Commission to ensure that inspection of the coroner service is aligned with the new local government arrangements for assessment and inspection (comprehensive area assessments).

*Police authorities*

47. As mentioned above, police authorities currently provide 90% of coroners' officers. The Bill will not alter this arrangement and it would be for the police and local authorities to agree any changes at a local level.

*Pathologists*

48. There are around 700 – 800 pathologists who regularly carry out post-mortems in England and Wales. Coroners commission these pathologists, generally on a private fee-based arrangement. Most pathologists are also employed by the health service. Whilst introducing national guidelines on the purpose and scope of post-mortems is expected to reduce the number of post-mortems commissioned, this is likely to occur gradually. The new

proposed system for Death Certification for England and Wales will also support more effective use of resources by diverting unnecessary referrals from the coroner to the proposed new Medical Examiners. It is recognised that pathologists will need to familiarise themselves with the reformed service and with any local changes. To this end the Ministry of Justice will work with pathologists during implementation. However, the overall impact upon this group is likely to be minimal.

*Voluntary organisations*

49. There are a significant number of voluntary organisations acting on behalf of bereaved people and protecting the welfare of the public within the funeral process. The coroner sections of the Bill and the public charter for bereaved people will address these groups' concerns by providing an improved, more consistent and more responsive service. The Ministry of Justice will also provide information to the public to explain the role of the coroner and to ensure that bereaved people know when and how to access the service.

*Funeral industry*

50. There are around 4,000 businesses in England and Wales operating in the funeral market. Some are large national organisations while others are small local businesses. The coroner measures in the Bill will not affect the way in which these firms do business although, as at present, funeral businesses would need to keep abreast of any local changes to coroner area boundaries. This will not have a significant impact.

51. Funeral directors sometimes need to visit coroners in order to collect certificates (e.g. in cases where there is going to be an inquest but the coroner has agreed to issue a burial or cremation certificate so that the funeral can proceed). A gradual move to a full-time coroner service should not cause any difficulties. Larger coroner areas would not necessarily mean reduced access locally. The Bill will allow for alternative arrangements to be put in place for certificates to be issued electronically from the coroner to the funeral director.

*Crematoria*

52. There are approximately 200 crematoria in England and Wales, 90% of which are run by the local authority and the remaining 10% are privately owned. The coroners' section of the Bill does not change the processes for cremation and so there is no significant impact on this group of stakeholders. The Ministry of Justice has consulted separately on proposals to consolidate and modernise cremation regulations [8] and revised cremation regulations came into effect in January 2009.

[8] Cremation regulations; consolidation and modernisation. See: http://www.justice.gov.uk/docs/cp1107.pdf

*Professionals involved in death certification*

**Doctors**

53. The changes we propose to the statutory framework in the Coroners and Justice Bill will place a duty on doctors to report deaths to the coroner and clearly define in secondary legislation the types of death that should be reported. We expect this to lead to a reduction in the cases reported to the coroner unnecessarily. The intention is to put existing good practice on a statutory footing, and to ensure consistency of approach across England and Wales. Consequently, it will not create an additional burden on doctors as, with the greater clarity provided, they should be referring fewer deaths to the coroner in the future.

**Civil Registrars**

54. Registrars play an important role in the death certification process, in particular referring deaths to the coroner in prescribed circumstances on receipt of information from the family when they attend to register a death. The coroner sections of the Bill will not impose additional burdens on registrars. On the contrary, the list of deaths that should be reported to the coroner will ensure that deaths requiring a coroner's investigation will be referred to them much earlier in the death certification process so that registrars will need to make referrals themselves less frequently in the future.

55. Doctors and registrars will need to become familiar with general reforms to the coroners system and any changes to coroner area boundaries at a local level. The Ministry of Justice will liaise with the representative bodies to agree how this communication can be best managed.

56. The Bill also includes Department of Health proposals[9] for reform of the death certification system. The impact of these proposals has been considered in a separate assessment which will be published in parallel with this document.

*Legal Aid*

57. Our current estimate based on our assessment of likely volume is that the new appeals process will increase pressure on the legal aid budget by an estimated £370k per year, which breaks down into £270k for legal help and £100k for exceptional funding. This has been agreed with the legal aid team in the Ministry of Justice and is included in the £6.5m annual running costs falling to the Department.

## Enforcement and Sanctions

58. In order to improve the service provided to bereaved people, the Bill creates new central functions and strengthens coroners' powers, rather than imposing a host of new statutory requirements. It will be for the Ministry of Justice and the new Chief Coroner to consider how well the new service is operating in relation to guidelines and standards as well as

[9] Consultation on Improving the Process of Death Certification. See: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_076071

the charter for bereaved people. The General Medical Council (GMC) will be responsible for dealing with complaints about medical professionals who fail to comply with their new statutory duty to report certain deaths to the coroner. The annual costs of enforcement are expected to be negligible.

59. The coroner sections of the Bill will introduce a small number of sanctions to ensure that processes and duties are observed. The details are set out in Table 1 below. The number of cases in which these sanctions are invoked is expected to be low and the impact on the prosecution agencies and the courts is therefore expected to be negligible.

**Table 1 – Proposed additional provisions**

| **Provision** | **Penalty** |
|---|---|
| Service on a jury by a juror in knowledge that he is not qualified for such service. | Level 5 fine[10] |
| Refusal by a juror to answer questions put to him to determine whether he is qualified to serve as a juror, intentionally or recklessly giving false answers to such questions. | Level 3 fine |
| Making false representations to the coroner with the intention of evading jury service, making such representations on behalf of another person with the intention of enabling that person to evade jury service. | Level 3 fine |
| Intentionally altering evidence or preventing evidence from being given, intentionally concealing or destroying a document | Level 3 fine or imprisonment for a term not exceeding 51 weeks, or both. |
| Giving false evidence unsworn. | A fine not exceeding £1000 or imprisonment for a term not exceeding 51 weeks, or both.<br>If the person guilty is under 14, the punishment is a fine not exceeding £250 |

[10] Current level fines are:-
Level 1 fine £200
Level 2 fine £500
Level 3 fine £1,000
Level 4 fine £2,500
Level 5 fine £5,000

## Implementation

*Key dates*

60. The following key dates are the current planning assumptions based on the Coroners and Justice Bill being introduced to Parliament in January 2009 and achieving Royal Assent by Autumn 2009,

| | |
|---|---|
| Appointment of Chief Coroner for "planning year" in advance of full implementation in 2011. | Spring 2010 |
| Planning year in which Chief Coroner works with Ministry of Justice to establish new central functions, and develop new systems, guidance and standards in advance of formal launch of new service. | April 2010 to March 2011 |
| Formal launch of new service, implementation of main reforms, piloting of appeals system and introduction of an inspection regime | April 2011 |
| Introduction of Appeals System | April 2012 |

*Managing change*

61. The Ministry of Justice is responsible for taking the Coroners and Justice Bill through Parliament and for working with coroners and other stakeholders to implement the reforms thereafter. This work will be managed as a formal change programme and will be subject to regular review. It will be managed in parallel and as far as possible, aligned with the implementation of the Department of Health death certification reforms (which are also included in the Coroners and Justice Bill).

*Communicating change*

62. The Ministry of Justice will provide information and training for coroners, coroners' officers and support staff about the changes resulting from the Coroners and Justice Bill, such as the new appeals system. We will also work with organisations representing other professionals who interact with the coroner service in order to agree how best the changes should be communicated to them.

63. The Ministry of Justice will continue to provide information to bereaved people, updating its range of leaflets to reflect the new arrangements. It will also provide (or fund) information and/or events dealing specifically with reform issues and with the charter for bereaved people.

*Post-implementation review*

64. The costs and benefits of the coroner reforms will be assessed 12-18 months after implementation of the coroner sections of the Bill, as part of a regular review process.

## Specific Impact Tests

| Test | Impact Test carried out? | Significant impact? | Commentary |
|---|---|---|---|
| Competition Assessment | Yes | No | The Office of Fair Trading asks nine questions about potential impacts. We do not believe that the coroner sections of the Bill will have an adverse impact on business or competition. |
| Small Firms | Yes | No | The coroner service has limited interaction with three groups of small firms – funeral directors, pathologists and body removers. The impact on these groups is assessed as minimal. |
| Legal Aid | Yes | Yes | Estimated legal aid costs are £370k a year. This has been factored into the annual cost of coroner reform that falls to the Ministry of Justice but these estimates will be tested by pilots of the appeals system. |
| Carbon and greenhouse gases | Yes | No | According to Defra's guidelines crematoria are not recognised as a key source of greenhouse gas emissions. In any event, the coroner measures in the Bill will not have an impact on the number of cremations. |
| Other Environmental Issues | Yes | No | No significant impact on the areas listed. |
| Health Impact Assessment | Yes | No | No significant impact on the areas listed. |
| Race, Gender and Disability Equality | Yes | No | Please see the Equality Impact Assessment at Annex C. |
| Human Rights | Yes | No | Consideration of the impact of the Bill on human rights is covered in a separate assessment. |
| Rural Proofing | Yes | No | No significant impact. |
| Sustainable Development | Yes | No | No detrimental effect on domestic or global policies to improve sustainable development. |

For more details on each test see Annex A. An assessment of the coroner sections of the Bill against the Hampton Review Principles is included at Annex B.

# Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

**Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.**

| **Type of testing undertaken** | ***Results in Evidence Base?*** | ***Results annexed?*** |
|---|---|---|
| Competition Assessment | No | Yes |
| Small Firms Impact Test | No | Yes |
| Legal Aid | Yes | Yes |
| Sustainable Development | No | Yes |
| Carbon Assessment | No | Yes |
| Other Environment | No | Yes |
| Health Impact Assessment | No | Yes |
| Race Equality | No | Yes |
| Disability Equality | No | Yes |
| Gender Equality | No | Yes |
| Human Rights | No | Yes |
| Rural Proofing | No | Yes |

# Annexes

**ANNEX A**

## Supporting information for each of the specific impact tests on the coroner sections of the Coroners and Justice Bill

### 1 Competition Assessment

This competition assessment applies to the funeral industry. In our view the Coroners and Justice Bill will have no direct impact on business or competition between businesses.

The Office for Fair Trading (OFT) asks nine questions in order to carry out a competition assessment for any new policies.

The nine questions are:-

1) In the market affected by the new regulation, does any firm have more than 10% market share?

Yes – the Co-Operative Funeral Service have a 14% share of the market, and Dignity have approximately 12%.

2) In the market affected by the new regulation does any firm have more than 20% market share?

No. See 1.

3) In the market affected by the new regulation, do the largest three firms together have at least 50% market share?

No. While there are around 4,000 funeral directors in the UK, 60% of them are independently owned.

4) Would the costs of the regulation affect some firms substantially more than others

No. There is no direct cost to business. As at present, all firms should ensure they are aware of any local changes to coroner area boundaries.

5) Is the regulation likely to affect the market structure, changing the number or size of firms?

No. The Bill focuses on improving the service to bereaved people. There is nothing to suggest that legislative changes will have this effect on the funeral industry.

6) Would the regulation lead to higher set-up costs for new or potential firms compared with the costs for existing firms

No. As above, there is nothing to suggest that this would be the case.

7) Would the regulation lead to higher ongoing costs for new or potential firms compared with the costs for existing firms?

No. As above, there is nothing to suggest that this would be the case.

8) Is the market characterised by rapid technological change?

No. This is not the case.

9) Would the regulation restrict the ability of firms to choose the price, quality, range or location of their products?

No, there is nothing in the Bill that would lead to such restriction of practice.

## 2 Small Firms Impact Test

The coroner system has limited interactions with three groups of small firms - funeral directors, pathologists and body removers. The reforms in the Bill do not affect the nature or quantity of those interactions and so the impact on small businesses is minimal.

*Funeral Directors*

Around 4,000 businesses in England and Wales operate in the funeral market. Some are large national organisations (e.g. Co-Operative Funeral Services) and some are small local businesses that fall within the small business criteria. The reforms in the Bill will not impact on the way in which these firms do business. As at present, firms should ensure they are aware of any local changes to coroner area boundaries and coroner contact details.

The National Association of Funeral Directors responded to the consultation on the draft Bill in 2006. They raised concerns about the size of whole-time coroner areas and the potential for delay in holding the funerals as a result of increased travel time for funeral directors who need to collect certificates from the coroner. However, changes to coroner boundaries will be made gradually and the effects on stakeholders will be taken into account when decisions are taken. Larger areas do not mean reduced access locally. Furthermore, the Bill allows for documents to be shared electronically.

The Ministry of Justice will work with representative groups to establish what information should be provided to the funeral industry about coroner reform.

*Pathologists*

There are around 700-800 pathologists who regularly carry out post-mortems in England and Wales (a total of 110,200 post-mortems in 2006). Pathologists are commissioned by the coroner, generally on a private fee-based arrangement. Most are also employed by the health service. While the introduction of national guidelines may reduce the number of post-mortems each year this would only happen gradually over time. The impact on pathologists is therefore expected to be minimal.

*Body removals*

In a number of coroner areas the local authority has contracted a private firm to move bodies from the scene of death to a mortuary. In other areas this is carried out by a local undertaker. The number of private body removal firms is not large (less than 100 in England and Wales). Again the Bill is expected to have a minimal impact on these firms. As now the local authorities would need to consider the effect on existing contracts when planning local changes to coroner area boundaries. .

## 3 Legal Aid Impact Test

Refer to paragraph 57.

## 4 Carbon and Greenhouse gases

Defra's environmental impact guidance lists six areas which are key sources of green house gases: energy; industrial processes; solvents and other product use; agriculture; land-use change and forestry; and waste. While cremation is a source of greenhouse gas emissions, the way that crematoria operate is outside the scope of the Coroners and Justice Bill.

## 5 Other environmental issues

Other issues considered in relation to the Bill are: vulnerability to the predicted effects of climate change; impacts on waste management; impact on air quality; material change to land or townscapes; water pollution; the disturbing or habitat or wildlife and the number of people exposed to noise or the levels of exposure. Coroner reform has no impact in these areas.

## 6 Health Impact Assessment

The Department of Health has developed a checklist to help assess whether there might be adverse impacts on health as a result of new legislation. The three questions are:

1 Will your policy have a significant impact on human health by virtue of its effects on the wider determinants of health?

The wider determinants listed cover income, crime, environment, transport, housing, education, employment, agriculture and social cohesion. There is nothing to suggest in any of the work done for this Bill that there would be an impact on any of these areas that might lead to a significant impact on human health.

2 Will there be a significant impact on any of the lifestyle-related variables?

The variables listed are: physical activity; diet; smoking, drugs or alcohol use; sexual behaviour; and accidents and stress at home or work. Bereavement is undoubtedly a stressful time for those involved. However, a key aim of these

reforms is to improve the service for bereaved people and so it is not considered that there would be a detrimental impact on any of these variables.

3 Is there likely to be a significant demand on any of the following health and social care services?

The services listed are: primary care; community services; hospital care; need for medicines; accident or emergency attendances; social services and health protection and preparedness response. The Bill focuses on improving the service provided to bereaved people and it will not have a significant impact on demand for these services. As part of the reform programme we will be looking at ways to make better use of the lessons learned at inquest in order to prevent further deaths.

## 7 Race, Gender and Equality Assessment

These three areas are covered by the Ministry of Justice Equality Impact Assessment, which is attached at Annex B.

## 8 Human Rights

It is mandatory that the explanatory notes that accompany the Bill contain a section on the ECHR. They clarify the areas that are connected to human rights legislation. For example clauses 5 and 10 regarding the purpose and outcome of an investigation are designed to ensure that the Article 2 right to an effective investigation is fulfilled. The clauses in Schedule 4 regarding powers of senior coroners are also designed with this in mind.

There are some clauses that raise issues around rights under Articles 1 and 8 regarding evidence and the compulsion of witnesses, and the duty to deliver objects considered to be treasure. However, it is considered that these provisions are a reasonable balance between the rights of the individual and the public interest in carrying out an investigation that has access to all the evidence, and that any interference under Article 1 Protocol 1 or Article 8 is justifiable in the public interest.

## 9 Rural Proofing

The coroner sections of the Bill focus on providing an improved service to bereaved people, the introduction of national leadership and the improvement of coroners' investigations. Therefore it does not have a significant impact on rural areas. Some stakeholders have raised concerns about the implications of moving to a whole-time coroner service. In practice, however, this would not reduce coroner resource. Nor would the creation of larger coroner areas mean reduced access locally as inquests could still be held in a number of different locations.

## 10 Sustainable Development

In line with Cabinet Office guidance we have considered the potential economic, environmental and social impact of the coroner sections of the Bill

(as set out above). The Bill also complies with the five principles of sustainable development:

- Living within environmental limits – no impact on greenhouse gas emissions.
- Ensuring a strong, healthy and just society – improving coroners' investigations and inquests; involving bereaved people in the investigation process and enabling them to appeal against specified coroner's decisions.
- Achieving a sustainable economy – no impact on business or competition.
- Promoting good governance – Chief Coroner to oversee the coroner service, to introduce national standards and best practice guidelines, and to hear appeals.
- Using sound science responsibly – Chief Coroner (supported by the new post of National Medical Adviser) may issue best practice guidelines on the use of post-mortems.

**ANNEX B**

## COMPLIANCE WITH HAMPTON PRINCIPLES

The Hampton Review was aimed primarily at business and reducing administrative and regulatory burdens for that sector. It set out ten principles for regulatory enforcement. These covered areas such as the use of comprehensive risk assessment; the way in which regulators should behave and the enforcement of regulations.

The review's central objective was to raise both the quality and effectiveness of the regulatory system, and sought to build on the strengths of the regulatory system as it exists at present, especially regulatory independence. It also considered that over time its proposals had the potential to reduce the direct cost of regulation to Government and regulated sectors.

The reform of the coroner system has minimal impact on business. The commentary below is a brief assessment against Hampton principles where they are relevant.

The Chief Coroner will be collecting information from coroners about the service provided and will be able to use this to identify particular issues that may arise and, in discussion with Her Majesty's Inspectorate of Court Administration (who will be undertaking inspections), focus attention as appropriate on those.

Inspection has been identified as a key part of reform of the coroner service, and in particular to the raising of standards. This will provide an external, independent review of the service and create a greater level of accountability. .

The draft 2006 Coroners Bill was consulted on with a wide range of stakeholders, and their comments have been taken on board in developing the coroner sections of the Bill further. The legislation has an extremely minimal impact on business, and no information is requested from business as a result of it. The new sanctions introduced do not impact on business.

Information about the reformed service, and in particular access to appeals, will be provided through local coroners. The Chief Coroner's office will also be available to provide information on processes and the rights of families.