

Reform of the coroners' service in England and Wales: policy-making and politics

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Summary

The Coroners and Justice Act 2009 promised an overhaul of the coroners' service, introducing much-needed efficiencies to benefit people bereaved by suicide and other sudden deaths. Central to these reforms was the introduction of a Chief Coroner to coordinate the system and exercise wider public health responsibilities. The coalition government's proposal to abolish the Chief Coroner's office on grounds of cost, ignoring the potential efficiency gains, has arrested implementation of coronial reforms. Policy-makers are urged to use economic evaluation to identify the reforms' most technically efficient components, bringing benefits to bereaved relatives, coroners' staff, public sector budgets, and public health.

Introduction

Long-debated reforms of the 800-year-old coroner system in England and Wales became law with the Coroners and Justice Act 2009, heralding improvements to the efficiency of the coroners' service, its capacity to support the bereaved people it serves, and its role in preventing future deaths^{1,2}. Clinicians had followed the legislative process closely, recognising the implications for patients and their relatives³⁻⁶. Coronial reform was agreed to be long overdue: resources were being wasted through unnecessary bureaucracy whilst funding inequities caused bottlenecks and delays. Central to the Act was the establishment of a new Chief Coroner, welcomed by the BMA, the public, and all political parties for its role in streamlining the service, settling costly disputes and improving accountability⁴. The intention was for the Chief Coroner to lead on a raft of reforms, effecting cost savings, efficiencies, and

service improvements. Yet only months after the Act had been passed a change of government brought the announcement of a comprehensive spending review, placing most of the coroner reforms on hold ⁷. The Chief Coroner's office was identified for abolition on grounds of expense. However this lacked any supporting cost analysis and ignored potential efficiency gains.

The average in-patient or community psychiatrist will experience the suicide of at least one patient annually, and will be well aware of the distress caused to relatives, fellow patients, and team members by an inquest ⁸. All clinicians will appreciate the public health and mental health benefits of the coronial reforms described here and their potential for wider cost savings, including those to the NHS. However these benefits need to be quantified explicitly if policy-makers are to be persuaded of their value. This article argues the general principle that responsible decision-making involves the most appropriate scientific analysis available, namely economic evaluation, and not solely the apparent subjectivity of politicians ⁹. With the future of the coroner reforms currently being debated in Parliament under the Public Bodies Bill there is still time for clinicians to contribute to the discussion by urging policy-makers to conduct detailed economic evaluations of each reform. After many years of consultation this might finally bring about some proportion of the intended benefits to bereaved relatives and coronial staff, as well as to public health.

Problems with the existing coroners' service

In England and Wales all violent, unnatural deaths, sudden deaths of unknown cause, and deaths in custody must be referred to a coroner: an independent judicial officer who may hold an inquiry to determine who has died, and how, when and where they came by their death. Each of these inquiries is conducted within a coroner's jurisdiction, assisted by coroners' officers, who also provide a family liaison role. In 2009 46% of all deaths registered in England and Wales were referred to a coroner, for which inquests were opened on 31,000 ¹⁰. In 2010 the average time taken to complete an inquest was 27 weeks, with the worst-performing areas taking up to 43 weeks ¹¹. Since the 1970's there has been a growing awareness of the difficulties faced by relatives in relation to coroner investigations and inquests ^{12 13}, particularly

in cases of suicide ^{14;15}. Qualitative research describes what can be a long and difficult process, involving frustrating administrative delays, a lack of consultation, confusing and intimidating experiences in the coroner's court, and a sometimes unanticipated verdict ^{16 14 15}.

There are two reasons for these failures: a lack of accountability and devolution of funding. Whilst the independence of the coronial service is crucial, particularly where investigations expose governmental failings, coroners are not accountable for decisions. Under an archaic system of devolved funding salaries and resources are provided by the local authority, the police authority or both, resulting in pronounced geographical inequities ¹⁷. There are no service standards and no culture of mandatory training, whilst unnecessary bureaucracy contributes to backlogs. Coroners' officers struggle with heavy caseloads which limit the degree of support they can offer bereaved families. Pilot schemes involving voluntary sector organisations like the Coroners' Courts Support Service have sought to compensate for gaps in service, but the current economic climate threatens the sustainability of such arrangements ¹⁸.

A 2003 independent review concluded that the coronial system was outdated, inconsistent and unsympathetic to families, proposing fundamental reforms led by a Chief Coroner ¹⁹. The Shipman Inquiry's 2003 report also concluded that there was insufficient medical knowledge in the coroners' system, a lack of leadership and training for coroners, and an inconsistent level of service for bereaved people ²⁰. These recommendations prompted the Labour government to announce plans for coronial reform, published for consultation as part of the Coroners and Justice Bill 2006. Reactions to the reforms were generally positive, despite reservations about financing. Plans to allow coroners to transfer cases more flexibly demonstrated clear efforts to reduce bureaucracy. However other opportunities for allocative efficiency had been missed, for example in ignoring the Shipman Inquiry's recommendation to introduce central funding ²⁰. The wider costs and consequences of three key reforms are discussed below: the establishment of a Charter for the Bereaved, the creation of the post of Chief Coroner, and the introduction of a right of appeal.

Key coronial reforms

1) Charter for the Bereaved:

The Bill announced a Charter for the Bereaved setting out a range of service standards and consumer rights ²¹. These included material improvements to premises, for example a private room for relatives attending an inquest, as well as improved support and information for any bereaved person brought in contact with the coroner's service. Information was to be provided on coronial procedures, arrangements for viewing the body, the rationale for a post-mortem, and where and when an inquest would be held. Coroners' officers were given responsibility for providing this support, but without plans to expand their numbers, contrary to the Shipman Inquiry's specific recommendation ²⁰. Workload reductions were anticipated through parallel reforms of the death certification process involving local medical examiners overseen by a National Medical Examiner ²². When piloted this had reduced the proportion of coroner-referred deaths by 10% ²³. However the possibility remained that the Charter might raise public expectations beyond the capabilities of the service ²⁴, offering bereaved people "a list of laudable but unenforceable empty promises" ²⁵ echoing experiences with the NHS Patients' Charter ²⁶. By overstressing coroners' staff and hampering any uptake of training there was a risk that standards might actually fall.

2) Chief Coroner:

A proposal to create the role of Chief Coroner presented a more affordable means of improving standards by liberating resources from wasteful bureaucracy. The intention was for a central leader to introduce consistency and transparency into the inquest service by streamlining functions, co-ordinating training and budgets, arbitrating over disputes, and standardising practice geographically. With a national overview of caseloads they would enhance technical efficiency (improved outcomes for a given cost) and allocative efficiency (redistributing resources to maximise outcomes) ²⁷, compensating in part for the failure to introduce central funding. These efficiencies would apply not only to the on-going functioning of the service but to the implementation of coronial reforms. Directing this overhaul would help achieve a major objective of the Coroners' Bill – enhancing the capacity of coroners' officers to provide or source support to bereaved people. Additionally by making all coroners accountable to the Chief Coroner autonomy from the government would be preserved.

Public health responsibilities were conferred on the Chief Coroner, for which autonomy was again essential. As a national figurehead they were expected to highlight coroners' recommendations on preventing future deaths, including those implicating government departments. They were also required to engage with regulatory bodies on prevention of deaths and provide reports on shortcomings to Parliament. Finally there was an expectation that they would ensure more consistent recording of coroners' verdicts, addressing the under-reporting of suicide ²⁹. A non-partisan figure such as a Chief Coroner would be best placed to redress this error, particularly where exposing any worsening of suicide rates would not be in the interests of government.

3) Right of appeal:

The proposal to introduce a right of appeal offered relatives the opportunity to contest a range of coroner's decisions, including inquest verdicts. It was popular with bereaved people who felt it would encourage more thoughtful decision-making ³⁰. The costs of this appeals system, estimated at £2.2 million per year ³¹, were to replace the expensive process of High Court applications and Judicial Review. However concerns were raised about affordability and the potential for uncontrollable demand. There were also wider public health ramifications for the collection of suicide statistics. A decline in suicide verdicts was a distinct possibility, either as a consequence of appeals or to avoid them. This would necessitate the revision of statistical conventions on suicide data analysis, to maintain standards on accuracy of monitoring ³². Whilst aware of the potential to increase costs, bereaved people felt that this was justified by ensuring a fair and robust system ³⁰.

Consultation process

Over the three years of consultation which followed the Bill's publication coroners' staff, police, local authorities, voluntary organisations, and bereaved people contributed to policy revisions. This resulted in the strengthening of an inquest's impact through requiring implicated agencies to act on its recommendations ^{33 34}, and the withdrawal of proposals threatening confidentiality of patient data ⁶. However media pressure ousted a reporting restrictions clause which would have protected relatives' privacy in high-profile deaths, for example in cases of apparent suicide ³⁵.

Overall stakeholder feedback praised the reforms' plans to provide training, reduce caseloads, and improve efficiency^{36 30}, but there were consistent concerns about affordability. Whilst these were acknowledged by Ministers³⁷, at no stage were they actually addressed, and when the Act was passed in November 2009 there were already doubts about the feasibility of their implementation.

The problem faced by any interested party appraising the Bill was that it lacked an accompanying economic analysis, balancing the expected costs, savings, benefits and harms of each coronial reform. Economic evaluation is a crucial component of evidence-based policy-making, helping identify the most efficient policies. Given the wide-reaching potential impact of the reforms an appropriate analysis would have taken a societal perspective, quantifying the costs and benefits directly affecting the Ministry of Justice and those indirectly affecting bereaved people, other government departments, the voluntary sector, and society. Alternative scenarios could then be compared to each other, including comparisons to the 'do nothing' approach. Without such rational analysis it has been impossible to answer the fundamental questions in public spending: whether the additional efficiencies would *balance* any increased costs, and whether the potential benefits would *justify* any additional costs³⁸.

Current state of play

Progress with implementation has hardly moved on since the Act passed into law in 2009. At that point consultation had started on the final drafting of the legislation, but coincided with the lead-up to a general election, as civil servants braced themselves for spending cuts. The outgoing Labour minister expressed fears for the reforms' implementation, reminding politicians of their cross-party support³¹. By May 2010 a Conservative-Liberal Democrat coalition government had been formed and immediately conducted a spending review to address the budget deficit. Newly-passed legislation was an obvious target, and civil servants were asked to review plans for coroner reforms³⁹. Further threats to their realisation loomed with the announcement of a 'bonfire of the quangos', including abolition of the office of the yet-to-be appointed Chief Coroner. This controversial decision, together with plans to shelve the appeals system and the National Medical Examiner, was justified on grounds of expense⁷ but with no economic evaluation to delineate how the costs, savings and wider utilities of each position were balanced.

Pressure group INQUEST argued that this was a false economy ⁴⁰, pronouncing that the reforms were “rendered completely hollow without the driving force and national leadership of a Chief Coroner” ²⁵. Parliament’s Public Administration Select Committee agreed, arguing for a careful re-evaluation using an appropriate “value-for-money test” ⁴¹. No economic evidence was forthcoming yet the proposals were fast-tracked for debate as part of the Public Bodies Bill 2010. Opposition arose from House of Lords peers who voted to protect the office of Chief Coroner, and the government responded with an apparent compromise. The current plan is to proceed with establishing a Chief Coroner’s office but to fragment its functions and transfer them to the Ministry of Justice ¹¹. The very basic cost estimates provided lack any supporting analysis ⁴², and offer no evidence that the Ministry of Justice will perform these functions more cheaply or efficiently. Such an arrangement would also compromise the impartiality of the coronial system, in direct contravention of the Shipman report’s recommendations on autonomy ²⁰.

Meanwhile the pace of implementation of the remaining coronial reforms remains slow. Ministers have announced plans to move forward with “some of the (Act’s) measures”, including provision of information and support for bereaved people, training for coroners’ staff, and reducing bureaucracy ⁷. Their clear reliance on the voluntary sector again lacks any consideration of economic sustainability. Consultation has re-opened on the Charter for the Bereaved as part of plans to issue best practice guidance, and the coroners’ rules will also be updated. If the government succeed in their plan to subsume the Chief Coroner’s role it is unlikely that these documents will have much impact without the single, dedicated national leader empowered to implement grass-root changes. This reinforces the opposition’s assertion that abandoning plans for an independent Chief Coroner could “end up costing more money than it is projected to save” ¹¹

Moving forward

Failures of the two successive governments involved in coronial reform have contributed to this stasis. Both have neglected the crucial contribution of scientific evidence in policy-making ⁴³, as a complement to the contribution of stakeholders ^{12;24;30;31;36;37}, and expert opinion ^{19;20}. Whilst the Labour government took care to counsel stakeholder opinion it failed to conduct the necessary economic evaluations. The coalition government's response to the public deficit may indeed be an attempt to limit wasteful bureaucracy, but without any explicit evaluation their approach risks sacrificing potential cost savings ³¹. The coroner reforms announced in 2006 reflected the value placed on consumer protection and service efficiency ²⁴. There is still an opportunity to realise at least some of the benefits originally intended, provided that the debate is informed by appropriate economic evaluation, and that the approach chosen provides a sufficiently wide perspective.

To move forward the government must set-out a clear matrix of direct and indirect costs, savings, utility gains and losses for each proposal, so that detailed economic evaluations can be conducted. INQUEST highlights the broad scope that should be taken, including costs to the NHS in managing the impact of delays on bereaved families' physical and mental health, costs to the justice system in reviewing coroners' decisions, and costs within the inquest service in investigating preventable deaths where failings had been ignored ⁴². The next stage would be a comparison of alternative scenarios, including a reconsideration of centralised funding and its impact on allocative efficiency within the coroners' service. Similarly a comparison of proposals for a Chief Coroner's office would seek to balance economies of scale against autonomy losses and any other direct and indirect utilities.

The outcome of this series of comparisons would be a ranking of proposals by cost-utility ratios; a comprehensive, systematic and explicit process to assist in decision-making ³⁸. Whilst such rankings would only be a guide to prioritisation, they would reduce the chances of human subjectivity dominating over scientific evidence, as has characterised the process of coronial reform to date. Once decisions are made over priority areas for implementation the process of secondary legislation can then commence, reaching agreement over any new rules and regulations governing their day-to-day operation. This whole process brings rationality into decision-making over social welfare, countering vested interests and giving scientific analysis its due

weight. It might finally provide a means of translating evidence-based policy into practice, and delivering some proportion of the intended benefits for bereaved people, government agencies, and society.

Conclusion

The coronial reforms enacted in 2009 had wide cost and utility implications. The rational and comprehensive process of economic evaluation forms part of a government's fiscal responsibilities in allocating scarce public resources, but has been lacking in decision-making over coronial reform. This has contributed to a 2-year stalemate involving much political wrangling. To prevent such situations from arising in the future, while also meeting the requirement for prudent public spending, policy makers are urged to use explicit economic evaluation in all such decision-making. Although this has been absent from coronial reforms, it is hoped that the imminent appointment of a Chief Coroner will bring about many of the benefits originally intended for bereaved people, coroners' staff, wider government departments, public health and society.

Footnote:

Details in this article were correct at the time of going to press (15 November 2011). Updates are available on the UK Parliament website (<http://services.parliament.uk/bills/2010-11/publicbodieshl.html>) and on the INQUEST website (www.inquest.org.uk). Legislative documents on the coroners' service and coroner reform are downloadable from the Ministry of Justice website (www.justice.gov.uk), with additional publications available on the UK Parliament website (www.parliament.uk). For further information, listen to BBC Radio 4's 'Coroners under Scrutiny' available to download until 2009: (www.bbc.co.uk/iplayer/episode/b0174gly/File_on_4_Coroners_Under_Scrutiny/).

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