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Coroners and Justice Act 2009

Burials and Cemeteries Advisory Group

23 November 2009

Final contents of the Act

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Aims

- Improve the **quality and accuracy of death certification** in England and Wales
- Deliver a service that is focused on the **needs of bereaved people**
- Deliver a more **consistent service**
- Enhance **investigations and inquests**
- **Allocate business** more effectively
- Ensure arrangements in place for **training** coroners, coroner's officers and staff
- Strengthen coroners' powers to **prevent future deaths**
- Greater **openness** in relation to coroner system

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Leadership

- Chief Coroner
- Deputy Chief Coroners
- Medical Adviser to the Chief Coroner
- Coroner for Treasure
- All coroner appointments made locally but with national oversight

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Greater accountability

- National Standards and guidance
- Appeals system
- Charter for bereaved families and complaints system
- Inspection
- Annual report to Parliament

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Role of Chief Coroner

Judicial

- Appeals
- Transferring cases
- Practice directions
- Authorisation for entry, search & seizure

Leadership

- Guidance and standards
- Training
- Annual Report
- Resources

Administration

- Oversight of appointments
- Operational management and review
- Investigations lasting more than 12 months
- Helping to secure information in relation to deaths abroad

Other issues

- Post-mortems
- Juries
- Transfers to Scotland
- Legal aid
- Cases where highly sensitive material, typically intercept, is relevant
- “Rule 43” reports

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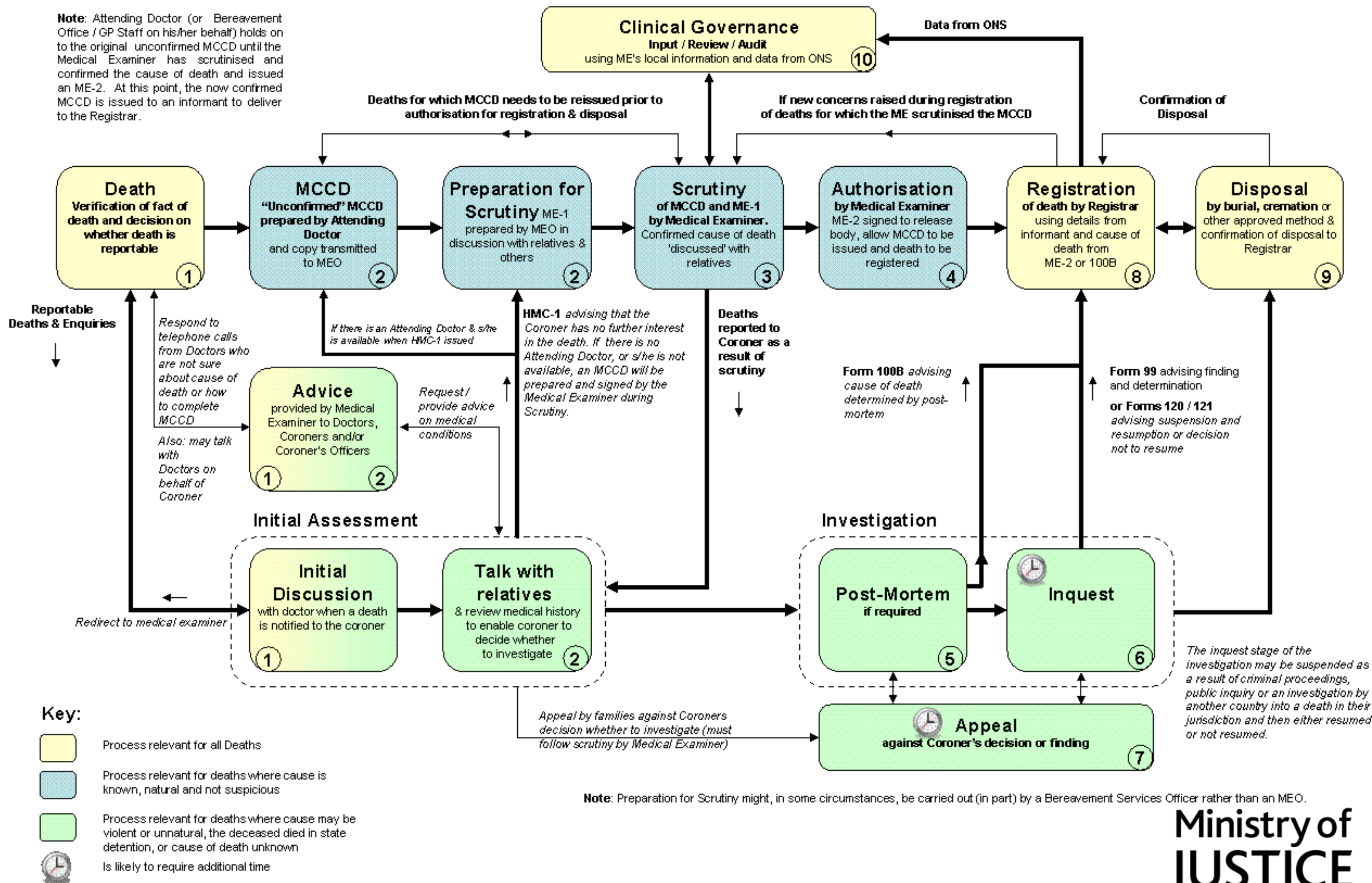
Death certification

- Medical examiners will scrutinise and confirm the cause of all deaths that are not investigated by the coroner.
- A single system for authorising cremations and burials – authorisation from the Medical Examiner will replace the current cremation forms and will also apply to burials
- Medical Examiners to provide general medical advice to coroners
- They will be attached to their local Primary Care Trust (Local health Board in Wales) and will not be accountable to the coroner but will work closely with him or her
- Leadership to be provided by National Medical Examiner
- New process intended to be transparent, quick and convenient

Death certification & coroner investigation process



MoJ implementation activities

- Explore **ways of working** for Medical Examiners and coroners
- Draft **secondary legislation** to govern the day-to-day operation of the coroner service
- Design new **national roles** and support offices - e.g. Chief Coroner, Medical Adviser – and make key appointments
- Work with HMICA and the Audit Commission to agree approach to **inspection**
- Design new **appeals system**
- **Training** for coroners, officers and administrative staff on new legislation and process
- Produce new coroner **forms**/ templates and make associated **IT** changes

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Key milestones

Event	Date
Coroners and Justice Act 2009	November 2009
Identify and appoint Chief Coroner	Early 2010
Develop policy and draft secondary legislation	2010 - 2011
Shadow Year	April 2011 – March 2012
Implement new coroner legislation and practices (except appeals)	April 2012
Introduce Medical Examiner system (Department of Health)	From April 2012
Pilot appeals system	From April 2012
Implement new appeals system	2013/14

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Next steps

- Work with Department of Health & General Register Office to agree implementation plans and timetable
- Start developing secondary legislation
- Start work to appoint a Chief Coroner
- External “health check” by the Office of Government Commerce - January 2010

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