



Management Summary of the Report of a Fundamental Review – Death Certification and Investigation in England, Wales and Northern Ireland.

Key Changes:

1. There should be a consistent, professional service, employing full time legally qualified professionals as Coroners, with responsibility for the service resting with the Lord Chancellor.
2. There should be a consistent service to families across the country. This will be underpinned by a Family Charter, which will have legal backing, and cover areas such as families' rights to information.
3. The service should deal effectively with legal and health issues and support and audit the death certification process. To help achieve this each Coroner's area will have a doctor acting as a Statutory Medical Assessor.
4. There will be a 'two tier' certification system applying to all deaths equally whether the body is buried or cremated. The first certifier should usually be the doctor looking after the person who has died. The second should be from a panel chosen and supported by the Statutory Medical Assessor at the Coroners Office.
5. There should be more informative and accessible outcomes to Coroners' death investigations. This should include fuller conclusions at inquests with a strong bias to narrative and preventative findings.
6. There should be a proper recognition of the worth of Coroner's Officers through the provision of training and a widening of their skills base.

Structural Changes:

1. The responsibility for appointing and supporting Coroners will pass to the Lord Chancellor.
2. Responsibility for provision, management and financing of Coroner's Officers should be transferred from the Police Service and Local Authorities to the Court or Tribunal Service depending on which is chosen as the new base for the Coroner Service.
3. Some Coroner's Officers should be appointed as Registrars of Deaths in order to register all deaths reported to the service.
4. Coroner's Districts will be reduced from the present 136 to a number broadly in line with Police Authorities.
5. A full time Chief Coroner will be appointed to run the service.
6. Each new jurisdiction will be led by a full time Coroner, supplemented by part-time coroners if the work justifies it.
7. A full time Medical Assessor will be appointed to each jurisdiction. The main purpose of the post will be to support the Coroner in ensuring that the death certification process is being properly done, with particular reference to the vast majority of deaths that pass through the Coroners Office and where no further action is required.