



FOIL UPDATE

June 2010

Reform of the Coroner System

The Ministry of Justice has issued a consultation paper to take forward the latest step in reforming the coroners' system in England and Wales. The aim is to consult on the detail of the proposed new rules, as the implementation programme of the new system in Part One of the Coroners and Justice Act 2009 is rolled out. The policy of the Act is, over time, to reduce significantly the number of deaths reported to coroners.

The consultation paper extends to 170 pages and covers a wide number of issues. Only some of the areas are of potential interest to FOIL members and this Update focuses on those, namely:

- Deaths to be reported to a senior coroner
- Post mortem examinations
- Disclosure of information by coroners
- The conduct of the inquest
- Appeals

Deaths to be reported to a senior coroner

When the Coroners and Justice Act 2009 comes into force, when someone dies the default position will be for an attending medical practitioner to review the information provided by the person who verified the death, together with the deceased's medical records and complete a medical certificate of cause of death (MCCD). A medical examiner (a new post) will scrutinize the MCCD. This will entail a proportionate review of medical records, as well as consideration of the circumstances leading to the death and any concerns raised by the family. In certain circumstances deaths will be reported to a senior coroner.

Section 1 of the Coroners and Justice Act 2009 says that senior coroners must investigate a death if he/she has reason to suspect that, amongst a list of other reasons, the deceased "died a violent or unnatural death". No single definition of 'unnatural death' is given but the following categories fall within that definition:

- The death may have been caused by violence, trauma or physical injury, whether intentional or otherwise.
- The death may have been caused by poisoning.
- The death may be the result of neglect or failure of care.
- The death may be related to a medical procedure or treatment.
- The death may be due to an injury or disease received in the course of employment, or industrial poisoning.

Draft guidance for medical practitioners on the above categories is included in the consultation paper, to assist them in deciding if a senior coroner should be notified. This is at a fairly basic level, for example:

"Case/ circumstance: The deceased died as a result of violence, trauma or physical injury whether intentional or otherwise

A violent death involves some sort of trauma or physical injury. For example, if the deceased:

- *Died as a result of trauma or injuries inflicted by someone else or by him/herself.*
- *Died as a result of trauma or injuries sustained in an accident, such as a fall or a road collision."*

Looking at the guidance provided on the other categories: death by poisoning includes death caused by illicit drugs, medical drugs and toxic chemicals. Death by neglect or failure of care can include a failure to provide medical care. A death related to a medical procedure may include a death that occurred unexpectedly given the clinical condition of the deceased, a mistake in the treatment or a death where a medical procedure or treatment has caused or contributed to death.

Three examples are given of "death by injury or disease received in the course of employment":

- *"A current or former coal miner who died of pneumoconiosis*
- *A current or former furniture worker who died of cancer of the nasal sinuses*
- *A current or former construction worker who died of asbestos-related lung-disease e.g. asbestosis or mesothelioma*

This extends to scenarios in which the deceased may have contracted a disease as a result of the employment of another – for example, someone who died of asbestosis as a result of washing their partner's overalls which were covered in asbestos"

The consultation asks:

Do you agree with the suggested cases and circumstances in which a registered medical practitioner must notify a senior coroner of a death? If not, what alternative or additional cases and circumstances would you suggest?

Comments are requested on the draft guidance. In particular, short illustrative examples are requested that could be included in the guidance.

Post-mortem examinations

The main purposes of the changes in relation to post-mortem examinations include a desire to ensure that examinations are carried out only when required: to ensure that examinations are completed to the required degree of certainty to establish the cause of death: and a wish to enable less invasive examinations to be conducted when they establish the cause of death to the agreed degree of accuracy.

Under the 2009 Act, Section 14 allows a coroner to request a 'suitable practitioner' to make a post-mortem examination of a body. Under Section 14(1) the coroner may do this either if the coroner is responsible for conducting an investigation into the death in question or, in occasional circumstances, to decide whether the duty to conduct an investigation has arisen. Section 14(2) makes clear that the coroner's request may specify the kind of examination to be made. The examination could be a fully invasive post-mortem, but could be carried out by less invasive means, for example, by MRI scan.

The consultation paper considers the purpose of a post-mortem:

"At its most fundamental level, we believe that the purpose of the coroner's post-mortem examination is to provide the coroner with sufficient information to

carry out his or her legal duty of establishing the cause of death, when it is unknown or uncertain, so a decision may be made as to whether an inquest is required or the death can be registered without an inquest.....

However, some believe that coroners' post mortem examinations should have additional purposes. In particular it is argued that - if carried out to a greater degree of accuracy - they can play a key role in preventing future deaths, particularly in identifying whether there is a specific underlying case such as an inherited genetic defect that was responsible for the death and may be present in other family members, or may be passed on to future generations".

A key factor for the Government is that the views of the bereaved family should, as far as possible, be taken into account throughout a coroner's investigation process. Matters of costs are also relevant: the more detailed and complex the post-mortem and the more information that is expected, the more expensive it is likely to be.

At the moment the Government does not intend to change the format of post-mortem examination reports and the information they contain, but views are sought on whether the present system works well or whether there could be improvements to the format and content of these reports.

The consultation paper seeks comments on the following:

- ***When a post-mortem examination is required***
- ***The degree of accuracy required by a coroner's post-mortem examination.***
- ***When might a coroner wish to consider authorising a post-mortem examination to be carried out by a less invasive method?***

Disclosure of information by coroners

With a view to achieving one of its key aims, of improving the standing and involvement of bereaved families in investigations, the new Charter for Bereaved People will give the family greater access to relevant documents, on request and free of charge, in advance of the inquest. Such an approach is not intended to change the inquisitorial nature of the coroner's function.

The consultation paper recognises that in attempting to ensure that family members have greater opportunities for disclosure, it is important not to set up a system that overlooks the rights of other interested persons.

Under Section 47 of the 2009 Act 'interested persons' include:

- "(f) a person who may by any act or omission have caused or contributed to the death of the deceased, or whose employee or agent may have done so; and
- (m) any other person who the senior coroner thinks has a sufficient interest.

In the government's view secondary legislation or guidance is needed to:

- Clarify what may or may not be disclosed and when;
- Ensure that all interested persons, whether family members or not, have a right to request information.

'Information' refers to such items as post mortem reports, witness statements, investigation reports and other relevant documents.

Current rules require a coroner, on the application of a properly interested person and on payment of a fee, to supply to them a copy of any post-mortem report, certain notifications, any notes of evidence, or of any document put in evidence at an inquest. The 2009 Act provides for regulations to be made regarding disclosure of information. Under the 2009 Act the general principle for disclosure is that coroners should disclose information, on request, to interested persons, and that an interested person may request disclosure of a document at any time. There will be exceptions to the general principle, for example, some documents may be subject to legal privilege or public interest immunity. It is not proposed that all interested persons should have all discloseable material provided to them automatically, nor is it proposed that if one interested person requests information it will automatically be sent to all others. There is also a need to recognize that a substantial amount of material comes from bodies such as the HSE and the police which have their own disclosure policy and practice which coroners will need to take into account when providing disclosure.

The consultation paper asks for comments on the following:

Do you agree with the approach that interested parties should not automatically be sent information but should be made aware that they are entitled to request it, and be made aware of requests made by other interested persons?

What level of requests for information from other interested persons would you expect to see?

How common is charging for disclosure in practice at present? Should the rules specify the circumstances in which a coroner can charge? What levels of fee should be payable, and to whom should it be paid, for example, to the coroner or the local authority?

The conduct of the inquest

With regard to evidence at the inquest it is proposed that provisions similar to the current Rules 37 and 37A, on the admissibility of documentary evidence and public inquiry findings, are introduced. The Government notes, however, that there have been critical comments from members of the senior judiciary that Rule 37 is unduly complicated, and although intended to make the admission of documentary evidence more flexible it has, in fact, had the opposite effect.

Under the 2009 references to 'inquisition' and 'verdict' are abolished. Instead the coroner will make a 'determination' and 'findings'. The consultation raises questions over what at present are called 'short form verdicts'. These include 'accidental death', and 'industrial disease'. 'Open verdicts' and 'narrative verdicts' are also available. The Government believes that these can lead to misunderstanding and inconsistencies, and make it difficult to keep statistics on different types of death. A number of other short form verdicts which coroners may consider using have been proposed, including:

- Died from injuries received in the course of a road traffic collision
- Died from trauma following an un-witnessed fall
- Died from trauma consistent with or following a fall whilst suffering from severe natural disease.

At present the rules for summoning witnesses is largely informal. Power to summon witnesses is included in the new Act but no practical mechanisms are set out and it is proposed that these should be included in the new rules. Although there is currently no

provision for a coroner to accept unsworn oral evidence the new Act opens the way for this to be accepted in certain limited circumstances.

The consultation paper requests comments on issues including the following:

- ***Should the procedures for summoning witnesses be put on a more formal footing, in similar terms to those regarding the summoning of jurors, for example?***
- ***Should there be a formal basis for coroners to accept unsworn evidence at inquests?***
- ***Should the position on admissibility of documentary evidence be extended or clarified?***
- ***Should a new list of short form determinations be established and, if so, what should the categories be?***

Appeals

The 2009 Act will create a new system enabling appeals against certain decisions taken by coroners: the first national system of its kind anywhere in the world. It is proposed that:

- A notice of appeal should include a declaration that an attempt has been made to resolve the matter informally directly with the coroner.
- The Chief Coroner may disregard an appeal if he or she decides it is vexatious or frivolous
- The Chief Coroner will determine the method of considering the appeal, whether by paper or oral hearing.

Views are sought on the proposals.

Other issues included in the consultation are transferring cases from one coroner area to another; the retention of bodies; entry, search and seizure; complaints, training of coroners, their officers and staff: and death registration procedures. There will be a separate consultation on the death certification process later this year.

If you have any views or comments on the proposals please contact Shirley Denyer on shirley.denyer@foil.org.uk by 16 June please.

The full consultation paper can be accessed on the MOJ website:
<http://www.justice.gov.uk/consultations/reform-coroner-system.htm>

The consultation closes on 1 July 2010.

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