Ministry of Justice

Consultation Paper CP 5/2011

The draft Charter for the current coroner service

A response by the Association of Personal Injury Lawyers

5 September 2011

The Association of Personal Injury Lawyers (APIL) was formed by claimant lawyers with a view to representing the interests of personal injury victims. The association is dedicated to campaigning for improvements in the law to enable injured people to gain full access to justice, and promote their interests in all relevant political issues. Our members comprise principally practitioners who specialise in personal injury litigation and whose interests are predominantly on behalf of injured claimants. APIL currently has over 5,000 members in the UK and abroad who represent hundreds of thousands of injured people a year.

The aims of the Association of Personal Injury Lawyers (APIL) are:

- to promote full and just compensation for all types of personal injury;
- to promote and develop expertise in the practice of personal injury law;
- to promote wider redress for personal injury in the legal system;
- to campaign for improvements in personal injury law;
- to promote safety and alert the public to hazards wherever they arise; and
- to provide a communication network for members.

APIL's executive committee would like to acknowledge the assistance of the following members in preparing this response:
Karl Tonks – APIL Vice President;
Michael Imperato – APIL Executive Committee Member;
Paul Balen – APIL member.

Any enquiries in respect of this response should be addressed, in the first instance, to:
Katherine Elliott, Legal Policy Officer
APIL
Unit 3 Alder Court
Rennie Hogg Road
Nottingham NG2 1RX
Tel: 0115 958 0585; Fax: 0115 958 0885 E-mail: Katherine.elliott@apil.org.uk

Introduction

APIL has campaigned for improvements and reform to the coroner system for many years and welcomes the Government's commitment to address inconsistencies and inefficiencies in the delivery of services through the coroner system to bereaved families, witnesses and other interested parties. However, APIL remains concerned with the decision to not fully implement the Coroners and Justice Act 2009 and to transfer the duties of Chief Coroner to an alternative body. The implementation of the Coroners and Justice Act 2009 in full, with the appointment of a Chief Coroner and the introduction of a Charter could have provided full reform of an archaic and inefficient coroner system.

In our response to this consultation we offer some comment on the detail of the Charter and also provide our submissions to the specific questions.

Executive Summary

This Charter provides the opportunity to offer bereaved families a good understanding of the coroner process and the level of service to expect. A coroner's investigation can be a most distressing time for bereaved families and interested parties, and so it is important that a standard of service is developed but also that families know what to do if they are not happy with the service they have received. APIL therefore welcomes the opportunity to respond to the Ministry of Justice's (MoJ's) consultation on the draft Charter for the current coroner service.

- We welcome any attempt to provide bereaved families and interested parties with simple, easy-to-understand information about the coroner process and what they can expect.
- Even though the document does not appear to be legally binding it may lead the way in creating a standard level of service or accepted culture from the coroner's service.

- The draft Charter does provide enough detail about current coronial practice, although we do have some suggested amendments to several clauses of the Guide and Charter, which are detailed in our response below.

Consultation Questions

Q. 1 Do you agree that the Charter and the Guide are complementary and best published together in one booklet?

We agree that it makes sense to publish the Guide and Charter together as one document and expect that this is what members of the public would hope to see rather than two separate documents. We welcome any attempt to provide bereaved families and interested parties with simple, easy-to-understand information about the coroner process and what they can expect.

Q. 2 Do you agree that the Charter should include witnesses and all other properly interested persons, as well as bereaved people? If not, why?

We agree that the Charter should include witnesses and all other properly interested persons as well as bereaved people.

Q. 3 Does the draft Charter contain enough detail about current coronial practice? If not, what else should be included? (Please bear in mind that some information is contained in the Guide rather than the Charter.)

The draft Charter does provide enough detail about current coronial practice, although we do have some suggested amendments to several clauses of the Guide and Charter[1].

Part 1 paragraph 2.4

[1] *The draft Charter for the current coroner service consultation paper CP 5/2011*, Ministry of Justice, published 19 May 2011, Annex A.

There should be an explanation that a copy of the reports produced as a result of an investigation conducted by an independent body will be sent to the bereaved family and interested parties. Bereaved families and interested parties would expect to receive a copy of these reports and so this should be included within the Guide.

Part 1 paragraph 4.1

This paragraph is not an entirely accurate reflection of the process and so we suggest adding at the end of this paragraph,

> *However, the coroner can still hold an inquest when the death is determined as natural causes.*

Part 1 paragraph 7.1

At the end of this paragraph there should be a definition or explanation of a pathologist. This definition should explain the pathologist is independent of the NHS and the coroner even though it is the coroner who appoints him. A suggested definition is,

> *It is the coroner who appoints the pathologist. He is employed or engaged for this purpose by the coroner even though he may be employed elsewhere by the NHS. The pathologist will be independent (and relatives and any other interested parties can insist on this); must have suitable facilities for the conduct of a post-mortem and be of an appropriate discipline. A paediatric pathologist would therefore be appointed in the case of the death of a child.*
>
> *It is custom and practice therefore that if a death has occurred in a hospital in which it is suspected that the failure of treatment may have contributed to the death, the coroner should select a pathologist from another hospital or area.*[2]

Part 1 paragraph 7.2

[2] Clinical Negligence, Association of Personal Injury Lawyers, General Editor Paul Balen, published in 2008 by Jordan Publishing Limited, Page 90 paragraph 5.3.1.

It needs to be stated in this paragraph that a relative or interested person cannot prevent a post mortem from taking place if the coroner has ordered one to be undertaken.

Part 1 paragraph 7.3

For consistency the following phrase should be added after the word relatives:

> *Or any other interest parties.*

Part 1 paragraph 8.1

It should also be stated here that the post-mortem report gives the medical cause of death.

Part 1 paragraph 9.1

This paragraph is misleading as it suggests that copies of the medical records may be obtained from the coroner whereas this is actually applied for from the relevant medical provider.

Part 1 paragraph 10.1

Most coroners will give the deceased's relatives a choice about the retention of organs following a post-mortem examination. At the end of this paragraph we suggest inserting:

> *Tests on some organs may take some time. The coroner may seek guidance from bereaved families and other interested parties as to whether they would prefer the body to be released for burial or cremation without those organs or if they are prepared for there to be a delay before the whole body can be released after the tests have been completed.*

This can therefore allow for an aspect of closure to take place for the relatives while the investigation may be ongoing.

Part 1 paragraph 14.3

This statement should be an express statement and provide absolute clarity on the subject of pre-inquest hearings. In addition, the following should be inserted at the end of the paragraph,

> *Any person with factual information relating to the death of the deceased must make this known to the coroner prior to the resuming of the inquest.*

Part 2 paragraph 1.1

Inserted as additional bullet points at the end of this paragraph should be,

- *Supply a list of witnesses and copies of any statements or documents relied upon by the coroner if requested to do so by a relative or interested party.*
- *Enquire with the relatives and interested parties of the deceased as to the preferred language that the inquest is conducted in or if translation services are necessary.*

Part 2 Paragraphs 2 and 3.20

Neither in the guide nor the Charter does it explain to the bereaved relatives or interested parties that the inquest will be recorded and that they may obtain a copy of this recording or how to do so. We suggest that this should be inserted into the flowchart at paragraph 2 and also in between paragraph 3.20 and 3.21.

Part 2 paragraph 3.15

The disclosure of documents has been a recurring problem previously in relation to inquests. In order to put an end to uncertainty on this subject, there should be reference to a specific timeframe in this paragraph. Paragraph 3.15 should read as follows,

> *In advance of the inquest, the coroner's office will disclose to properly interested persons, on request, relevant documents to be used in the inquest* ***at least four weeks before the start of the inquest****. However, it is possible that for legal reasons the coroner will either not be able to disclose all the documents or part of a document he*

or she intends to use at the inquest. The coroner will explain on request why he or she has not disclosed a particular document, or part of a document.

Part 2 paragraph 3.16

Again at this paragraph there should be a time period specified to provide better clarity. This paragraph should read as follows,

Where the coroner decides to hold a pre-inquest hearing, the coroner's office will give reasonable notice to properly interested persons of the time, date and location of the hearing, the purpose of the hearing and their rights to participate in it.

Part 2 paragraph 3.17

As a reflection of common decency we would expect to see all coroners offering bereaved families a private waiting room in order that the relatives may be kept separately from all other parties involved in the inquest, including the person who may potentially be responsible for the death of their loved one. Therefore *"Wherever possible"* should be removed from the beginning of this paragraph.

In addition to this, the coroner's office should also be able to provide those that are legally represented with a private consultation room and this should be expressed within the Charter.

Q. 4 Are the sections on how to complain about the conduct of a coroner, and the level of service received, easy to understand? If not, how could they be improved?

The sections of the Guide and Charter on how to complain about the conduct of a coroner and the level of service they received are both comprehensive and easy to understand. We do not recommend any amendments to these sections.

Q. 5 What are your views on our proposal for a committee of voluntary bereavement organisations to assess the impact that the Charter has on the coroner service and to report their findings to the Secretary of State?

A committee of voluntary bereavement organisations would be well placed here to assess the impact of the Charter on the coroner service and to report their findings to the Secretary of State.

Q. 6 Is the Charter a user-friendly document, and are there any other terms that need to be included in the Glossary?

The Guide and Charter appear to be user-friendly documents and easy to understand with little jargon, although there are other organisations that are closer to bereaved members of the public which may be better placed to answer this question.

Q. 7 Have all the responsibilities of bereaved people and others who come into contact with the coroner service been included? If not, what other responsibilities should be included?

The responsibilities of bereaved people and other interested parties have been explained well within this document.

Q. 8 Do you have any other comments on the draft Charter?

This Charter provides the opportunity to offer bereaved families a good understanding of the coroner process and the level of service to expect at a distressing time. Even though the document does not appear to be legally binding it may lead the way in creating a standard level of service or accepted culture from the coroner's service. We welcome the Government's commitment to address inconsistencies and inefficiencies in the delivery of

services through the coroner system to bereaved families, witnesses and other interested parties.

APIL is also disappointed with the MoJ's decision to not fully implement the Coroners and Justice Act 2009 and transfer the duties of Chief Coroner to an alternative body.

- Ends -

Association of Personal Injury Lawyers

Unit 3 Alder Court, Rennie Hogg Road, Nottingham, NG2 1RX

● T: 0115 958 0585 ● W: www.apil.org.uk ● E: mail@apil.org.uk