Ministry of Justice

Implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009

A response by the Association of Personal Injury Lawyers

April 2013

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation with a 20-year history of working to help injured people gain access to justice they need and deserve. We have around 4,700 members committed to supporting the association's aims and all of whom sign up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives and academics.

APIL has a long history of liaison with other stakeholders, consumer representatives, Governments and devolved assemblies across the UK with a view to achieving the association's aims, which 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;
- To provide a communication network for members.

Any enquiries in respect of this response should be addressed, in the first instance, to:

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Introduction

We welcome the opportunity to respond to a second consultation focussing on the coroner reforms. APIL members have a unique view of the coronial system, as they serve bereaved people during a traumatic time. We welcome any measures that will improve disclosure and access to information for the bereaved; which will put the needs of bereaved people at the heart of the coroner system, and will make the system more efficient.

Our remit extends only to personal injury law, including clinical negligence; therefore we have only answered the questions which are relevant to bereaved families and the expert solicitors who represent them at inquests.

Q1. Do you agree that the proposals set out in this consultation paper will impose no significant new burdens on local coroner's services or others? If you disagree, what new costs would arise? And how could these be mitigated?

Anecdotal evidence from coroners suggests that they expect that the workload following these and other recent proposals such as the introduction of medical examiners will actually increase. It is essential that coroners and their staff are provided with adequate resources.

Q3. Do you support the proposal to amend the Judicial Appointments Order 2008 so that Fellows of CILEX are eligible for coronial appointments? Please give reasons for your response.

We are supportive of the proposals to allow Fellows of CILEX to be eligible for coronial appointments. A wider eligibility pool will ensure that those best suited to the role can be selected. There should be a rigorous appointment process, to ensure that only those with the relevant skills and expertise are able to apply.

We are, however, disappointed by the removal, in schedule 3 of the 2009 Act, of eligibility of medical practitioners of five years standing or more[1]. Medical practitioners will be experienced and have the relevant skills to carry out the role of coroner effectively. We do not understand the rationale for providing for legal executives to be appointed, but not experienced medical practitioners. APIL suggests that doctors should be able to qualify, if they have received suitable legal training.

Q4. In your experience what difference has the current *Guide to coroners and inquests and Charter for coroner services* made since it was published?

[1] Paragraph 34 of the consultation document

We feel that the guide issued was well intentioned, and will have gone some way to ensure that bereaved people were informed of the coronial process. We are supportive of any measures which ensure that bereaved people receive the information that they require in order to participate fully in the investigation process. We support the reform's aim to put the bereaved people at the centre of the process, and giving them as much information as possible will be a step towards this. A guide can, however, only do so much to achieve this aim. The service is only as good as those working within it, and the amount of funding that it receives. Therefore APIL is sceptical of the actual practical difference that the guide has made to the service received by bereaved people.

Q5. The new *Guide to coroner services* revises the *Guide to coroners and inquests and charter for coroner services,* so that it is consistent with the 2009 Act. Do you think the new document is a helpful summary of what to expect during a coroner investigation? If not, please explain your answer.

We are supportive of keeping bereaved families informed about the coronial process, to allow them to participate fully in the investigation, and we believe that the new guide could be very useful in doing this (subject to the caveat above in question four). For example, the flowchart at section 3.1 of the new guide is clear and comprehensive, and will give an insight into the process to those involved.

However, we do have concerns that the target audience for this guide is very varied, and this creates difficulties for those putting the guide together. Some people will want as much information as possible, whilst others will want just the most basic information, and to those people, the amount and detail of information contained in the guide could be very daunting. Whilst we understand that attempts have been made with the new guide to make it more concise, we feel that most bereaved people will find a shorter, less detailed guide, similar to the one provided by Action against Medical Accidents (AvMA), easier to access, and therefore preferable at such a traumatic time.

Q6. Is there anything else we should cover in the *Guide to coroner services,* or cover differently? If so, please explain your answer.

We feel that there could be more clarity in certain areas in the *Guide to coroner services.* For example, the guide does not clearly state anywhere that a person is entitled to legal representation. The overarching tone of the guide, in fact, appears to be encouraging people not to engage legal representation, as they will not require it. This is demonstrated at section 9 of Annex D, which provides information about the inquest. Nowhere in this section is it made clear that a person is entitled to have representation. Under section 9.5, where the

guide lists who can attend an inquest, legal representatives are not included. The tone is further demonstrated at paragraph 9.11, where the guide says that in most cases “you will not need to employ a solicitor”.

APIL finds this deeply unsatisfactory, as it should be made clear that a bereaved person is entitled to be legally represented throughout the process. The other parties will more than likely have legal representation, which will leave the vulnerable bereaved party unrepresented – creating an uneven playing field.

A further issue with the guide is at Section 10.3 of Annex D. This begins “Any civil proceedings will normally follow the inquest”. The wording suggests that a civil claim will automatically follow the inquest. This is not true, and could be misleading for the lay person reading this. This section of the guide needs to be reworded, to make clear that whilst a civil case, should it happen, more usually takes place after rather than before an inquest, this is by no means an automatic occurrence. It should also be stated that the costs of instructing a lawyer at the inquest may be recovered in civil proceedings which are subsequently successful, as this forms part of the investigation process.

Q7. Should the new coroners’ rules include a target date for completing inquests? If so, what should this target be? Would three months be appropriate? Please give your reasons.

We feel that the new coroner rules should include a target date for completing inquests, and three months would be a suitable target. Inquests, and awaiting the results of inquests, are extremely distressing times for a bereaved family. A target date will provide some certainty for the family and its legal representative, which could go some way to reducing the stresses and anxieties of the process. A caveat to having a target date would be that the legal representative of the bereaved, or the bereaved themselves, could say that they did not want the coroner to list the inquest for that date. The caveat will help to prevent unnecessary distress to the bereaved family. It will also ensure that, if there has been no wish from the family not to list the inquest for the target date, the coroner will carry it out on time and they cannot use the distress of the family as an excuse to delay.

We agree that three months is a suitable target, because as mentioned in the consultation document at paragraph 8 page 24, the bereaved will need sufficient time to grieve in order to be able to participate fully in the inquest process. A longer time period may be needed to ensure that an effective and thorough investigation can be carried out.

Q8. Are you aware of a time when a coroner has in practice needed to be available out of hours for duties *not* relating to a post-mortem examination or organ donation? If so, please give details.

Our members have not had any complaints concerning this. As long as the coroner is accessible when out of the office, via mobile phone for example, and information is readily available out of hours, then no issues will arise.

Q9. Are you content with this approach to the drafting of the regulations on post-mortem examinations? If you are not, please give your reasons.

APIL feels that it is vital that the new proposals contain a deadline for coroners to complete reports. At present, some of our members have had to wait up to six months for a report, and this is extremely distressing for the bereaved family.

Q10. Are you content with the draft regulation which says that a body should normally be released within 30 days, and that if this is not possible, the coroner must explain why? If not, please explain your answer.

We are content with the draft regulation.

Q11. Do you agree that one month (with the possibility of seeking an extension) should be sufficient for a person to respond to a coroner's reports of actions to prevent other deaths? If you do not, please explain your reasons.

One month should be sufficient for a person to respond to a coroner's reports of actions to prevent other deaths. Interested parties will already be on notice from the inquest as to what the issues are, and how they are expected to respond. It is important that once an issue has been identified, the people concerned acknowledge this and put into place measures as efficiently as possible to ensure that no further incidents occur.

We welcome with the addition, stated at paragraph 23 of the consultation document, that response to coroners' reports must include a timetable for the action proposed to be taken to prevent other deaths. This will help prevent further incidents occurring in the future, and will also go some way towards reassuring the grieving family.

Q12. Do you agree that the draft regulations to be made under s 43 will ensure more consistent standards in the coroner investigation process? If not, please give details.

Yes.

Q13. Do you agree with the time limit for notifying interested persons of the arrangements for the inquest hearing? And do you agree with the requirement on coroners to publish the arrangements for an inquest hearing? If you do not, please explain your reasons.

Yes. However where there are a large number of documents or witness statements sufficient notice should be given to ensure that these can be considered.

Q14. Are you content that our proposed rules on disclosure will help bereaved people and other interested persons play a more active part in the investigation process (where they choose to do so)?

Q15. Do you have any suggestions as to how the rules on disclosure could be improved? If so, please explain your answer.

We are extremely supportive of any move towards prompt and full disclosure. It is imperative that bereaved families and their representatives have access to as much information as they feel appropriate. Disclosure will ensure that an investigation into a death is as thorough as possible, and make sure that lessons can be learned to prevent circumstances surrounding a death recurring. Disclosure also aids the grieving process. Particularly where the parties are legally represented the coroner should also disclose those documents he has received during his investigation but does not intend to rely upon at the inquest. This ensures full transparency and avoids one interested party submitting documents to the coroner on the basis that they should not be disclosed further. This also gives interested parties time to make submissions to the coroner that evidence he has disregarded prior to listing the inquest may in fact be relevant.

At paragraph 26 (page 21) of the consultation document, it is said that for post inquest disclosure, it is permitted for coroners to continue to charge a fee for disclosure of hard copy documents. It cannot be right that after losing a family member whilst in the care of the state, the bereaved family can be charged hundreds of pounds for access to inquest documents. Although there is a caveat included in the new rules, that people will only be charged where the hard copy has been requested, or where electronic disclosure would not otherwise be possible, we believe that all disclosed information should be freely available.

Q16. Are you content with the proposed rules on evidence a) written evidence; b) video link; c) screened evidence? If not, please explain your answer.

We are supportive of video links, as these will help the hearing run as efficiently as possible, and enable the coroner to gather as much information as possible to help with the inquest. If witnesses are out of the jurisdiction or unable to attend court for some reason, video links

will allow them to participate in the inquest nevertheless. APIL is supportive of any methods which allow full attendance by all witnesses, which in turn will help to achieve a fuller and more comprehensive investigation.

Q17. Do you agree with new rule 25 and the requirement for a coroner to record inquest proceedings? Should the rules contain sanctions for misuse of recordings? Please give your reasons.

We do not think it is necessary for the rules to contain sanctions for misuse of recordings. If the inquest proceedings to be recorded take place in public, with anyone free to watch and listen, we do not understand how there could be a "misuse" of such a recording.

Q18. Are you content with the draft rule and form on conclusions, determinations and findings? If not, how could they be improved? Do you agree with the addition of the new short-form conclusions "drink/drug related" and "road traffic collision"? Please give your reasons.

We agree that for drink and drug related, and road traffic collision cases, there should be a shortened process, so that there will be more time to commit to a thorough inquiry in more complex cases.

Q19. Do you agree that the draft rules on inquests to be made under s 45 will help make inquests more consistent? If not, please give details.

Consistency is a laudable aim, and one that would be extremely advantageous to families and their legal representatives. Consistency will aid legal representatives in advising the bereaved on what to expect from the inquest process, and in turn, this will help the bereaved cope in the distressing circumstances. We are unsure, however, whether the draft rules will actually achieve the desired consistency.

Accountability to the chief coroner through a national framework will be the reform which will make the most difference in making inquests more consistent. A national framework overseen by the chief coroner will ensure uniform practices across the different coroner areas.

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