

**Ministry of Justice**

**Proposed amendments to Rule 43 of the Coroners Rules 1984**



**A response by the Association of Personal Injury Lawyers**

**March 2008**

The Association of Personal Injury Lawyers (APIL) was formed by claimant lawyers with a view to representing the interests of personal injury victims. APIL currently has around 5,000 members in the UK and abroad. Membership comprises solicitors, barristers, legal executives and academics whose interest in personal injury work is predominantly on behalf of injured claimants.

The aims of the association 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.

APIL's executive committee would like to acknowledge the assistance of the following members in preparing this response:

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APIL welcomes the opportunity to respond to the Rule 43 consultation and is generally supportive of the Government proposals. Consultations, though, are no substitute for a comprehensive Coroner Reform Bill which will modernise the current archaic and fragmented coronial system. The association was very disappointed when the bill failed to appear, as promised, in the Queen's Speech but acknowledges the Government has deferred rather than abandoned its legislation. APIL therefore urges to the Government to bring forward its bill as soon as possible, for the sake of certainty, clarity and, most importantly, the concerns of bereaved people.

## **Executive summary**

- APIL agrees with the proposal to place coroner Rule 43 reports on a statutory footing;
- There should be greater sanctions than 'naming and shaming' if responses are not received within the deadline, such as fines;
- The association strongly believes that the reports and responses should be published in full;
- Coroner reports must be centrally collated and analysed;
- The reformed coronial system must be adequately resourced from the centre in order to prevent a 'postcode lottery' situation.

### **1. Do you agree that a coroner should have the power to make a report, even when it was not announced at inquest?**

APIL agrees with this proposal. Coroner reports will be a crucial aspect of the whole process for bereaved families and should contribute to the prevention of future similar tragedies, which is one of the main concerns of most bereaved families.

## **2. Is the time limit for a response about right? Should there be a greater sanction, and if so what, other than 'naming and shaming' for a failure to respond to reports?**

There is obviously an arbitrary element in all deadlines such as this, but the association believes that 56 days is an acceptable period in which responses can be completed.

There should be greater sanctions available if the organisation or person does not respond within the stated deadline. The coroner, for instance, could summon the person whose duty it was to respond to a formal meeting where he could be compelled to explain why he has not complied with the statutory duty. This is similar to the power coroners already possess to subpoena witnesses to appear before them during an inquest.

If the person fails to attend then the Chief Coroner should be provided with the powers to impose fines or declare the wrongdoer to be in contempt of court. It is essential that sanctions should reflect the seriousness of not complying with the original report as the whole purpose of the proposed changes is to ensure that lessons are not just learned but acted on effectively. Flagging up failures in the Ministry of Justice bulletin, as the paper proposes, does not go nearly far enough.

## **3. Do you agree with the general principle that coroner reports and responses should be shared with interested persons and relevant organisations?**

The association agrees with this general principle.

**4. Can you think of any circumstances when it would be inappropriate to share reports and responses in this way?**

As the whole point is to learn lessons and take actions, the association finds it impossible to accept that there will be occasions when reports and responses should not be shared.

**5. Do you agree with the proposal for coroners to copy their report and any response to interested persons and to the Lord Chancellor? If not, how else could we ensure that these people receive this information?**

The association agrees with this point.

**6. Do you agree that only a summary of reports and responses should be published?**

APIL submits that the presumption in the new rules should be that the reports and responses will always be published in full. Once again, it has to be stressed that the fundamental purpose of Rule 43 is prevention and it is hard to see how this can be achieved if publication of reports is limited to a summary. It will also allow bereaved families, and the general public, to be able to identify the organisations which have taken the remedial action necessary to ensure fatalities do not recur in similar circumstances.

It should not be a consideration that full disclosure might inhibit the amount of information included. We are, after all, dealing with a situation where a death has

occurred. Transparency and accountability should be the core aims of the new rules or bereaved families will feel that the system is simply too secretive. The proposed Charter for Bereaved People should include a commitment that bereaved families will be able to gain full access to coroner reports and the responses.

## **7. How could coroners and/or the Ministry of Justice disseminate lessons learned more widely and more effectively?**

It is essential that the coroner reports are centrally collated and analysed, otherwise the present fragmented system will be replicated. Ministry of Justice officials or the proposed coronial council could provide the necessary manpower to achieve this. A pertinent analogy is the role of the Chief Medical Officer, who correlates the reports from the National Patient Safety Agency and urges appropriate remedial action.

It cannot be stressed strongly enough that these reports must be effectively followed up. It is no use ordering action to be taken if it is never checked whether it actually has been taken.

## **8. Is there any particular information you think it would be useful to include in induction and in-service training provided to coroners?**

The importance of following up the reports and discerning any patterns in deaths should be included in the training programme.

## **9. General comments on the proposed amendments to the Coroners Rules 1984, and on the way these would work in practice.**

APIL is in favour of most of the Government's proposals and welcomes the clear intention to improve the Rule 43 process. One element which should be mentioned is resources. The new system must be properly funded if it is to function effectively. The association expressed concerns in its response to the Draft Coroners Bill about the intention to fund the system locally rather than centrally. APIL has real concerns that local authorities will provide different levels of funding, leading to different standards of service. This will negate one of the key reasons for reforming the system in the first place. It would be a great disappointment to bereaved families if any reforms were hamstrung from the start by lack of resources.