MEETING NOTES

DATE: 8 September 2010
SUBJECT: APIL East Anglian Regional Meeting
LOCATION: The Holiday Inn, Norwich
ATTENDEES: Sharon Allison, William Armstrong (Speaker), Richard Barr, Simon Bransby, Amanda Cavanagh, Colin Cook, Mark Copley, Julie Crossley, Simon Davis, Heather Duffy, Pamela Hoare, Jeremy Ives, Jacqueline Lake, Trefine Maynard, Jan Parry, Felix Parry, Sandra Patton, Rosamund Rhodes-Kemp, Hannah Rutterford (Regional Co-ordinator), Jane Stockings, Mick Upton (Regional Secretary), Nicholas Ware, Richard Wood.

1. INTRODUCTION BY HANNAH RUTTERFORD (HR)

HR welcomed everyone to the meeting and introduced the speaker, Mr William Armstrong, HM Coroner for the County of Norfolk (WA).

2. EC UPDATE BY HANNAH RUTTERFORD (HR)

HR provided an EC update covering various topical issues.

APIL's President, Muiris Lyons, conducted a series of media interviews on the issue of the Lord Young health, safety and compensation culture review. APIL have sent Lord Young a paper which outlines the need to provide education about the difference between accidents and negligence. APIL's paper explains that claims, in the main, have fallen over the last ten years and it states that health and safety laws have worked in helping to protect people from needless injury. The paper suggests that the answer is not to have a general assault on health and safety, but to ensure that the regulations are understood and properly applied.

APIL are still monitoring the progress of the new RTA claims process. Backlogs in registrations have now cleared and the portal is running more efficiently but anyone with problems should report them to Abi Jennings at the APIL office.

APIL have been asked for information about successful claims concluded under the new RTA claims process where a medical report has been required. Anyone willing to assist should contact Abi Jennings.

APIL will continue to keep members up-to-date on developments regarding the Jackson review. Members are encouraged to read the Weekly News, Connect and PI Focus emails/publications to keep up with these developments.

APIL continue to lobby for an Employer's Liability Insurance Bureau and have asked for a meeting with a new minister dealing with this issue. In the meantime the ABI is pushing hard to develop a new EL Tracing Office, although this will not be compulsory, nor will it be independent. APIL are still looking for evidence to assist with the campaign. If you can help please contact Lorraine at the APIL office.

APIL are disappointed that the Draft Civil Law Reform Bill was not included in the Queen's Speech in May. Of greatest concern is that Governments over the last 11 years have failed to implement Law Commission recommendations to increase general damages, in most cases by 50%. APIL are trying to get these issues back on the political agenda but need case evidence of injustice to support their arguments. Please contact APIL if you can assist. Clients must be willing to share their story, able to explain how they have been affected, be able to say why the lack of an increase in damages caused injustice and how extra money would have assisted them. They must also be prepared to be named, possibly be photographed and give their address (not house number).

The ABI published its guide to Third Party Capture, or what it termed Third Party "Assistance." APIL issued a press release condemning the guide and the language it used, this was featured on the Law Society Gazette. APIL have also issued warning postcards, warning about the

dangers of exploitation. APIL need more examples of third party capture cases, but not those involving Quinn Direct, as broader evidence is needed.

A working group is to be set up to consider difficulties experienced with the NHSLA system and to improve dialogue between APIL and the NHSLA.

The Civil Justice Council completed its review and re-draft of the pre-action protocols on 15 July 2010. Timeframes regarding updated protocols are currently unclear.

The implementation of the pleural plaques compensation scheme has been delayed. No explanation for the delay has been given but APIL have been told that it should be implemented "soon."

A working party has been formed to look into problems with how the CICA operates, including delays, availability of funds to pay claims and how lawyers are paid. An initial meeting with the CICA has now taken place. APIL need evidence of these problems in practice to support their arguments.

3. INQUESTS AND THE CORONER'S COURT – AN OUTLINE, BY WILLIAM

WA gave an insightful and interesting talk on the role and the history of the Coroner's Office and the Coroner. A comprehensive handout, covering all of the issues covered by WA's talk is available on the APIL website.

WA's talk attracted a number of questions afterwards.

WA was asked whether a Coroner can make recommendations under Rule 43 of the Coroners Rules 1984 (for example for reviews of, or improvements to safety procedures) if there is a jury at the inquest. WA stated that only the Coroner can make recommendations under this rule, although a jury can give a verdict which criticises a person or organisation.

WA was asked whether advocates can make a submission that the Coroner should make a recommendation under Rule 43. WA said that advocates may make limited submissions. Rule 43 is an important part of the inquest process but a coroner has to be careful not to go beyond his remit.

WA was asked what he sees as his obligation to family members. WA said that there is no obligation outlined in the law but he is of the view that where the family are not responsible for the death, the Coroner is providing a service for the public, and in particular that family and as such Inquest Support will assist the family to reassure them and give support. WA makes a point of ensuring that family members are able to sit at the front if they wish so they do not just feel as though they are part of an audience. He tries to address them by name and acknowledge them at the outset of proceedings. Coroners' approaches vary.

WA was asked whether he has difficulty getting documents from the HSE when they are investigating a matter, and whether he has to wait until an investigation has concluded. He advised that usually the HSE will wait until the inquest has concluded, before investigating because they may get information from the inquest. Usually the HSE are cooperative but they can be difficulty. The Coroner has no control over the HSE although he can direct the police.

WA was asked whether asbestos-related deaths are reportable and whether the Coroner gets a copy of the post-mortem. They should be reported but aren't always as doctors do not always understand that they constitute an industrial disease. WA does not always receive a post-mortem.

MICK UPTON (Taylor Vinters, Cambridge)
Associate

08.10.2010