



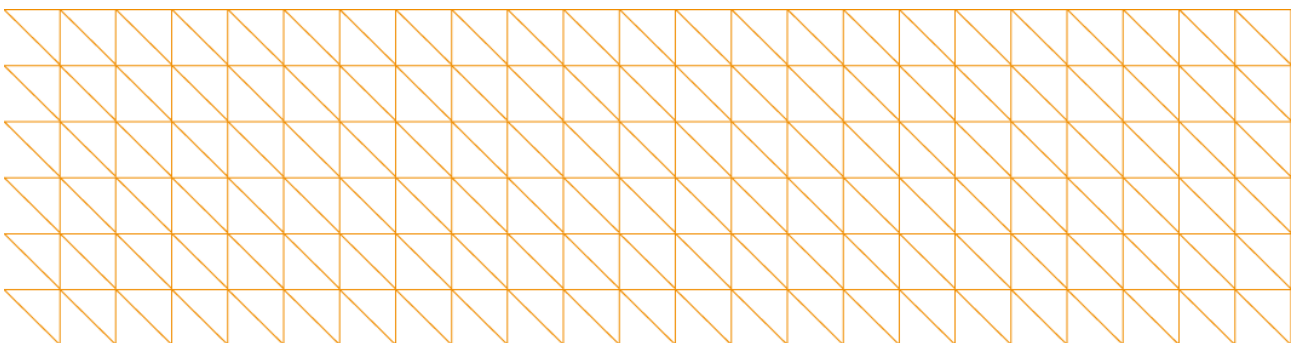
Ministry
of Justice

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

Response to consultation on rules, regulations,
coroner areas and statutory guidance

Response to Consultation CP2/2013

This response is published on 4 July 2013



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

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Response to consultation carried out by the Ministry of Justice.

This information is also available on the Ministry of Justice's consultation hub:
<https://consult.justice.gov.uk/>.

About this consultation

To: Coroners and those who work within and who fund the system, bereavement support organisations and the general public

Duration: From 1 March 2013 to 12 April 2013

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Introduction and contact details

This document is the post-consultation report for the consultation paper, *Implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009*.

It includes:

- a summary of the consultation and its responses, including our next steps
- a detailed response to the specific questions raised in the report
- a list of those who responded to the consultation.

If you require a copy of this report (including an alternative format version) please contact Reshma Bhudia at the address below:

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Minister's Foreword

I am very pleased to publish the Government's final plans for implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009.

This document summarises the views we received in response to our recent consultation, *Implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009*, and sets out the changes we are making as a result. I am extremely grateful for every one of the almost 300 responses that we received. Your views have been invaluable in helping us to refine our proposals.

While we received a range of views, there was broad consensus on most of the key issues. Some changes have been made to the detail of our proposals, reflecting the constructive comments we received.

The original aims of the 2009 Act reforms were to put the needs of bereaved people at the heart of the coroner system; for coroner services to be locally delivered but within a new national framework of standards; and to enable a more efficient system of investigations and inquests. I am confident that our revised proposals, together with the appointment of the first Chief Coroner of England and Wales, will enable these aims to be met.

Alongside publication of this response document, the Lord Chancellor and I have now laid in Parliament the new rules, regulations and orders that will give effect to our reforms, with a view to bringing these changes into force at the end of this month. We are also revising the draft *Guide to coroner services* in light of your comments, ahead of publication later this year.

All respondents to the consultation agreed that reform of the coroner system is long overdue. Today, I am pleased to say, such reform is now imminent.



Helen Grant
Parliamentary Under-Secretary of State for Justice

Executive summary

Summary of consultation

The consultation paper *Implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009*, published earlier this year, sought views on a proposed new national framework of standards for coroner investigations and inquests under the Coroners and Justice Act 2009¹ ('the 2009 Act'). Our proposals were formulated in partnership with the Chief Coroner of England and Wales, His Honour Judge Peter Thornton QC.

The aim of the framework is to improve the experience that bereaved people have of coroner investigations, while making investigations more efficient for coroners and the local authorities that fund them.

In the consultation we sought views on key parts of this new framework including:

- New coroners regulations governing the investigation process, to be made under section 43 of the 2009 Act;
- New coroners rules to be made under section 45 governing the practice and procedure at inquests;
- New regulations about allowances, fees and expenses in connection with investigations and inquests, to be made under Schedule 7;
- *A Guide to coroner services*, new statutory guidance on the way in which the coroner system should operate for bereaved relatives, to be made under section 42;
- New coroner areas for England and Wales to be made in an order under Schedule 2.

¹ <https://consult.justice.gov.uk/digital-communications/coroner-reforms>

Consultation respondents

The consultation ran from 1 March to 12 April 2013, although a short extension was granted where requested because of the Easter holidays. It asked 21 questions and we received just under 300 responses, from the following categories of respondents:

Type of Respondent	Number of respondents	% ²
Academic	4	1
Coroner	94	32
Coroner's Officer	11	4
Faith Group	5	2
Government / Parliament	12	4
Lawyer	18	6
Local Authority	35	12
Medical	36	12
Member of the public	23	8
Other	11	4
Police	11	4
Voluntary Organisation	35	12
TOTAL	295	100

² rounded up / down to nearest full %

Main changes to our approach following consultation

We have carefully considered the responses to each of the questions, as summarised in the *Responses to specific questions* section of this document.

Overall there was support for the proposals and agreement that they would enable a better and more efficient service for those affected by a coroner investigation.

In the consultation document we stated that our proposals were not intended to result in significant new cost burdens for coroners and the local authorities that support them. We received many comments on whether the proposals would be cost-neutral to implement (question 1) which we have taken into account in amending our rules and regulations.

Regulations on investigations

There was consensus from respondents that the requirements in the draft regulations and rules to communicate with all interested persons (rather than a nominated person/people) at various points during an investigation would be unmanageable in practice (questions 12 and 19). We have amended the relevant rules and regulations, in most cases, to require the coroner to notify “the personal representative or next of kin” and “any other interested persons who have made themselves known to the coroner”.

The main comments on our draft regulations on post-mortem examinations (question 9) were that coroners and their officers should not need the pathologist’s permission to attend a post-mortem examination; and that the coroner should be able to consent to other persons attending. We have amended the regulation accordingly.

Respondents were broadly content with the draft regulation which says that a body should normally be released within 30 days (question 10). We have changed the regulation slightly to put the emphasis on release of the body “as soon as reasonably practicable”, but requiring the coroner to notify the deceased’s next of kin or personal representative if the body cannot be released within 28 days.

Regarding coroners’ reports on actions to prevent other deaths, respondents generally felt that the proposed time limit of one month for an organisation receiving a report to respond was insufficient and would have an adverse impact on the quality of response (question 11). We have therefore restored the deadline for responses to 56 days.

Respondents were generally content with other draft regulations although we have made some minor changes to address some of the comments received (question 12).

Rules on inquests

There was consensus that attempting to complete all inquests with three months (question 7) would lead to increased costs, and would in many cases be unachievable where a death was being investigated by an outside organisation (such as the Health and Safety Executive). For these reasons we have set the limit for completing inquests at six months, or as soon as practicable after that date.

Some respondents felt that the rule requiring all inquest openings and pre-inquest reviews to be held in public would put pressure on court accommodation, which could delay proceedings (question 19). Others pointed out that pre-inquest review hearings often debated complex points of law which may be ruled out of scope from the main inquest hearing and which should not be aired in public. Our revised rules therefore provide for exceptions to the requirement to hold in public the opening of the inquest and the pre-inquest review.

Respondents felt that the proposed requirement for coroners to give interested persons one month's notice of the arrangements for the inquest (question 13) was unnecessarily restrictive and could delay inquests. We have therefore altered the rule to say that the coroner must notify people within a week of setting the date for the inquest.

We have made some minor changes to the rules on written and video link evidence to allow greater flexibility (question 16).

We have also made some changes to the (newly titled) "Record of the inquest" form to reflect responses received about the short-form conclusions which coroners may use (question 18).

Some coroners, coroners' officers and local authority respondents said that our proposed rules on disclosure of documents before an inquest and recording of inquests would lead to higher costs (questions 14 and 15). However, others said they already disclosed information and recorded proceedings in the way envisaged by the rules.

Respondents asked about how various elements of disclosure would work in practice and we have made some additional minor changes to improve the draft rules. In particular, given the requirement (question 17) for a coroner to record every inquest, we have removed the requirement for the coroner to disclose his or her notes of an inquest.

Regulations on fees, allowances and expenses

Some coroner respondents said that our draft regulations would increase burdens, in a reformed coroner system, particularly as these did not reproduce the current provision (contained in the Coroners' Records (Fees for Copies) Rules 2002³) that allows coroners and local authorities to charge a reasonable fee for provision of transcripts. We have therefore added an equivalent provision to our new fees, allowances and expenses regulations to enable coroners to charge as they do now for transcripts (question 21). We have also made other minor technical changes to the fees regulations for clarity.

Other consultation areas

There was general support for the proposed *Guide to coroner services* which will combine and replace the current *Guide to Coroners and Inquests and Charter for Coroner Services*. We received many helpful suggestions as to improvements we could make and will incorporate these into the final document (questions 5, 6 and 7).

³ <http://www.legislation.gov.uk/ukxi/2002/2401/contents/made>

Respondents were generally content with the proposed new coroner areas that will be specified under the 2009 Act (question 2). We are proposing only one change to the areas presented in the consultation paper at the request of the local authority concerned (Coventry).

We will also bring forward changes to the Judicial Appointments Order 2008 so that Fellows of the Chartered Institute of Legal Executives (CILEX) will be eligible for coronial appointments under the 2009 Act (question 3). We received a variety of views on this and feel that on balance it is appropriate to make CILEX fellows eligible to apply for any advertised coroner position, with all such appointments to be made on merit.

Next steps

We have worked closely with the Chief Coroner on these in light of the consultation responses. The publication of this document coincides with the laying of these rules and regulations (alongside other technical supporting legislation) in Parliament. At the time of publishing we anticipate that all these provisions will come into force in late July 2013.

We are currently revising the new *Guide to coroner services* and plan to issue this in the coming months. We are aware that coroners' offices still have supplies of the current *Guide to Coroners and Inquests and Charter for Coroner Services*. As the substantive changes between the two documents are minimal, in order to make best use of resources, we plan to issue the new booklet when supplies of the current document have decreased.

We plan to review the impact of implementation 18 months after the coroner reform provisions come into effect. This will include analysis of any costs and benefits. We will consider the form that this review should take with representatives from the Local Government Association, coroners and their officers and staff, local authority coroner service managers and the Department for Communities and Local Government.

Responses to specific questions

Question 1: Do you agree that the proposals set out in this consultation paper will impose no significant new burdens on local coroner services or others? If you disagree, what new costs would arise? And how could these be mitigated?

Just over half of respondents disagreed – i.e. thought there would be new burdens. Just under a third did not answer the question and the remainder agreed there would be no significant burdens.

The main concerns were as follows:

- New burdens from attempting to meet a three month target for completion of an investigation (question 7)
- Disclosure rules – postage and administrative costs; increased requests for disclosure as a result of the rules (questions 14 and 15)
- Recording of inquests – equipment and administration (question 17)
- Holding all inquest hearings in public – time and court accommodation (question 19)
- Perceived new obligation for coroners to be on call for organ donation queries (question 8)
- Larger coroner areas leading to greater travelling burdens for staff in coroners' offices and for bereaved people (question 2)
- Requirements to communicate with all interested persons (rather than a nominated person/people) at various points in an investigation (question 12)
- Time and cost of amending coroner information on websites (question 13)
- Meeting the service standards of the guide to coroner services (questions 4 to 6)

We have also considered the impact of the proposals against the statutory obligations under the Equality Act 2010⁴.

Individuals and groups representing certain faiths, notably the Muslim and Jewish faiths, have voiced concerns about possible delays in releasing bodies for funerals, and expressed a belief that there should be an increase in the availability of less invasive post-mortem examination methods. The new regulations permit expeditious release of bodies where appropriate, as well as permitting

⁴ Under section 149 of the Equality Act 2010, when exercising their functions, Ministers and the Department are under a legal duty to have 'due regard' to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other prohibited conduct under the Equality Act 2010;
- advance equality of opportunity between different groups (those who share a protected characteristic and those who do not); and

foster good relations between different groups. Having 'due regard' needs to be considered against the nine 'protected characteristics' under the Equality Act 2010 – namely race, sex, disability, sexual orientation, religion and belief, age, marriage and civil partnership, gender reassignment, pregnancy and maternity.

less invasive post-mortem examinations (questions 8, 9 and 10). Another positive impact of the policy is the protection for vulnerable witnesses giving evidence (question 16).

No disproportionate equality impacts were identified by respondents. However the need to continue to consider faith requirements of the bereaved is apparent.

Response:

We have taken respondents' views into account when finalising the rules and regulations and have made amendments to, as far as possible, mitigate any potential burdens of the proposals. Details are in the response section for each of the questions highlighted above.

Although we believe there will be no significant burdens arising from implementation of the proposals, we plan to review their impact 18 months after implementation, to assess benefits, costs and savings.

Question 2: Do you have any views on the proposed changes to coroner areas under the 2009 Act? If so, please give details.

A third of respondents answered this question. Of these around two thirds supported the proposal; a quarter had mixed views or qualified support, and a very small minority said they did not support the proposals.

There was support from those coroners and local authorities affected by the proposed mergers. For instance the Durham Coroner supported the proposed merger of the North District of Durham with the South District of Durham and Darlington, saying that this would have taken place some years ago were it not for the legislative difficulties involved with a unitary authority. Surrey County Council (not affected by the proposed mergers) said, "As long as the mergers are locally driven, there appear to be no issues with this statement"

Some respondents (for instance the Berkshire Coroner, the National Bereavement Alliance, Cruse Bereavement Care, the Association of Private Crematoria and Cemeteries and Leigh Day solicitors) had reservations about larger coroner areas and the impact on those travelling to an inquest. The National Bereavement Alliance said:

"The move to fewer but larger coroner areas with full time caseloads could improve expertise, experience and consistency. However, we are concerned about any change which could lead to families having to travel longer distances to attend inquest hearings."

Response:

Respondents were content with the proposals and these are reflected in the orders we are making under Schedule 2 to the 2009 Act.

However Coventry has since retracted its earlier request to merge the Coventry and Warwickshire coroner districts and so we will not be pursuing this merger at the present time.

Question 3: 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.

Around a third of respondents said they supported the proposal; a third said they did not; and a third expressed no view.

Some, especially current coroners, felt that extending eligibility in this way would lead to a diminution in standards. Concerns included that CILEX fellows had no experience of dealing with juries. The East Anglian Coroners' Society argued that there was no need for the amendment as there was no shortage of solicitors and barristers who wish to undertake coronial work.

Others welcomed the proposed amendment because of its potential to increase the diversity of coroners and competition for the role, especially given that all coroners appointed under the 2009 Act will need to be legally qualified (rather than medically or legally qualified as at present). The Oxfordshire Coroner said, "I am also a deputy district judge and I am aware that Fellows of CILEX have been eligible to be appointed as judges for some time".

INQUEST qualified their support for the proposal, saying:

"Generally we welcome proposals that seek to professionalise the coronial system further, and align it with the judicial system in the civil and criminal courts, and this is such a proposal. We therefore support it, provided that those who become coroners through the Legal Executive route receive the same training as those who are otherwise legally qualified. In addition we would point out that some inquests, in particular those engaging Article 2, can be long, complex jury cases involving numerous advocates and detailed questions of law and that any coroner (CILEX fellows or otherwise) hearing those cases must undergo suitable additional training."

Response:

We intend to amend the Judicial Appointments Order as proposed, later in 2013, extending eligibility for coronial offices to CILEX fellows. This change relates solely to eligibility. CILEX fellows wishing to apply for such posts will be assessed alongside all other applicants and appointments will be based purely on merit.

Question 4: In your experience what difference has the current *Guide to coroners and inquests* and *Charter for coroner services* made since it was published?

Views were mixed. Some suggested that the current Guide had increased transparency of standards and best practice and helpfully reduced the number of queries to coroners' staff; others felt that it had made no or little difference, or had increased questions to staff.

Positive impact

In support Gloucester County Council said:

"It has raised awareness of national standards with staff in the Coroners service, with local Councillors and Chief Officers in the Council. The public are better informed as to what they should expect and what to do if they don't get the service that they should."

Essex County Council had also found the Guide and Charter useful to the local authority as well as bereaved people:

"The current Guide has been an extremely useful aid, an authoritative Guide to distribute to the bereaved. The inclusion of guidelines has assisted the Service in planning and goal setting and given a wider perspective of their work to the staff of the Service."

The Cardiff and Vale of Glamorgan Coroner said:

"It has been really helpful to give information to families and other properly interested persons about what the coronial process entails and particularly what assistance is available. I am pleased to be able to hand out a copy to every single bereaved family who are to go through the inquest process. This is definitely a well done to the MoJ."

Less positive impact

No respondents felt that the document had had a negative impact. However the Blackburn, Hyndburn and Ribble Valley Coroner commented that he felt it was probably too long a document for bereaved people to read. The Suffolk Coroner said:

"Anything that improves information and understanding of the service is a good thing, but my approach has always been to put the bereaved at the centre of the process and practice in a family friendly manner so it has not changed the approach we take."

While the current Guide is sent to every coroner's office, the Bereavement Advice Centre questioned its availability in practice:

"Our callers have never been offered the booklet or found it on line and call us because they have not been able to find information elsewhere. Our callers come from all parts of the country. The booklet will only be useful even when revised if it is proactively offered to families, including posting it out as soon as possible after first contact, especially if it is clear the investigation will probably lead to inquest."

Disaster Action said there was still inconsistency between areas:

“It appears to have remained the case that experience of the coroners’ service remains inconsistent, with some coroners and officers paying clear attention whereas others may not have been. The bereaved with whom we are in contact have very variable experiences in their contact with the service.”

Some respondents (e.g. RoadPeace and the Victims’ Services Alliance) said that it was hard to judge the impact of the document as (until this consultation) there had been no formal feedback exercise. Cruse Bereavement Care suggested a feedback form would be helpful.

Response:

The new *Guide* will be statutory guidance issued by the Lord Chancellor under powers in the 2009 Act. It will therefore have added weight and importance and coroners’ offices will be expected to issue it to anyone coming into contact with the coroner system for the first time.

Question 5: 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.

Just over a third of respondents felt the new Guide was helpful; just over a quarter had mixed feelings; another quarter did not answer the question; and one in ten felt the guide was not helpful.

Against this backdrop we received a variety of views on different aspects of the guide. Some respondents (such as Essex County Council, the National Bereavement Alliance and Tom Luce CB, who conducted the 2003 review on death certification in England, Wales and Northern Ireland) supported the amalgamation of the previous Charter and Guide into one document, but others (such as Cardiac Risk in the Young) did not.

Some coroners were concerned about managing expectations of those reading the Guide. The Birmingham Deputy Coroner said:

“This is a document which raises expectations which many Coroners will not be able to meet, given the constraints placed upon them by Local Authority facilities. Although it has a proper place in the provision of information it loses impact when it raises expectations in this way.”

The Coroners’ Society of England and Wales similarly feared that, “Expectation will lead to disappointment if there is not investment in infrastructure and training for officers and coroners’ staff”. However Merseyside Police had the opposite view, namely that, “The guide provides a minimum standard and should not be seen as a barrier to delivering an excellent standard of service”.

Some respondents were concerned about what they perceived as new standards in the proposed document although these are already included in the current *Guide to coroners and inquests and Charter for coroner services*.

NHS Wales Shared Services Partnership - Legal and Risk Services said the content of the document was excellent and self-explanatory; however, “We find in the NHS that pamphlets any longer than 2 pages are simply not read and the more useful explanatory process comes via the telephone or face to face meetings with the relevant team.” Stoke on Trent City Council also suggested simplification could be helpful. However the Inner South London Coroner said, “It is concise and to the point”. The Human Tissue Authority stated:

“The Guide provides a great deal of helpful information. It would benefit from a “Plain English” review to ensure that its language, style and content make it accessible to all those who seek guidance from it.”

Response:

We propose to keep the structure of the new Guide the same as the draft on which we consulted. We will make some minor changes and these are covered under question 6. We are, however, considering formulating a short ‘quick reference’ version of the document.

Question 6: Is there anything else we should cover in the *Guide to coroner services*, or cover differently? If so, please explain your answer.

We received a variety of helpful suggestions as to improvements that could be made to the new Guide, including the following:

- There should be more detail on the Department of Health's death certification reforms, including medical examiners.
- The complaints section should be amended to make clear that referral to the General Medical Council should be the last port of call when there is a complaint about a pathologist, and should only be resorted to when complaints at a local level (i.e. to the doctor's employer) have not achieved their end.
- There should be more prominence given to provision of documents to bereaved people before the inquest.
- It would be helpful for bereaved people – and would save time for coroners' offices – if national sources of support were listed in the guide, along the lines of/including the Department of Health's publication *Help is at hand*.
- There should be more details on particular diversity issues – such as the right to request an interpreter; and faith requirements.
- There should be more detail or separate guides on certain types of investigations – such as suicide, deaths in custody, military investigations and child deaths.
- The guide should not mention organ donation as it will often be received after the timeframe for organ donation has passed.
- There ought to be reference to the option of paying for legal representation, or seeking pro bono representation.
- There should be more explanation of what an "open verdict" is.
- As well as referring to the Press Complaints Commission Editors' Code of Practice (which covers print publishers and their websites) the guidance should also refer to the appropriate broadcasters' regulators such as Ofcom and the BBC Trust.
- The glossary should include a description of the terms senior coroner, area coroner and assistant coroner.

Response:

We are revising the new Guide in light of comments received. We plan to publish a revised version on-line later in the year and, as with previous versions, will send hard copies to all coroners' offices across England and Wales.

Question 7: 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.

There was consensus that inquests should be concluded as soon as possible, but views were mixed as to an appropriate target. Just over half of respondents agreed there should be a target whilst a quarter said there should not be. Just under a fifth of respondents supported a three-month target and over half explicitly disagreed.

Resources

Some coroner respondents said that their offices would need extra resources (such as an extra coroner's officer or an extra court room) in order to meet a three month target. There was particular concern about a three month target when considered alongside the proposed requirement for a coroner to give interested persons one month's notice of an inquest and the requirement for an inquest to be opened in public (see response to question 13 for more details).

Reliance on third parties

Various respondents made the point that a three-month target would be very challenging to meet in cases where a coroner was dependent for evidence that was relevant to an investigation on outside agencies – such as the police, the Health and Safety Executive; the Prison and Probation Ombudsman; Collision Investigators; the Crown Prosecution Service; the Air Accident Investigation Branch; the Independent Police Complaints Commission; British Transport Police; or overseas authorities. Representative of views was the Southern Regional Coroners' Managers' Group which said:

“A 3 month target is achievable only for natural deaths. Coroners have no powers to compel outside organisations to contribute to meeting a target. A 3 month target may lead to more adjournments, with the extra work that this would involve. It would also be a hard target to meet when combined with the new rule saying the coroner should give interested persons 1 month's notice of an inquest.”

The London Veterans Advisory and Pension Committee said that, “The target date should be set once the investigation reports are complete and witness availability is known. A date for a pre-inquest hearing should be set and a date for the inquest provisionally set and confirmed at the pre-inquest hearing. This is important for all Military Inquests.” The Royal British Legion also pointed out practical difficulties in meeting the target in relation to service personnel deaths.

Managing expectations

There were some concerns about a three month target creating expectations that could not be met. The Black Country Coroners Managers' Group believed that:

“The setting of targets should only be undertaken if they are achievable. There are often circumstances outside of the Coroner's control that lead to genuine delay in hearing inquests.

“Public expectation should not be raised for the sake of 'setting a target', as experience demonstrates this leads to unnecessary complaints that can add further burdens to limited resources.”

The Childhood Bereavement Network commented that:

“We welcome inclusion of a target date for completing inquests, as we believe this will reduce the length of time which some families have to wait. However, setting a target should not be allowed to jeopardise the meaningfulness of the inquest.... Families report significant distress when a date is set for an inquest and it is then postponed, sometimes repeatedly. Reducing delays in completing inquests means that families will know the cause of death sooner, and can begin to build the story with the children in the family.”

Bereaved people

Other respondents – for instance Support After Murder and Manslaughter, PAPYRUS and member of the public, Mary Page – suggested that three months was appropriate as it was only after the inquest that bereaved people could move on. Some (e.g. the Cornwall Coroner and member of the public, Emma Attris) said that inquests should take place as soon as possible so that witnesses remember events. Some, such as NHS Wales Shared Services Partnership - Legal and Risk Services, said three months was too soon for bereaved people:

“In one of the areas I cover, the Coroner does work to a target of 3/4 months. This can be too short a time period for the family... It obviously makes it very difficult for the relatives to ask questions as they can barely speak for crying. I think the target of 3 months is perhaps too short but 4, 5 6 months would be more appropriate.”

Six month target

Many respondents (including the Coroners’ Officers and Staff Association, The Royal College of Pathologists, the Northern Coroners’ Society and the Milton Keynes and Mid Kent and Medway Coroners), suggested that six months was a reasonable target. The East Anglian Coroners’ Society said:

“If there is to be a target, it must be realistic, say 6 months, which is in line with the average time to complete the investigation. Bereavement can take 6 months to reach the position for the family to feel able to deal with an inquest.

“After 6 months the chief coroner should be told what the reason is for the delay, eg delays in getting reports, particularly outside agencies and in deaths abroad.”

Response:

We have amended rule 8 to say a coroner must complete an inquest within six months of the date on which the coroner is made aware of the death, or as soon as is reasonably practicable after that date.

Question 8: 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.

Most respondents did not answer this question or responded 'no'. Most of those who answered this question 'yes' were coroners.

Other reasons given for out of hours work included:

- Permission to view a body in the mortuary out of hours
- Requests for "Out of England" paperwork – i.e. to move a body abroad for a funeral
- With regard to mass fatalities – setting up a temporary mortuary; planning discussions with the senior investigating officer and identification officer and attending the first meeting of the strategic command group
- Viewing of a body at the scene of the death
- Discussions when bones were found
- Exhumation
- Calls from doctors about issuing Medical Certificates of the Cause of Death and junior doctor queries
- Regarding sensitivities around a child death
- Disaster Victim Identification
- Deaths abroad/bodies repatriated
- Transfer of deaths to another jurisdiction (especially if organ donation is being considered)
- Deaths in custody.

Some respondents said such issues were a matter of course and part of a coroner's day to day duties, although this could be difficult to manage. The Coventry and Warwickshire Coroner said:

"I personally deal with all 'out of hours' work and have done so for past 5 years. It is gruelling to be on call 24/7. Much of the work outside office hours could and should wait until the next working day. The Coroner should only be available for authorising post-mortem examinations and organ donation."

The intention of the proposed new regulation was to reduce the burden on coroners of the 1984 rule (4) which says a coroner should at all times be ready to take on any duties in connection with inquests and post-mortem examinations. However, some coroner respondents felt that the draft regulation would be a new burden for them. The South Eastern England Coroners' Society said:

"Members expressed very strong feelings that draft Regulation 4 is in principle unjust. The requirement to be available at all times must recognise the impact of the European Working Hours Directive and Article 8 rights and night-time calls must be resourced where coroners are already working long hours in the day-time. This requires either a rota duty system involving deputy cover or proper recompense where the coroner makes himself available outside normal hours."

Response:

We have changed the wording of regulation 4, but not the aim, which is to ensure that coroners are available out of hours only for essential work. The revised regulation therefore says that a coroner must be available at all times to address urgent matters relating to an investigation into a death which must be dealt with immediately and cannot wait until the next working day.

Question 9: Are you content with this approach to the drafting of the regulations on post-mortem examinations? If you are not, please give your reasons.

Most respondents said they were content with the draft regulations or did not express a view. Just over a third were not content, most of whom were coroners.

Attending an examination (draft regulation 10 (4))

Some coroners (including the North Manchester, Worcestershire and Durham Coroners and the Northern Coroners' Society) argued that, given that the post-mortem examination is held at the coroner's request as part of his or her investigation, coroners and their officers should not need the pathologist's permission to attend a post-mortem examination.

Other respondents were concerned that (unlike rule 7 of the 1984 rules) the draft regulation did not provide for other persons to attend even if they had the coroner's consent.

Professor John P Cassella of the Department of Forensic Science and Crime Science at Staffordshire University and Simon Davies, Major Trauma Co-ordinator at University Hospital of North Staffordshire NHS Trust, both asked that the regulation be extended to enable "other suitable" medical/nursing professionals and students access to post-mortem examinations. This would enable current local agreements and practices to continue for training purposes.

Notification of examination (draft regulation 10 (2))

Several coroners said that the extended list of people to be notified of a post-mortem examination would increase costs. The North Wales (East and Central) Coroner said there should be flexibility as to appropriate persons to notify:

"I consider it would be a huge burden (and an additional drain on limited resources) to notify in writing the various people required by the draft regulations".

The Cardiff and Vale of Glamorgan Coroner said the regulation would mean a very considerable added burden for the local authority to provide staff to enable the deceased's regular medical practitioner and hospital always to be notified of the time and date of the examination, whether the practitioner wanted it or not.

Other issues

Some respondent suggested that more detail should be included on retention of material after a coroner's investigation has finished.

Comments that relate to fees for post-mortem examinations are covered under question 21.

Response:

We have amended what is now regulation 13 so that a coroner must notify the persons listed in paragraph (3) of the date, time and place of the post-mortem examination unless "to do so would be impracticable" or would cause the post-mortem examination to be unreasonably delayed.

We have amended 13 (3) so that the coroner must notify only the personal representative or next of kin of the deceased or any other interested person who has notified the coroner in advance, of his or her desire to be represented at the post-mortem examination.

We have amended 13(4) to say that a trainee doctor, medical student, other medical practitioner “or any other person” may observe a post-mortem examination with the consent of the coroner (rather than the pathologist).

Regulation 14 now makes it clear that any tissue retained after the period of time required by the coroner for the purposes of the post-mortem examination must be held in accordance with the Human Tissue Act 2004.

Question 10: 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.

Over half of respondents said they were content; around a sixth said they were not; and the remainder did not answer the question.

The Bereavement Advice Centre said:

“The aim should be to release a body as soon as possible (consistent with necessary investigations). Even 30 days is a very long time to wait for a funeral. Release should always be within 30 days unless there are exceptional circumstances but a delay of 30 days needs to be explained to the next of kin.”

Some qualified their support. Several local authorities (e.g. Surrey, Northamptonshire and Kent) were concerned that 30 days was in fact too long given body storage costs and the impact of long retention on families. The North Manchester Coroner said that it was ‘extraordinary’ to retain a body for longer than 5 working days unless the death is suspicious. He said that, “a provision for release within 30 days will permit unnecessary drift and serve to delay release”. Gloucester County Council agreed and said that normally a 14 day limit would be appropriate.

Some were satisfied with the rule provided there was provision for faith requirements wherever possible: Brethren Christian Fellowship, Tottenham Park Islamic Cemetery, the Childhood Bereavement Network, the Gardens of Peace Muslim Cemetery Trust.

The Berkshire Coroner said that the most likely occasion when 30 days would be exceeded was in criminal cases where the body had to be retained for a second post-mortem examination in the interests of justice of potential defendants or where there was a conflict within families as to who should take responsibility of the body and whether there should be a cremation or a burial.

Several respondents (including the Association of Chief Police Officers and Greater Manchester Police, the Suffolk Coroner and Essex County Council) mentioned Home Office Circular 30/1999 on *Post-mortem examinations and the early release of bodies*. This says that, “If the police have reason to believe that a person will be charged with a homicide offence within 28 days of the discovery of the offence, the coroner will be so advised and will retain the body until a person has been charged, or until the expiry of the 28 days.” Gloucestershire Coroner’s Court said, “The present Home Office guideline is that a body should not be retained more than 28 days and therefore alteration to 30 days is of little consequence”.

Response:

We have changed the emphasis in what is now regulation 20 so that the coroner must release the body “as soon as reasonably practicable” and if the body is not released within 28 days then the coroner must notify the next of kin or personal representative of the delay. This should ensure timely release of bodies, where possible, and greater consistency with current practice.

Question 11: 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.

Three quarters of respondents answered this question. Just over a third of all respondents were content, but two fifths were not.

The coroner consensus (e.g. Coroners for North Yorkshire East, Cheshire, Berkshire, Blackburn Hyndburn and Ribble Valley, Greater Manchester North, Manchester City, Worcestershire) was that a month was too short for a response to a report to prevent other deaths and that the current 56 day limit was appropriate. The Cardiff and Vale of Glamorgan Coroner said:

"This is unreasonable and will result in perfunctory replies that do not go the heart of the matter. Sometimes, the recipient of the report will have to do quite some work, particularly if within a large organisation, in order to tackle the report properly. Far better to wait a little - which can do no harm in this situation, the inquest having been concluded - and have a considered and meaningful response. The present 56 days is appropriate."

Other stakeholders expressed a similar view. The Medical Defence Union said:

"We believe the current time limit of 56 days is a fairer reflection of the fact that in some cases, such as those where we assist our medical members, a number of individuals within an organisation need to be consulted in order to provide the coroner with a properly considered response. The time limit should encourage swift responses but without compromising the aim of ensuring appropriate action is taken to prevent other deaths. We do not believe a time limit of one month would achieve this in complex clinical cases."

However some respondents supported the proposal. For instance the Royal British Legion said that, "A reduction of the time limit to a month will encourage public authorities to look at any systemic failures which have been highlighted at the inquest sooner and if necessary make key changes. It also places greater importance for organisations to look at systemic failures." And Action against Medical Accidents (AvMA) said, "As a patient safety organisation we consider that once a risk of future deaths has been identified it should be acted on as a matter of priority."

Response:

We have taken on board the comments received, and in particular in relation to the potential impact on the quality of the responses to coroners' reports, and amended what is now regulation 29 to restore the deadline for such responses to 56 days.

Question 12: Do you agree that the draft regulations to be made under section 43 will ensure more consistent standards in the coroner investigation process? If not, please give details.

Two fifths of respondents agreed that the regulations would ensure more consistent standards; around one in six disagreed; and around two fifths did not answer the question. Views were largely consistent across all groups.

Brighton and Hove City Council said:

“These seem likely to help the Chief Coroner achieve his aim of bringing into existence a more modern coroner service, which is consistent in its practices and is structured so that it works positively for the benefit of bereaved persons and the wider public.”

The Worcestershire Coroner said that the regulations required ‘coherent guidance’ to accompany them.

In responding to this question, some respondents also put forward views as to how particular regulations could be improved.

Response:

We have made a number of changes to the regulations in response to comments received, including greater consistency on the arrangements for notifying interested persons during the investigation process.

A detailed guide to the 2009 Act and the new rules and regulations has been issued to coroners and guidance on the main changes will shortly be issued to local authorities.

Question 13: 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.

Around two fifths of respondents were content with the time limit for notifying interested persons but only a fifth of coroners were. Over half of respondents across the board were content with the requirement to publish inquest arrangements in advance of the hearing.

Views were given on the following issues:

Giving one month's notice of an inquest and having a three month target to complete an inquest

Many respondents (for instance Essex County Council, the Mid Kent and Medway Coroner, Stoke on Trent City Council) said that the requirement to give notice of one month of an inquest combined with a target date of three months to complete the inquest would be very challenging to meet. The North Yorkshire East Coroner felt that the time limits for notification of the inquest were unnecessarily restrictive and bureaucratic.

Flexibility

Many respondents stressed the need for flexibility. The East Anglian Coroners' Society said, "One month is too long - flexibility is required. Many inquests can be dealt with within one month of being ready." Sheffield City Council (Medico Legal) reflected the views of many respondents when they said:

"Flexibility is needed in dealing with the complexities of assembling all parties required for an inquest. A court slot may unexpectedly become available at short notice and if all those who need to be at the inquest are also available there should be no reason why it can't go ahead. Interested parties should in any case always be consulted where appropriate and informed."

The Northern Coroners' Society, the Coroners' Society of England and Wales and the Wiltshire and Swindon Coroner, as well as the National Bereavement Centre, also stressed the need for flexibility. INQUEST said that different notice periods would be appropriate for simple cases and complex 'Article 2' cases.

Other respondents (such as the Coroner's Officers and Staff Association, James Cook University Hospital in Middlesbrough, and Browne Jacobson LLP) said that medical witnesses would need more than a month's notice of an inquest.

Notifying all interested persons

Several respondents commented that there would be practical difficulties, and unnecessary work, arising from the need to notify all interested persons of the inquest.

The Staffordshire Coroner said, "Currently we notify the identified next of kin and anyone who specifically asks to be notified and it works well. Most families will notify those who wish to attend the inquest and it is not unusual to have sometimes up to 10 people attend."

Making inquest details publicly available

Although there was general support for this draft rule, some coroners (eg Berkshire, Blackburn Hyndburn and Ribble Valley and North Manchester) queried what 'publishing' meant in practice.

Response:

We have altered rule 9 to say that the coroner must notify the personal representative or next of kin and "any other interested persons who have made themselves known" to the coroner of the date, time and place of the inquest hearing; and that this must be within one week of setting the date for the inquest (rather than having to give a month's notice). This change of emphasis means that prompt notice must be given to relevant persons, but at the same time allowing coroners the flexibility to schedule early hearings.

Coroners will be issued guidance on publishing arrangements for inquest hearings.

Question 14: 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)?

Half of respondents were content with the draft rules on disclosure. A fifth were not and around a third did not respond.

Several respondents (such as the East Anglian Coroners' Society, the Gloucestershire, Coventry and Warwickshire, and Oxfordshire Coroners, and Sheffield City Council) said they already disclosed information as envisaged by the new rules. Of those that responded positively, INQUEST said:

“In our experience, alongside unnecessary delay, disclosure (or a lack of it) is the key issue of concern to families in the inquest process. It is a major step forward to have provision within the rules that formalises a right to disclosure, and the coroner’s power and duty to make disclosure, particularly to families. We welcome it wholeheartedly. We believe that the formalisation of the disclosure process will allow families and other interested persons to play a more active part in the coronial process. However, for this to work in practice coroners will in the first place need to be in possession at all times of documents that are received or generated by others, e.g. the police, HSE, PPO and IPCC, and separate provision may need to be made in that regard to require such persons to provide all potentially relevant documents to coroners without delay.”

Member of the public, Emma Attris, said:

“Transparency is very important in demystifying a process which few members of the public are familiar with. The more information someone is given about what will be discussed at the inquest, the less scary and intimidating the process will be. The prospect of attending the inquest is daunting and stressful, especially if you are worried that you will hear new facts or information at the inquest which will come as a shock or surprise.

“The express permission to share information by email is important as it reduces delay and expense and is what people expect in today’s technology driven world.”

However, the Worcestershire Coroner was concerned about the risk of overburdening some families “particularly where lots of irrelevant paperwork is produced but not used at the inquest”. Cruse Bereavement Care said that families needed to be “sensitively forewarned” when information was provided which may be particularly distressing.

Some respondents were concerned about resource implications of the draft rule on coroners and local authorities. These concerns are detailed under question 15 below.

Response:

See question 15 for amendments to the draft rules.

Question 15: Do you have any suggestions as to how the rules on disclosure could be improved? If so, please explain your answer.

Less than half of respondents made suggestions, and most who did were coroners or local authorities.

Resources, efficiencies and charging

Some coroners feared that the rule as drafted would result in more requests which, in turn, would require additional photocopying and resource costs and said there should be an allowance for the administrative costs involved in providing disclosure before an inquest. Sheffield City Council already disclosed documents. They said that:

“Disclosure of documents prior to the commencement of the inquest has become a job in itself, and is not a job for the coroner’s officer as they often do not know what they can and can not disclose. Waiting for permission to disclose can be long and drawn out. I often disclose lever arch files full of documents and colour copy photos to 2 or 3 different PIPs. This is a big job and charging for it may focus the requesting parties mind regarding which documents they need.”

Gloucester County Council suggested there should be an administration fee as well as a cost for copying, and was concerned about the potential for the measures to be abused by interested persons.

However, the Milton Keynes Coroner felt the proposal could lead to resource savings in some cases:

“Giving a direction, for instance, that a bundle of documents for use at the inquest should be agreed beforehand would save a considerable amount of wasted paperwork and costs in that in my experience where notes and records stretch to over three volumes, the number of pages actually referred to during the course of the inquest are limited to perhaps to twenty pages. If more consideration were given prior to the inquest for disclosure of documents that are relevant then there could be a considerable saving in the cost of disclosure and also the time spent at the inquest. I appreciate that this may only be possible where the interested persons are represented. I have also found that there can be considerable savings made by following such a procedure where the Coroner sits with a jury because it saves bulky jury bundles having to be prepared.”

The Nottinghamshire Deputy Coroner suggested a “disclosure pack” that could be produced for sending to all interested persons, in many cases electronically. Similarly the Southern Coroners’ Society said that, “The coroner should have to disclose only documents that are relevant to inquest, and in one batch rather than piecemeal”.

Relevance / sensitive information

Some respondents were worried about having to disclose irrelevant information, inadvertently disclosing sensitive information, or spending a lot of time redacting. The Coroner for Cardiff and the Vale of Glamorgan said, “Medical records 500 pages long could be said to be relevant, but the reality is that the coroner has admitted one crucial page as an exhibit and doesn’t even keep the rest. 500 pages have been provided, only one page has been admitted”. She added that the rules

needed to be clear “that disclosure applies to documents that have been admitted/are to be admitted in evidence at inquest, rather than documents simply provided to the coroner”.

The West Somerset Coroner was concerned about the risk of disclosing sensitive information:

“The risk is that a large file of papers may contain reports from the Crown Prosecution Service, summaries of evidence prepared by police officers and addresses that should not be disclosed. Sometimes detailed inspection incurs considerable time with cost implications and Local Authorities should be advised about this.”

Disclosing coroners’ notes

The North East Kent, East London and City of London Coroners argued that a coroner’s notes of an inquest should not be disclosable, as did the West London Coroner:

“Rule 13(c): the disclosure of notes of evidence is unnecessary and can be omitted. A recording is already available under (d). Coroners (who ask the majority of questions unlike judges in trials) do not have time to take full notes and sometimes need to closely engage and maintain eye contact with a reluctant or distressed witness. It is often necessary to note personal comments to aid memory and the recollection of the evidence and the demeanour of witnesses when it comes to preparing a summing-up.”

Response:

We have not added a test of “relevance” to the disclosure provisions as rule 15 already includes a restriction on disclosure where the coroner “considers the document to be irrelevant to the investigation”. We have, however, deleted from rule 13 the requirement for the coroner to disclose his or her “notes of evidence” given that all proceedings are to be recorded.

Question 16: Are you content with the proposed rules on evidence – a) written evidence; b) video link; c) screened evidence? If not, please explain your answer.

Half of respondents said they were content; a minority said they were not, and a third did not answer the question.

a) Written evidence

The rule was generally welcomed. Some coroners (for example the Worcestershire, North Yorkshire East, Cardiff and Vale of Glamorgan and Durham Coroners and the East Anglian Coroners' Society) said that the draft rule did not permit "new" evidence to be considered during the inquest. The rule needed to be amended as it could otherwise de-rail an inquest.

Lester Morrill Solicitors and the City of Manchester Coroner said that the rule should allow written evidence on who the deceased was, as well as where and when he or she died and how he or she came by his/her death".

Disaster Action said that, "Non-attendance should only be in exceptional circumstances, not just where good and sufficient reason". The Royal British Legion agreed, saying, "We suggest that sufficient reasons should be given as to why an individual would be unable to attend and that all other means of providing oral evidence should be exhausted prior to admitting evidence in written or video form".

ASLEF commented that in cases of suicide involving a train or the rail network, they would like it to become standard practice for a coroner to accept a written statement from any train driver involved to be read out in court as evidence and not require them to attend the inquest.

b) Video link

Respondents were generally content with the proposed rule. However some pointed out that, in practice, very few coroners' courts had a live video link facility.

Some pathologists, such as Forensic Pathology Services in Oxfordshire, and Marion Malone of the Great Ormond Street Hospital for Children Department of Histopathology, supported pathologists giving evidence by video link. Similarly Gloucester City Council highlighted the potential cost-savings in terms of witness travel expenses.

Coroners for Sunderland, the Isle of Wight and the City of Manchester were concerned that the only test for allowing video link evidence was expediency. It was suggested that the provision should be linked to current criminal law tests for its use, for instance safety or witness protection. They also suggested voice distortion to protect witness identity.

c) Screened evidence

Respondents were generally content with the proposed rule.

Irwin Mitchell LLP said that, "Before making a decision about the use of a screen, a coroner should be required to consider any submissions by properly interested parties." However the Berkshire Coroner said that the requirement to consider views expressed by "any third party" will mean that

agencies such as the press will have the right to make submissions when they are not a party to the inquest process. The Northern Coroners' Society agreed that, "Additional time/delay is likely to be involved in considering and ruling upon submissions from interested persons about this."

Response:

What is now rule 23 has been amended so that the coroner will no longer have to announce "at the beginning of the inquest" his or her intention to accept written evidence. This is to enable the coroner to announce and use written evidence that he or she becomes aware of during the inquest.

We have also amended the rule so that written evidence will be permissible when it concerns who the deceased was, as well as how, when and where the deceased came by his or her death

Rule 17 has been amended so that evidence by video link will be permissible not just when it will allow the inquest to proceed more expediently, but also when it is "otherwise in the interests of justice".

We have amended rule 18 to allow the coroner to permit screened evidence only where this would be likely to improve the quality of the evidence, or is in the interests of justice or national security.

Question 17: 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.

Recording of inquests

The majority of respondents supported the proposal for coroners to record all inquest hearings, with a small minority opposed to this. There was similar support for sanctions for misuse of recordings.

Some coroner and local authority respondents said they already recorded inquests and provided recordings to interested persons.

Support After Murder and Manslaughter stressed the benefit of recordings to bereaved people:

“Most families just want to have a record of what has been said in the coroner’s court as they are very stressed during the inquest and often can’t remember what was said. There is plenty of evidence that suggests that when you are stressed you can’t retain information so being able to have a transcript or recording of the inquest is very important to bereaved families.”

Some respondents qualified their support of the draft rule, or asked about practical issues arising from it. The Torbay and South Devon said:

“It is not practical to keep an accurate note of the proceedings and move an Inquest at a reasonable pace. There should be no requirement to keep a detailed note as well as a digital recording.”

The Wiltshire and Swindon Coroner and Cumbria County Council asked whether the pre-inquest hearings and inquest openings also needed to be recorded. The Coroner said he often opened an inquest in open court but as a paper exercise if no-one is present. He said, “Having to record such hearings will be time consuming so the coroners ought to be able to exercise discretion if he/she is the only person in court”.

The West Manchester Coroner firmly opposed releasing recordings of inquests:

“The idea of the distress of bereaved witnesses being available to be listened to again and again is repugnant.....What is important here is the evidence given by the witness, which clearly can be contained in a transcript of the hearing.”

Members of the public, Nicole and Chris Taylor, shared their own experience of a recorded inquest:

“Our Inquest was recorded by the Coroner. We received a CD copy and shared this with the Crown Prosecution Service. They found it very difficult to hear anyone other than the Coroner and witness... For this to work effectively Inquests need to be held in a suitable environment and with suitable permanent equipment that captures the proceedings.”

Sanctions for misuse of recordings

Some coroners (e.g. Cheshire and Berkshire) were worried that recordings could be broadcast, and perhaps altered, on social media. It was suggested that there should be sanctions against the

misuse of recordings, including misuse by broadcasters. The North and West Cumbria Coroner stated:

“If recordings are to be handed over there must be robust and tougher sanctions punishable harshly—as this really would be not only “contempt” of the Court—but also the feelings of distraught witnesses/family members who might find their tearful testimony broadcast. Imprisonment should be a sanction for any misuse of the recording.”

The Brighton and Hove Coroner added:

“Some persons giving evidence may feel inhibited by knowing that what they are saying is being electronically recorded. If the coroner were able to state that serious sanctions would be invoked in the case of misuse of such recordings, this might reassure them.”

However other respondents felt sanctions would not be helpful. The Worcestershire and Surrey Coroners said that sanctions would not help in the modern world of social media.

One of the Brighton and Hove Assistant Deputy Coroners felt that, “A simple signed undertaking form would be appropriate.” The Association of Personal Injury Lawyers also felt there was no need for sanctions in the rules and Colchester Hospital University Foundation Trust’s Guy Singleton said that contempt of court ought to be sufficient deterrent against misuse.

Response:

We have amended the rules (13 and what is now 26) so that coroners will be required to make and keep a recording of an inquest hearing but will not have to take notes of evidence. This requirement will apply to all hearings, including openings and pre-inquest reviews.

The rules now include a new statutory form to accompany disclosed documents, including recordings, which explains that unauthorised use of such documents may be contempt of court and sets out the possible penalties for this.

Question 18: 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.

Two fifths of respondents said they were content; a third did not express a clear view; and a quarter were not content with the draft rule and form on conclusions, determinations and findings.

Draft rule and form on conclusions, determinations and findings

Those who responded expressed a wide range of views. Some objected to the change of language and the move to replace terms such as “inquisition” and “verdict”, although these changes were made by the 2009 Act and not the new rules.

Various suggestions were made about additional or alternative short form conclusions (by for instance the Medico-Legal Committee of the Coroners’ Society of England and Wales, East Anglian Coroners’ Society, and the coroners for North Staffordshire, North Manchester and Sunderland) including:

- “neglect”
- “deliberate self harm”
- “self harm but intent could not be ascertained”
- “recognised complication of surgery”
- "acute psychiatric adverse reaction to medication"
- “abortion”.

In addition to these, research conducted on behalf of the MoJ into the rise in the number of “unclassified verdicts” over the last five years has suggested there may be scope for introducing a new short-form category for cases where medical or surgical intervention had been unsuccessful⁵. Two independent assessors (former coroners) analysed a random sample of 2,196 such verdicts recorded between 2007 and 2011, suggesting that there is a need for such deaths to be categorised by short form. The MoJ is considering with the Chief Coroner whether to include such a category in the future.

New short-form conclusions “drink/drug related” and “road traffic collision”

Overall there was support for these new short form conclusions. The Berkshire Coroner said, “There is clearly confusion amongst coroners as to how best to record drug related deaths and, on occasion, road traffic collisions. It is better to have them separated out than included under the “misadventure” heading which is often the case”. The Norfolk Coroner said that “Road Traffic Collision” (as already applied in his jurisdiction) as opposed to “Accidental Death” in road traffic collisions cases was appropriate. However Dr Paul Pilkington and Sara Blackmore SpR Public

⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199793/coroners-statistics-bulletin-2012.pdf

Health said that the list was “unhelpful as it combines both risk factors (eg drink/drug use) and mechanism of death (eg road traffic collision)”.

The Road Safety Statistics team at the Department for Transport supported the introduction of “road traffic collision”, arguing that would save time and resources for both police forces and coroners. However, they recognised that “road traffic collision” might also cover some of the other conclusions (e.g. “suicide” or “natural causes”). They suggested that:

“An alternative would be to add the fact that the death was in a road traffic collision to be added as a separate piece of information, perhaps as a supplementary conclusion... We would also be keen that, if someone was killed in a road traffic accident involving a driver who was above the legal blood alcohol content limit or drug limit that the death is recorded as 'road traffic collision' rather than 'drink/drug related' (or, alternatively, both recorded as supplementary conclusions).”

Some respondents (e.g. Professor David Healey) of the Hergest Unit in Bangor said that coroners should note where people have been on antidepressant or other drugs at the time of death (suicide) even where the death is not from an overdose, as usage can be linked to taking one's own life.

Some thought that “drink related” was too broad (and could for example include deaths from excessive consumption of water) and that “alcohol related” would be a more appropriate description.

The Independent Chair of Child Death Overview Panel for Teesside was concerned that, as phrased, drug-related could also capture deaths related to medication errors, paracetamol overdoses, and unexpected reactions to prescribed medication, “none of which would be helpful additions to this category”. Professors David Gunnell (University of Bristol), Nav Kapur (University of Manchester) and Keith Hawton (University of Oxford) and POPYRUS were concerned that coroners may choose the short-form conclusion “drink/drugs- related”, “to avoid delivering an appropriate suicide verdict.”

Suicide standard of proof

We also received comments on the most appropriate standard of proof needed for a coroner or jury to give a “suicide” conclusion at an inquest. Under current practice (common law precedence), coroners may return a verdict of suicide only where the criminal standard of proof has been established, i.e. that it was beyond reasonable doubt that the deceased intended to take their own life. Some respondents expressed strong views on whether the current criminal standard should be replaced by the civil standard.

Civil standard

Some respondents (e.g. the Inner West London Coroner, Madeleine Moon MP, Royal College of Psychiatrists, INQUEST and Lester Morrill Solicitors) said the civil standard of proof was most appropriate. The National Suicide Prevention Strategy Advisory Group at the Department of Health advised that, “We strongly believe that it is time for the coroner's determinations to catch up with the decriminalisation of suicide over 50 years ago and adopt a civil standard of proof for suicide”.

The Alliance of Suicide Prevention Charities and PAPYRUS also supported a change, saying that, “We believe that the effect of the current burden of proof is that inquests can have the effect of stigmatising suicide and reinforcing outdated attitudes to those who take their own lives.”

Criminal standard

Other respondents (such as the Medico-Legal Committee and Law Review Committee of the Coroners’ Society of England and Wales, and the Coroner for North Wales (East and Central) were strongly in favour of retaining the criminal standard of proof. The Coroner for Wiltshire and Swindon argued that, “If someone takes their own life or someone else’s the standard should be the same in my opinion”.

The Coroner for Powys, Bridgend and Glamorgan Valleys agreed that the criminal standard of proof for suicide should remain, “given the emotional and financial implications for the family.” The Coroner for North Yorkshire East said:

“The standard of proof for unlawful killing and suicide should remain as the criminal standard of proof. I appreciate that the criminal standard of proof for suicide is a consequence of the fact that originally suicide was a crime. It is important however, in any suicide Inquest, to establish beyond merely a balance of probabilities that the deceased did intend to take his own life. There are often life insurance implications resting on the decision but in any event, I would always want to be satisfied to a greater extent than a mere balance of probabilities.”

Response:

We have renamed the “Conclusion” form (2) in the Rules the “Record of the inquest” for greater clarity.

On this form, we have amended the “drink related” short-form conclusion to read “alcohol related”.

As the requirement to use the criminal standard of proof when returning a suicide verdict is established under case law rather than coroner legislation we cannot take forward a change in the law through secondary legislation flowing from the 2009 Act. However the Chief Coroner and the MoJ are considering the views expressed on this issue.

Question 19: Do you agree that the draft rules on inquests to be made under section 45 will help make inquests more consistent? If not, please give details.

Views were mixed. Two in five respondents agreed the rules would improve consistency; one in five felt the rules would not help; and the remainder did not express a clear view.

The Medico-Legal Committee of the Coroners' Society of England and Wales said, "Too much emphasis is placed on consistency in circumstances where Parliament has determined that the coroner service should remain a local service, not a national one." However the Law Society said, "The draft rules should serve to encourage more consistent standards in the conduct of inquests".

INQUEST welcomed the rules but said:

"On their own they will not necessarily lead to greater consistency in decision-making. To ensure this happens the new rules will need to be supported by clear guidance from the Chief Coroner, agreed protocols with investigatory bodies, mandatory training for coroners and, crucially, proper funding for bereaved families' representation at inquests."

Others used this question to provide general comments on the drafting of the rules.

Response:

We have made some further changes to rule 11 in response to answers given to this question, including clarifying when the opening of an inquest or a pre-inquest review hearing should be held in public.

As noted above, the Chief Coroner has issued to coroners a detailed Guide to the 2009 Act and the new rules and regulations.

Question 20: Would any of the proposed regulations for juror and witnesses allowances lead to increased costs for local authorities? If you think so, please give details.

Just under a quarter of respondents felt there would be increased costs; just over a quarter disagreed; and half did not answer the question.

Some felt costs would increase in relation to those allowances where increases were proposed, and some said this would be balanced by reductions elsewhere. For instance Dr Rosemary Scott from the Department of Histopathology, University College of London, and Gloucester County Council said that the opportunity for video or written evidence would save the expense of bringing witnesses into court – such as where there was a pathologist's report on the cause of death which was not contentious.

Brighton and Hove City Council said that it:

“welcomes and supports the principle set out in the consultation document that amendments should only take place where no additional burden is imposed on local authorities. As reiterated throughout this response, the council is concerned at the possible emergence, as implementation of the new rules beds down, of currently unforeseeable and unquantifiable costs.”

The Berkshire Coroner was concerned that allowances were artificially low. However, Sefton Metropolitan Borough Council said that, where possible, only "actuals" should be paid for, reimbursing the exact costs rather than using an allowance system, as this may reduce costs.

The Coroners' Society of England and Wales felt there would be an increase in the number of jury inquests which would lead to higher levels of expenses. However others (such as Action against Medical Accidents) felt there would be fewer jury inquests. Some felt juror allowance caps were too low and others that rates were excessive. Most expressed no concerns.

Some people felt there should be a cap on expert witness costs. However, others felt coroners should have discretion to pay more than the given maximums in certain cases. The West London Coroner said that, “In due course, it would be helpful to have some national guidance on fees for expert witnesses as there are significant disparities”.

One respondent said that larger coroner areas would mean increased travel costs. Another said that the new medical examiner system would increase medical expert fees.

Response:

We are not making any changes as a result of answers to this question.

Question 21: Do you have any comments on the draft regulations to be made under Schedule 7 in addition to your answer to question 20 above? If so, please give details.

Less than half of respondents answered this question. There were however one or two comments on most of the draft regulations.

Fees for copies

Some respondents (Childhood Bereavement Network and National Bereavement Alliance) said there should be no fee for copies for bereaved people. Others such as the Worcestershire Coroner and Birmingham Deputy Coroner pointed out that guidance was needed on the interpretation of draft fee regulation 35 as it would not be appropriate to charge an interested person £50 for ten single page documents.

Fees for transcripts

There was concern that the draft regulations did not make specific provision for transcripts, meaning that coroners could charge only the fee for copies rate for a transcript. The Cheshire Coroner wrote that, *"The only way that I can provide a "note of evidence" is to have a transcript typed. £5 for the first 10 pages and 50p thereafter which would put my local authority severely out of pocket as the transcripts have to be typed externally."*

Similarly, the York Coroner said that, *"The fees for disclosure after an Inquest are hopelessly inadequate. Typed transcripts are regularly requested by people who are unable to process a compact disc or memory stick. Typed transcripts will therefore continue to be required"*. The Coroner for Wiltshire and Swindon said that a deaf person would need a transcript rather than a recording.

Recording of an inquest

There were concerns from several respondents that £5 was too low for a recording of an inquest. A few different suggestions were made as what would be appropriate, of up to £25.

There was however no overall consensus of views and no breakdown for the suggested increased fees.

Transferred investigations

There were mixed views on paying fees for investigations transferred between coroners, either by the coroners themselves or under direction from the Chief Coroner. There was some concern about the transferring local authority paying for an investigation when the Chief Coroner directs a transfer. The Berkshire Coroner asked who would be responsible for the costs of any judicial review of the inquest.

Gloucester County Council said that if a coroner happened to be an expert in a certain area of work, they may have requests to investigate, or hear cases from other jurisdictions. If they agreed this (rather than waited for the Chief Coroner to direct a transfer) it would place an unfair burden on their local authority. They suggested that in such cases the costs should remain with the originating coroner.

Some local authorities (Southern Regional Coroners' Managers' Group and responses from individual local authorities which are members of the group, and Northamptonshire County Council) said that there was potential for local authorities to be paying twice for case work if coroners were salaried and then cases were transferred between jurisdictions by the Chief Coroner. *“The transferring coroner would still be paid by his/her local authority for the work (s)he was not doing on a transferred case, plus the transferring local authority would need to pay the recipient local authority for continuing the investigation after transfer.”*

However the counter-view was also expressed, namely that in all transferring cases the transferring local authority should meet all the costs.

Post mortem examinations

Some respondents (such as the Isle of Wight, West Manchester and Surrey Coroners and South London and Brighton Deputy Coroners) felt the fees for post-mortem examination practitioners were too low. Mara Quante, Consultant Histopathologist, Royal Sussex County Hospital, said that:

“Post mortems don't only consist of the actual examination but collection of results, notes and histories which then need to be summarised in a cause of death. Often they require histological examination too. With the introduction of medical examiners, this is likely to increase. Often many weeks are spent trying to come up with a cause of death and a descriptive and accurate post mortem report (not only a 'tick boxing' exercise). I therefore feel that the current fee for a pathologist is not reflective of the work we do.”

Some respondents said that forensic post-mortem costs should be explicitly referred to in the regulations, and that (East London Assistant Deputy Coroner), “Where there is a delay in identifying a suspect the coroner will undertake a second post mortem for the prospective defence case. This cost should be recoverable”. Others said there should be mention of the differential costs of a less-invasive post-mortem examination. Yet others questioned why we had retained reference to ‘post-mortem examinations requiring additional skills’ when the 2009 Act removes the 1988 Act’s reference to ‘special’ post-mortem examinations. Others said the regulations should mention ancillary investigations such as histology.

Professional witnesses

Several respondents said that most medical witnesses suffer no financial loss from their attendance at inquests as they are paid employees. They suggested that there should be a reimbursement of reasonable financial loss only. There was also a request for inclusion of a London weighting.

Doctors’ reports

Kent County Council suggested that regulations should include fees for doctors’ reports, given lack of standard practice concerning coroners’ requests to doctors for a report covering the deceased's medical history and medication.

Delegation of functions

Several respondents suggested that draft fee regulation 3 should be amended to allow the local authority, rather than the coroner, to calculate the allowance payable. The Lincolnshire Coroner said:

“A coroner is a doctor and/or a lawyer, but not an accountant. Consequently, such matters should be handled by the Finance Department within each local authority.[...] The coroner should not have to personally pay the fees and expenses but ensure that they are paid as this is an administrative - often a local authority function on a local authority computer finance package.”

Response:

We have made a number of changes to the Coroners Allowances, Fees and Expenses Regulations in response to the comments received. In particular, new regulation 12 (4) replaces Rule 2 of the old Coroners' Records (Fees for Copies) Rules 2002, allowing coroners to charge for transcripts.

The regulations around fees for transferred investigations are now in the Coroners (Investigations) Regulations. In cases where the Chief Coroner directs a transfer of an investigation, the regulations now make clearer that the transferring authority should pay only fees, allowances and expenses (and not salary which is paid by the receiving authority regardless of transfer) of the receiving coroner. They also allow the Chief Coroner to determine which coroner's authority should pay such costs.

We have included a new regulation 13 to replace the provision in Section 27 of the Coroners Act 1988 on providing the local authority with accounts, and providing for reimbursing the coroner.

We have not introduced any additional fees as a result of this consultation as any increases would represent a new burden for the public purse.

We are producing guidance for local authorities on the new regulations and other changes under the 2009 Act.

Consultation Co-ordinator contact details

If you have any comments about the way this consultation was conducted you should contact Sheila Morson on 020 3334 4498, or email her at: sheila.morson@justice.gsi.gov.uk.

Alternatively, you may wish to write to the address below:

**Ministry of Justice
Consultation Co-ordinator
Better Regulation Unit
Analytical Services
7th Floor, 7:02
102 Petty France
London SW1H 9AJ**

Consultation principles

The principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation are set out in the consultation principles:

<https://www.gov.uk/government/publications/consultation-principles-guidance>.

Annex A - List of respondents

Academics

Professor John P Cassella, Department of Forensic Science and Crime Science, Staffordshire University
Christopher Sargeant, University of Cambridge
Dr Paul Pilkington and Sara Blackmore, University of West England
Yoon Loke, Norwich Medical School

Coroners

Avon
Berkshire
Birmingham (Assistant Deputy)
Birmingham (Deputy)
Black Country
Blackburn Hyndburn and Ribble Valley
Brighton and Hove
Brighton and Hove (Assistant Deputy Coroners - 3 responses)
Brighton and Hove (Deputy)
Cardiff and Vale of Glamorgan
Ceredigion
Cheshire
City of London
Cornwall
Coroners' Society of England and Wales
Coroners' Society of England and Wales Law Review Committee
Coroners' Society of England and Wales Local Government Committee
Coroners' Society of England and Wales Medico-Legal Committee
Coventry and Warwickshire
Cumbria North and West
Cumbria South and East
Cumbria South and East (Deputy)
Devon (Deputy)
Durham North and South Districts
East Anglian Coroners' Society

East Midlands Coroners' Society

East Sussex

Essex and Thurrock

Gloucestershire

Greater Manchester North

Greater Manchester South

Greater Manchester South District (Deputy)

Hertfordshire

Hull and East Riding (Recently Retired Coroner)

Isle of Wight

Lincolnshire Central

Lincolnshire South

Liverpool

London East

London East (Assistant Deputy)

London Inner South

London Inner West

London North

London South

London South (Deputy)

London West

London West (Assistant Deputy Coroners, 2 responses)

Manchester (City)

Manchester West

Mid Kent and Medway

Milton Keynes

Newcastle

Newcastle upon Tyne (Retired Deputy), Northumberland North (Assistant Deputy), Gateshead and South Tyneside (Assistant Deputy)

Norfolk

Norfolk (Assistant Deputy)

North East Kent

North Northumberland

North Wales (East and Central)

North West and North Wales Coroners' Society

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North West Wales
North Yorkshire East
North Yorkshire Western District
North Yorkshire Western District (Deputy)
Northern Coroners Society
Nottingham and Nottinghamshire (Assistant Coroner)
Nottinghamshire
Nottinghamshire (Deputy)
Nottinghamshire (Assistant Deputy)
Oxfordshire
Powys
Shropshire, Telford and Wrekin
South Eastern England Coroners' Society
South Wales Coroners' Society
South Western Coroners' Society
South Yorkshire West
Southampton and New Forest
Southern Coroners' Society
Staffordshire North
Staffordshire South
Suffolk
Sunderland
Sunderland (Assistant Deputy)
Surrey
Swansea, Neath and Port Talbot
Teesside (Coroner and Assistant Deputy)
Torbay and South Devon
West Midlands and Central Wales Regional Coroners' Society
West Somerset
West Yorkshire (former coroner)
Wiltshire and Swindon
Worcestershire
York

Coroners' Officers

Berkshire
Coroners' Officers and Staff Association
Isle of Wight
Lancashire
Liverpool (4 responses)
North Yorkshire
Sunderland
West Mercia

Faith Groups

Board of Deputies of British Jews
Brethren Christian Fellowship
Gardens of Peace Muslim Cemetery Trust
Tottenham Park Islamic Cemetery
Union of Orthodox Hebrew Congregations

Government / Parliament

All Party Parliamentary Group on Suicide and Self-Harm Prevention
Department for Transport – Road Safety Statistics Team
Home Office – Forensic Science Regulation Unit
Human Tissue Authority
Joan Walley MP
Judicial Appointments Commission
Ministry of Defence
National Offender Management Service
National Suicide Prevention Strategy Advisory Group
Office of Rail Regulation
Prisons and Probation Ombudsman
Serious Organised Crime Agency (SOCA)

Legal

5 Essex Court
Association of Personal Injury Lawyers
Berrymans Lace Mawer LLP
Birmingham Law Society

Browne Jacobson
Chartered Institute of Legal Executives
Capsticks Solicitors
DAC Beachcroft LLP
Farleys Solicitors
FOIL (Forum of Insurance Lawyers)
Hilary Meredith Solicitors
Irwin Mitchell Solicitors
Law Society
Leigh Day
Lester Morrill Solicitors incorporating Davies Gore Lomax LLP
NHS Wales Shared Services Partnership-Legal and Risk Services
Thompsons Solicitors
Westmorland General Hospital Legal Adviser

Local authorities

Association of Chief Trading Standards Officers
Birmingham City Council Licensing and Public Protection Committee
Black Country Coroners Managers' Group
Blackburn with Darwen Council
Brighton and Hove City Council (2 responses)
Bristol City Council
Buckinghamshire County Council
Cumbria County Council
Devon County Council
East Sussex County Council
Essex County Council
Gloucester County Council
Kent County Council
Lancashire County Council
Lincolnshire County Council
London Borough of Bexley
London Borough of Bromley
London Borough of Southwark
Manchester City Council

Midlands and Eastern Region (MERG) LA Managers of coroners' services
Northamptonshire County Council Registration Service
Northumberland County Council
Nottingham City Council
Rhondda Cynon Taff County Borough
Sefton Metropolitan Borough Council
Sheffield City Council
Sheffield City Council (Medico Legal)
Somerset County Council
Southend-on-Sea Borough Council
Southern Regional Coroners' Managers' Group
Stoke on Trent City Council
Sunderland City Council Bereavement and Registration Service
Surrey County Council
Wiltshire Council

Medical

Andrew King, Pathologist
Association of Anatomical Pathology Technology
Barnet and Chase Farm Hospitals NHS Trust
Brighton and Sussex University Hospitals NHS Trust
British and Irish Paediatric Pathology Association (BRIPPA)
British Association of Perinatal Medicine (BAPM)
Guy Singleton, Colchester Hospital University Foundation Trust
Dr DA Agbamu, Consultant Histopathologist, Wirral University Teaching Hospital NHS Foundation Trust
Dr Jane Barrett, President of the Royal College of Radiologists
Dr JH McCarthy, Consultant Pathologist, Cheltenham General Hospital
Dr Mark Howard, Department of Histopathology, Royal Sussex County Hospital
Dr Martin Ward Platt, Independent Chair of Child Death Overview Panel for Teesside
Dr Rosemary Scott, Dept of Histopathology, University College London
Dr Stephen Leadbeatter - Forensic Pathologist and Lecturer
Faculty of Forensic and Legal Medicine of the Royal College of Physicians
Fiona Murphy, Assistant Director of Nursing, Bereavement and Donation, Bolton NHS Foundation Trust, Wroughton, Wigan and Leigh NHS Foundation Trust and Salford Royal NHS Foundation Trust
Forensic Pathology Services - Drs NRB Cary, RC Chapman, AW Fegan-Earl, NCA Hunt, PG Jerreat, SM Poole, B Swift, Prof RA Risdon

General Medical Council

Gloucestershire Consultant Pathologist

James Cook University Hospital, Middlesbrough

John Martin Corkery, Programme Manager, National Programme on Substance Abuse Deaths

Mara Quante, Consultant Histopathologist, Royal Sussex County Hospital

Marion Malone, Great Ormond Street Hospital for Children, Dept of Histopathology

Medical and Dental Defence Union of Scotland

Medical Defence Union

Medicines and Healthcare Products Regulatory Agency – Medical Devices Division

Professor David Gunnell (University of Bristol), Professor Nav Kapur (University of Manchester)
and Professor Keith Hawton (University of Oxford)

Professor David Healy, Hergest Unit, Bangor

Professor Simon Maxwell, Medical Director, Centre for Adverse Reactions to Drugs Scotland

Royal College of Anaesthetists Lay and Clinical Members of Council

Royal College of Pathologists

Royal College of Psychiatrists

Royal Devon and Exeter Hospital

Sebastian Lucas, Emeritus Professor of Pathology and consultant pathologist, St Thomas's Hospital

University Hospital of North Staffordshire NHS Trust – Trauma Service Office

Yorkshire Ambulance Service NHS Trust

Members of the public

Alick Moore

Cathy Franklin

Don Hart

Eileen Guinee

Elaine Isaacs

Emma Attris

Gemma Stockford

Graham King

Hilary Abrey

Julia Wood

Karen Lyn Baker

Khuddadad Choudhrey

Lanny Hobson PhD MD

Lily Lewy

Margaret Gardener

Mary Page

Maureen Davy

Nicolas M Wheatley

Nicole and Chris Taylor

Sheila M. Bird

Teresa Evans

Tom Luce

Tony and Yvonne Brown

Other

ASLEF

Association of Private Crematoria and Cemeteries

Camden New Journal

London Veterans Advisory and Pension Committee

East Midlands Trains

Media Lawyers Association

National Association of Funeral Directors

Newspaper Society

Press Complaints Commission

Royal Statistical Society

Society of Editors

Police

Association of Chief Police Officers and Greater Manchester Police

Independent Police Complaints Commission (IPCC)

Merseyside Police (3 responses)

Metropolitan Police Service

Police Federation of England and Wales

Surrey Police

Sussex Police (2 responses)

West Midlands Police Assistant Chief Constable (Crime)

Voluntary groups

Action against Medical Accidents (AvMA)

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Adverse Psychiatric Reactions Information Link (APRIL)
Advocacy After Fatal Domestic Abuse (AAFDA)
Alice Barker Trust
AntiDepAware
Bereavement Advice Centre
Bliss, the special care baby charity
British Heart Foundation
CALM, the campaign against living miserably
Cardiac Risk in the Young (CRY)
Childhood Bereavement Network
CO-Gas Safety Charity
Coroners' Courts Support Service
Cruse Bereavement Care
Disaster Action
Fataluk.com
Gas Safety Trust
INQUEST
Judi Meadows Memorial Fund
Marchioness Action Group
Matthew Elvidge Trust
National Bereavement Alliance
PAPYRUS Prevention of Young Suicide
Refuge
RoadPeace
Royal British Legion
Samaritans
Sands, the stillbirth and neonatal death charity
Sudden Death Police Complaints
Support After Murder and Manslaughter (SAMM National)
Survivors of Bereavement by Suicide
Survivors of Bereavement by Suicide – Cumbria group
TASC (The Alliance of Suicide Prevention Charities)
Victims Service Alliance
War Widows' Association of Great Britain

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