Ministry of JUSTICE

Reform of the coroner system - next stage

Preparing for implementation

List of questions for response

We would welcome responses to the following questions set out in this consultation paper.

Please email your completed form to: olga.kostiw@justice.gsi.gov.uk

Question 1.	Do you agree with cases and circumstances in which a registered medical practitioner must notify a senior coroner of a death? If not, what alternative or additional cases and circumstances would you suggest (bearing in mind the coroner's remit to investigate deaths as defined in section 1 of the 2009 Act)?

Comments: Section 1 The Coroners and Justice Act 2009 requires that the Coroner must as soon as practicable conduct an investigation into the death where the deceased died a violent or unnatural death, the cause of death is unknown, the deceased died whilst in custody. This should be extended to cover the situation where the death is unexpected and or where there is doubt about the cause of death, this is often the case with vulnerable people for example neonatal deaths or the elderly or those with learning difficulties.

The Act requires deaths be reported only if the death was violent or unnatural, cause of death is unknown or the deceased died whilst in custody or state detention. Our concern is that while the immediate cause of death of these vulnerable people or other during the course of medical treatment may be known it is nevertheless sudden and unexpected. For instance the deceased may have died of peritonitis following surgery to the bowel . The cause of death is known, it is not violent but we would argue you cannot know if the death was unnatural in those circumstances until the Coroner has carried out his/her investigations. If such deaths are not investigated the true cause, such as system failure is not identified and the opportunity to learn and improve patient safety is lost. Furthermore by using the term *state detention* the statute would exclude the elderly, long term disabled or severely ill who may be inpatients who are too ill to consent to their admission but are still in the care of the state. It would also exclude voluntary psychiatric patients as they are not deemed to be detained by the state yet often, given their poor condition of health, wholly in the control of the state. Those circumstances, we would argue, increases the responsibility of the state to keep those patients safe and yet are circumstances not catered for by these provisions. We would also argue that the duty to investigate should apply to those in private residential care such as elderly care homes and private residential care homes for those with learning difficulties as they too are by the very nature of their circumstances vulnerable persons.

Question 2.	We would welcome comments on the draft guidance for registered medical practitioners which explains the cases and circumstances in which a senior coroner should be notified of a death. In particular, short illustrative examples that could be included in the guidance.

Comments: Such guidance is welcomed as a means of achieving consistency of approach across the UK. The examples we provide below include the deaths of vulnerable persons both in state and private care, consistent with our response above.

The guidance needs to ensure that medical practitioners are aware of the need to refer to the coroner in the following circumstances

1. Where an SUI (Serious Untoward Incident) report is indicated or carried out

2. Where deaths occur unexpectedly, particularly in the following circumstances

(i) Over a weekend or bank holiday period.

(ii) When nursing staff are known to be in short supply.

(iii) When locum doctors are on call without a Consultant overseeing them or when they are on duty with doctors with less than 1 years PQE

Examples:

1. Mr A is detained under the MHA. He has alcohol induced dementia, is frail and aged 77, and is a danger to himself. He attacks another inpatient and is restrained violently by security guards. He falls in the course of the restraint. 2 days later he develops respiratory distress and then pneumonia and dies. His primary cause of death is not the forcible restraint but we would argue he may have suffered injury as a result of the forcible restraint that ultimately led to his death and the method of restraint should be a matter for a coroner's investigation.

2. In 2007 an elderly (80 year old) man (S) with acquired brain damage who is a known diabetic is admitted to a care home. He has a history of refusing to take his insulin medication and the family have advised the staff that his medication, which has been approved by the diabetologist and the family must be given. Allegedly the medication was not given due to A's refusal to co operate, this was despite the fact that it was accepted that A didn't have capacity to refuse. He did not receive medication and went into a ketoacidotic crisis and was referred to hospital. He was treated in hospital for

diabetic ketoacidosis and a secondary urinary infection where he remained for 4 days, he developed C-diff (a bacterial infection that causes gastro-enteritis) whilst in hospital and died. The cause of death was given as Diabetic Ketoacidosis, urinary sepsis and part 2 C-diff diarrhoea. We would argue that the real cause of death was the failure to administer the insulin and or possibly the failure to identify and treat a urinary infection. Arguably the failure of S to receive his medication would now be dealt with under the Mental Capacity Act 2008 but the other issues remain.

3. Where the Hospital Trust carries out a Serious Untoward Incident (SUI) report. R was a 66 year old, healthy man with a history of mild and well controlled asthma. R was admitted to hospital in March 2009 with his first mild asthma attack. The admission was on a Saturday evening. R was seen by an A&E doctor and was diagnosed with acute asthma and pneumonia. He was given a broad spectrum antibiotic, steroids, bronchodilators and oxygen. He was transferred to an acute medical unit in the early hours of the following morning, and he was still on continuous oxygen. He had episodes of shortness of breath and reported feeling unwell. By 1800 hours that day he had deteriorated rapidly, a critical care specialist was contacted but before he could attend, R arrested and died. The cause of death was given as severe aortic stenosis and bronchial asthma, the case was not referred to the coroner.

   An SUI report was prepared which concluded that outreach was never called to see the patient during the day. It recommended that medical and nursing staff have a greater understanding of the importance of vital signs when monitoring a patient, the need for more frequent observation, reviewing EDOD scores and actions to be taken and reviewing how to record vital signs. It also recorded that the referral process needed reviewing and that on call rotas should have a balance of locum staff and full time Trust doctors.

   The Trust admitted to the family that patients are lost at weekends which would not otherwise be lost

   The family are currently still fighting for an inquest.

Question 3.	Given new ways of delivering health services, particularly to the terminally ill, should the time period for a death to be automatically reported to a coroner be extended to 28 days, from 14 days, of a doctor not having attended their patient? Or should there be no time limit at all?
Comments:	We would agree with commentators who felt the time limit meaningless. Given the advances in medical treatment we firmly believe that there should be no time limit for referral and it should be left to the discretion of the attending practitioner, in discussion with the Medical Examiner

Question 4.	What channels should be used to provide training and guidance for medical practitioners on the cases and circumstances in which a senior coroner should be notified of a death?
Comments:	The Royal Colleges would be ideally placed to produce Greentop guidelines to their members and training can be incorporated at various stages of a doctor's training starting at Medical School.

Question 5.	Do you agree with the proposed arrangements for dealing with registered medical practitioners who consistently or deliberately fail to notify a senior coroner of a death(s)? If not, what alternative arrangements – short of creating a new offence - would you suggest?
Comments:	Yes

Question 6.	Whether there are other main circumstances when consideration should be given to cases being transferred
Comments:	We believe that cases should be transferred where complaints are made by properly interested persons, not just family members. Restricting the category to family members only is unnecessarily restrictive.

Question 7.	"Who pays" in circumstances where an investigation is transferred whether on the direction of the Chief Coroner or by agreement between the coroners concerned
Comments:	The originating local authority should pay in all circumstances. If one district has an unusually high number of cases eg due to the presence of a port or hospital, additional resources should be provided to them to manage the demand.

Question 8.	On the process for notification of transferred investigations (Chapter 2, paragraph 17), that: - Coroners A and B must agree at the time of transfer which of them will confirm in writing, to any identified interested persons, that the transfer had taken place, and write to those interested persons within 5 working days. - Coroner A must give coroner B the relevant paperwork within 5 working days of receiving the direction from the Chief Coroner.
Comments:	We have no objection to this proposed process.

Question 9.	What do respondents consider to be the purpose of a coroner commissioned post-mortem examination?
Comments:	The purpose is to identify the cause of death, and where cause of death is unclear to provide clarity and forensic evidence to enable an investigation into the cause of death that will remove uncertainty for the deceased's family.

Question 10.	In addition to ensuring greater consistency in the commissioning of post-mortem examinations, how may the number of post-mortem examinations be reduced?
Comments:	We do not believe the number of post-mortem examinations could or should be reduced. They are necessary to identify causes of death and forensic evidence to assist the coroner in his/her inquisition. There is evidence from trials run in Manchester that the use of MRI post mortems leads to key evidence being missed.

Question 11. Should consultation with the relevant next of kin about the examination occur, as a matter of best practice, before the examination takes place (except in cases of suspected homicide)?
Comments: Always, as at this stage a detailed history from the relevant next of kin provides an opportunity to carry out a wider post mortem to ascertain underlying health conditions and so as to inform the development of public health policy generally. However this should never be performed without family agreement. The process should be formalised to eradicate inconsistency of information provision between coronial districts.

Question 12. Where it has not been possible, for whatever reason, to obtain such consent, how should matters relating to tissue retention be dealt with? Does the current '3-month rule' work in practice? Should the 3 months begin from the date of the conclusion of the examination?
Comments: No destruction of tissues should be carried out before the Inquest has been heard. The current proposals suggest 3 months from date of death. We consider this inconsistent with the need to involve families and obtain consent. If the inquest has not concluded, destruction of tissues should not take place to avoid inadvertent destruction of evidence. Often families take months post death to identify the issues they are concerned with about their relation's death, and the 3 month rule, if followed, could mean they could not carry out their investigations of the retained tissues, nor ask the Coroner to carry out PM examination of those tissue samples.

Question 13. When might a coroner wish to consider authorising a post-mortem examination to be carried out by a less invasive method?
Comments: We believe that there are limited circumstances in which an MRI post mortem may be carried out, but evidence derived from the Manchester pilot has, we understand, shown that in very limited circumstances where the cause of death is uncontroversial, the use of MRI is welcomed by certain religious groups. It is certainly our experience that post mortems because of the invasive nature of them, can add to a family's distress. Nonetheless, we are concerned however that over reliance on MRI post mortems will prevent the coroner from carrying out a full investigation because he/she will not be able to gather all relevant information.

Question 14.	Who might be designated as suitable to conduct post-mortem or related examinations if they are not registered medical practitioners? Your responses will help us identify which categories of persons should be designated by the Chief Coroner under powers contained at section 14(3)(b) as well as informing future guidance on the use of alternative post-mortem examination methods.

Comments: We cannot suggest what other parties would be suitable to carry out a post mortem examination if they are not a medical practitioner. This is because clinicians bring with them a wealth of learnt and acquired specialist medical knowledge and this is not something that can be passed on or practiced by, for instance, a technician carrying out a post mortem by checklist and without in-depth medical understanding.

Question 15.	Do respondents agree that, providing a body has been identified, 30 days should be the maximum time by which the body of someone who has died should be released for a funeral? Your responses will inform regulations on the preservation, retention, release or disposal of bodies to be made under powers contained at section 43(3)(g)

Comments: We are concerned that burial should not take place until adequate samples have been taken. In at least 2 cases where we have been involved issues arose concerning possible cross contamination from a blood sample in the Scientific Services lab, and/or inadequacy of samples taken. In one case because there was insufficient blood samples for the tests to be rerun, the question of exhumation arose which was very distressing for the family. It was resolved in the end by another lab finding an aliquot of blood which they ran tests on. The results of those tests are in dispute given the amount and quality of remaining blood sample available and this has lengthened the hearing time of the inquest and of course increased costs unnecessarily. In another case we were involved in failure to take proper samples and store them appropriately which meant an open verdict was recorded as it was not possible to conclude the means by which the deceased came to his death.

Question 16. Do respondents have any views as to what the format and contents of the post-mortem request and report forms should be, in future? Your responses will inform regulations to be made under section 43(1)(b)
Comments: The PM should specify the circumstances of the death and the pathologist should have available the medical records before completing the Post Mortem report. The Pathologist should have full details about the deceased's previous medical history and medication as well as information about the dose and length of time they had been receiving this medication where available The report should also specify the Pathologist's opinion on the circumstances giving rise to death. We have often had experience of Coroner's officers advising us of a view the Pathologist has (eg death of a foetus due to cord compression) yet that opinion is not contained in the post mortem report. This is not helpful in terms of transparency and will usually necessitate calling the Pathologist to give evidence at the Inquest; an increase in costs that could be avoided if transparency was applied in terms of the contents of the report being communicated to the families immediately. Too often we have also attended an inquest to hear the pathologist give evidence that could have been set out in their report. We suspect the very limited fee paid to the pathologist and limited resources available to them leads to them not consistently carrying out a detailed post mortem and reluctance to put in writing any concerns they may have about cause of death.

Question 17. Who do coroners envisage carrying out these functions on their behalf? Do coroners envisage delegating this task to coroner's officers, the police, or someone else entirely? Who do other consultees feel should carry out this task on behalf of the coroner? Who do you think would be suitably qualified to carry out this task on behalf of coroners?
Comments: Coroners officers should only carry out this task under guidance from a coroner and with the benefit of detailed training, however we consider that the request for post mortem should only be made by the coroner with the assistance of the medical examiner, as both have the expertise and knowledge of issues that the Pathologist needs to investigate. We do not believe it is a delegable task to other unqualified members of staff.

Question 18.	Should the person entering, searching and seizing have in their possession, in every circumstance, some form of documentation stating their authority to be on the land or premises and to remove items and documents?
Comments:	Yes

Question 19.	We propose that the procedure for obtaining permission to carry out a search, and the process for carrying out search and seizure, should where possible, mirror the process used by the police in accordance with the Police and Criminal Evidence Act 1984. This could be achieved by way of a code of practice, as was proposed during Parliamentary debates on this issue. Do you consider this approach is appropriate?
Comments:	Yes

Question 20.	Do you have views on the other aspects of the proposed procedure for entry search and seizure set out in Chapter 4?
Comments:	No

Question 21.	In normal circumstances, should some form of notice be given to the landowner/occupier that entry, search and seizure is to be undertaken? Is 48 hours a suitable period of notice?
Comments:	Yes to both

Question 22.	Do you agree that we have captured the right principles and struck a proper balance between those which compete?
Comments:	Yes

Question 23. Should we permit requests to be made at any stage in a coroner's investigation? If so, how long should coroners be given to respond to requests, in order to not delay investigations, but to provide them with workable timescales?

Comments: Yes as new evidence may arise that would if ignored lead to inadequacy of the coroner's enquiry. We wish to emphasise that there needs to be clarity over what documents parties are entitled to as of right.

Parties should be equally entitled to see all documents generated as part of the inquest process; this should be as a matter of right rather than discretion. Exceptions may be made, such as where the family are unrepresented and the post mortem report might be considered particularly distressing for them to read, e.g. Cases of suicide, but the reasons for withholding the information should be clearly stated. We refer to Jervis on Coroners (12th Edition) paragraph 18-34 where it refers:

> ***"The Coroner must upon application and payment of any prescribed fee supply to any properly interested person a copy of any report of a post mortem examination…"***

It would appear that if you are a person who is entitled to be represented at the Inquest then you should be eligible to receive a copy of the post mortem report.

If there were disclosure of documents in this way at the outset then any requests to the Coroner can be made at the Pre Inquest Review stage, this is likely to be documents or statements made in the preparation of a SUI, protocols and guidelines etc. Broadly we envisage an equivalent to the pre action disclosure procedure.

The entitlement to documents would be medical notes, statements, documents prepared by the police during the course of any criminal investigation, SUI, post mortems.

With regard to evidence gathering while the Coroner has wide powers of discretion but they don't have any real or substantive power for example to compel a party to prepare statements and or disclose documents within a certain time. If there is failure to prepare or disclose then there is no remedy available to the coroner to punish the offending party. This needs to be addressed.

The investigative nature of the coroner's court is such that it is not appropriate for coroner's to use the same sanctions as are available to a judge or master e.g. Unless Orders, and precluding a party from relying on evidence unless it is exchanged on time. Perhaps the power to fine for delay or omission which occurs without good reason would be one solution. Such a power would also enable a coroner to effectively case manage an inquest and this in turn could limit the delay experienced by families, and also identify a time frame

for when the inquest might be heard.

Parties should not be precluded from making a request but if this is made following the pre inquest review it should be open to all parties to make representations as to whether a second pre inquest review is necessary. For short requests pre inquest reviews could be dealt with by telephone in much the same way as case management conferences are in the civil courts.

Question 24. What do you expect the level of take-up to be of the Charter for the Bereaved's provision for information to be disclosed to bereaved people, free of charge? How would it compare to current requests?

Comments: We would expect it to be higher given the production of a new MOJ leaflet on the Inquest process and provision of public education through organisations like AvMA, British Legion, Mencap, Mind etc

Question 25. Are there any circumstances where bereaved people should pay for disclosure of material?

Comments: We do not accept that charges should be made but if any charge is to be made it must be capped as in the case of requests for medical records (ie a flat fee of £50 with the fee waived for those unrepresented or on a low income). However provision must be made swiftly and within one working week to keep the Inquest process moving swiftly forwards and to reduce the risk of families waiting an unreasonable length of time for an inquest.

Question 26. What would the impact be on coroners and their staff of disclosing information free of charge, to bereaved people and possibly to other interested persons? What would the costs be and how would those costs be comprised?

Comments: There has been evidence that the burden of providing records to patients has been heavy on the NHS. We are concerned that this could create a similarly heavy burden on the coroners' service if they do not get provided with suitable office equipment. We have been told by some officers that they do not have access to a photocopier, or they do not have access to facilities to produce large volume copying. However we would envisage that by providing adequate office facilities to the coroners service this problem could be erased and the provision of documents should be dealt with. We would also point out that the current situation whereby documents are not provided to families consistently causes increased costs and distress to the families who often only discover there are these documents available after going to lawyers. It hinders the coroner's investigations and is not transparent.

Question 27. We do not propose that interested persons should have all disclosable material provided to them automatically, or that if one interested person requests disclosure it should be automatically sent to all others. We propose instead that they should be made aware that they are entitled to request the information. It will be a matter for them as to whether they make the request, including in relation to assisting with an appeal application. Do you agree with this approach? If not, please suggest an alternative.

Comments: All parties should be able to access the same documents and they should all be notified at the outset of what documents are available. However we are concerned that a family without legal representation or advice from a specialist advice service may not understand what documents they require and will not request documents at the key time or at all. We believe therefore that automatic disclosure should be made to the families, who do not have the benefit of in-house legal teams and resources to pay for legal advice as do Trusts, Businesses, and government bodies, and who will most likely already hold many of the documents that the Coroner will be disclosing to the families.

An initial failure to request the documents should not prevent them from requesting them later on.

Question 28. What level of requests for information from other interested persons would you expect to see, and why?
Comments: We envisage the families being the most important and primary party requesting documents as it is likely that any other interested parties will be privy to many documents already and may be the author of some of them. For instance Trusts that produce a Serious Untoward Incident report (SUI) can provide that to the Coroner but the family will not automatically get a copy unless the coroner provides it. That document will contain an investigation and analysis of the events leading to the deceased's death and the family and other interested parties should be privy to it.

Question 29. How common is charging for disclosure in practice at present? Should we specify the circumstances in which a coroner can charge?
Comments: It is not common in our experience. We do not accept that charges should be made.

Question 30. What levels of fees should be payable?
Comments: We refer to our replies above

Question 31. To whom should the fee be paid? If paid to a coroner's office, should the fee be passed on to the relevant local authority?
Comments: We refer to our replies above

Question 32. Once an investigation is completed, should we specify a time limit for obligation for requests to a coroner to disclose information – e.g. 6 months/a year after the conclusion of the investigation – so that, after a certain period, a coroner will have discretion to refuse a request for information?
Comments: We see no good reason for a time limit to be imposed. Many families do not appreciate at the time of inquest that there were questions about the circumstances of death and often find after the event they still have questions to ask. In lieu of reopening the inquest allowing them further access to records without time limit allows them to come to terms with the death, to formulate in their minds the questions they have and to review the documentation which may in fact answer those questions. Automatic disclosure would of course allow a time limit to be imposed and obviate the unwanted costs of holding documents indefinitely.

Question 33. Should a formal requirement for the opening of an inquest be retained?
Comments: No as it often confuses families and adds unnecessary bureaucracy to the family. It exacerbates their distress having to attend a 2 minute opening of the Inquest and would be better dealt with by advising them in writing of the opening of the Inquest and provision of documentation.

Question 34. Should there be a formal requirement for an inquest, when relevant, to be held as soon as possible after the death?
Comments: Yes so long as inquests are not driven through at speed to meet targets before investigations are properly concluded. We have seen a number of inquests where the coroner has proceeded with an inquest hearing despite knowing that a Trust has not yet concluded its SUI, for instance, or where a Child Death Review is pending. To hold an inquest where relevant inquiries are being held concurrently and not to await the outcome of those highly relevant inquiries will inevitably lead to coroners reaching erroneous conclusions as to causes of death. If full pre inquest disclosure is given and the coroner makes good use of the PIR coupled with having power to impose financial penalties as a remedy for parties delaying in disclosing or delivering up documents then inquests can be time managed. Given the duty for Coroner's to investigate the circumstances of a person's death it may not be possible to carry out an inquest immediately after a person's death. We suggest the inclusion of a provision that coroners must refer to the Chief Coroner if a case is more than 12 months old.

Question 35. Should the procedures for summoning witnesses be put on a more formal footing, in similar terms to those regarding the summoning of jurors, for example?
Comments: This should be put on a formal footing as far to often we have had experience of witnesses treating requests to attend Inquests with a lack of respect to the families and other parties involved, on one occasion a key witness refusing to attend over 4 different dates set for the hearing. A formal procedure leaves all parties in no doubt of the requirement for them to attend if the Coroner so requests.

Question 36.	Should the circumstances when vulnerable or potentially vulnerable witnesses are to be granted special measures while giving evidence be put on a formal basis?
Comments:	Yes, to ensure all parties are clear about procedures – it is not acceptable to allow the coroner unfettered discretion to determine who is vulnerable and entitled to anonymity as it may lead to unfair decisions and allow key witnesses to be shielded from giving evidence in a transparent manner. If anonymity is granted the witnesses must be clearly heard by all interested parties and the Jury and only the general public excluded. To extend anonymity in an Inquest where no blame can be adjudged to any witness, or criminal liability is grossly unfair and will hinder the Coroner's investigations in pursuit of compliance with the Human Rights Act.

Question 37.	In what circumstances do consultees think coroners should exercise powers to withhold names or other matters?
Comments:	see our answer to 36

Question 38.	Should there be a formal basis for coroners to accept unsworn evidence at inquests?
Comments:	No – all evidence should be given under Oath or Affirmation as it currently is.

Question 39. Should the position on admissibility of documentary evidence be extended or clarified?
Comments: Yes, this is a complex area. Many coroners are fettered in the scope of their investigations by institutions arguing documents should not be disclosed and by their lack of legal knowledge about the admissibility of evidence. Coroner's court rules provide virtually no guidance about the admissibility of evidence and we think it essential that a civil code of admissibility of evidence is devised as soon as possible. The current situation is not conducive to transparent processes and increases costs of the proceedings unnecessarily as often the only recourse to an arbitrary decision by a coroner that a document is not admissible is Judicial Review. Consideration should also be given to documentation compiled by the police in the furtherance of their investigations. We currently have two cases where police investigations are underway. The nature of their investigations is not clear, although one is almost certainly in relation to gross negligence manslaughter but we haven't seen any statements taken by treating clinicians or reports obtained from independent medics, if any exist. We also do not know if any independent experts have been instructed by the police, although we assume that they will require independent medical expert evidence in order to establish what the acceptable standards of medical care are, and from that determine whether the standards falls so low as to be considered gross negligence. Clearly their investigations are covering key issues that the family should be aware of, and the coroner and failure to disclose to the Coroner will lead time and again to erroneous verdicts.

Question 40. Is there an argument for retaining or reducing the requirement for documents to be kept for 15 years, as is the case at present – particularly in view of the new appeal arrangements against coroners' decisions which the Act establishes?
Comments: No, none whatsoever. However we do consider that documents should not be retained beyond the period for appeal as the costs of storage could be better put to providing increased facilities to the Coroner's Service. However prior to destructions all interested parties should be given a minimum period 3 months to advise if they wish to obtain copies of the documents.

Question 41. Should a new list of short form determinations be established; and if so, what should the categories be?
Comments: Firstly we agree a new list should be established. the existing formulations are outmoded and reflect a society with different values than our current one and do not reflect the huge advances in medical science that have altered the treatment options and potential outcomes, nor the availability of advance forensic scientific methods to investigate causes of death. We have taken note of Mr Burgess's suggested list of short form verdicts. We would wish to see added to those some that reflect circumstances arsing from death following medical treatment. For instance, • Died from injuries following a delay in diagnosis, • died from injuries resulting from surgical error • died from injuries received in the course of a violent act • died from injuries received in the course of labour • died from injuries caused by a failure to administer appropriate treatment to those detained in custody, in a mental health institution or as an inpatient due to ill heath and a need for treatment.

Question 42. Should coroners be required to return a narrative determination in any case where they are unable to attribute one of these determinations?
Comments: Yes, in any event a narrative verdict is highly informative to families and to other interested parties and aids those interested parties in identifying what actions may be taken to prevent similar deaths in the future. The coroner's service must work towards reducing deaths in custody, and of patients, and cannot do so if there is no attempt to provide a detailed analysis of the cause of death and how a similar death may be avoided in the future. However we are also concerned that the narrative verdict can be used as an excuse to do little more than recite the deceased’s name, when they died etc. If as we agree narrative verdicts are retained there should be guidance as to what should be put into the verdict.

Question 43. Should the rules contain something on the availability and use of narrative determinations, and if so, what?
Comments: No, a narrative verdict arises in the circumstances where death does not fit an existing short form verdict. Altering and expanding the range of short form verdicts will make it easier for Coroners to give an appropriate short form verdict. However we do believe that short form verdicts with no explanation of how they are arrived at are harsh on families and other interested parties, and they should always be supported by a narrative explanation.

Question 44. We would welcome comments from respondents on any of the issues contained within the Coroners Rules 1984 that are likely, in substance, to be replicated in the new rules.
Comments: Save where our responses elsewhere in this consultation touch on the issues contained in the Coroners rules 1984 we have no further comment to make

Question 45. Are there any other areas where respondents suggest the Chief Coroner may consider issuing guidance in relation to the administration and conduct of inquests?
Comments: Location of hearing, who may be called, We recommend guidelines on the circumstances when a second inquest should (as opposed to might) be called – currently the subject of a fiat by the Attorney General or Judicial Review for a second inquest.

Question 46. Do you agree that the person who wishes to appeal must complete a notice of appeal in order for the Chief Coroner to consider the appeal?
Comments: Yes so long as assistance is provided to them to complete it, for instance by providing specific funding to a national advocacy group to provide advice at a set cost to prepare the appeal notice. Lay people are the most likely to appeal and are not trained or equipped to undertake that procedure without specialist assistance.

Question 47. Do you agree that the notice of appeal should include a declaration that an attempt has been made to resolve the matter informally directly with the coroner of his office. If so, should this also apply where an appeal is about a post-mortem and therefore must be made within a very short timescale?
Comments: No. This gives individual coroners and officers who hold particular views an opportunity to delay an appeal and prolongs a family's agony in trying to ascertain the cause of their loved one's death. Our experience of the complaint procedure in the NHS is that it consistently delays resolution of claims. In the interests of all parties if there is to be an appeal it should be able to proceed swiftly without requiring the appellant to go through other administrative processes, especially as most appellants will, we envisage, be families. Excess procedure deters them from utilising the process. This defeats the object of the Charter which aims to bring families into the process not exclude them further.

Question 48. Do you agree that the Chief Coroner may disregard an appeal if he or she decides the appeal is vexatious or frivolous, and must document his or her reasons for doing so?
Comments: No, this must be dealt with in a hearing. An appeal should be a right, not something allowed at the discretion of one individual for public interest reasons.

Question 49. Do you agree that the Chief Coroner will determine the method of considering the appeal – i.e. whether there should be a paper or oral hearing?
Comments: There should be an opportunity for the appellant to challenge the method of determination.

Question 50. Do you agree the proposed timescales set out for lodging appeals and for the Chief Coroner to rule on appeals?
Comments: 15 working days is too short a period to allow for an appeal against a final decision. The most likely appellant will be the family. They will be distressed and unable to make clear decisions in the aftermath of distressing and painful hearing. A time period of at least 6 months should be allowed. However, where the appeal may be against an interlocutory decision during the lifetime of the inquest, the time period should be 30 days.

Question 51. Do you agree with the content of the tables for training of coroners, their officers and staff? Is there anything missing?
Comments: In principle we agree. However a key area is not covered and that is dealing with inquests following medical treatment. Many inquests are heard without obtaining medical records. Many coroners we feel are untrained in interpreting records and therefore place excessive reliance on those involved in the deceased's medical care and therefore potentially biased medical witnesses for interpretation. We are an organisation that specialises in delivering medical and legal training to doctors and lawyers involved in medical law in a range of arenas (e.g. civil claims, HRA cases, complaints, delivery if improved safety outcomes) and propose that we provide training in medical legal issues to experts. An example of some of our training courses is attached. On legal issues we would recommend that coroners (and possibly their officers) receive training on disclosure. We also recommend bereavement training for coroners and all their members of staff

Question 52. Should only some training be compulsory – if so what – e.g. induction training? Why?
Comments: We believe there should be a compulsory training programme throughout in order to achieve consistency of performance amongst or coroners.

Question 53. If compulsory, or part compulsory, should training have to happen before a coroner / officer / staff can operate, or within a certain period of their beginning – say 3 or 6 months? Or should only particular duties be exempt until training is received?
Comments: Training for coroners should be consistent with the Judiciary generally. After appointment they should undergo training before they take up their posts. This training requirement applied to all newly appointed judges regardless of previous experience or qualifications. In addition they should have an ongoing training programme similar to that of the judiciary

Question 54. Should trainees have to complete a certain number of training days per year, or certain modules? What should the requirement be?
Comments: Yes. A training programme similar to that of the judiciary

Question 55. If training is compulsory, what might be effective sanctions to ensure completion?
Comments: Coroners should be prevented from sitting until training is complete

Question 56. What should happen if training is compulsory and someone cannot complete it – because of work commitments, illness, or lack of authorisation from managers?
Comments: There should be discretion; the applicant may have a reasonable excuse for not doing it as soon as possible, eg long period of sickness or maternity leave. If an applicant is absent from the job for 1 year then they should have to undergo a refresher course.

Question 57. Assuming full induction has been received, should the minimum number of training days be the same for each category of person to be trained?
Comments: No, only coroners need updates in the law and refreshers.

Question 58. Who do you think would be best placed to deliver training and why?
Comments: The Judicial Studies Board with involvement from patient groups such as AvMA and HRA groups or experts

Question 59. Should the Chief Coroner approve a provider before they can train coroners, coroner's officers and support staff?
Comments: Yes

Question 60. Should there be a mix of providers, depending on the event?
Comments: Yes

Question 61. Should training provide Continuing Professional Development (CPD) credit for coroners?
Comments: No Coroner's should be on the same footing as the judiciary. Refresher courses should be sufficient

Question 62. Should there be training courses – possibly residential – for induction courses for coroners and officers; and continuing professional development training?
Comments: Yes for Coroners. No for Coroner's officers etc, they are not administering justice or making findings

Question 63. Should there be on site locally delivered training – for local issues?
Comments: This seems sensible, particularly for Coroners' staff and may work in a similar way to the court user groups.

Question 64. Should there be E-learning – for refresher training; updates on developments / changes; and information which it is useful to have permanently available to refer to?
Comments: Not exclusively. Coroners need to learn in a collegiate atmosphere and make contacts as other lawyers do. Group learning makes it easier to ensure that all attendees are aware of the standard expected of them. E- learning is too remote generally for what is already a fairly isolated position but may be suitable for certain aspects of the work such as studying new legislation.

Question 65. Should some types of training event be open to a mixed audience – e.g. coroners, their officers and other staff, medical examiners, medical examiner officers, local authority staff? If so, which?
Comments: Yes, particularly on collecting in evidence, dealing with family grief, and compiling witness evidence.

Question 66. Should coroners be expected to devise an initial induction package locally for new area and assistant coroners, and / or for coroners' officers and staff, based on a central template provided by the Chief Coroner's office? Or do coroners believe this is not part of their role given that they do not have direct management responsibility for any of these groups?
Comments: Coroner's will not have the time to manage this sort of thing which can only lead to variation in the standards of training employed and a lack of consistency. There are already difficulties with inconsistent standards and procedures (such as on disclosure) across the country this needs to be tackled as a matter of priority. The training needs to be centralised.

Question 67.	Are there any other issues the Chief Coroner should consider in drawing up training regulations?
Comments:	We have no suggestions

Question 68.	Should an equivalent short death certificate be issued by a registrar of births and deaths free of charge for each death registered in England and Wales? Please include the reasons for your views.
Comments:	We do not see why this is considered necessary

Question 69.	Should a short certificate omit any information about the occupation and other details of the person who has died, and the person who has authorised registration of the death?
Comments:	No this could cause unnecessary upset to a family and what does it gain?

Please complete the section overleaf to tell us more about you.

About you

Please use this section to tell us about yourself

Full name	Catherine Hopkins
Job title or capacity in which you are responding (e.g. member of the public etc.)	Legal Director Action against Medical Accidents Head of AvMA's inquest project
Date	30 June 2010
Company name/organisation (if applicable):	Action Against Medical Accidents
Address	44 High Street
	Croydon
Postcode	CR0 1YB DX 144267 Croydon 24
If you would like us to acknowledge receipt of your response, please tick this box	X☐
Address to which the acknowledgement should be sent, if different from above	

Deleted: ly

If you are a representative of a group, please tell us the name of the group and give a summary of the people or organisations that you represent.

AvMA is a UK wide charity that campaigns for patient safety and justice

We have recently set up a project to provide free representation at inquests for families of people who have died during medical treatment in nursing homes of similar residential settings

We attach further information of our project (with the hard copy only)