Coronial Reform

The Ministry of Justice will deliver a reformed coroner service by implementing Part 1 of the Coroners and Justice Act 2009 (excluding sections 19 to 21 which deal with death certification on which the Department of Health will lead).

Proposed timetable

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>Early/Mid 2010</td>
<td>Appointment of Chief Coroner [delayed until ?]</td>
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<tr>
<td>July 2010</td>
<td>MOJ policy consultation on the Act's secondary legislation</td>
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<tr>
<td>Late 2010</td>
<td>MOJ drafts secondary legislation [delayed until ?]</td>
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<tr>
<td>Early/Mid 2011</td>
<td>Consultation on draft secondary legislation [delayed until ?]</td>
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<tr>
<td>Late 2011</td>
<td>Finalise secondary legislation [delayed until ?]</td>
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<tr>
<td>April 2012</td>
<td>Launch new coroner service</td>
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<td>(except for appeals system which will be a year later) [delayed until ?]</td>
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Before we look at the proposed reforms, a brief summary of the current regime will enable us to see how the Act will achieve its aims of a better and more open coroners' system.

Summary of the current coroner system

Every death in England & Wales must be certified by a doctor or investigated by a coroner before it can be registered by a registrar.

Coroners investigate deaths that are violent, unnatural or where the cause of death is unknown. All deaths in prison and police custody are referred to the coroner.

The purpose of the coroner’s investigation (see rule 36 Coroners Rules 1984) is to establish the following:

- who the deceased was
• how, when and where the deceased came by his death
• the particulars for the time being required by the Registration Act to be registered concerning the death and
• neither the coroner nor the jury shall express any opinion on any other matter

The coroner may order a post mortem examination carried out by a pathologist. In a significant proportion of cases the post mortem reveals a natural cause of death and the investigation can be concluded.

In the remaining cases, the coroner opens an inquest (a public hearing) to establish the cause and circumstances of death.

In 2008, 47% of all registered deaths in England & Wales were reported to the coroner. Of these, 46% involved post mortem examinations and in 13% an inquest was held.

Reported deaths to coroners have increased since the Shipman murders and in light of an increase in use of deputising services by GPs. This means a lot of deaths can not be certified by a doctor immediately (because they have not seen the deceased within a certain time frame) and which are therefore reported to the coroner.

History of the current Reforms

Since the mid 1990s concerns have been raised about the effectiveness of the coronial system. Major disasters such as Hillsborough, Zeebrugge and the Marchioness brought the Coroners Court into the spotlight. Further concerns about how the service operates became headline news with the cases involving unauthorised removal and retention of body parts from post mortem examinations (the Alder Hey and Bristol Hospitals) particularly as this was largely without the coroner's knowledge.

Coronial law has been developing in light of the European Convention of Human Rights (ECHR) as inquests are increasingly the method by which the State can meet
its obligations under Article 2 of the ECHR to conduct an inquiry into the full circumstances of the death. This is usually invoked where the death has occurred in a police shooting or whilst in custody or where a state agent is implicated. Often these inquests are high profile, can be complex and are held with a jury.

In 2003, the Shipman Inquiry examined the coroner system (Lady Justice Smith's 3rd report) as did Tom Luce's Fundamental Review of Death Certification and Investigation (2003). Both reports concluded that the service was:

- fragmented
- variable in quality and consistency
- ineffective in part
- very much dependent on those working within it

The reports highlighted deficiencies in the system as follows:

- insufficient involvement of family and friends in the coroner's investigation
- absence of quality controls and independent safeguards
- inconsistent levels of service
- lack of consistency, leadership or training by or for coroners
- an absence of medical knowledge

The Select Committee on Constitutional Affairs published a report on “Reform of the coroners' system and death certification: Eighth Report of Session 2005-6” urging an overhaul of the system.

**The Coroners and Justice Act 2009**

The Act received Royal Assent on 12 November 2009 and includes measures to:

- reform and clarify the law on homicide, in particular to the partial defences
update the language of the offence of assisting suicide
establish a new Sentencing Council for England and Wales, with a strengthened remit to promote consistency in sentencing practice
create a new national coroner service, led by a new chief coroner
create a new system of secondary certification of deaths that are not referred to the coroner, covering burials and cremations
enable the courts to pass an indeterminate sentence for public protection for certain terrorist offences
prevent criminals from profiting from publications about their crimes
amend the Data Protection Act to strengthen the Information Commissioner's inspection powers
re-enact the provisions of the emergency Criminal Evidence (Witness Anonymity) Act 2008 so that the courts may continue to grant anonymity to vulnerable or intimidated witnesses where this is consistent with a defendant's right to a fair trial
allow the courts to grant Investigative Witness Anonymity Orders in certain gun and knife crime cases
extend the use of special measures in criminal proceedings, such as live video links and screens around the witness box, so vulnerable and intimidated witnesses give their best evidence

The most controversial aspect of the bill are the provisions regarding secret inquests where a judicial inquiry under the Inquiries Act 2005 will take place. The provisions had previously been mulled as part of the Counter-Terrorism Act 2008, though ultimately they were dropped before the Counter-Terrorism Bill was finalised. Last minute concessions as the Coroners and Justice Bill passed through parliament included giving the Lord Chief Justice the power to veto any requests for private inquests and also the power to decide who the judge will be.

A copy of the Act can be downloaded in pdf form at:

Section 47 of the Act, which came into force with immediate effect, introduces a statutory definition of an "interested person". The definition is slightly wider than the
The other changes to coronial law introduced by the Act are not yet in force. They will come into force on dates to be notified by orders made by the Lord Chancellor and the Secretary of State.

What is the aim of Coronial Reform?

With these criticisms of the coroners system in mind, the Coroner's and Justice Act 2009 aims to:

- **Introduce National Leadership to the service**

The Lord Chief Justice will appoint a High Court or Circuit Judge after consultation with the Lord Chancellor. There will also be Deputy Chief Coroners who may be either High Court or Circuit judges or senior coroners.

They will be supported by a team of administrators. It has not yet been decided where the office will be based. (unlikely to be Sutton Coldfield Town Hall!).

The Act replaces terms “coroner”, “deputy coroner” and “assistant deputy coroner” with “senior coroner”, “area coroner” and “assistant coroner”

Other changes in terminology – verdicts will be determinations about the factual matters they are required to decide

The Chief Coroner's role will be a combination of leadership and judicial function.

Leadership role:
• Setting national service standards
• Issuing guidance and practice directions
• Monitoring performance, especially delayed investigations
• Developing an induction and on-going training programmes for coroners
• Making regulations about the training of coroners' officers and staff
• Dealing with non-judicial complaints against coroners
• Providing an annual report to parliament
• Liaising and working with local authorities, police and stakeholders

Judicial functions:

• Hearing appeals against coroners' decisions
• Monitoring coroner workloads across England & Wales
• Transferring investigations from one coroner to another where appropriate to ensure best use of expertise and resources and to avoid delays.

“We know that many of you are awaiting with keen interest, the announcement of the appointment of the first Chief Coroner for England and Wales. The new Lord Chancellor and Secretary of State for Justice has considered this and in light of the financial challenge facing Government as a whole, has asked that no announcement be made at this time. He has also asked that my team review the scope and timing of the plans to implement the coroner measures contained in Part One of the Coroners and Justice Act 2009, and to provide further advice to him and to the Minister responsible for coroner reform, Jonathan Djanogly MP.” Deputy Director responsible for Coroners, Burials and Legal Service Regulation and Redress 21st May 2010

Are the reforms likely to be subject to much more modification?

When will they be implemented?

Is there any money to fund these reforms?
• **Deliver an improved service for bereaved people**

A new Charter for Bereaved People setting out what sort of information and services bereaved people, coming into contact with the coroner system, can expect to receive enabling them to better participate in coroner's investigations. This will also include rights of appeal against certain decisions made by the Coroner. The Ministry of Justice expects to consult on the Charter for the final time during 2011. Bereaved people can expect a more consistent and improved service with the issuing of national guidance and practice directions by the Chief Coroner.

The Charter will set out the standard of service that bereaved people can expect from a reformed system including:

- the right to report a death to the coroner
- progress reports from the coroner's office
- what to expect from a coroner's investigations
- rights to participation
- rights of appeal and complaints
- responsibilities of family members

• **Clarity of purpose and outcome of coroners' investigations, including inquests**

The Act clarifies the purpose of investigations, including inquests and defines which deaths should be investigated, which cases should be held with juries (likely to increase slightly to just over 2%) of all inquests and that coroners may not determine any matters of criminal or civil liability. (r36 and existing law?)

The Act sets out that coroners conduct *investigations*. It recognises that there are 4 main stages in an investigation and that particular cases may be discontinued after any of these stages:
i. A coroner decides whether the death is one in which he or she should investigated;

ii. if so, a coroner decided whether a post mortem examination is required or if not, that the death may be registered on the basis of medical or other information that has been received;

iii. if a post mortem examination has taken place, the coroner decided whether the death can be registered and the case discontinued, or whether the case should go on to an inquest;

iv. An inquest is held.

The duty to investigate is set out in Part 1, Chapter 1 of the Act:

1 Duty to investigate certain deaths England & Wales

(1) A senior coroner who is made aware that the body of a deceased person is within that coroner's area must as soon as practicable conduct an investigation into the person’s death if subsection (2) applies.

(2) This subsection applies if the coroner has reason to suspect that—

(a) the deceased died a violent or unnatural death,

(b) the cause of death is unknown, or

(c) the deceased died while in custody or otherwise in state detention.

(3) Subsection (1) is subject to sections 2 to 4.

(4) A senior coroner who has reason to believe that—

(a) a death has occurred in or near the coroner's area,

(b) the circumstances of the death are such that there should be an investigation into it, and

(c) the duty to conduct an investigation into the death under subsection (1) does not arise because of the destruction, loss or absence of the body, may report the matter to the Chief Coroner.
(5) On receiving a report under subsection (4) the Chief Coroner may direct a senior coroner (who does not have to be the one who made the report) to conduct an investigation into the death.

(6) The coroner to whom a direction is given under subsection (5) must conduct an investigation into the death as soon as practicable.

Under the old regime, the coroner's jurisdiction and decision to inquire arose under s.8(1) of the Coroners Act 1988 where:

- the body is lying within the coroner's district; and
- there is reasonable cause to suspect that either
  - the death was violent or unnatural or
  - was a sudden death of unknown cause or
  - the death occurred in a prison

Section 1(2)(c) of the Act widens the circumstances of where death may have occurred to include custody and state detention other than just prison alone. This will include places of detention such as secure accommodation for young offenders, immigration detention cells, any form of police custody (e.g. the deceased was under arrest anywhere), hospitals where detention is pursuant to the Mental Health Act 1983, court cells, cells at a tribunal hearing, military detention and detention in transportation between 2 institutions.

Currently, if the initial information suggests that one of the above criteria might be met then the coroner must enquire further on much the same lines as the procedure for “investigations”. However, under the new Act, there are additional powers to obtain evidence and access to medical advice which aim to ensure more effective inquests.
Purpose of investigation

This is set out in Part 1, Chapter 1, section 5 which now specifically sets out the requirements under the ECHR to ascertain *where appropriate* in what circumstances the deceased came by his death. The numerous cases which have considered the scope of an inquest in the context of the State's obligations under Article 2 of the ECHR are likely to remain good law so it is not clear at present as to what additional impact this provision is likely to have. The obligation of the coroners court to pay due regard to the ECHR is well established in UK domestic law. The relevant section in the new Act states as follows:

5 Matters to be ascertained

(1) The purpose of an investigation under this Part into a person's death is to ascertain—

(a) who the deceased was;

(b) how, when and where the deceased came by his or her death;

(c) the particulars (if any) required by the 1953 Act to be registered concerning the death.

(2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c. 42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.

(3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than—

(a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
“Short form verdicts” and “narrative verdicts”

The 2009 Act abolishes references to “inquisitions” and “verdicts” (adversarial) which will be replaced by “determinations” made by the coroner and “findings” in respect of matters which need to be ascertained.

Short term verdicts

The most common “short term verdicts” available to corners and juries are:

- natural causes
- accidental death
- misadventure
- suicide
- industrial disease
- dependence on drugs
- non dependent abuse of drugs
- stillbirth
- want of attention at birth
- lawful killing
- unlawful killing

In addition, the options of “open verdicts” and “narrative verdicts” are also currently available.

This can lead to inconsistencies and misunderstanding. At the moment the issue is subject to consultation and there is a debate as to whether a pro-forma for
determinations should be included in the new rules including a list of categories of
death and if so, what those categories should be.

The list of categories and pro-forma are currently undecided and awaiting response
to consultation but Michael Burgess OBE (Coroner for Surrey & the Queen's
Household) has suggested a number of other short form verdicts as follows:

- died from unforeseen complication of a necessary therapeutic procedure
- died from an overdose of drugs either self administered or administered by
another
- died from injuries received in the course of a road traffic accident
- died from trauma following an un witnessed fall
- died from trauma consistent with or following a fall whilst suffering from severe
natural disease
- dies from self-inflicted injuries but the intention of the deceased was unclear

The question posed is, should coroners be required to return a narrative
determination in any case where they are unable to attribute one of these
determinations? This would mean an end to “open” verdicts, currently returned in
about 7% of inquests each year and which families find profoundly unsatisfactory in
reflecting the cause of death.

**Narrative verdicts**

As can be seen problems in the existing short term verdicts have led towards a
greater use of narrative verdicts which are returned in approximately 10% of cases.

In cases which engage Article 2 of the ECHR following on from *R v HM Coroner for
the Western District of Somerset ex parte Middleton [2004] UKHL 10*, coroners have
more options open to them including a narrative determination if that would better describe the circumstances of the death. Under the new regime, it is anticipated that the Chief Coroner may consider issuing guidance on the circumstances in which a narrative determination would be considered appropriate.

- **Implement a new effective death certification system – more effective investigations and inquests**

Currently there is no statutory duty on doctors to refer deaths to a coroner. At present the only specific duty falls on registrars pursuant to the Birth and Death Regulations 1987, prison governors to report the death of an inmate and on the commanding officer or commandant to report the death of a person in the UK in naval quarters or in the army, or air force establishment.

In practice the majority of deaths are referred to coroners by attending doctors or police – some general “broad brush” guidance for doctors exists. Generally the doctor will have had to have seen the deceased after death or within 14 days before death if reference to the coroner is to be avoided.

A new death certification system will run parallel with the Act to ensure appropriate deaths are reported to the coroner – currently the system is overloaded due to over reporting which can cause unnecessary anxiety to families. But watch out all you Dr Shipmans....all deaths which do not go to the coroner will be considered instead by the new medical examiners, so if they take a different view from the certifying doctor, there is the safety net of referral to the coroner at a later stage.

*Key Points*

- When someone dies, the default position will be for an attending practitioner (s20(1)) to review the information provided by the person who verified the death together with the deceased's medical records etc and to complete a medical certificate of cause of death (MCCD).

- A medical examiner (a new post) will scrutinise the MCCD. This will entail a
The medical examiner will also have access to existing clinical governance data. If they are content, the medical examiner will confirm the cause of death on the MCCD and the death can be registered.

In certain cases, deaths will be reported to a senior coroner rather than being dealt with by an attending practitioner and medical examiner, in the following situations *(the Act defines “attending practitioner” as a registered medical practitioner who attended the deceased before his or her death”)*:

- attending practitioner reports death to senior coroner (in discussion with the medical examiner)
- attending practitioner completes the MCCD but after scrutiny the medical examiner refers death to senior coroner
- no attending practitioner or the doctor who attended deceased before he died is not available within a specific period of time and so another medical practitioner refers the death to a senior coroner
- the police or other person reports the death directly to a senior coroner
- The senior coroner will carry out an initial assessment based on the information and provided by the police or medical practitioner. If the coroner decides that there is no need for coroner investigation, s/he will refer the case to the medical examiner.
- If the coroner retains the case, s/he will open an investigation into the death and certify the cause of death based on information obtained by a post mortem and possibly an inquest.
• Section 18 of the 2009 Act gives the Lord Chancellor a power to make regulations requiring a registered medical practitioner, in prescribed cases or circumstances, to notify a senior coroner of death of which the practitioner is aware. The purpose of these new regulations and the guidance (yet to be produced) is to specify the cases or circumstances in which death must be referred to a senior coroner and to ensure consistency across England and Wales.

• Following consultation and feedback gathered, the cases and circumstances where it is suggested deaths must be reported (though the guidance is presently awaited) to a senior coroner are where the death may be caused by or related to:

• poisoning
• intentional self-harm
• neglect or failure of care
• a medical procedure or treatment
• an injury or disease in the course of employment or industrial poisoning or
• the death occurred whilst the deceased was in custody or state detention whatever the cause of death
• the cause of death is unknown

• **Improve medical support for coroners**

One function of the new **medical examiners** is to provide general advice to coroners on case by case basis (in the old days – medics could be appointed as coroners – some of you may recall Dick Whittington – not the chap with the cat but the coroner who presided at Birmingham Coroners Court before Mr Aidan Cotter)

The medical examiner's advice may avoid the need for coroner to commission post mortem in some cases.
At a national level there will be a Medical Adviser to the Chief Coroner who will be appointed – one of his/her roles will be to issue guidance and contribute to training on medical matters. This part of the Act will be lead by the Department of Health, not the Ministry of Justice. The relevant provisions are:

Part 1, Chapter 1,

19 Medical examiners England & Wales

(1) Primary Care Trusts (in England) and Local Health Boards (in Wales) must appoint persons as medical examiners to discharge the functions conferred on medical examiners by or under this Chapter.

(2) Each Trust or Board must—

(a) appoint enough medical examiners, and make available enough funds and other resources, to enable those functions to be discharged in its area;

(b) monitor the performance of medical examiners appointed by the Trust or Board by reference to any standards or levels of performance that those examiners are expected to attain.

(3) A person may be appointed as a medical examiner only if, at the time of the appointment, he or she—

(a) is a registered medical practitioner and has been throughout the previous 5 years, and

(b) practises as such or has done within the previous 5 years.

(4) The appropriate Minister may by regulations make—

(a) provision about the terms of appointment of medical examiners and about termination of appointment;

(b) provision for the payment to medical examiners of remuneration, expenses,
fees, compensation for termination of appointment, pensions, allowances or gratuities;

(c) provision as to training—

(i) to be undertaken as a precondition for appointment as a medical examiner;

(ii) to be undertaken by medical examiners;

(d) provision about the procedure to be followed in connection with the exercise of functions by medical examiners;

(e) provision conferring functions on medical examiners;

(f) provision for functions of medical examiners to be exercised, during a period of emergency, by persons not meeting the criteria in subsection (3).

(5) Nothing in this section, or in regulations under this section, gives a Primary Care Trust or a Local Health Board any role in relation to the way in which medical examiners exercise their professional judgment as medical practitioners.

With the anticipated dissolution of Primary Care Trusts, it is likely that the appointment of medical examiners will be undertaken by the independent NHS Commissioning Board or similar body.

The appointment of a National Medical Examiner is covered by Part 1, Chapter 1, section 21:

21 National Medical Examiner England & Wales

(1) The Secretary of State may appoint a person as National Medical Examiner.

(2) The National Medical Examiner is to have—

(a) the function of issuing guidance to medical examiners with a view to securing that they carry out their functions in an effective and proportionate manner;

(b) any further functions conferred by regulations made by the Secretary of State.
(3) Before appointing a person as National Medical Examiner or making regulations under subsection (2)(b), the Secretary of State must consult the Welsh Ministers.

(4) A person may be appointed as National Medical Examiner only if, at the time of the appointment, he or she—

(a) is a registered medical practitioner and has been throughout the previous 5 years, and

(b) practises as such or has done within the previous 5 years.

(5) The appointment of a person as National Medical Examiner is to be on whatever terms and conditions the Secretary of State thinks appropriate.

(6) The Secretary of State may pay to the National Medical Examiner—

(a) amounts determined by the Secretary of State by way of remuneration or allowances;

(b) amounts determined by the Secretary of State towards expenses incurred in performing functions as such.

(7) The National Medical Examiner may amend or revoke any guidance issued under subsection (2)(a).

(8) The National Medical Examiner must consult the Welsh Ministers before issuing, amending or revoking any such guidance.

(9) Medical examiners must have regard to any such guidance in carrying out their functions.

The Medical Adviser to the Chief Coroner will provide national leadership on medical issues and will be responsible for:

- Developing national standards and guidelines for coroners on a range of issues including the use of post-mortems and other tests, the release of bodies and organ and tissue retention;
• Representing the Chief Coroner in discussions with organisations such as the British Medical Association (BMA), the General Medical Council (GMC), the Royal College of Pathologists, the Human Tissue Authority and the Department of Health;

• If appropriate, advising the Chief Coroner on medical issues relating to appeals.

• **Relaxation of boundary restrictions**

Geographically based system of “coroner areas” but less rigid restrictions on where post mortems examinations or inquests may be held (both subject to guidance by the Chief Coroner). This allows for more effective investigations and inquests and better allocation of resources.

Power to transfer from one coroner to another by Chief Coroner or by agreement between the coroners concerned. For example deaths of military personnel where the bereaved family live in Scotland or Northern Ireland, the new regime allows for the opportunity for investigation to be transferred to those countries.

• **New Coroner areas and appointment systems**

Current coroner districts vary in size – the aim is to have areas over which one full time coroner will preside with support from part time coroners where required (for example, in large geographical areas). Appointments of coroners, deputy and assistant deputy coroners in the existing regime is opaque especially for deputy and assistant coroners who are appointed directly by coroners.

The new nationally monitored appointment system will lead to greater consistency and transparency in the recruitment process across England and Wales.

• **Powers of Entry, Search and Seizure**

Intended for two main purposes:
• deaths which are reported to coroners where they themselves conduct an investigation
e.g. Hospital death – unknown cause or unnatural
Death from mesothelioma (unnatural because of asbestos exposure)

• deaths which are being or have been investigated by another organisation
e.g. Police, HSE, transport branch, PPO, IPC
Where on receipt of interim information or the organisation's final report, the coroner decides to secure further information in order to fulfil his/her responsibilities.

Under the Coroners Act 1988 and the Coroners Rules 1984, coroners do not have any power to enter and search premises or seize evidence. In most circumstances, the police have a responsibility to make their own assessment and collect evidence.

The Act gives coroners new statutory powers to enter and search land or property and seize items which are relevant to their investigations. This is not intended to extend the number of cases which coroners are responsible directly for investigating or to cut across the roles of other investigators. Other than in very exceptional circumstances, the powers are unlikely to be discharged by the coroner personally in the immediate aftermath of the death being discovered. They are primarily intended for situations where the police have immediately eliminated the possibility of suspicious death but where the information they have provided to the coroner leads him/her to request the police to seize specific items (or direct a coroners officer to do so) if the owner of the material is unable or unwilling to consent to the material being removed;

or

where a coroner has already received an investigator's report and the coroner decided that further evidence is required which could be in the premises where the death occurred or where the body was discovered or premises where the coroner believes there is material relevant to the death.
The exercise of these powers outlined in Schedule 5 of the Act is likely to be scrutinised by both the families of deceased and other interested bodies such as hospitals, etc.

Under paragraph 1 of Schedule 5, the coroner has the power to order disclosure of and production of witness statements.

It is intended that the new procedure for search and entry (permitted under s 43 (3)(h) of the Act will mirror s.15 and 16 of the Police and Criminal Evidence Act 1984 regarding safeguards and execution.

- **Independent inspection and accountability**

There are no current inspection arrangements. HM Inspectors of Court Administration (HMICA) were the appointed inspectors but in December 2009 it was announced that there are plans to abolish the organisation before the reforms take effect!

Apparently “alternative arrangements are under active consideration”.

Coroners continue to be answerable to the Lord Chancellor and the Lord Chief Justice and will be accountable to the Chief Coroner for the operation of the Charter for Bereaved People and other national standards which he or she prescribes.

Future emphasis appears to be towards looking after bereaved families rather than merely exercising a judicial function, so that the ‘softer’ aspects will receive greater attention. It is likely that more attention will focus on how bodies such as Hospital Trusts and their staff respond to requests for information and address problems. It seems inevitable that the risks to an organisation’s reputation will increase.

These changes reflect the trend towards greater scrutiny of public bodies seen elsewhere for example, NHS practice in general, and are likely to lead to an increase in the level and detail of information Trusts and similar bodies are required to provide
to Coroners. Legally trained Coroners whose practices will be regularly audited are likely to conduct more forensically rigorous investigations, and consequently staff and managers giving evidence will be given a tougher time.

Training of staff and managers to respond appropriately to requests for information, giving evidence, and managing appropriate remedial actions will be increasingly important in maintaining (or redeeming) the reputations of their organisations when things go wrong. It is inevitable that things will go wrong from time to time, but how a Trust responds may make all the difference.

- Effective Appeals system

Currently, challenges to coroner decisions are by way of Judicial Review or by Attorney General agreement that the decision should be reconsidered by the High Court.

The new system removes this restricted access for bereaved families. The Chief Coroner or deputy Chief Coroner can consider appeals about decisions set out in section 40 of the Act. The types of decision which can be appealed was decided upon after consultation when the Bill was in its early stages with the aim of ensuring a proportionate balance between the rights of families and other interested persons and to avoid the system being overwhelmed.

Section 40(1) and (2) of the Act allows for an interested person to appeal to the Chief Coroner against the following decisions of a coroner:

- a decision whether to conduct an investigations into a person's death
- a decision whether to discontinue an investigation after post mortem
- a decision whether to resume an investigation which has been suspended
- a decision not to request a post mortem examinations
- a decision to request a second post mortem unless the decision is to request an examination of a different kind from the previous one
- a decision to give a notice about witnesses or evidence for an investigation
• a decision whether there should be a jury
• a decision whether to exercise a power to give a direction excluding certain persons from all or part of the inquest if the coroner determines it is in the interest of national security
• a decision contained in a determination as to the answer to certain questions (who the deceased person was; how, when and where the deceased came by his or her death; and, where relevant, including in what circumstances the deceased came by his or her death)
• a decision contained in a finding as to the particulars required by the Births and Deaths Registration Act 1953 to be registered concerning a death
• A failure to make any of the decisions above

Section 40(5) also allows a person who the coroner has decided is not an interested person in his investigation to appeal against that decision.

It is readily apparent that there is much more accessibility to a streamlined and simpler appeal system for families and interested persons. Many procedural and interim decisions can now be challenged directly to the Chief Coroner who can:

• change the determination of finding within the corner's decision
• quash the determination of finding
• order a fresh investigation
• substitute any other decision that could have been made
• quash the decision and remit the matter for a fresh decision
• where there has been a failure to make a decision the Chief Coroner can make any decision that could have been made or return the matter to the coroner for a decision to be made

An important new development is the power conferred by section 40(8)(d) which permits the Chief Coroner to make any order he or she thinks appropriate, including an order as to costs.

The next level of appeal against a decision of the Chief Coroner following an appeal under s.40 of the Act is to the Court of Appeal on a question of law.
Section 45 of the Act will provide for time limits and regulate appeals practice and procedure.

- **Power to make reports to prevent future deaths.**

At present this power is contained in the *Coroners Rules 1984 rule 43* as amended in July 2008 by *Statutory Instrument 2008 No. 1652*. This has now been moved to the primary legislation in *Paragraph 7 of Schedule 5 to the Act* with the intention that guidance to coroners will lead to greater consistency in its use across England and Wales.

The power to make reports is likely to be used more frequently than the previous rule 43.

In the current coronial system, the use of rule 43 has been recently considered in the *Court of Appeal* (January 11, 2010) *Regina (Lewis) v Coroner for Mid and North Division of Shropshire and Another* Before Lord Justice Sedley, Lord Justice Rimer and Lord Justice Etherton (Judgment December 21, 2009).

The case considered the issue of causation and whether matters which were possibly (rather than probably, i.e. on the balance of probabilities) causally relevant should be left to a jury. The Court held that there was only a power, but not a duty, on a coroner to leave possibly, but not probably causative matters to the jury.

The Court of Appeal so held in a reserved judgment in dismissing an appeal by the applicant, Keith Lewis, against the dismissal by Sir Thayne Forbes ([2009] EWHC 661 (Admin)) of judicial review proceedings brought against the Coroner for Mid and North Shropshire, Dr John Ellery, who had not given any opportunity to the jury to express a view on the action which was taken after the applicant’s son, Karl, was found hanging in his prison cell at Stoke Heath Young Offender Institution (there was significant delay after the deceased was found hanging before he was cut down and given medical attention).
It was held that Rule 43 of the Coroner’s Rules exists to canvas matters which may be risks and which should be addressed by relevant authorities in order to prevent future deaths. Coroners have a wide scope to comment on failures in a system in order to prevent deaths. Failure to report such matters under Rule 43 may amount to a breach of a coroner’s duty but as Rule 43 exists, Article 2 does not impose an additional duty on a jury to consider possible and not probable causes of death.

The coroner in this case had written an extensive Rule 43 letter to the Home Office and to the particular Young Offender’s Institute in which the deceased had been detained at the time of his death, but had not addressed the issue of the role played by the prison officer after the deceased hanged himself.

The Court stated that although Rule 43 does not oblige the coroner to report all matters touched upon at an inquest that give rise to a risk of death, circumstances, particularly in light of the Article 2 obligation, might be such that the failure to report on a systemic failing via a Rule 43 letter constituted a breach of the Article 2 duty. It is likely that, as a consequence of this judgment, coroners will be particularly vigilant to raise all matters in their Rule 43 correspondence revealed in evidence as matters to be addressed in order to prevent the recurrence of similar fatalities. As already noted above, Paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009, means that the coroner will, in future, be under a duty to report any such matters, and the subject of Rule 43 reports will no longer be left to his/her discretion.

- Coroner for Treasure

At a local level, coroners have a duty to investigate treasure finds. Under the new Act, jurisdiction will be given instead to a single Coroner for Treasure. This will enable coroners to (put their metal detectors away) focus on death investigations and enable the Coroner for Treasure to become a national (darling) expert and a source of advice to the very distinct groups interested in treasure investigations.