Implementing the Coroner Reforms in Part 1 of the Coroners and Justice Act 2009

Response of Berrymans Lace Mawer LLP

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About BLM

Berrymans Lace Mawer LLP, blm-law.com is a law firm that provides clear concise advice to a broad range of commercial and insurance clients. Our clients are drawn from across the commercial sector, FTSE-100 companies, the insurance industry, local authorities, the public sector and professionals.

We have nine offices across the UK and Ireland: Birmingham, Bristol, Cardiff, Dublin, Leeds, Liverpool, London, Manchester and Southampton. The firm is approaching 1,400 strong, with 166 partners and more than 700 additional legal professionals.

Introduction

The firm is often instructed to appear at Inquests. In general, those instructions will be to represent and assist employers, motorists and members of the medical professions and others who have been involved in some way in the incident leading to a death. In some instances our instructions are also to represent the family of the deceased.

We support the reform to date and the objective of a transparent, consistent and efficient coroner system.

Responses

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

We anticipate that the overall result of the proposals should be a costs neutral position.

2. Do you have any views on the proposed changes to coroner areas under the 2009 Act, as set out in the table at Annex E? If so, please give details.

We consider that the proposed changes to the coroner areas are sensible (adopts better geographical locations) and should result in a more streamlined coronial jurisdiction.

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.

Yes. Fellows of CILEX who meet the eligibility criteria set out in the Judicial Appointments Order (as amended) i.e. those with a sufficient level of experience and who are working within a relevant area of law, should be considered for coronial appointments.

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

The Guide is a useful introduction for those without advice and representation.

5. The new Guide to coroner services (at annex D) 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.

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We consider that the new Guide is a useful reference point for those involved in a coroner investigation, particularly the family of the deceased. How the Guide is received and interpreted by bereaved families is a question better answered by them. We suggest that some additional explanation might be used in respect of the use of the word “blame” at paragraph 9.1. We are concerned that without further explanation an expectation may be raised that cases may be referred to the police or CPS more routinely than occurs in practice because the distinction between civil and potential criminal liability is not drawn.

Additionally, in its current form (annex D) the Guide is lengthy and we anticipate that bereaved families and particularly those with learning difficulties may be put off by this and not read the document.

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

Other than the point raised in our response to 5 it is our view the new Guide is comprehensive.

7. Should the new coroner’s rules include a target date for completing inquests? If so, what should the target be? Would three months be appropriate? Please give reasons.

No. The time within which an inquest is held is often not in the coroner’s control. Investigations into deaths, particularly those where prosecuting authorities are involved, are not straightforward and it is difficult to predict from the outset how long they will take. We consider that having a target date for completing inquests may encourage some coroners to place arbitrary time limits thus restricting time for the properly interested persons to receive relevant disclosure and complete their investigations.

Only if other bodies such as prosecuting authorities were also subject to time limits would a target date for completing the inquest investigation process be appropriate.

We do however suggest that an aspirational 3 month target date for a Pre-Inquest Review Hearing should be considered in appropriate cases. These may be by telephone conference or in person and will be an opportunity to effectively manage the process and deal with any questions and expectations of the family. If this suggestion is adopted then the 3 month aspirational target date should be mentioned at paragraph 9.4 of the Guide.

If a target date for an Inquest is to be considered, we propose that it should be not less than 12 months from the date of death as in our experience, this timeframe is more likely to be achievable.

However, there are those Jamieson type inquests where the issues and evidence in terms of the Rule 36 (Coroner’s Rules 1984) questions are straightforward and no expert evidence is required. In these circumstances, a target date of 3 or 4 months would be appropriate.

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.

No.

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.

Yes.
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.

Yes.

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.

Yes. However, we consider that a weakness in the current system is the absence of a central register for properly interested persons, and the greater public, to consult to see whether earlier Rule 43 (Coroner’s Rules 1984) recommendations have been made by a coroner and/or complied with by the properly interested person.

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

Yes. The draft regulations are clear and should ensure greater uniformity and more consistent standards in the coroner investigation process.

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.

Yes.

14. Are you content that our proposals on disclosure will help bereaved people and other interested persons to play a more active role in the investigation process (where they choose to do so)?

Yes. However, we consider that the coroner should be required to provide disclosure within a specified time limit from the date the investigation begins, subject to him/her being able to notify interested persons if the time limit cannot be met together with reasons for this. We suggest that 21 days should be sufficient.

We welcome the e-disclosure proposals and agree that this should help reduce the current administrative and financial burdens on the coroner and the coroner’s staff.

Under the new regulations, we note that the coroner will be able to determine the ‘relevance’ of a particular document and disclose redacted copies where he or she considers it appropriate. We consider that it would be useful for the new regulations to set out how a properly interested person would be able to invite a coroner to review his/her decision, and suggest that written representations within say, 14 days of the date of disclosure, or lodged 14 days before the pre-inquest review, would be appropriate. Regulations should also require that a sufficient description of the document should be given together with the reasons why the coroner has decided it is not relevant. This will assist interested parties to make relevant and cogent representations where they then consider it appropriate to do so.

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

No. However, where possible, we would advocate simultaneous rather than sequential disclosure by all the properly interested persons.
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.

Yes. In terms of (b) and (c), evidence via video-link and screened evidence is established practice in criminal, civil and other tribunal cases and we no reason why it should not apply at an inquest.

17. Do you agree with the new rule 25 requirement for a coroner to record inquest proceedings? Should the rules contain sanctions for misuse of recordings? Please give your reasons.

Yes. We consider that recordings, where you can listen to the tenor of the evidence and pick up on nuances and intonation, are far more valuable than a hard copy transcript. Recordings should also avoid allow all the evidence to be heard and avoid the description “inaudible” that often appears in a transcript.

We are not entirely sure what is meant by ‘misuse’ but anticipate that any ‘misuse’ could be dealt with by the coroner under the current rules governing contempt of court.

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.

Yes.

We agree with the addition of the short-form verdict ‘road traffic collisions’ for the reasons set out in consultation document.

We suggest that it would only be appropriate to use the short-form verdict ‘drink/drug related’ where the evidence suggests, on the balance of probabilities, that the primary cause of death was drink/drug related.

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

Yes. What was formerly good practice is being enshrined within the new regulations and should help ensure a more uniform and consistent approach.

20. Would any of the proposed regulations for juror and witnesses allowances lead to increased costs for local authorities?

No as the proposed regulations state that where costs are increased then the current rates will remain. However, we envisage that practical difficulties may arise as to which rate(s) should apply.

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

No.