Coroner's Unit,
Ministry of Justice,
5th Floor, Steel House,
11, Tothill Street,
London SW1H 9LH. 18 February 2008.

Dear Sir,

Re: Proposed Amendments to Rule 43 Coroner's Rules 1984

I have been asked to reply on behalf of the Faculty of Forensic and Legal Medicine to the proposed amendments to "*Rule 43" Coroner's Rules 1984*, and I thank you for this opportunity to respond to the questions you have raised.

Having considered the questions in turn, the response is:

Question 1: Yes

Question 2: The time limit of 56 days seems reasonable. If a definitive response can not be produced in that time (perhaps because the issues are complex or involve considerable expense) then an interim response should be produced. However, the imposition of a duty without a sanction for the breach seems pointless. A financial sanction is unlikely to be practical, and therefore "naming and shaming" and exposure of the organisation would seem to be an appropriate measure.

Question 3 and 4: Whilst the general principle of sharing the report and the response should be adopted, the Coroner should be able to exercise discretion (*may* instead of *must*). There are occasions where it may undesirable or indeed distressing to share a report or response with someone who is anxious to move on with their life and regards the Inquest as closure.

Question 5: Yes

Question 6: This depends on how good and succinct is the original report and response. If some editing is necessary before publication, ~~but~~ the Coroner should approve the text to be published, to ensure that the concerns and issues have been clearly expressed.

Question 7: This must surely be a matter for the Ministry of Justice and not for the Coroner who is an independent judicial officer. However, in many cases, the means of dissemination will be obvious, for example a report to the Chief Medical Officer may result in the matter being raised in one of the regular communications from the CMO to all doctors; a report to the Ministry of Transport may result in a communication to

all Borough Traffic Surveyors; a report to the Railway Accident Investigation Board may generate a communication with various rail operating companies and so on.

Question 8: This matter is best considered by the Coroner's Training Group, who will doubtless cover the matter in training sessions (probably post-induction training).

Question 9: In general, the proposal is overlong as a piece of text, and it would be helpful if the issues could be condensed into a shorter version.

Question 10: It is to be hoped that the proposals may help raise the profile of the Coroner's reports and the responses obtained. However, in many instances that might otherwise demand a *"rule 43 letter"*, the Coroner will have taken steps to alert those in a position to make changes long before the Inquest is heard and indeed evidence may be given at the Inquest to explain the improvements that have already been made to avoid similar deaths.

I hope these comments will assist you and if I can help further, please do not hesitate to contact me.

Yours faithfully,

Dr Elizabeth Stearns
Vice President Coroner's Section.