



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

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| 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)? |
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| Comments: | No comment |
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| 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 | We would welcome comments on the draft guidance for registered medical practitioners which explains the cases and circumstances in which a senior coroner should be notified of a death.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. |
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| 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? |
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| Comments: | No comment |
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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: No comment

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: No comment

Question 6. Whether there are other main circumstances when consideration should be given to cases being transferred

Comments: No comment

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: No comment

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: No comment

Question 9. What do respondents consider to be the purpose of a coroner commissioned post-mortem examination?

Comments: The purpose of an autopsy under the authority of the Coroner is to determine the cause of death on a balance of probability and not simply to determine a possible cause of death on only a limited evidential basis. The difficulty, especially with section 19 of the Coroner's Act 1988, is that it allows a restrictive interpretation in determining whether an inquest is necessary by apparently being satisfied with the sometime speculative determination of a possible cause of death rather than the probable cause of death. The new Coroner's Rules under the 2009 Act should, therefore, also take away the restriction in the existing 1984 Rules that tissue retention, or histological sampling is limited to material that has a "bearing on the cause of death." The autopsy examination should, within the discretion of the pathologist and the Coroner, include histological tissue sampling in accordance with Royal College of Pathology guidelines. The Coroner's Rules should not fetter the extent of the examination, unlike the existing Coroner's Rules which, inevitably, contribute to the determination of merely a possible cause of death rather than a probable cause of death because the requirement to limit tissue sampling to material that has a bearing on the cause means that the investigation of important negative histological findings that contribute to a full understanding of the probable cause of death are lost. The purpose of a Coroner's autopsy is to determine the cause of death and there is no logical basis for limiting the extent of the examination. By analogy, there is no limit upon a psychiatrist as a member of the Mental Health Tribunal under the Mental Health Act 1983, as amended 2007, when the psychiatrist performs a specialist psychiatric examination to determine a patient's mental disorder. The extent of the questions and psychiatric examination are not limited merely to determining the psychiatric diagnosis because all the information is required in order to exclude or give weight to certain evidence in reaching a probable classification and diagnosis of the patient's mental disorder.

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: The Faculty is concerned by the government's view that too many Coroner post-mortems are carried out. The Faculty believes that this view tends to promote the practice of Coroner's investigations being limited to determining a speculative, possible cause of death by less accurate investigations or examinations as these tend to meet reduction targets. However, for the purposes of this consultation, the Faculty submits

that to reduce the numbers of what prove to be in retrospect “unnecessary” Coroner’s autopsies then the government should seek to increase the rate and provision of autopsies by consent within NHS hospitals and otherwise implement the proposed changes by way of the Medical Examiner system so that the Coroner Service is not faced with the demands or obligations to determine the cause of death by way of autopsy in what, in all reasonable circumstances, is probably a natural cause of death. Under the current legislation, Coroners who are legally qualified and do not have a medical background, or readily accessible medical advice, are more likely to resort to an autopsy under section 19 of the Coroner’s Act in the face of, arguably, unreasonable refusal to issue a medical certificate of the cause of death on a balance of probability or to seek consent for a hospital autopsy. Medically qualified Coroners, or dually medically and legally qualified Coroners are in a better position to rebut spurious arguments or apparent refusal of doctors to issue medical certificates of the cause of death. Their insight enables them to make a decision that the cause of death is natural. Certification of the cause of death is a matter for the doctors who treated the patient in their last illness and, therefore, if of the view that there is a probable cause of death then the Coroner need not assume jurisdiction to perform an autopsy under section 19 or conduct an inquest. The Department of Health and the NHS should provide training support and education to support and develop skills of doctors in issuing medical certificates of the cause of death that take into account an autopsy by consent and, thereby, drive up the rates of these autopsies and, proportionately, decrease the pressure on legally qualified Coroners without sufficient medical support who can, therefore, only resort to autopsy examinations as part of their initial investigations.

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: The Faculty of Forensic and Legal Medicine’s response to this question is that a degree of consultation with the relevant next of kin is good practice but need not extend to an analysis of which people are within qualifying relationships as defined by the Human Tissue Authority codes of practice. It can be limited to properly interested persons who have been identified and engaged with the Coroner’s court. The results of any consultation between the Coroner and a relevant person about the examination should be on the basis that the Coroner’s decision has not been delegated to those persons but that the views will

be taken into account by the Coroner in making the final decision.

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: In response to this question and, with respect, the Faculty believes that the Ministry of Justice is mistaken in its understanding and reference to the "3-month rule." The three month period that is referred to in Human Tissue Authority codes of practice and communication pathways is a regulatory policy decision taken by the Authority that is not contained within the Human Tissue Act. The need for this regulatory policy was driven by the confusion caused by the drafting and implementation of the Coroner's Rules 9 and 12, 1984, as amended 2005, brought in by the then Department of Constitutional Affairs. The Coroner's Rules, as amended, introduced an express limit to the period for which tissue obtained during a Coroner's autopsy, or post-mortem, could be retained, even though the Coroner's authority to request or direct an autopsy was exempt from the consent requirements of the Act, by virtue of section 11 of the Human Tissue Act 2004. This had the effect of giving the Coroner authority to proceed with an autopsy without consent but, thereafter, an obligation to put options to properly interested persons about what to do with the tissue when the Coroner's "functions" under the Coroner's Act 1988 had ended. The inherent confusion in these definitions is caused by a combination primarily of a lack of communication between Coroners and establishments licensed by the Human Tissue Authority for the removal and storage of post-mortem tissue but, also, legal uncertainty. In a variety of cases the time when the Coroner's function has ended remains a moot point subject to various legal arguments. This uncertainty about when the Coroner's function has ended, in relation to a particular case, and lack of communication between the Coroner and licensed establishments, leads to tissue being held by licensed establishments when it is not clear to the licensed establishment whether the Coroner has set a specific retention period; when or whether that retention period has ended and a lack of communication about whether the options that the Coroner is obliged to put to properly interested persons has resulted in any decision about whether the tissue can be used for medical research, or other purposes, returned to the properly interested persons, or destroyed or disposed of by the

licensed establishments. The 3-month rule policy is an indication by the HTA to the post-mortem sector that it licenses that when the establishment finds that it has tissue in relation to which there is uncertainty about the wishes of properly interested persons for further retention for medical research, or other purposes, return or disposal, then after a three month moratorium, in order to try establish the position, the tissue should be disposed of so if in retrospect it appears that within that three month period the licensed establishment had been unknowingly storing the tissue without appropriate consent, or an exemption, then there would be no basis for taking regulatory action against the establishment. One solution would be that in view of legal uncertainty about when the Coroner's function might be finished, including the possibility of an inquest being quashed by the High Court many years after the original inquest and in relation to cases where there has been an autopsy in lieu of an inquest whether completion of the Coroner's function is postponed indefinitely, then rules should provide and recognise that retention is a matter for the discretion of the Coroner and the pathologist and certainly in relation to processed tissue blocks and microscopic slides it should be presumed to be an indefinite retention for archive purposes if the Coroner exercises his or her discretion on that basis and that the only option to consider is in relation to consent for use of the tissue for other scheduled purposes under the Human Tissue Act, such as medical research or for the diagnostic benefit of others, or further determining the cause of death. The alternative is that if the disposal or return options are to be included because presumed tissue retention is not acceptable, then the rules should provide for the issue of funeral forms by the Coroner, such as the cremation 6 form, or burial order, are conditional upon the receipt by the Coroner of a decision on those options and an obligation under the rules for the Coroner to communicate the decisions so obtained to the licensed establishment.

Question 13. When might a coroner wish to consider authorising a post-mortem examination to be carried out by a less invasive method?

Comments: This issue is linked to the definition of the purpose of a Coroner's post-mortem. Less invasive post-mortem examination, including post-mortem resonance magnetic resonance imaging scanning, is often used to determine a possible or speculative cause of death and not necessarily the probable cause of death. It is largely driven by pressure from certain communities who are in turn driven by the inadequacies of the death certification service in which patients who have probably died of natural causes but for whatever reason a medical certificate is not issued and the Coroner's Service then comes

under pressure to find “a cause of death” by magnetic resonance imaging scanning in circumstances where post-mortem radiology is less effective at determining causes of death such as when the mode of dying is essentially one of organ system failure. Less invasive investigations may be an adjunct to autopsy examination, especially in cases where there are space occupying lesions, such tumours or haemorrhage and in cases of trauma that can be demonstrated on digital radiographic images. At best, the option of employing less invasive methods gives hope or a chance that the investigation will not need to progress to an autopsy examination in certain cases .It is not appropriate to use less invasive methods simply as an expedient measure for speculatively guessing at a cause of death thereby avoid making difficult but necessary decisions for determining the probable cause of death.

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: The only people that the Faculty would envisage to fall within this small and narrowly defined group would be toxicologists or other forensic or biomedical scientists who can perform what are defined under the existing Coroner’s Act 1988 as “special examinations”. In certain cases specific scientific tests, or forensic examinations, might give “the cause of death” without the need for any further autopsy or post-mortem examination. For example, designating a toxicologist to conduct an examination to provide an opinion as to the cause of a death by toxicological compounds would seem to be reasonable in certain clearly defined cases or circumstances. For example, in suspected drugs related deaths an analysis and report about the levels of certain compounds and an interpretation of the toxicological findings could lead to a professional scientific opinion about the probable cause of death without the unnecessary removal, examination and dissection of visceral organs by a Histopathologist.

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 agree that 28 – 30 days should be the maximum time. However, we are concerned that in homicide cases the practice of second autopsies and the existing guidance is not justified. When a forensic post-mortem has been performed by an Home Office accredited forensic as they must be, then a second autopsy for a potential defendant otherwise not traced or charged probably adds little to the interests of justice because the second examination occurs in a vacuum without any understanding about what a future defence strategy might be. Equally, it is possible to observe the practice of defence representatives who when their client has been charged and there can be no dispute about the cause or mechanism of the homicidal death, a second autopsy is simply requested automatically or routinely. We think that in homicide cases after a 28-day period, following the first forensic post-mortem the body should be released without a second post-mortem unless somebody has been charged in the meantime and in relation to when a person has been charged, then the defence team must make a decision within 7 days of the charge and do not necessarily get the benefit of the balance of the initial 28-day period simply to make up their minds because they should be able to quickly understand what the defence strategy is to be and how a second opinion or autopsy is going to advance the defence of their client. In this regard, the Coroner should also have a degree of discretion to refuse a second defence autopsy, subject to written and oral submissions, for the defendant as a properly interested person, to show which autopsy issues of causation may be the subject of cross-examination at the Crown Court and that a second autopsy is necessary in the interests of justice.

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: These forms should reflect what we have said above that the purpose of the Coroner's post-mortem is to determine the probable cause of death and, therefore, should reflect best practice in accordance with the Royal College of Pathology guidelines about the

nature and extent of a full autopsy examining the organs from every body cavity including the skull and appropriate histological examination at the discretion of the Coroner and pathologist for determining the cause of death in a particular case. The reports and forms and documentation should reflect that the extent of the examination should not be fettered and that the retention of microscopic slides and processed tissue blocks should be presumed, again subject to the discretion of the Coroner and the pathologist, and that use of retained material for medical research and other schedule purposes under the Human Tissue Act, is the only matter about which properly persons must be consulted.

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: No comment

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: No comment

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: No comment

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 comment

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: No comment

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

Comments: No comment

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: No comment

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: No comment

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

Comments: No comment

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: No comment

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: No comment

Question 28. What level of requests for information from other interested persons would you expect to see, and why?

Comments: No comment

Question 29. How common is charging for disclosure in practice at present? Should we specify the circumstances in which a coroner can charge?

Comments: No comment

Question 30. What levels of fees should be payable?

Comments: No comment

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: No comment

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: No comment

Question 33. Should a formal requirement for the opening of an inquest be retained?

Comments: No comment

Question 34. Should there be a formal requirement for an inquest, when relevant, to be held as soon as possible after the death?

Comments: No comment

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: No comment

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: No comment

Question 37. In what circumstances do consultees think coroners should exercise powers to withhold names or other matters?

Comments: No comment

Question 38. Should there be a formal basis for coroners to accept unsworn evidence at inquests?

Comments: No comment

Question 39. Should the position on admissibility of documentary evidence be extended or clarified?

Comments: No comment

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 comment

Question 41. Should a new list of short form determinations be established; and if so, what should the categories be?

Comments: No comment

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: No comment

Question 43. Should the rules contain something on the availability and use of narrative determinations, and if so, what?

Comments: No comment

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: No comment

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: No comment

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: No comment

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 comment

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 comment

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: No comment

Question 50. Do you agree the proposed timescales set out for lodging appeals and for the Chief Coroner to rule on appeals?

Comments: No comment

Question 51. Do you agree with the content of the tables for training of coroners, their officers and staff? Is there anything missing?

Comments: No comment

Question 52. Should only some training be compulsory – if so what – e.g. induction training? Why?

Comments: No comment

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: No comment

Question 54. Should trainees have to complete a certain number of training days per year, or certain modules? What should the requirement be?

Comments: No comment

Question 55. If training is compulsory, what might be effective sanctions to ensure completion?

Comments: No comment

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: No comment

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 comment

Question 58. Who do you think would be best placed to deliver training and why?

Comments: No comment

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

Comments: No comment

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

Comments: No comment

Question 61. Should training provide Continuing Professional Development (CPD) credit for coroners?

Comments: No comment

Question 62. Should there be training courses – possibly residential – for induction courses for coroners and officers; and continuing professional development training?

Comments: No comment

Question 63. Should there be on site locally delivered training – for local issues?

Comments: No comment

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: No comment

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: No comment

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: No comment

Question 67. Are there any other issues the Chief Coroner should consider in drawing up training regulations?

Comments: No comment

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: No comment

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 comment

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

About you

Please use this section to tell us about yourself

| | |
|---|--|
| Full name | Dr Andrew Scott Reid |
| Job title or capacity in which you are responding (e.g. member of the public etc.) | Vice-President Faculty of the Forensic and Legal Medicine of the Royal College of Physicians |
| Date | 22 June 2010 |
| Company name/organisation (if applicable): | |
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| If you would like us to acknowledge receipt of your response, please tick this box | <input type="checkbox"/> Yes (please tick box) |
| Address to which the acknowledgement should be sent, if different from above | |
| | |
| | |

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.

This is the response of the of the Faculty of Forensic and Legal Medicine to the Ministry of Justice consultation. The Faculty has consulted its membership and this response takes into account the results of the consultation with the Faculty's members. The response is, therefore, confined to the part of the consultation on issues relating to Chapter 3 about post mortem examinations and retention of bodies.
