



## briefing

Health, Safety and Environmental - December 2009

### Coroners' Reform

Coroners and Justice Act 2009

**After much controversy and debate, the Coroners and Justice Act 2009 ('the Act') received Royal Assent on 12 November 2009. Part 1 of the new Act introduces a new framework for the Coronial system in England and Wales and represents the first major reform of this system in over one hundred years. The Act is of importance to NHS bodies and to their employees who may be required to participate in a Coronial investigation and to give oral evidence in the Coroner's Court.**

Only two of the provisions within Part 1 came into force with **immediate effect**. These are: section 48 deals with general interpretation and section 47 which is the definition of an **interested person** i.e. the persons or organisations who may ask questions at an Inquest. An interested person/organisation now extends to any person whom the Coroner considers '**has a sufficient interest**'.

The remainder of Part 1 will come into force **on dates yet to be determined**.

In summary, the main reforms are as follows:

#### 1. Chief Coroner:

A Chief Coroner will be appointed and they will have responsibility for overseeing the Coronial system throughout England and Wales. The Chief Coroner will be a High Court or Circuit Judge and will prepare an annual report for the Lord Chancellor, which must include details of all investigations which have been ongoing for in excess of one year and an assessment of the consistency of standards between Coroners areas. The Chief Coroner will also have the power, together with the Lord Chancellor, to make Regulations for the training of Coroners and Coroners' staff.

#### 2. Appeals:

Section 40 enables an interested person to Appeal to the Chief Coroner against a Coroner's determination of issues such as: the decision to conduct, discontinue or resume an investigation; whether or not to request a post-mortem; the production/disclosure of evidence; and the use of a jury. It will also be possible to Appeal to the Chief Coroner against a Coroner's finding that a person is not an interested person.

On Appeal, the Chief Coroner will be able to amend or quash a determination or finding; substitute or make any decision which could have been made; or quash a decision and remit it back to the Coroner for a fresh decision. The Chief Coroner will have the power to award costs.

Appeals will also be permitted, on a question of law, from a decision of the Chief Coroner to the Court of Appeal.

Appeals to the Chief Coroner on questions regarding the scope of the Inquest or the witnesses to be called cannot be brought. Any such decisions can, however, continue to be judicially reviewed.

#### 3. Duty to investigate:

The Act imposes a duty upon the Coroner to investigate if: the deceased died a violent or unnatural death; the cause of death is unknown; or the deceased died in custody. However, the Coroner must suspend investigations in circumstances where a person may be charged with certain offences or where certain criminal proceedings are brought. The Coroner will hold an Inquest into a work related death if the Police/Crown Prosecution Service decide to not to bring a criminal prosecution. At this stage, the Joint Investigation will be formally handed over to the Health and Safety Executive ("HSE") who will await the outcome of an Inquest before bringing a prosecution for breaches of health and safety legislation.



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#### 4. Purpose of the Inquest:

The matters to be determined by the Coroner remain: [the identity of the deceased and when, where and how the deceased came by his/her death](#). It remains the case that, in general terms, a verdict cannot appear to determine any issue of criminal or civil liability on the part of any person/organisation.

Section 5 of the Act, deals with the matters to be ascertained by the Coroner. It states that when necessary, so as to avoid a breach of the right to life under [Article 2 of the European Convention on Human Rights](#), the purpose of ascertaining [how, when and where](#) the deceased came by his/her death includes the purpose of *'ascertaining in what circumstances the deceased came by his or her death.'* This provision gives statutory force to the principle previously embedded into the Coronial system by case law which provides that where the state, or an agent of the state, is involved in a death; the Coroner has the discretion to widen the scope of their Inquiry.

This principle does not apply to private organisations but, increasingly, has significant implications for the public sector particularly the NHS. Indeed, the scope of the ['Article 2 duty'](#) has been broadened in recent years, and has been held to apply to deaths in hospital to include the death of a patient detained under the Mental Health Act 1983 if there is likely to have been a failure to take reasonable steps to protect the deceased from a risk to their life of which they ought to have known. Given this, and the principles in Section 5 of the Act, it is likely that increasing numbers of healthcare related deaths will be held to require the application of Article 2, or at the very least a broader Inquiry.

If Article 2 is found to apply, then the Coroner is bound to undertake an ['Article 2 Inquest'](#). An Article 2 Inquest differs from a standard or domestic Inquest in depth – and will have far greater impact on for the NHS body and its staff. For example, an Article 2 Inquest will involve careful scrutiny of issues including: the organisation, management and systems; staff training and records; medical record keeping, with adverse inference drawn from their absence; any culpable conduct; and lessons for the future.

In our experience, these Inquests are complex and lengthy and often involve a number of Interested Persons, including the bereaved family, all of whom play an active role in the pre-Inquest preparations and at the final hearing itself. In particular, these Inquests are often difficult and invasive for employees giving oral evidence and the impact that they have upon an NHS body and its people should not be underestimated.

The verdicts available to the Coroner and a jury are unchanged.

#### 5. Conduct of Inquests:

The Coroner has the power to require a person to attend to give evidence and/or to produce documents at an Inquest or by written statement; and enter, search and seize if so authorised by the Chief Coroner.

NHS bodies will be aware that, for some time, Coroners have had the power to serve Rule 43 letters setting out their recommendations for the prevention of further death. Since July 2008, recipients of Rule 43 letters have been required to respond to such letters in writing within 56 days. The correspondence can, of course, be publicised.

The provisions of Rule 43 are mirrored in the new Act. If a Coroner is concerned that circumstances creating a risk of other deaths will occur or continue to exist, they are required to report the matter to the person who the Coroner believes may have the power to take action.

#### 6. Calling a Jury:

Section 7 of the Act requires a Coroner to call a Jury if the death: occurred in custody; was either violent or unnatural or the cause unknown; resulted from the act or omission of a police officer; or was caused by a notifiable accident, poisoning or disease.

The Coroner can also call a Jury if he considers [there is sufficient reason to do so](#).

#### 7. Suspending an Investigation on the direction of the Lord Chancellor:

Paragraph 3 of Schedule 1 sets out, what is likely to be, the most controversial aspect of this Act. This requires the Coroner to suspend an investigation at the request of the Lord Chancellor (i) on the grounds that the cause of death is likely to be adequately investigated by an inquiry under the Inquiries Act 2005 and (ii) where a senior judge has been appointed to Chair that Inquiry with the approval of the Lord Chancellor. Serious concern has been raised by various Human Rights groups who believe that this power will serve to enable the Government to override the general principle that Inquests should be held in public and lead to the conduct of ['secret inquiries'](#) thereby avoiding the publicising of sensitive evidence. The Government has publically stressed that this power would be rarely



used.

#### 8. Appointment of Medical Examiners:

The Act provides for the appointment of medical examiners by Local Health Boards and Primary Care Trusts and also for the appointment of a National Medical Examiner with the function of issuing guidance to medical examiners.

Regulations will be issued in due course which provide for the medical **practitioner** who attended the deceased before death to prepare a certificate stating the cause of death. The certificate will then be given to the medical **examiner** so that they can confirm the cause of death. Where the medical examiner cannot confirm the cause of death, a Coroner must be notified. Cases can also be referred to the medical examiner by the Coroner and a medical examiner has the power to make whatever enquiries appear necessary to establish the cause of death.

The introduction of a medical examiner system, with its independent scrutiny of certificates, is designed to address the weaknesses in the current Coronial system as identified by the Shipman Inquiry.

#### 9. Advocacy at Inquests:

The Act amends the Access to Justice Act 1999 and allows for public funding to be available for advocacy/representation at certain Inquests, including Inquests into the deaths of persons detained in custody; during the course of arrest and persons in active service in the Armed Forces. Persons detained in custody will include detained patients under the Mental Health Act 1983.

Case law currently confirms that the reasonable costs incurred by bereaved families in securing legal representation at an Inquest can be recovered in the course of a civil claim for damages arising out of the death.

#### 10. Secondary Legislation/Guidance:

In early course, we expect to see Guidance as to the way in which the Coronial system is to approach the issue of 'interested persons'.

In the future, we expect to see new Regulations and/or amendments to the existing Coroners Rules setting out the procedures to be adopted by Coroners across

England and Wales thereby serving to promote much desired certainty and consistency of practice.

#### Comment

In recent years, Inquests involving sudden or unnatural deaths in hospital and mental health facilities have become increasingly lengthy, complex and invasive. In real terms, even if the circumstances of a death suggest that a full Article 2 duty does not arise, it is often the case that the Coroner will require a full and detailed Inquiry to incorporate due investigation of systemic failures. The new Act does not, in our view, change this. Indeed, the increased availability of public funding will inevitably lead to more bereaved families retaining expert representation to assist them throughout the course of a Coronial investigation and at the Inquest hearing.

Ordinarily, an Inquest will only be held if the Police/Crown Prosecution Service decides not to bring any criminal proceedings relating to the death. HSE will usually await the outcome of an Inquest before deciding whether or not to bring a criminal prosecution under the health and safety legislation. It must, however, be remembered that the Police/CPS can review their decision in the light of evidence given at an Inquest. It is essential, therefore, that NHS bodies ensure that their response to Coronial investigations and Inquests is properly managed.

In the course of his/her Inquiry, a Coroner will liaise with the Police and HSE and obtain copies of any documentation, witness evidence, expert reports and/or investigation reports that may be of assistance at an investigation. There are currently no rules for the advance disclosure of evidence and whilst at an Article 2 Inquest the Coroner should take all reasonable steps to obtain and disclose to the bereaved family any relevant evidence, it is within the discretion of the individual Coroner as to the evidence that he/she discloses to the interested persons in advance of an Inquest. Practice varies greatly. We expect to see Regulations or Guidance addressing this particular issue in early course.

It is increasingly common for Coroners to call Pre-Inquest Hearings to be attended by the Interested Persons with a view to dealing with issues such as: the scope of the Inquest; disclosure, names of witnesses to be called to give oral evidence; any legal issues arising; dates and time estimates for the Inquest. Indeed, we have experience of a Coroner appointing his own legal representative to assist him in this process. It is essential that NHS bodies derive as much benefit as



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possible from a Pre-Inquest Hearing with a view to securing the fullest possible disclosure to enable full and detailed preparation for the Inquest. Most certainly, the legal representatives of the bereaved family will be seeking full disclosure at the earliest opportunity.

It is also essential that due regard is paid to the interests of NHS employees throughout this process, particularly those who may have personal liabilities arising out of the death. Individuals who are required to give oral evidence at an Inquest may find that their evidence is closely scrutinised by legal representatives, particularly Counsel instructed by the bereaved family, who may be critical of their personal conduct. All witnesses are entitled to expect the appropriate level of support in the preparation for and conduct of an Inquest. Indeed, an individual employee or employees may require separate legal representation from their NHS employer. This must be identified at the earliest possible opportunity and suitable arrangements put in hand.

Rule 43 is of particular significance to the NHS. It is often the case that, in the event of a healthcare related death, a Coroner will consider the issue of remedial measures necessary to prevent a re-occurrence of the circumstances that led to the death with a view to making suitable representations. This can reflect poorly on the NHS body and attract unwelcome publicity. In our view, it would be prudent for an NHS body, having conducted its own internal investigation, to identify and action any such remedial measures in order that a comprehensive response may be given to the Coroner's queries at Inquest. It will, of course, be the aim of an NHS body to avoid the need for the Coroner to make any Rule 43 recommendations.

At Morgan Cole, it is our practice to support our Clients through all aspects of a Coronial investigation and Inquest and, in particular, we strive to provide the appropriate level of support, where appropriate, for our Client's employees who are required to participate in what can be a difficult and arduous process. We strive to ensure that the fullest possible preparation is undertaken in the lead up to an Inquest hearing and, indeed, we like to commence our preparation from the outset of an incident to ensure that our Clients benefit from early critical incident planning and management.

Our team consists of lawyers who are genuine specialist in their field and who have extensive experience of assisting our Clients throughout all aspects of Police/HSE investigations to include interviews under caution; Coronial Investigations and Inquests and criminal prosecutions in both Magistrates and Crown Courts.

### More information

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