Ministry of JUSTICE

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

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)?
Comments:	We agree with the cases and circumstances outlined where a registered medical practitioner must notify a Senior Coroner of a death. Quite rightly this includes instances where the deceased died a violent, natural or unknown cause of death. We also agree that deaths in state detention should be included in this category, which will encompass not only deaths in prison and police custody but also those in mental health institutions and immigration detention centres. We express disappointment that deaths as a result of events in the theatre of war are not included in this category. There is a pressing need for independent oversight of practises and procedures undertaken by the Armed Forces and the Ministry of Defence.

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	We would welcome comments on the draft guidance for registered medical practitioners which explains the cases and circumstances in which a senior coroner should be notified of a death.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.
Comments:	The draft guidance contained in the consultation documents are helpful and the categories are comprehensive. We nevertheless repeat our observations concerning deaths of those serving in the Armed Forces and additionally observe that if death results from those serving either as fulltime or volunteers in the Armed Forces then the same or similar safeguards and guidance laid down for those who die in custody should apply. Additional questions should be included covering the safety procedures relating to the security of weapons. Generally we do not feel that the guidelines should be interpreted to tightly and that it should be emphasised that they are no more than guidelines and that registered medical practitioners should still be afforded flexibility to report in cases which they feel are appropriate.

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?
Comments:	We are of the view that although the time limit should be extended it should be specifically stipulated to provide for certainty.

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:	Essentially training and guidance should be provided by the relevant medical body responsible for the conduct of medical practitioners although there should be a significant input from the Chief Coroner's Office, which we anticipate will provide a clear indication as to the approaches which should be taken. For this we refer to comparative jurisdictions such as Australia where the State Coroner has oversight in such processes.

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:	It is important that registered medical practitioners are given sufficient support and guidance as to their new responsibilities and initially it should be the responsibility of the new coronial service to train and advise the medical profession. But consistent and deliberate failure to notify would completely undermine the objectives of the Act and the proposed arrangements for dealing with transgressions is appropriate. Nevertheless there needs to be strict monitoring of compliance and particular attention paid to the recommendations in the Shipman Report.

Question 6.	Whether there are other main circumstances when consideration should be given to cases being transferred
Comments:	Cases which involve a significant number of bereaved families who wish to attend the full hearings should be held and accommodated in facilities which can comply with the Article 2 requirements of full participation in death investigation. This may, in exceptional circumstances require cases to be transferred to other coronial jurisdictions. We note and support the opening observations in chapter 2 of the attached notes emphasising the importance of taking into account the needs of the bereaved family which hitherto, we conclude, do not seem to have been a priority at many coronial investigations.

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:	In such circumstances the originating local authority should meet expenses. We agree with paragraph 12 of the accompanying Notes in that this approach guards against any financial incentive for an originating authority (Coroner A) transferring to a different jurisdiction. We have considered the two exceptions outlined in the Note dealing with deaths abroad or in hospitals on boundaries between coroners areas and agree with the exception principle concerning that first exception. We also agree with the second exceptional principle relating to multi deaths amongst boundaries. We would add that in relation to the first exception 13(b) relating to a soldier killed in action abroad that this particular exception be a firm stipulation given the present difficulties of bereaved families having to travel to the area of repatriation.

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:	We agree

Question 9.	What do respondents consider to be the purpose of a coroner commissioned post-mortem examination?
Comments:	We agree with the observations in chapter 3 of the Note.

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:	Consistency should not be judged by how many post-mortems maybe reduced. We are of the view that greater consistency can be achieved by a clear protocol as to how many post-mortem examinations are actually carried out.

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 full involvement of next of kin and the bereaved should be an essential feature of the new Act and the practices which it brings into play. The only exception to this should be where a criminal offence is suspected by the law enforcement authorities. Even in such cases there should be a general rule that next of kin should be informed of an examination within a stipulated period of time unless the coroner is convinced it is inappropriate.

We would like to emphasise that the exception of suspected homicide should be the only exception.

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: We are conscious of the provisions contained in the Human Tissue Act 2004 and the 2001 Bristol and Alder Hey Hospital Reports. We agree that the general principle should be that retained material be destroyed within a three month time period but that that time period should begin after any subsequent post-mortems and not the coroner's commissioned post-mortem in the case of deceased whose death maybe the case of criminal proceedings. It is often a requirement of proper defence preparation that further post-mortems are required to consider causes of death and that the obtaining of public funding for this to be undertaken often delays the post-mortem. A three month time period beginning at the end of the coroner's commissioned examination will place too much of a time pressure upon the defence legal team.

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

Comments: Whilst the views of all interested parties should be taken into account as to methods of post-mortem and that methods such as MRI or CT scans could be appropriate they should never be used in cases of deaths which are either of suspicious or unknown causes.

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:	We express concern that post-mortem examinations should be conducted by individuals who do not have registered medical qualifications and see no reason why the present situation should be changed.

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 recognise that presently there is no time limit within which the coroner must release the body. We have significant concerns about setting in stone any maximum time by which a body should be released. Often in criminal cases a second or even subsequent post-mortem is required by the defence legal team and that the failure of such an opportunity may result in abortive criminal proceedings and a proper verdict, either guilty or not guilty being jeopardised. Sometimes the prosecution requires subsequent post-mortems and a time limit of any length similarly hamper the prosecution. We are aware that the needs of the bereaved must be taken into account but these should be balanced with the 'fair trial' principles. We are of the firm view that there should be no strict time limit. Alternatively if there is such a time limit imposed there should be a facility for representations to be made to the Senior Coroner to extend them. Such representations could be made in writing, with the opportunity to make oral representations should a request be refused. We also suggest a fast track facility or means of communication with the Chief Coroner permitting defence teams to contact him/her directly to make such representations. The agreement should not be limited to the application of the coroner but should be given to the defence legal teams to facilitate their direct representations to the Chief Coroner. We emphasise that this need is founded partially on the requirement for speed when public funding is an issue-a common problem and concern in murder cases as well as instances at the place of work or corporate manslaughter where causation maybe an issue. It is also founded on the principles of disclosure.

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:	The forms should facilitate any observations as to any potential wider enquiry as to a cause of death which may impact upon any potential systemic failures which may in the future be an issue.

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:	This Working Party accepts the wisdom of certain independent experts assisting the coroner. We do have concerns that such delegation should be to independent bodies. At times in inquests the criminal or quasi criminal investigation into the death is criticised. In such circumstances should it be envisaged that there will be such criticisms then the police should not be one of those delegated bodies referred to in the consultation Notes.

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:	Anyone entering premises or property should have documentation authorising their behaviour. These will be at times draconian powers and should only be exercised upon identification much in the same way as the police are authorised.

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: We accept that powers of entry, search and seizure are necessary, as they are in the criminal arena but they do need to be governed by appropriate codes of conduct and there must be significant grounds of the exercise of such power and an opportunity to seek to exclude such documents after legal argument should an interested party see fit.

We nevertheless accept that there is a need for coroners to be able to seize documentation or inspect documents in the possession of organisations or individuals (for instance hospital records or research documents). Where documents have been seized and relied upon there should be a process of disclosure to relevant parties where appropriate. For instance, where computer records are sought from an individual who has been involved in electronic communication with a deceased through chat rooms that focus on suicide and methods of self harm.

The proposed delegated power of search should however be limited to police officers only and not to Coroner's Officers. Police officers are familiar with procedure as to search and seizure and this is likely to be more efficient and less likely to be challenged for breach of PACE procedures. Alternatively all search officers delegated by coroners should be accompanied by a police officer. Other parties who attend at the address to assist with specialist search and seizure should come from an approved list of parties held by the coroners office (an example of such is a list already used by the police force).

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: See above. There should be a procedure governing continuity, disclosure and recording of documents seized.

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:	Notice should be given to landowners/occupiers and we agree that forty eight hours is suitable. This may not be appropriate in cases where the coroner is of the view that advance notice may result in the destruction of evidence. Additionally, the coorner should use an equivalent of a Book 101 procedure detailing property seized which should be signed and given to the owner/occupier to provide for a proper chain of continuity.

Question 22.	Do you agree that we have captured the right principles and struck a proper balance between those which compete?
Comments:	We refer to our answers above.

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:	Requests should be permitted at any stage because it maybe that a party will only become interested during proceedings as to information before the coroner which relates to them. With the significant progress in software a policy of scanning documentation in all new cases would reduce costs significantly as any interested party could be emailed with or provided with a disc of the relevant material on it for a very limited cost. This would also assist in data management for the coroners office and the overall turnaround time for the disclosure of material substantially reduced. Workable timescales should be in place but these timetables should be on a case by case basis baring in mind the amount of material relating to the inquest and the needs of the interested parties.

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: We expect the take up to be significant. We would hope and anticipate that it will be in excess of the current regime providing that information relating to the Charter is properly publicised to those who may seek to utilise it. On this subject much will depend upon government funding provided for implementation.

Question 25. Are there any circumstances where bereaved people should pay for disclosure of material?
Comments: There are no circumstances (save where the individual is vexatious) where the bereaved should have to pay for disclosure. The principle of full participation as laid out in Article 2 of the Convention should guide the approach of the court.

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: Any impact upon coronial administration of disclosure to bereaved families should be secondary to the courts legal duties to the bereaved and interested parties. We are of the view that costs of disclosure of material could be reduced if a policy of electronic storage of date is introduced. The cost of both time and finance will soon be met and indeed surpassed if all documents are scanned in PDF form and stored. The cost of their disclosure to bereaved parties will be significantly less. This will have a two fold benefit of reducing the emotional burden of bereaved parties by reducing the time that they have to wait for documents and replication of material will be easily undertaken.

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: If all material was stored electronically in PDF form then cross party disclosure could take place at minimum cost and all parties would benefit from being on the same footing.

If electronic storage of material is not adopted then there should be an equivalent of disclosure schedule used in criminal proceedings which should regularly reviewed and updated to ensure that should a party have an interest in a document they are aware of its existence and who has sight of it.

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

Comments: The types of request for disclosure will inevitably vary on a case by case basis. In cases where there is a greater public interest; health and safety failures, the sort of information requested may well trespass into the realms of data protection and sensitive material.

Medical research results or biotech material for new drugs maybe sort by bereaved families in cases where parties have been involved in drugs trials. In military inquests sensitive military and ministerial decision making documentation maybe sort by families of those who died in the theatre of war. Furthermore disclosure of any recommendation or scientific papers pertaining to equipment or material which may have caused death may also be required.

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

Comments: There is no charge within the criminal jurisdiction and the principal of equality of arms still has a significant influence upon this area.

In cases of complexity although or those that generate voluminous amounts of documentation a provision for inspection is provided following from which parties can indicate what documents are required for copying. This procedure could easily be implemented in the coroners court.

Question 30. What levels of fees should be payable?
Comments: Any fee which is considered appropriate should be on a non-profit based basis.

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: The fee should be paid to the Coroner's Office and retained in a central Coroners fund. This is to ensure that the fee is not elicited on a profit based basis.

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: There should not be a time limit on disclosure at the conclusion of an investigation if the material is stored electronically or even if the documentation is stored in a paper format there is no reason to suspect that upon a proper request the information should be time limited. Any interested party, as long as they are in a position to justify an interest, in accordance of the authority of Driscoll should be entitled to ask for the material. Such person may include legal representatives involved in putting together material for a class action or civil action. If a time limit is nevertheless put in place, then it should be for a reasonably long period of time, and the discretion to refuse should be used sparingly and subject to judicial review if an interested party so wishes. We would like to emphasise that the decision making of the coroner as to disclosure should be transparent to all parties to assist with the understanding of the process and to facilitate any subsequent challenges. We refer to the established criminal protocols as to disclosure and relevance and commend these principles to the coronial regime. There is an important principle that should be maintained of equality of arms and if one party in the inquest has disclosure all other interested parties should of right, be made aware that it has been disclosed. The practice of late disclosure or even disclosure during the inquest hearing should be avoided. It has been particularly deprecated in the court of appeal and a system of advanced disclosure such as that in the criminal jurisdiction should be rigorously implemented.

Question 33. Should a formal requirement for the opening of an inquest be retained?
Comments: On balance the formal requirement for the opening of an inquest should be retained or at least some other procedure whereby the public at large are informed that an investigation is underway. It also brings to the attention of potential interested parties the forthcoming hearings.

Question 34. Should there be a formal requirement for an inquest, when relevant, to be held as soon as possible after the death?
Comments: We are of the view that there should be a formal requirement for an inquest to be held as soon as possible after a death. This will be of particular assistance to bereaved families who will be grieving and to ensure that if there are any legal actions flowing from the death (such as industrial class action) that it does not impact upon civil proceeding time limits. Time limits are further acute in potential Human Rights Acts claims where the limitation period is strictly enforced at one year from the relevant event.

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: The present regime of summoning witnesses is ad hoc. We consider that witness summoning should be put on a more formal footing and that the provisions within the Act given coroner's powers to summon witness is welcomed. We commend the procedure used in the criminal jurisdiction which provides for potential contempt proceedings if witnesses do not comply. Furthermore the rules in the criminal courts relating to the provision of documentation, sometimes from third parties, compelling such production, should also be a provision in the new coronial jurisdiction.

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: Again, the criminal jurisdiction has much to offer in this respect. Provisions set out in the Youth Justice and Criminal Evidence Act provides useful guidance. The use of special measures within the criminal courts has been successful in providing best evidence. A form of special measures is already used in sensitive military inquests where witnesses are screened and at times provided with anonymity. All these measures should be available although the principle of open justice should always be the general starting point.

Question 37.	In what circumstances do consultees think coroners should exercise powers to withhold names or other matters?
Comments:	We refer to our observations above and emphasise that the open justice principles should be paramount. Only in exceptional cases should names or other identifying details be withheld and by this we mean where there is a real and evidential threat of death or injury to an individual. Other circumstances would include where there is a risk of national security although the evoking of national security should not be agreed to by coroner's in a general or 'knee jerk' way. We emphasise that, in accordance with legal authority, national security does not mean political embarrassment.

Question 38.	Should there be a formal basis for coroners to accept unsworn evidence at inquests?
Comments:	There should be a discretion for coroner's to accept unsworn evidence. Although we observe in the consultation Note at paragraph 38 that there is no provision for a coroner to accept unsworn oral evidence, in practise coroner's do adopt the observations in expert reports or scientific documentation often written some years before the inquest. This documentation can be extremely valuable and coroners should be entitled to use their discretion to accept unsworn evidence. In some circumstances they should indicate that the weight attached to it is reduced as a result of its status. This should not detract from the best evidence principles that the giver of evidence if required, should be called and be open to examination. We observe with some disappointment that particularly in military inquests the lack of participation of members of the United States Armed Forces has not allowed this to happen.

Question 39.	Should the position on admissibility of documentary evidence be extended or clarified?
Comments:	The admissibility of documentary evidence and the information contained therein can produce significant information to an inquest. It is therefore important that all documentary evidence is admissible provided that it can be authenticated. All of this is predicated by the relevancy test. In the criminal arena relevance can be tested by reference to the Criminal Procedure and Investigation Act section 8 procedures. There is no equivalent procedure in the coroner's court whereby a party can challenge disclosure decisions. Presently the attitude to disclosure and consequently the admissibility of documentary evidence is idiosyncratic. We would like to add at this point that the coroners should have a facility to write letters of request to parties abroad to obtain evidence if he/she considers it appropriate.

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: Presently the coroner may retain documentation until he or she is satisfied that it is not required for the purposes of any other legal proceedings.

We are of the view that material should be retained for the fifteen year period to accommodate all appeal procedures.

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

Comments: We consider that the short form verdicts suggested by Michael Burgess should be adopted (see paragraph 26 page 58 of the Note). We are particularly concerned that any short form verdict should provide for findings which relate to systemic failure.

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: The requirement to return a narrative determination should be retained. Where the coroner is unable to place a cause of death into one of the Burgess categories. Although we recognise that the Coroner's Court is not there to find upon any criminal or civil case it is settled law that a coroner's narrative can assist in any subsequent civil action. As such the narrative should provide this facility. We recognise that this would mean an end to the open verdict facility.

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

Comments: The provision of narrative determinations should be enshrined within the rules encompassing the observations made in questions 41 and 42 above.

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:	We agree with the expansion of the rules relating to location of inquests which offers flexibility and accessibility to participants. We particularly refer to the coroner's ability to sum up evidence to the jury at the end of an inquest. Whilst this is appropriate given that the parties or their legal representatives are not permitted to address the jury the coroner should not be allowed to direct the jury as to any factual conclusions that they may reach. By way of expansion we would not favour the coroner being given the same power as a judge to give his or her personal impression of the evidence. In criminal procedures the advocates have an opportunity of putting alternative constructions to the jury.

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: We welcome the innovation of the Chief Coroner and recognise that hitherto the organisation of the Coroner's Courts had been unstructured and required unification.

In particular the proposed appeals process is welcomed. We agree that the process should remain informal as far as possible however it is suggested that a uniform approach should be adopted with a single point of contact within the Coroner's Office as a means of passing on representations about complaints. Resolution of matters before the inquest proceeds is prudent and in effect mirrors the preparatory hearing points in Complex Criminal Cases.

A full notice indicating that efforts have been made to resolve any matters informally is both appropriate and comparative with the present judicial review process. It is also right that the Chief Coroner should give full reasons to any findings made by him. It is proposed that the Chief Coroner will have a right to choose whether representations should be made orally or in writing – the proposal that the interested party can make representations to have an oral hearing is vital. Perhaps a mirroring of the Court of Appeal (Criminal Division) approach could be adopted, that written submissions will be the first step, if these are refused then there should be a right to make the applications orally if the reasoning is not accepted. The Chief Coroner can of course indicate from the outset that they believe that the hearing should be oral.

The time scale set should be reasonable and allow each party sufficient time to respond as well as having an opportunity to apply for an extension of time to make representation.

The proposed time scales outlined in paragraph 29 of the Note are too short. We are of the view that there should be seven days in the instance of a decision on whether or not to hold a post-mortem.

In respect of other cases twenty eight days should be the time limit, allowing interested parties to obtain legal or medical advice where appropriate and to consider the merits of any appeal.

The proposed sixty day time limit to appeal against an investigation is appropriate.

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: Yes

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:	Yes. This mirrors the judicial review process and is perfectly appropriate. With regards to appeals about post-mortems the appeal process should be fast tracked, a decision provided within forty eight hours permitting other avenues of appeal being explored if appropriate.

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:	Yes in exceptional circumstances.

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:	Whatever approach is taken clarity and uniformity is vital. As in the criminal jurisdiction all appeals should initially be in writing. If the coroner refuses the appeal on the papers then, as in the criminal arena, the opportunity to appeal before the court should be available. In exceptional cases, for instance those involving important principles of law or in cases of sensitivity the Chief Coroner should be able to facilitate an immediate oral hearing.

Question 50.	Do you agree the proposed timescales set out for lodging appeals and for the Chief Coroner to rule on appeals?
Comments:	We are of the view that the timescale set out for the lodging of appeals and for the Chief Coroner to rule on appeals is too short. We wish to emphasise that decisions upon the availability of public funding are often protracted and sometimes require legal advisors to act on a pro-bono basis so as to properly assist bereaved families. Furthermore medical advice may require advanced funding. As such our proposals contained earlier in this consultation document should be considered.

Question 51.	Do you agree with the content of the tables for training of coroners, their officers and staff? Is there anything missing?
Comments:	We agree the above. It is important the training should not be contained within a single event but should be ongoing much in the way the legal profession are required to maintain continual training throughout the year and in a consistent fashion.

Question 52.	Should only some training be compulsory – if so what – e.g. induction training? Why?
Comments:	All training should be compulsory to provide for consistency of quality.

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:	This compulsory training should occur before any individual can perform their duties again to provide for consistency of quality and confidence from the public in that benchmark.

Question 54.	Should trainees have to complete a certain number of training days per year, or certain modules? What should the requirement be?
Comments:	Yes. Again we refer to the CPD regime within the legal profession which require points to be awarded for recognised training events.

Question 55.	If training is compulsory, what might be effective sanctions to ensure completion?
Comments:	As with the legal profession any significant or consistent failure can result in disciplinary procedures.

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:	Sanctions should be at the discretion of professional bodies.

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:	There should be a distinction between the number of training days required depending upon the complexity and seniority of the position.

Question 58.	Who do you think would be best placed to deliver training and why?
Comments:	The professional bodies representing the operatives would be in the best position to provide the training.

Question 59.	Should the Chief Coroner approve a provider before they can train coroners, coroner's officers and support staff?
Comments:	Training should be available from various providers and should be approved by the Chief Coroner to provide uniformity of approach and consistent quality.

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

Question 61.	Should training provide Continuing Professional Development (CPD) credit for coroners?
Comments:	Yes. See the legal profession blue print.

Question 62.	Should there be training courses – possibly residential – for induction courses for coroners and officers; and continuing professional development training?
Comments:	Yes. There is considerable merit in occasional residential courses to enable the transfer of views and experiences between operatives from different areas, again to enforce the unification of the process.

Question 63.	Should there be on site locally delivered training – for local issues?
Comments:	Yes. Local coronial jurisdictions can come by virtue of their geographical position cater for particular types of inquest. For instance the Wiltshire area will cover RAF Brize Norton where bodies of deceased service personnel are repatriated. Local training on aspects of military inquests would therefore by appropriate.

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:	Yes.

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:	Yes. Historically the Office of Coroner has included those trained in both the legal and medical professions. Legal professionals, the police and any other profession with a legitimate interest in the coroner's system should be able to attend training events. This will be particularly necessary as the provisions within the 2009 Act are brought into law and an understanding of the new system becomes essential.

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:	It is desirable, certainly from the prospective of legal practitioners that all those who will work within the new system are fully aware of how it works. It is therefore sensible that coroner's take responsibility for their areas to ensure this is facilitated.

Question 67.	Are there any other issues the Chief Coroner should consider in drawing up training regulations?
Comments:	No other issues are apparent.

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:	We are of the view that a short death certificate should be available free of charge. Presently there is only scope for full death certificates and there maybe some delay in their production. We consider that there is merit in providing bereaved families in appropriate circumstances to have a short form death certificate to present to organisations such as banks or utility companies who simply require confirmation of the fact of death.

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:	Providing that such information is not sensitive and will not delay the issuing of such certificate then we can see no reason why the certificate should omit information about occupation and other details of the deceased and the person who has organised registration of the death.

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

About you

Please use this section to tell us about yourself

Full name	Criminal Bar Association
Job title or capacity in which you are responding (e.g. member of the public etc.)	
Date	30/06/10
Company name/organisation (if applicable):	Criminal Bar Association
Address	289 – 293 High Holborn London
Postcode	WC1V 7HZ
If you would like us to acknowledge receipt of your response, please tick this box	X (please tick box)
Address to which the acknowledgement should be sent, if different from above	Lesley Bates
	23 Essex Street
	London WC2R 3AA

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.

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