



REFORMS TO THE CORONERS SYSTEM

THE DRAFT BILL

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Taken from a lecture given by Dominic Kay on 31st January 2007.

1. To appreciate fully the forthcoming reforms to the coronial system, it is necessary to spend a short time considering the history of the role of coroner and the coroner's jurisdiction under the present system.

The history of the role

2. The office of coroner as we know it is virtually unique. Many nations had the English legal system imposed on them during the days of the Empire, thereby acquiring the office of coroner, but just as our coroner's work and role has changed out of all recognition over the past couple of centuries, overseas coroners have developed their roles in a multitude of different directions.

3. Our coroners' role is unique, not only on the world stage, but also within our own legal system; coroners in England and Wales have a role of an inquisitor rather than simply presiding over court proceedings. It is a role which can be traced back within our legal system to the reign of Richard I in 1194. Until that time, justice had depended upon feudal Lords and the King's Sheriffs. The 1194 Articles of Eyre first outlined the office of coroner, and even at this early date the office was responsible for, amongst other things, examining cases of sudden death.

4. As time passed, the coroner's role transformed into one of a medico-legal witness and a string of statutes, beginning with the 1275 Statute of Westminster, began to define the duties of coroners. Since the Statute of Westminster, the coroner's role has been consolidated time and again; 1751 saw the enactment of the first Coroners Act, followed by the Births & Deaths Registration Act 1836 which saw the office begin to grow in importance. The office of coroner as we know it today was produced by the County Coroners Act 1860, this being perfected through further legislation in 1887, 1926 and 1980.

5. The legislation currently governing the role is found in the Coroners Act 1988 and the Coroners Rules 1984.

The Present System

6. **Qualification**

To be appointed as coroner an applicant must have been qualified as a solicitor, barrister or medical practitioner for a minimum of 5 years; in reality, successful applicants tend to have been practising for far greater periods.

7. **Removal from office**

Under the Coroners Act 1988 the Lord Chancellor has power to remove a coroner from office for inability or misbehaviour in the discharge of his duty. He also has a common law power to dismiss a coroner for neglect of duty. As with Judges, removal of a coroner from office is very rare.

8. **Part-time coroners**

There are approximately 123 coroners in England & Wales, but only about 26 of those are full-time; many of the remainder are solicitors and/or barristers in private practice who attend to coroner's work on a part-time basis.

Jurisdiction

9. The coroner's power to inquire into the circumstances of a death is wide ranging, although ultimately the right to inquire (i.e. jurisdiction) is determined by statute.

10. The coroner's powers to acquire jurisdiction over a body are set out in s8(1) of the Coroners Act 1988 which states:

"8(1) Where a coroner is informed that the body of a person (the deceased) is lying within his district and there is reasonable cause to suspect that the deceased-

- (a) has died a violent or unnatural death*
- (b) has died a sudden death of which the cause is unknown*
- (c) has died in prison or in such place or in such circumstances as to require an inquest under any other Act*

then whether the cause of death arose within his district or not the coroner shall as soon as practicable hold an inquest into the death of the deceased either with, or subject to sub-section (3) below, without a jury”

11. *“the body of a person”*

In the vast majority of cases the presence of a body (and the necessity of a coroner’s inquest) will be all too apparent. There are a number of situations where problems can arise, for example human remains of great age, partial remains or a foetus. These matters provide their own complications and are worthy of an article to themselves. For the purposes of this article I restrict my comments to cases where the presence of the body is clear.

12. *“lying within his district”*

Coroners’ jurisdiction arises from the presence of a body rather than where the death occurred, and although in certain circumstances there can be territorial transfers under s14 Coroners Act 1988, this general rule means that the question of where an inquest will be held is less problematic than one might think. Examples of where death occurred in one territory/district but falls to a different coroner by virtue of this rule include the recent inquests into deaths of soldiers in Iraq (all heard by the Oxford Coroner on the basis that the bodies are flown into RAF Brize Norton in Oxfordshire) or where a body is washed up on a shore, the death having occurred in another county or even country.

13. “reasonable cause to suspect...”

Once it has been established that there is a body lying within a coroner’s jurisdiction, it then falls to be considered whether the death might fall within one of the three categories under s8(1) of the Act (above), thereby requiring a coroner to hold an inquest. Deaths in health and safety related cases will almost always fall within s8(1)(a) – “*has died a violent or unnatural death*” and whilst a number of cases have considered the issue and definitions of “*violent*” and “*unnatural*”, as a very general rule if a death flows from any sort of traumatic event, accidental or deliberate, self-induced or otherwise, the death falls within the meaning of ‘violent or unnatural’.

Review of the Coroner System

14. In 2001, the Home Office ordered a fundamental review of the coronial and death certification system under the chairmanship of Mr Tom Luce, former Head of Social Care Policy at the Department of Health. Following a considerable programme of consultation, on 4th June 2003 the review group published the Report of a Fundamental Review of Death Certification and Investigation in England, Wales and Northern Ireland. The report called for a number of changes to improve efficiency and increase public confidence in the coroner service. The report declared that “*neither the certification nor the investigation system is ‘fit for purpose’ in modern society. Both need substantial reform*”. The full report is available to download from The Stationery Office at www.archive2.official-documents.co.uk/document/cm58/5831/5831.htm or via the Home Office website (www.homeoffice.gov.uk). A summary of the proposals is as follows:

(a). **A consistent professional service based on full-time leadership:**

- a national jurisdiction within the responsibility of the DCA;
- a Chief Coroner plus an Inspectorate to monitor standards;
- a Rules Committee to promote consistency;

- reduction to c. 60 full-time coroners with jurisdictions based on police areas;
- additional part-time 'deputies' as caseload demands;
- structured and mandatory training.

(b). **Consistency of service to families:**

- a statement of families' right to specified information;
- a right to formal review of decisions to order or refuse an autopsy;
- proper links with bereavement services;
- a mechanism for complaints.

(c). **Appointment in each area of a Statutory Medical Assessor (SMA) to:**

- bring a new dimension of medical expertise into coroner service;
- support the coroner in death investigations;
- supervise cases involving death from natural disease;
- create appropriate links with public health and other safety networks.

15. The publication of The Luce Report coincided with the third report of the Shipman Inquiry. Dr Harold Shipman, a general practitioner was convicted in 2000 of murdering 15 of his patients. His case prompted an inquiry ('the Shipman Inquiry'), the third report of which considered the work of coroners and the death certification system, and how they might be reformed to minimise not only the chance of another professional operating unnoticed (as Shipman had) but also to deal with a system which had a poor record of dealing with large (and often high profile) inquests such as those concerning Hillsborough, the Zeebrugge Ferry and the Marchioness disasters. The Shipman Inquiry was chaired by Dame Janet Smith, an Appeal Court judge, and was published in July 2003. All six reports of the Inquiry are available online at www.the-shipman-inquiry.org.uk/reports.asp.

16. Dame Janet Smith concluded that “*the current...coronial system requires radical change*”.

The Report contained far reaching recommendations, most notably:

- The coronial system should be retained, but in a form entirely different from at present. There must be radical reform and a complete break with the past, as to organisation, philosophy, sense of purpose and mode of operation.
- The new Coroner Service should provide an independent, cohesive system of death investigation and certification, readily accessible to and understood by the public. It should seek to meet the needs and expectations of the bereaved. It should provide a thorough and open investigation of all deaths giving rise to public concern. It should ensure that the knowledge gained from death investigation is applied for the prevention of avoidable death and injury in the future.
- The Coroner Service should provide leadership, training and guidance for coroners.
- Many of the functions currently carried out by coroners (who, in the main, have a legal qualification only) require the exercise of medical judgement. Some of those functions require legal expertise. In the future, those functions should be carried out respectively by a medical coroner and a judicial coroner.
- The Coroner Service should have a corps of trained investigators, who would replace the coroner's officer but have a greatly enhanced role.
- The Coroner Service must be, and must be seen to be, independent of Government and of all other sectional interests. Ideally, the Coroner Service should be associated with both the Department for Constitutional Affairs and the Department of Health.
- The Coroner Service should be governed by a Board. Three of the members of the Board would be the Chief Judicial Coroner, the Chief Medical Coroner and the Chief Coroner's Investigator. The Service should also have an Advisory Council.

- The Coroner Service should be administered through a regional and district structure, with a regional medical coroner and at least one judicial coroner assigned to each region. There would be ten regions in England and Wales, coinciding with the ten administrative regions. Each region should be divided into between three and seven districts, each with a population of about a million. Each district office would have a medical coroner, one deputy medical coroner, a team of coroner's investigators and a small administrative staff.
- All deaths should be reported to the Coroner Service, which would take responsibility for certification of the death and for deciding whether further investigation was necessary. The Coroner Service would take primary responsibility for all post-death procedures.
- In general, there should be an inquest only in a case in which the public interest requires a public investigation for reasons connected with the facts and circumstances of the individual case. There should be a few quite narrow categories in which an inquest would be mandatory. Otherwise, the decision whether the public interest required an inquest would be for the judicial coroner and would be subject to appeal.
- If criminal proceedings have been commenced, there should be no need for an inquest to be opened and adjourned. If the proceedings resulted in a conviction, the medical coroner would usually need to do no more than write a report recording the fact of the conviction, the cause of death and the brief circumstances of the death. If the proceedings led to acquittal, the death would be referred to the judicial coroner for inquest.
- If any other agency (such as the Health and Safety Executive) were to investigate a death, the medical coroner would take no action, other than that necessary to

establish the cause of death. When the other agency's investigation was complete, its report, together with the result of the medical coroner's investigation into the cause of death, would be sent to the judicial coroner. The judicial coroner would then decide whether any further investigation was required or whether an inquest should be held. If no inquest were to be held, the judicial coroner would write a report.

- There should be a statutory duty on any 'qualified' or 'responsible' person to report to the Coroner Service any concern relevant to the cause or circumstances of a death of which s/he becomes aware in the course of his/her duties. The duty should be to report as soon as practicable any information relating to a death believed by that person to be true and which, if true, might amount to evidence of crime, malpractice or neglect.
- Any decision made by a medical or judicial coroner would be subject to judicial review. However, a quicker and cheaper means of appeal should be provided, whereby decisions of the coroners that are wrong in law, plainly wrong on the facts, fail to set out the facts found or fail to give reasons for the conclusions can be set aside.

Coroner Reform: The Draft Bill

17. The Government drew on recommendations from The Luce Report and the third report of the Shipman Inquiry to produce the position paper "*Reforming the coroner and death certification service*". The paper proposed a system with oversight of all deaths based around full time independent coroners with legal qualifications who would be closely supported by appropriate medical expertise. It also proposed tightening up the death certification process by increasing medical scrutiny in the system.
18. An oral statement was made to the House of Commons by the Rt. Hon. Harriet Harman MP (Minister of State at the Department for Constitutional Affairs (DCA) with responsibility

for coroner reform) on 6th February 2006 regarding the Government's approach to coroner reform. A briefing note circulated at that time gave further details of the reform plans. The main aims of reform were to improve the service provided to bereaved people, to introduce national standards and national leadership, and to improve the efficiency and effectiveness of coroner investigations.

19. Then, on 12th June 2006 the DCA announced its intention to proceed with the reform process by way of a draft Coroners' Bill to enable pre-legislative scrutiny by the Constitutional Affairs Committee.

20. The draft bill contained five key reforms:

- Bereaved people will be able to contribute to coroners' investigations to a greater extent;
- National leadership will be introduced through a new chief coroner;
- Coroners will become full-time and current boundaries will be reshaped;
- Coroners will have new powers to ensure better investigations and inquests;
- Coroners will have better medical support and advice at both local and national level.

21. The rights of bereaved relatives in the new Bill

The following rights appear to be the key to "*putting the interest of bereaved relatives first*":

- The right to ask the coroner for a second opinion on death certificates;
- The right of appeal to the Chief Coroner;
- The right to be provided by the coroner with an explanation of the rights and obligations in relation to the inquest;
- The right to be informed and consulted by the coroner who must treat relatives with sympathy and dignity;
- The right to expect that the inquest will comply with their expectations.

Will these 'rights' make a difference to bereaved relatives? I suspect not; they appear to do little more than pay lip service to the groups who campaign in relation to the rights of those affected by the inquest system.

22. Changes to the role of coroner

The Bill intends that the current array of coroners, some full-time and some part-time, some medical and some legal, should become a full-time professional service with the country divided into coronial areas where there will be senior, area and assistant coroners (as opposed to the existing coroner, deputy coroner and assistant deputy coroner). Coroners are to be lawyers, although provision will be made to cater for existing coroners who have medical qualifications, and the numbers will be cut dramatically from the existing 120-odd full and part timers to approximately 60 full-timers. All coroners will be funded by their respective local authorities.

23. When will an inquest be held?

Clause 1 states that there will be a duty on a coroner to investigate:

- Violent or unnatural deaths; or
- Where the cause of death is unknown; or
- Where there is a death in prison or of someone detained in custody.

24. Clause 10 goes on to define the purpose of the coroner's investigation as being "*to ascertain who the deceased was and when, where and by what means he came to his death*". Clause 10(2) requires the scope of the inquiry to be widened to include "*in what circumstances the deceased came by his death*", where Article 2 of the European Convention on Human Rights applies. This suggests that a 'normal' inquest (i.e. not under Cl 10(2)) will not be concerned with the circumstances by which the deceased came by his death.

25. When will a jury be summoned under the new Bill?

The present position regarding juries is set out in s8(3) Coroners Act 1988. It states:

“8(3) If it appears to a coroner, either before he proceeds to hold an inquest or in the course of an inquest begun without a jury, that there is a reason to suspect –

(a) that the death occurred in prison or in such a place or in such circumstances as to require an inquest under any other Act;

(b) that the death occurred while the deceased was in police custody, or resulted from an injury caused by a police officer in the purported execution of his duty;

(c) that the death was caused by an accident, poisoning or disease notice of which is required to be given under any Act to a government department, to any inspector or other officer of a government department or to an inspector appointed under section 19 of the Health and Safety at Work etc Act 1974;
or

(d) that the death occurred in the circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public,

he shall proceed to summon a jury in the manner required by subsection (2) above.”

26. Under the draft Bill, the summoning of a jury would be mandatory only where the deceased dies in custody or as a result of the act of a policeman in the execution of his duty. In any other case, the coroner retains a discretion as to whether he should summon a jury. Many practitioners with experience of inquests involving juries, not least in cases involving workplace deaths, will see this as a positive move.

27. Disclosure of documents

Under the present system a coroner has no power to order disclosure of documents other than to apply for a High Court / County Court subpoena. Clause 42 of the draft Bill seeks to address this issue and provides coroners with powers to issue notices. The power includes:

- the right to issue notices requiring relevant documents (or any other item) to be produced; and
- the right to issue notices requiring individuals to provide evidence in the form of a witness statement.

28. Schedule 4 of the draft Bill states that a person is guilty of an offence if he does anything intended to have the effect of distorting or otherwise altering any evidence provided for purposes of investigation, or if he prevents any evidence being given or intentionally suppresses or conceals a document.

29. Powers of entry, search and seizure

The draft Bill also gives the coroner far reaching powers in respect of entry, search and seizure. Clauses 50 and 51 combine to allow a coroner, on written authority of the Chief Coroner, to have the power to enter and search land and, if he has reasonable grounds for believing that it may assist an investigation, seize any object and/or inspect and take copies of any document. The Chief Coroner will only give such authorisation if the coroner has reasonable grounds to suspect that there may be something on the land which is relevant to the investigation and either access has been/would be refused or it is impracticable to communicate with the person entitled to grant such access.

30. Appeals under the draft Bill

The draft Bill affords a right of appeal to the Chief Coroner against all decisions, determinations and findings of coroners, including the decision whether or not to hold an

inquest, verdicts and procedural decisions. This will mean that Judicial Review will cease to be the normal route of challenge. Appeals from the Chief Coroner on points of law will lie to the Court of Appeal.

The Health & Safety Lawyers' Association response

31. The HSLA has taken the opportunity to submit a written response to the draft Bill, raising the following areas of concern:

(i). **Resources and funding**

The Association states that the draft Bill does nothing to address “*the lacuna as to who should investigate for the coroner*”. Coroners often rely upon investigations and evidence gathered by health and safety inspectors when dealing with inquests into work-related deaths. This situation fails to recognise the very different ambit of an inspector’s criminal investigation as against the limited requirements facing a coroner under Clause 10 of the Bill (namely who has died, when, where and by what means).

The absence of funding for investigations by coroners inevitably leads to the speed of proceedings (both coronial and criminal) being dictated by the speed with which health and safety inspectors can produce reports in respect of investigations. The Association states that such delays, especially in respect of criminal proceedings, are unacceptable.

The Association also states that the draft Bill fails to advance proposals for improved funding for coroners to undertake investigations and to gather evidence. It is suggested that this means that the system will continue to rely upon health and safety inspectors’ investigations, thereby continuing disputes in respect of disclosure and potential prejudice to future criminal proceedings.

The Association states:

“a properly resourced investigation by a coroner into a work-related death would provide a focussed investigation into the circumstances relevant to the inquest, the holding of an inquest within a reasonable time and would permit the instigation of proceedings for health and safety offences to follow in a more timely manner with a minimised risk of prejudice to any party to such proceedings through pre-inquest disclosure of material irrelevant to the inquest”.

(ii). Clause 42(2)(a)

Clause 42(2)(a) of the draft Bill provides that a senior coroner may require a person *‘to provide evidence to the senior coroner in the form of a written statement’*, but a person subject to such a requirement may claim pursuant to 42(4)(b) that *‘it is not reasonable in all the circumstances’* to require him to comply’, on which basis the requirement may be revoked or varied.

The Association points out in its written response that this draft clause does not include provision for the requirement to be subject to a prohibition on the use of such a statement against the maker in any criminal proceedings and it takes no notice of the right of a person not to incriminate himself.

(iii). Clause 50 and 51

The Association notes that the proposed powers of entry, search and seizure exercisable by a coroner appear not to be subject to the provisions of the Police and Criminal Evidence Act 1984, all other similar powers exercisable by other investigators being subject of Code B of the Code of Practice. This may call into question the future admissibility in criminal proceedings of evidence so seized. The Association recommends that *“at the very least”* the exercise of these powers should be expressly governed by the relevant provisions of Code B.

Conclusions

32. First impressions from the legal profession and other interested parties suggest that the Government has underestimated the extent of the reform that is required, and whilst it is largely considered that the key elements are acceptable, the Bill is unlikely to survive in its present form; if it does, many will consider it a missed opportunity to overhaul what is presently thought to be an ineffective and unsatisfactory system. Whilst many of the proposed reforms address major weaknesses in the current system, it is far from the “*radical change*” called for by Dame Janet Smith.

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January 2007

References:

Jervis on Coroners - (12th Revised Edition) Jervis/Matthews/Foreman

Coroners' Courts – A guide to Law and Practice (2nd Edition) Dorries

Report of a Fundamental Review of Death Certification and Investigation in England, Wales and Northern Ireland – 2003

The Third Report of the Shipman Inquiry – Chaired by Dame Janet Smith