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

GENERAL COMMENTS FROM THE ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH:

There are two general points which this College wishes to make, but they do not fit easily into the framework of questions. The two general points as are follows:

Medical Examiners: These are mentioned and this is clearly going to be quite an important, responsible and time-consuming post. However, there is really no detail provided about this in this document, which gives the College major cause for concern as it is probably the area that impacts most upon our Fellows. There is no information as to the seniority of such doctors, the training required, the sort of job description that is envisaged, nor the appointment process. The College is concerned that these duties may be going to fall upon the Responsible Officer, when they are appointed, or the Medical Director, both of whom are more than over-burdened in other ways. In particular, because these people are going to have to ratify Death Certification pretty rapidly, they are going to have to be available at short notice for a lot of the time. Therefore the question obviously arises as to what happens in their absence for whatever reason.

Death Certification: The second point is that we are aware that there are also going to be new arrangements for Death Certification, and the College feels it is important to emphasise that these arrangements, to which we do not have access at present, must dovetail in with the reforms to the Coroner System.

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 would suggest the following modifications:

Case/circumstance 2 – the deceased died *or may have died* as a result of violence, trauma or physical injury whether intentional or otherwise. We believe that the addition is required because there are some instances when there is a possibility rather than a reasonable certainty of death due to these causes. An example might be a severely/terminally ill patient who falls out of bed sustaining some injuries although they apparently die of another cause.

In respect of case/circumstance 3 and 6, we would suggest an alteration such that the second bullet point in case 3 is altered to read "medical drugs (e.g. a self administered overdose or *an excessive dose not administered by a medical practitioner*)". This would then enable case/circumstance 6 to relate to all medical errors in one section which we feel is clearer. In respect of case/circumstance 6, the first bullet point requires clarification (please see some proffered examples of clinical scenarios attached). In the same section, bullet point 3 probably also needs modifying as, at present, this could be interpreted as applying to recognised complications of entirely appropriate treatment. If all reported to the Coroner this would be increasing, rather than lessening, the burden. We also wonder whether a family request for a Coroner's investigation should also be allowable.

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:	Please see illustrative examples in Section 1 of "Additional notes".

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:	The opinions of our Fellows vary and there is no consensus on this time limit.

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:	Initial training for medical practitioners should start during the Medical School curriculum, should again be included at hospital induction as well as being a core competency in the Foundation and Core Medical Curricula. Training could also be available online, perhaps through the auspices of the GMC. We would also recommend that a flow chart is available on all Medical wards in the hospital outlining the cases and circumstances in which a senior coroner should be notified of a death. There are funding implications such that this is not a cost neutral exercise.

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:	We believe that the Medical Director of a hospital or PCT should initially deal with these matters and, if unresolved, the GMC.

Question 6.	Whether there are other main circumstances when consideration should be given to cases being transferred
Comments:	We feel it inappropriate for us to 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:	We feel it inappropriate for us to 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:	We feel it inappropriate for us to comment.

Question 9.	What do respondents consider to be the purpose of a coroner commissioned post-mortem examination?
Comments:	The purpose of a Coroner commissioned post mortem examination is to establish the cause of death, to exclude foul play and to answer specific questions such as whether or not this was related to industrial/occupational disease and, in certain circumstances, establish whether or not genetic/hereditary disease or other infective diseases were present.

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:	We suspect that there will not be a fall in the number of post-mortem examinations, although it should be noted that the number of hospital instigated post-mortems has fallen progressively over the last 20 years. We believe that the number of post-mortems is as likely to increase because of increased public awareness and expectations of medical treatments.

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:	Yes.

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 agree, and the 3 month rule should start from the date of conclusion of the examination.

Question 13.	When might a coroner wish to consider authorising a post-mortem examination to be carried out by a less invasive method?
Comments:	When the envisaged test/investigation will provide the answer, for instance, an X-ray or other imaging procedure might detect a fracture or perforation, a percutaneous biopsy might provide a tissue diagnosis. Further limited examination may be particularly desirable in patients certified as dying of carcinoma with unknown primary site, as this might have implications for the surviving relatives.

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 feel that these examinations must be performed by medically qualified practitioners.

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:	Yes.

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 request should include a narrative history, a differential diagnosis, the results of relevant investigations and also highlight any concerns of the medical staff or their family. The report should automatically be copied to the General Practitioner, the consultant in charge, plus the family on request.

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:	We feel it inappropriate to 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:	We feel it inappropriate to 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:	We feel it inappropriate to 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:	We feel it inappropriate to 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:	We feel it inappropriate to comment.

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

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:	We believe that requests should be allowed at any stage in the investigation, particularly from the family. The response should be as soon as possible depending upon the circumstances.

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 would anticipate increasing demand and increasing costs but are not qualified to compare it to current requests and costs. Perhaps disclosure free of charge should be limited to next of kin.

Question 25.	Are there any circumstances where bereaved people should pay for disclosure of material?
Comments:	No.

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:	We are not qualified to assess this.

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:	Some of our Fellows express concerns that involved clinicians are not routinely given the results of Coroner's findings; apart from the clinical usefulness of this information, it can also provide an important learning point.

Question 28.	What level of requests for information from other interested persons would you expect to see, and why?
Comments:	We would anticipate a high demand in cases where there is a potential for further civil or criminal prosecutions.

Question 29.	How common is charging for disclosure in practice at present? Should we specify the circumstances in which a coroner can charge?
Comments:	We are not qualified to comment.

Question 30.	What levels of fees should be payable?
Comments:	We are not qualified to 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:	We are not qualified to 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 specific comment.

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

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

Comments: Yes, but in complex cases this may be a matter of months.

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: Yes.

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: Yes.

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

Comments: Where national security is involved. You might also consider issues of confidentiality where such conditions such as alcoholism or HIV infection are involved.

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

Comments: Opinion is divided amongst our Fellows but if such evidence is accepted it should carry less weight.

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:	Yes. We suggest as an additional bullet point to Para 26, "died from a recognised complication of a diagnostic/therapeutic procedure".

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:	Yes.

Question 43.	Should the rules contain something on the availability and use of narrative determinations, and if so, what?
Comments:	We believe that narrative determinations should be reserved for specific situations or where additional information might assist in clarification.

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: See Q37 response.

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: If the appeal relates to a post-mortem, we feel that sufficient time must be allowed to allow study of the report and to seek expert help.

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.

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: Yes.

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

Comments: Yes.

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

Comments: In Table 1, Para 10, we would include under the third bullet point "medical practitioners". A suggestion was also put forward that perhaps Coroner's Officers can be replaced by a police surgeon because such a person would be both medically qualified and will have undergone forensic training and have a good understanding of the process.

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

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:	It should happen before starting duty.

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. We suggest you follow the practice of other professional bodies.

Question 55	If training is compulsory, what might be effective sanctions to ensure completion?
Comments:	Appointees should not be allowed to take up appointment until satisfactorily trained.

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:	-

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 view.

Question 58.	Who do you think would be best placed to deliver training and why?
Comments:	We suggest multi-source training including medical practitioners, lawyers, the police, psychologists and forensic medicine specialists. A formal curriculum should be developed.

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

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.

Question 62.	Should there be training courses – possibly residential – for induction courses for coroners and officers; and continuing professional development training?
Comments:	All these components should be part of a structured training programme.

Question 63.	Should there be on site locally delivered training – for local issues?
Comments:	All these components should be part of a structured training programme.

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:	All these components should be part of a structured training programme.

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:	Some events could be open to a mixed audience e.g. discussions on bereavement and management of the bereaved family.

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:	Local induction is important.

Question 67.	Are there any other issues the Chief Coroner should consider in drawing up training regulations?
Comments:	Some of our Fellows felt that the level of current support from the Coroner's Officer to be inadequate, others have found them most helpful and supportive.

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:	-

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:	-

ADDITIONAL NOTES:

1 Short Illustrative Example that could be included in the Guidance in reply to Question 2: Suggestions received from Fellows

Case/circumstance 6 (bullet point 1)

Could be illustrated by MRSA bacteraemia after elective surgery. Reporting of this type of circumstance could uncover universally bad practice or could happen by chance and misfortune.

Alternatively, cardiac arrest in an elderly patient receiving blood transfusion prior to investigation of severe anaemia.

Another example would be a patient suffering a major gastrointestinal haemorrhage secondary to their anti platelet therapy, dying as a result.

In respect of bullet point 5, an example could be the late recognition of acute renal failure in a patient with co-existing severe illness (e.g. pneumonia or recent surgery). The late recognition of a complication has increased the morbidity and mortality for this patient.

2 Late comments received from one of this College's expert Fellows

- Some of the language needs a little more attention to standardisation. On page 13 and at several points, the nature of "the practitioner" should be specified either as a medical practitioner, a hospital medical practitioner or general medical practitioner as specified for the section. Medically qualified doctors should be referred to as registered medical practitioners throughout and should not be confused with practitioners (possibly science or other doctoral graduates). General medical practitioners should be identified separately as their responsibilities and duties are separate with distinct capacity to summarise information to report the potential or presumed cause of dying. At points, the document specifies "loved ones" which appears to be inappropriate terminology and should presumably reflect the next of kin and not pre-judge emotional attachment.

- The College feels that the further move away from a medically qualified coroner re-affirmed here is a mistake. This promotes rather than minimises confusion at the outset on any issue of death that a medically qualified coroner can often quickly address and allay fears over at early stages of enquiry. In addition, it is felt that non-medical coroners can sometimes be slow to grasp the details of cases in practice.

- This new guidance should also outline the characteristics of deaths that do not require referral to the coroner as well as those that are required to be appropriate deaths for referral to the coroner. Currently, there is a large measure of confusion among both junior and senior doctors as to what does not require referral which, in itself, has resulted in more referrals.

- The rights of a doctor who is accused of "neglect" should be recognised and while they may not be allowed to be involved in post-mortem examination, it is clear that they might be reasonably allowed to be present at the examination. This would facilitate explanation to the responsible pathologist completing the post-mortem examination and again allow an integrated assessment to be made without prejudicing his/her findings materially.

- The power to appoint judges to complex cases is clearly appropriate, but the setting of these powers should be outlined in some detail.

- Where a medical practitioner reports a death due to suspicions of culpable human failure, the point of reference should be specified as direct to the coroner and not through a coroner's officer.

- A regards the disclosure of information to families, while this is undoubtedly positive, all materials that are so released must be made available with the full awareness of all medical practitioners that their reports and comments to a coroner are potentially to be made available for public circulation, and are therefore not submitted as confidential comments. The current provisions to protect the reporter from intimidation should be studiously preserved.

- One of the most critical aspects of this reform is in fact rather buried and downplayed within the document. The concept that non-medically qualified persons should conduct post-mortem analysis needs to be opposed in principle. Non-medical staff or PhD forensic science staff have little or no ability to integrate the findings of disease processes. Any such activity must at the very least be integrated with the supervision of a medically qualified coroner or pathologist to oversee such activity. There is room for huge confusion with PhD doctors being misrepresented as medically qualified commentators on the process of death or dying, and this is not only counter-productive but a serious error.

About you

Please use this section to tell us about yourself

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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.

The Royal College of Physicians of Edinburgh (RCPE) is a professional membership organisation. Our principal concern is to develop and oversee an ongoing programme of medical examinations, education and training for qualified doctors who wish to undertake postgraduate education and training in order to pursue a career in specialist (internal) medicine.

In addition to providing educational and professional support for doctors, the RCPE is actively involved in representing the views of doctors in discussions with others, including government, and promoting the public health.