



**RESPONSE TO THE
CORONERS UNIT
MINISTRY OF JUSTICE
DISCUSSION PAPER**

**“CORONERS REPORTS TO PREVENT FURTHER DEATHS:
PROPOSED AMENDMENTS TO RULE 43
OF THE CORONERS RULES 1984”**

MARCH 2008

INTRODUCTION

This is the response of the Royal Society for the Prevention of Accidents (RoSPA) to the Ministry of Justice’s Discussion Paper, “Coroners Reports to Prevent Further Deaths: Proposed Amendments to Rule 43 of the Coroners Rules 1984”. Rule 43 of the Coroners Rules 1984 states:

A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly.

Around 450 coroner reports are made each year, which is just less than one report for every 50 inquests. They address a wide variety of issues, including the prevention of road traffic and rail accidents, the provision of appropriate healthcare and the prevention of suicide in custody. The majority of reports are issued to public sector organisations, in particular to those with responsibility for roads and for healthcare.

In order to make more effective use of coroner reports, the government proposes to:

- Give the coroner a wider remit to make reports to prevent future deaths.
- Impose a duty on the relevant person or organisation to respond to the report.
- Provide statutory authority for the coroner to share reports with interested persons and any person or organisation who may find it useful,
- Enable the Lord Chancellor to make the report, or a summary of it, available to the public generally.
- Disseminate lessons learned from individual cases more widely.
- Promote the importance of making reports through coroner training and guidance.

RoSPA General Comments

RoSPA supports the proposals to strengthen the powers of Coroners to issue reports and to require those receiving such reports to consider and respond to them.

From the standpoint of enhancing accident prevention, RoSPA believes that the Coroners' Service has a vital role to play in providing a 'reality check' on the efficacy of systems and arrangements designed to control the risk of accidental injury. Although, in the case of work related accidents and road accidents, other agencies may be involved (particularly in an enforcement context), coroners have a vital role to play in ensuring that the facts about accidental deaths are brought to light, including any gaps in prevention.

It is also important to ensure that reports and recommendations are directed to the most appropriate body.

Another key issue is 'proportionality'. For instance, RoSPA has disagreed with a number of recent coroner comments regarding the testing of swimming ability on school and adventure trips and the use of buoyancy devices in adventurous activities, as we did not believe the recommendations would prevent a repeat of the incident, but would potentially place a disproportionate burden upon manager and activity providers.

Coroners need to be able to identify and use relevant experts and industry representation, and to have the time and resources to establish who best to speak to.

Coroners need better training, support and encouragement to make full use of their powers under rule 43 and to draw clear conclusions and make any necessary recommendations in the narrative accompanying their findings. Beyond this there is a need to provide greatly enhanced training for coroners and other members of their teams.

RoSPA COMMENTS ON THE SPECIFIC PROPOSALS

Making Coroner Reports

Under the current rules, coroners can make reports to prevent the recurrence of *similar* deaths. We propose to widen the rules so that coroners may make reports to prevent *any* deaths based on the evidence they have accumulated during their investigations, or what is heard at inquest. This will allow the coroner to report issues that may be peripheral to the current case but which could nevertheless prevent death(s) in future.

Coroners will also have powers to make reports where they have adjourned and not resumed inquests. Coroners will also be able to make reports, even when they do not announce their intention to do so at inquest.

Question 1

Do you agree that a coroner should have power to make a report, even when it was not announced at inquest?

RoSPA's Response

RoSPA supports this proposal. Improving Coroners' ability to make reports on specific issues that may help to prevent future deaths is entirely sensible and welcome, and in our view, will make a very positive contribution to preventing avoidable deaths.

It is essential that Coroners draw on appropriate experts and expert knowledge when producing their reports and recommendations, and that reports are directed to the organisation best able to consider and implement the Coroner's recommendations.

Responding to Coroner Reports

In around a quarter of cases, the coroner receives no response to their report. We propose to create a statutory duty for the relevant person to respond in writing within 56 days, although the coroner could extend the deadline at his or her own discretion. Having a duty to respond does not mean that the person or organisation is obliged to act upon the report, but they will be expected to give proper attention to the issues, to consider remedial action, and to inform the coroner in writing of what they intend to do as a result. Failure to respond would be flagged in the regular bulletin produced by the Ministry of Justice.

Question 2

Is the time limit for a response about right? Should there be a greater sanction, and if so what, than “naming and shaming” for a failure to respond to reports?

RoSPA’s Response

RoSPA supports this proposal. It is important to ensure that individuals or authorities to whom the Coroner sends a report properly considers the report, and what action they should or could take as a result. A 56 day period for responding seems more than sufficient, especially as anyone struggling to meet this deadline can ask for an extension.

We suggest that since most reports are sent to public authorities, ‘naming and shaming’ should be a sufficient sanction. However, if it proves otherwise, then presumably stricter sanctions can be considered at a later date.

Sharing and Publishing Coroner Reports and Responses

Under the current system, bereaved families and other interested persons are not always informed of the detailed content of a coroner report or the nature of any response. It is proposed that coroners would have a *duty* to copy reports and responses to interested persons who were notified of the inquest under rule 19 of the Coroners Rules; and the Lord Chancellor, thereby giving him an overview of the numbers of reports being made and the sort of issues being addressed. This would also enable his officials to prepare summaries, for publication, of reports and action taken.

Coroners would also have a *power* to copy reports and responses to other stakeholders, such as relevant regulatory bodies or the Health and Safety Executive.

The Lord Chancellor will have power to publish a copy of the report, or a summary of it. The Lord Chancellor will also have power to publish responses to reports, in full or in summary. However, organisations which respond to reports will be able to make representations to coroners that their response, or a summary of it, is not published.

In practice, we envisage very few reports and responses being published in full, not least because we think it might have the effect of inhibiting the amount of information that is included in them – to the detriment of the overall prime objective of preventing future deaths.

Question 3

Do you agree with the general principle that coroner reports and responses should be shared with interested persons and relevant organisations?

Question 4

Can you think of any circumstances when it would be inappropriate to share reports and responses in this way?

Question 5

Do you agree with the proposal for coroners to copy their report and any response to interested persons and to the Lord Chancellor? If not, how else could we ensure that these people receive this information?

Question 6

Do you agree that only a summary of reports and responses should be published?

RoSPA’s Response

RoSPA supports the principle of coroner’s reports, and responses to them, being published, either in summary or in full. We agree that care needs to be taken to ensure that this does not inhibit the amount of information that is included, especially, in responses to Coroner’s Reports. This seems less likely if summaries, rather than full reports, are published. However, full reports should be available, particularly to families, others involved and to organisations who may be able to take action to prevent similar deaths occurring in future.

Producing a Regular Bulletin

The Ministry of Justice (and subsequently the Chief Coroner) would produce a regular bulletin on coroner reports and responses. One of the objectives would be to identify trends emerging from the reports and to highlight lessons learned that could be applied at a national level. The Lord Chancellor would require coroners to provide particulars of any person or organisation that has failed to respond to a report and this information will be contained in the bulletin.

The next step would be for coroners and the Ministry of Justice to find ways of disseminating lessons learned at local level to a wider audience. Your responses to this paper will inform how this is done. For example, one approach would be to summarise the key points emerging from coroner reports across the country in a single publication, similar to *Fatal Facts*, which is produced by the National Coroners Information System in Victoria, Australia.

Question 7

How could coroners and/or the Ministry of Justice disseminate lessons learned more widely and more effectively?

RoSPA’s Response

Publication of national report, collating the information contained in the local reports would prove to be an invaluable source of data for the government, local authorities and a wide range of organisations.

There are innumerable means of disseminating such a report: the internet, professional and trade journals, libraries and information centres, universities and other educational establishments and directly through organisations such as RoSPA.

RoSPA also recommends that the full reports are placed into a database, as happens in Australia, which can then be searched and interrogated by researchers and those working in accident and injury prevention. Such a information tool would be invaluable in identifying trends in fatal accidents and in identifying and implementing measures and policies to reduce such risks.

Training and Guidance

The use of coroner reports varies widely between individual coroners. This may be due to a variety of factors. Nevertheless, we believe that more could be done to encourage greater use and to this end we recommend that information on coroner reports should be routinely included in induction and in-service training.

Question 8

Is there any particular information you think it would be useful to include in induction and in-service training provided to coroners?

RoSPA’s Response

It would be useful to ensure that induction and in-service training includes the value of coroners making reports and of ensuring that they receive appropriate responses to them. The fact that this will help to prevent further tragedies and will influence the activities of a wide range of government and non-government bodies to help them improve the effectiveness of their work. Case studies of ways in which reports have led to safety improvements would be useful, as would

Training in accident causation and prevention should form part of the extended training for coroners. As well as training in general principles of accident causation (including, for example, fault tree analysis, error types, human factors, risk assessment/management etc.) coroners and their support staff need a good general grasp of principles of prevention. Many coroners for example, may unwittingly hold simplistic views about the nature of error and harbour general biases about human behaviour, which may lead them to blame individuals (frequently accident victims themselves) without being able to set such error in the context of wider organisational and safety systems failures.

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Technical support

Besides the provision of training, this extension of the coronial inquisitorial system may also require coroners to be able to appoint expert assessors and advisors, particularly those who are skilled in investigation processes and have technical knowledge in the fields concerned.

RoSPA thanks the Ministry of Justice for the opportunity to comment on these proposals. We have no objection to our response being reproduced or attributed.

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