Implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009

Consultation on rules, regulations, coroner areas and statutory guidance

Response from Thompsons Solicitors

April 2013

About Thompsons

Thompsons is the UK's most experienced trade union and personal injury law firm. It has a network of offices across the UK, including in the separate legal jurisdictions of Scotland and Northern Ireland.

Thompsons has represented families in many major tragedies such as Hillsborough, Piper Alpha, Kings Cross and Ladbroke Grove. The firm also acts on behalf of families of individuals killed in workplace accidents and regularly represents families who have lost loved ones due to industrial diseases such as mesothelioma and pneumoconiosis.

The firm is involved in around 50 inquests a year either on behalf of the family of the victim of a workplace fatality or by acting for a union member who, as an employee, was associated with an incident that led to a death.

We gave evidence to the Department of Work and Pensions and Home Affairs select committee on the Corporate Manslaughter Bill and have responded to all the consultation papers dealing with coroner reform.

We welcome and support most of the proposals contained in the consultation. We will address only those questions relevant to our experience in representing the families of those who have been killed as a result of work-related accidents and disease.

Question 7: Should the new coroners rules include a target date for completing inquests? If so, what should this target be? Would three months be appropriate? Please give your reasons.

Three months as a target time limit is appropriate in straightforward cases. However, our concern is that while it is inevitable that more complex investigations, particularly those dependent on other bodies, will take longer, this can cause serious problems when there is a civil compensation claim. Such claims have to be brought within three years of the death.

We represented the family of a young man who died in 2009. It took over three years for his death to be properly investigated by the coroner. The delay caused agony for the family, which wanted the inquest to take place as soon as possible so that lessons could be learned from the tragedy.

We therefore suggest that in allowing a longer time for completing inquests in complex cases, a target date should still be identified and that this should be 12 months from registration of the death.

Question 10: Are you content with the draft regulation which says that a body should normally be released within 30 days, and that if this is not possible, the coroner must explain why? If not, please explain your answer.

Yes.

Question 11: Do you agree that one month (with the possibility of seeking an extension) should be sufficient for a person to respond to a coroner's reports of actions to prevent other deaths? If you do not, please explain your reasons.

Yes. We welcome the change in the time limit. Speed of response is absolutely fundamental when a death has been the result of health and safety failures. We would however wish to see meaningful sanctions imposed on organisations for failure to respond to a coroner within one month, or by the agreed extended deadline.

Question 12: Do you agree that the draft regulations to be made under section 43 (Annex A) will ensure more consistent standards in the coroner investigation process? If not, please give details.

Yes. However, we note the new rules in respect of the retention and preservation of material from a post-mortem examination. Retained samples can be crucial evidence in, say, lung disease cases. Samples should be routinely retained whenever industrial disease is the cause of death.

Question 14: Are you content that our proposed rules on disclosure will help bereaved people and other interested persons play a more active part in the investigation process (where they choose to do so)?

Yes.

Further information

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