

This is the fifth and final bulletin about the Coroners and Justice Bill, which has now become the Coroners and Justice Act 2009. If you would like to receive this Bulletin in a different format, please contact Olga Kostiw at [olga.kostiw@justice.gsi.gov.uk](mailto:olga.kostiw@justice.gsi.gov.uk)

## Parliamentary Timetable

After the last update in July, the Bill went through Lords Report Stage and Third Reading in October. This was followed by Commons Consideration of Lords Amendments, where the House of Commons looked at all the amendments made in the House of Lords. Once agreement was reached between the two Houses, Royal Assent was given. The Bill became the Coroners and Justice Act 2009 on 12 November.

## Main changes in the House of Lords

Lord Bach had promised to look again at the issue of **numbers of jurors**. Although summoning jurors can be a difficult administrative process for coroners, it was decided that the minimum and maximum number of jurors should stay at the current levels of 7 and 11. This was widely welcomed.

The Government inserted the role of **National Medical Examiner** into the Bill. He or she will be responsible for leadership of the new medical examiners, and will also liaise with the Chief Coroner's office on matters which overlap between the two systems, such as when a registered medical practitioner should report a death directly to the coroner.

The Government also introduced the role of **Medical Adviser to the Chief Coroner** in the Bill. He or she will provide advice to the Chief Coroner on any medical matters which impact on the coroner system, including in relation to appeals and post mortems. The role will also include liaising with the National Medical Examiner on the national job description of the medical examiners.

**Reports to prevent future deaths** are an important part of a coroner's role, and the Government has strengthened the law which underpins them. In future, the coroner must make a report, if he or she believes that action could be taken to prevent future deaths. Any organisation which receives a report must respond on what action has been taken. Finally, a summary of reports will be published in the Chief Coroner's annual report.

The Government agreed that arrangements should be put in place so that the reasons for **investigations lasting over 12 months** are recorded. Coroners must therefore report to the Chief Coroner any investigation that has not been completed within 12 months, but also when that investigation is completed. The number of these investigations will be collated and included in the Chief Coroner's annual report.

The inquests into the deaths of service personnel in Iraq and Afghanistan remain a matter of public importance. In order to ensure that they are dealt with efficiently and as quickly as possible, the Act was amended so that the Chief Coroner will **monitor service personnel death investigations**. He or she will also arrange training, where necessary, to make sure that coroners are fully trained to preside over such investigations.

The Coroners' Society of England and Wales had raised concerns about the powers on **entry, search and seizure** in the Bill. The Government went some way to address these concerns through amendments allowing searches to be authorised over the telephone rather than in writing. The Chief Coroner will record the reasons for such searches, and a summary of reasons will be included in the annual report.

**Legal aid** for investigations where the person died on active service or in state detention has been brought within the formal scope of the civil legal aid scheme. It will still be means tested and will need to meet specified criteria, but it will enable the Legal Services Commission to make decisions on these cases without reference to Ministers.

Finally, the Government introduced amendments to the Bill to allow the Registrar General, with the agreement of the relevant Minister, to prescribe a new form of **short death certificate**, which will omit the cause of death. This would be in addition to the full death certificate, but would enable families to inform most organisations of the death of their loved one without having to reveal the cause of death.

## Final amendments in the House of Commons

There are some very rare cases where there may be evidence relevant to the inquest which cannot be publicly disclosed, and there are no alternative measures available – such as those used in the inquest into the death of Jean Charles de Menezes – to enable an inquest to take place.

After prolonged debate in both Houses, the following procedure was agreed. When the coroner has determined in consultation with interested persons that an Article 2 compliant inquest cannot take place, the matter will be referred to the relevant Secretary of State. He will then inform the Lord Chancellor, who, in consultation with the Chief Coroner, will need to be satisfied every effort had been made for an Article 2 compliant inquest to take place. If so satisfied, the Lord Chancellor will approach the Lord Chief Justice for approval to the appointment of a senior judge to chair an inquiry. If such approval is given, the relevant Secretary of State will formally establish the inquiry and appoint the judge as chair, and the Lord Chancellor will request the coroner to suspend his or her own investigation.

## Summary of previous amendments to the Bill

In due course, we will produce a plain English guide on the final content of the new coroners' legislation. This summary only covers the changes made to the Bill, excepting those set out above.

Deaths of service personnel abroad, where the family is based in Scotland, may be investigated under the **Fatal Accident Inquiry provisions in Scotland** for most cases. It will mean that families will not have to travel to attend hearings in England and Wales.

The **Treasure** investigation system is reformed by removing the jurisdiction from local coroners, passing the cases to a national Coroner for Treasure. If a hearing is required, this may be held anywhere within England and Wales. The Crown will be able to disclaim an object earlier than at present, preventing unnecessary hearings. The prosecution period for reporting an item as a finder or acquirer is a maximum of 3 years, rather than the current 6

months. Interested persons will have a right of appeal to the Chief Coroner. It was intended in 2006 to include a **duty on acquirers to report treasure objects**, but this was not in the package of treasure reforms which was introduced at Lords Committee Stage. After further consideration, the duty was reinstated: a person who acquires (buys, inherits or is given) an object which they believe to be treasure to must report it to the Coroner for Treasure.

Coroners as well as judges will be eligible to be **Deputy Chief Coroners**. The number of Deputies will be decided in due course.

It will be possible for the Chief Coroner to call on a **range of people to investigate particular deaths**, when an investigation is particularly complex. The Chief Coroner will be able to appoint a current or retired High Court judge, a Deputy Chief Coroner, the Coroner for Treasure, or a retired coroner.

The legislation allows for **deaths outside the Northern Ireland jurisdiction to be investigated**, if the body is returned there. This is particularly to deal with deaths of service personnel, but will apply to all deaths outside Northern Ireland, if the death falls within the coroner's jurisdiction.

## Want to find out more?

A complete account all stages of the Act is at <http://services.parliament.uk/bills/2008-09/coronersandjustice.html>. This has links to debates, the versions of the Bill and the explanatory notes.

You can also contact the team which will now be working on the implementation of the Act:

- Geoff Bradshaw
- Chris Bell
- Elizabeth Knapp
- Olga Kostiw (contact point)  
[Olga.Kostiw@justice.gsi.gov.uk](mailto:Olga.Kostiw@justice.gsi.gov.uk)