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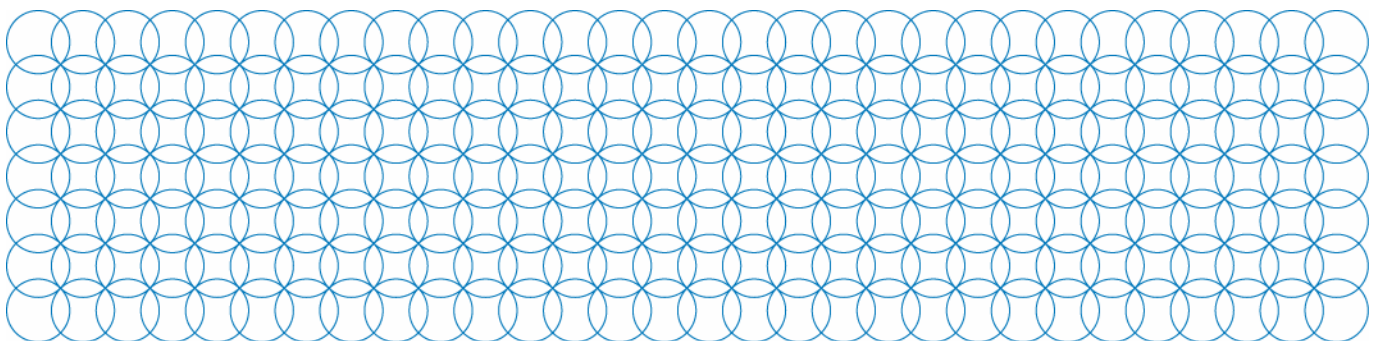
# **Pandemic influenza**

Draft guidance on the operation of the  
coroner system in England and  
Wales

**Consultation Paper [CP(L) 18/08]**

Published on 23 July 2008

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**JUSTICE**

## **Pandemic influenza**

Guidance on the operation of the coroner system  
in England and Wales

**A consultation produced by the Ministry of Justice.**

**This information is also available on the Ministry of Justice website:  
[www.justice.gov.uk](http://www.justice.gov.uk)**

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## Introduction

This paper sets out draft guidance for coroners and planners in the event of an influenza pandemic. We are seeking comments through a targeted consultation with interested stakeholders. The guidance will apply to England and Wales only.

Although in the main this consultation follows the Code of Practice on Consultation issued by the Cabinet Office, Bridget Prentice, Minister for State has decided that, because of the urgent need to finalise guidance and the specialist nature of the guidance, the consultation will last for six weeks rather than twelve. The targeted nature of the consultation will mean that stakeholders from relevant groups will have the opportunity to comment.

The proposals contained within the guidance do not impose additional burdens. They are designed to ease the pressure on the coroners system in the event of an influenza pandemic and are discretionary. Where legislative changes are made, these are intended for a very limited period only and would be in a period of extreme pressure. Consequently, the paper does not contain an Impact Assessment.

Copies of the draft guidance are being sent to:

- Coroners Society
- Coroners Officers Association
- Association of Chief Police Officers
- Local Government Association
- Local Resilience Forums
- Royal College of Pathologists
- British Medical Association
- Faith Communities Consultative Council
- Cruse Bereavement Care
- Inquest
- First Aid Nursing Yeomanry

Responses are welcomed from anyone with an interest in or views on the measures outlined in the guidance.

## Summary of proposals

This guidance is intended to assist **coroners** and **local planners** to prepare for and mitigate the effects of an influenza pandemic in England and Wales.

First, it sets out business continuity measures that could be planned and introduced locally by the coroner or under the aegis of the Local Resilience Forum. These are referred to as Phase One and Two Different Ways of Working and are:

- Prioritising disposal certificates over inquests
- Identifying and appointing additional assistant deputy coroners
- Redeploying staff from other local authority functions
- Pooling of resources between different jurisdictions
- Managing the number of coroner post-mortems.

The guidance also outlines a range of measures that would require changes to the current law. These are referred to as Phase Three Different Ways of Working. Government Ministers would decide if and when these should be introduced but they should nevertheless be taken into account when developing local plans. These measures are:

- Jury inquests to be held at the discretion of the coroner in all cases
- Simplifying arrangements for the appointment of deputy and assistant deputy coroners
- Greater flexibility for coroners to order post-mortems to be held outside of their jurisdiction
- Greater flexibility concerning where an inquest can be held and which coroner can hold an inquest
- Relaxing requirements to investigate deaths abroad.
- Increasing a coroner's ability to hold inquests based on documentary evidence, rather than requiring attendance of witnesses.

## Context and scope

1. A number of different central government departments and local service providers share responsibility for managing deaths. In May 2008 the Home Office issued 'Planning for a possible influenza pandemic: A framework for planners preparing to manage deaths' to help local planners to prepare for and mitigate the effects of an influenza pandemic. The Government's objectives are to ensure that the death management process continues to operate under the pressure of a large number of excess deaths, and to maintain compliance with human rights law, as well as consideration for the bereaved and dignity in dealing with deaths.
2. Coroners are independent judicial officers whose duty is to enquire into violent or unnatural deaths, sudden deaths the cause of which is unknown, or deaths in custody. The coroner, supported by coroner's officers and administration staff, will investigate the deaths reported to them, possibly ordering a post-mortem and holding a formal inquest. (Annex A provides further information about the current coroner system.)
3. In 2007 there were around 500,000 registered deaths in England and Wales, of which 47% (234,500) were reported to a coroner. Clearly it is not possible to forecast with complete confidence the number of excess deaths that are likely to result from an influenza pandemic. It is not possible at this stage to say with any certainty what impact a pandemic will have. It may be spread over one or more waves, each of around 15 weeks, which could be weeks or months apart. Due to this uncertainty, the Home Office National Framework posits a range of between 55,500 and 750,000 additional deaths in the UK over a 15-week period. The 750,000 is based on a reasonable worst case scenario of a clinical attack rate of 50% in a single wave of 15 weeks duration and an overall case fatality rate of 2.5%.
4. As influenza is a natural cause of death these cases should not theoretically require investigation by a coroner. However, it is anticipated that there will be a significant number of cases where a doctor is unable to complete a medical certificate of cause of death because no doctor has attended the deceased within the necessary period prior to death, and therefore an increase in the number of referrals to the coroner. There are other circumstances where a coroner must investigate (e.g. prison deaths) whether the cause of death is pandemic influenza or otherwise. But in any event a pandemic will inevitably affect the operation of the normal delivery of services by coroners and their officers.
5. Having considered the Home Office National Framework, the Ministry of Justice has issued this operational guidance for the coroner system in England and Wales. It suggests different ways of working in the event of a pandemic, and it is aimed at coroners and Local Resilience Forums, which are the principal mechanism for the co-ordination of multi-agency planning at a local level.

6. When developing business continuity plans, coroners and planners will wish to balance the public interest in the investigation of deaths by the coroner (and the coroners' legal requirement to do so), with the need to ensure that burial and cremation can take place in a timely manner, in order to minimise the pressure on body storage facilities. Separate guidance is also available on the management of death certification<sup>1</sup> and death registration<sup>2</sup> in the event of a pandemic. This should also be taken into account when developing local plans. Key measures in these other guidance are flagged in this document.
7. The main legislation governing coroners is the Coroners Act 1988 and the Coroners Rules 1984. The Government plans to reform the coroner system and a Coroners and Death Certification Bill has been included in the draft legislative programme for the 2008/09 session of Parliament. The guidance below applies to the current system. If and when reform is implemented, any amendments necessary to the guidance will be made. These should not affect planning assumptions – the measures described will be available in both the current and reformed systems.

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<sup>1</sup> *Pandemic influenza: Guidance on the management of death certification and cremation certification.* Published by the Department of Health.

<sup>2</sup> *Planning for a possible Influenza Pandemic: Guidance on Death Registration Services for Registration Service Managers and Practitioners.* Published by the General Register Office.

## Operational guidance

8. The Home Office National Framework outlines three phases of different ways of working in the event of an influenza pandemic. For some business areas there may be little substantive difference between the measures adopted in Phase One and Phase Two, so these are dealt with together in this guidance. Phase Three is dealt with separately.
9. As part of the planning process, coroners and planners may want to use the calculator provided in the Home Office framework, which enables the number of deaths to be forecast locally in a number of different scenarios. This will help planners to assess the potential impact on the coroner system (in terms of numbers of referrals) and to make proportionate contingency plans.

## Phase One and Two Different Ways of Working

10. Phase One Ways of Working are measures that can be implemented by an individual business area, in this case by the coroner. Phase Two Ways of Working form part of the Local Resilience Forum plan, relying on co-operation between one or more organisations to achieve the most efficient management of excess deaths. An important part of Local Resilience Forum plans will be to set out the agreement of business areas to move to Phase Two, and the triggers that will underpin this movement.
11. The point at which Phase One measures are implemented will be for the coroner to decide. The point at which Phase Two measures begin should be agreed locally through the Local Resilience Forum. In making plans, coroners and Local Resilience Forums should include arrangements to ensure a smooth transition back to business as usual.
12. In addition to the Phase One and Two measures suggested below, coroners should also be aware of the Department of Health's guidance on the management of death certification and cremation certification. This recommends that in Phase Two the common (non-statutory) practice of reporting all deaths that occur within 24 hours of admission to hospital to the coroner will cease. Coroners will need to agree with Local Resilience Forums when this measure should be implemented.

### **Identifying and appointing additional assistant deputy coroners**

13. Coroners and local planners should assess the need to appoint additional assistant deputy coroners to deal with additional deaths and absence of coroner staff (including the coroner) in the event of a pandemic. The calculator mentioned above may be a useful tool in this respect. If there appears to be a need for additional posts, the next step will be to identify a pool of suitable candidates. Assistant deputy coroners are paid on a fee basis, and so appointments could be made in advance of a pandemic at no cost, although clearly this is a decision to be taken locally.
14. To be qualified for appointment as a coroner, deputy or assistant deputy coroner it is necessary to hold a five year legal qualification that enables practice as a barrister or solicitor, and/or to be a legally qualified medical practitioner of not less than five years standing. There is likely to be an increased demand for medically qualified practitioners in the event of an influenza outbreak. It should also be noted that upon implementation of a reformed coroner system, those holding only a medical qualification will not be eligible to serve as a coroner. For these reasons, it is recommended that those identified for appointment in connection with a pandemic should be legally qualified.
15. Part of the planning process will be to consider how additional assistant deputies should be deployed to best effect. For example, if part of the local business continuity plan is to prioritise the issue of disposal certificates (see paragraph 27), it may be sensible for the additional assistant deputies to be allocated mainly or wholly to that task and trained accordingly.
16. Coroners and local planners should make arrangements for the induction and training of any additional assistant deputies. Although it may be sensible for an assistant deputy to work predominantly on pandemic cases they will have all the powers of a coroner, and may be required (dependent on local need) to deal with cases beyond those caused by the pandemic. This should be taken into account when deciding upon training and induction needs.

### **Redeploying staff from other local authority functions**

17. In the event of a pandemic it may be necessary to redeploy local authority staff to act as coroners' officers and coroners' administrative staff, helping to ensure that deaths are managed in a proper and timely way. It will be for planners to decide whether the aim of redeployment is simply to counter balance existing staff absences, or whether additional staff should be deployed to help manage an increased caseload.

18. Local Resilience Forums should facilitate discussion and agreement between coroners, local authorities and other service providers on the scope for redeployment. This is likely to include:
- Identifying which local authority functions would be able to release staff to act as coroner's officers and/or administrative staff.
  - Assessing the number/proportion of staff available and needed.
  - Agreeing redeployment and training arrangements for staff.

In the event of an outbreak, a final decision about staff redeployment will need to be taken locally, based on the severity of the pandemic, absences within the coroner's office and the relative priority of different services in those circumstances.

19. It is recognised that the police (who employ around 90% of coroners' officers) are unlikely to have spare capacity to redeploy staff to the coroner system. However, coroners and local planners will need to work with police authorities to ensure that coroners officers are not redeployed into other roles and to come to mutually agreed planning assumptions.
20. The role of a coroner's officer is relatively specialised and those transferring into the role will require training and support. The Ministry of Justice is working with the Coroner's Officers Association to produce a generic induction pack. This will include information about the role of the coroner and coroner's officers, key legislation and guidance, plus guidance on ways of working in the event of an influenza pandemic. Given that practices can vary between different coroner districts, the generic induction pack will need to be adapted by coroners and planners for local use.

### **Pooling staff with adjoining authorities/jurisdictions**

21. Planners may also want to explore the potential for neighbouring coroners and local authorities to pool staff in the event of a pandemic. This could be done in a number of ways. For example, coroners' officers and administrative staff could work across several coroner jurisdictions. In exploring this option, coroners and local authorities will want to consider the potential for co-location and/or remote working for coroners and coroners' officers and to build this into plans.
22. The purpose of pooling staff would be to help ensure that all jurisdictions are able to operate effectively in the event of an influenza pandemic. For example, it may be that one jurisdiction is particularly badly hit in terms of staff absence and would struggle to operate effectively in isolation. However, arrangements whereby jurisdictions were able to pool resources may help to mitigate the severity of the impact on the service provided.

23. In addition, it may be that pooling of staff may be able to create more efficient ways of working. For example, where staff are pooled, it may be possible to dedicate a member of staff purely to dealing with disposal of bodies (or to another area of work which needs to take priority) in a way which would more difficult to do if only one jurisdiction's staff were involved.
24. Local Resilience Forums should facilitate discussion and agreement between coroners, local authorities and police authorities as to the scope for the pooling of staff across jurisdictional boundaries. This should include agreement as to funding arrangements, as well as whether there is a need for a single operational centre. Consideration should be given to the fact that, without changes in legislation proposed at Phase Three, there may be some limitation on the coroner being able to sit with his or her staff. In particular, until Phase Three, coroners will only be able to move bodies to an adjoining jurisdiction to their own for the purposes of a post-mortem and this will need to be reflected in any plans to pool staff.

### **Managing the number of coroner post-mortems**

25. It is for the coroner to determine whether a post-mortem is necessary to determine the cause of death in cases referred to them, or whether the cause can be established on the basis of any other evidence. In 2007 47% (110,000) of all cases referred to a coroner were subject to a post-mortem examination, although the rate varied significantly between different jurisdictions from 27% to 78%.<sup>3</sup>
26. Were these proportions to be maintained in a pandemic, there could be a significant risk that mortuary and pathology services would be unable to deal with the volume of cases. The worst case scenario could see 750,000 additional deaths over a fifteen-week period. If 30% of these deaths (225,000) were referred to the coroner then, based on current rates, this would result in around 105,000 additional coroner post-mortems in a 15 week period.
27. Local authorities will need to assess the impact of a pandemic on mortuary capacity and to plan accordingly. However, coroners also will want to continue to ensure that post-mortems are ordered only when necessary.
28. Although influenza is a natural cause of death, it is anticipated that there will be a significant number of cases where a doctor is unable to complete a medical certificate of cause of death, and the deaths will therefore need to be referred to the coroner.

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<sup>3</sup> It should be noted that some of the differences may be due to local variation in definition and counting of referrals, and/or through the differences in cases which are reported to coroners in different jurisdictions.

29. More generally, when assessing the need for a post-mortem, coroners may wish to put more weight on documentary evidence and previous medical diagnosis than in usual circumstances, and to consider very carefully the need for a post-mortem examination in all cases referred to them, not just ones where influenza is the suspected cause. For example, deaths from mesothelioma may not routinely require a post-mortem. If the cause of death of the deceased had already been diagnosed, and the symptoms leading to death were consistent with that condition, a post-mortem may be unlikely to provide any new information.
30. In the event of an influenza pandemic, coroners will wish to consider how best to exercise their discretion in ordering post-mortems; with the emphasis on cases where otherwise it would not be possible to determine the cause of death. The simple checklist at Annex B may help coroners to determine whether a post-mortem is necessary in these circumstances. Ultimately however, the decision is for the coroner to make after assessing all the relevant circumstances.

### **Ensuring efficient issue of disposal certificates**

31. In the event of an influenza pandemic, and the associated increase in deaths over a relatively short period of time, the quick and efficient disposal of bodies assumes much greater importance. Were the disposal of bodies to be delayed, this would create delays for families in holding funeral services (and may create additional pressures on the funeral industry). It will also place great strain on body storage facilities, whether at funeral homes or mortuaries, which will in turn impact on the efficient management of deaths more generally.
32. Available statistics indicate that approximately 95% of disposal certificates are issued within one week of referral. This would indicate that the issuing of certificates is already a priority for coroners and staff. However, coroners should consider the need to dedicate additional time or resources, in consultation with local burial and cremation authorities (whose own pandemic planning may be based on a limited and fixed period between death and disposal of body). The pooling of resources (discussed at paragraphs 21-24) may be a measure which will provide particular assistance to ensuring a timely issue of disposal certificates.

## Phase Three Different Ways of Working

33. Phase Three Ways of Working all require changes to primary or secondary legislation, which will need to be implemented by Government Ministers. The Home Office National Framework explains how different Phase Three measures would be rolled out. Broadly, this will be a national decision taken by Ministers, based on information available.
34. The Home Office National Framework states that the precise arrangements for terminating Phase Three will be identified in the regulations which enable the implementation of Phase Three. It is intended that this will be a national decision, again taken in the light of the information available, and will be applied on a national basis. The exact timing of the revocation of Phase Three measures will depend upon the severity of the pandemic, and the impact this has on the service and the management of deaths more widely.
35. Where decisions have been taken in accordance with the emergency procedures, those decisions will continue to be valid even after the emergency procedures have been lifted. However, it will be open to the coroner (as at present) to change that decision should that be appropriate once emergency conditions no longer applied.
36. The legislative measures outlined below are largely discretionary. Planning should be on the assumption that they allow for a coroner to take certain measures without requiring him or her to do so. The one exception to this is the measure making coroners responsible for the appointment of a new deputy, or of additional assistant deputy coroners.
37. Coroners and local planners should familiarise themselves with the measures below and ensure that they are included in local business continuity plans. Coroners should also be aware of the Department of Health's guidance on the management of death certification and cremation certification. This explains that in Phase Three a registered medical practitioner who was not attending the deceased during their final illness will be able to certify a death if, to the best of their knowledge and belief, it was due to pandemic flu. In addition a registrar will not be required to report a death to the coroner where the certifying doctor has seen the patient in the 28 days preceding death (currently this requirement is 14 days). This should have the effect of reducing the number of deaths referred to the coroner. It also gives detail of a streamlined process for cremations, including a simplified 'Form B'.

### **Jury inquests to be held at the discretion of the coroner**

38. Under the Coroners Act 1988 the coroner is required to hold an inquest with a jury in certain specific circumstances. The coroner also has discretion to summon a jury in any case where it is deemed to be appropriate.
39. It is likely that the number of apparent natural deaths in custody will increase in the event of a pandemic because people in custody will be in closer proximity to each other, increasing the possibility of infection. This is likely to put additional pressure on those coroners with one or more prisons – or psychiatric hospitals or immigration centres - in their jurisdiction. Jury inquests require more resources than other inquests. In part this is due to the often complex subject matter but there is also the need to secure suitable accommodation, to summon jurors and to prepare the necessary paperwork for jurors. It may be particularly difficult to schedule jury inquests during an influenza outbreak, as jurors are more likely than usual to have pressing professional and personal commitments, or may fall ill themselves causing further delay to inquests.
40. To ensure that inquests are held in a timely manner, coroners will be given complete discretion in all cases over whether to hold a jury inquest<sup>4</sup>. This discretionary power will apply to both new and cases already referred to the coroner for a period of time prior to the introduction of Phase Three Ways of Working. When deciding whether to summon a jury the coroner may wish to consider:
- Whether the deceased was diagnosed with influenza.
  - The wishes of the deceased's family.
  - Whether it is necessary to summon a jury in order to maintain public confidence in the inquest.
41. It is very likely that there will still be cases of deaths in custody, such as apparent self-inflicted deaths, that would require a jury inquest. The measure is designed to allow coroners a suitable level of discretion where it is likely the death occurred as a result of pandemic influenza. Where the circumstances continue to warrant a jury inquest, then the coroner should hold one.

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<sup>4</sup> This complies with Article 2 of the European Convention of Human Rights, which requires an investigation into all deaths that occur through the act of an agent of the State.

42. In those cases where it is deemed appropriate to summon a jury, it would be for the coroner to decide whether to proceed or to suspend the inquest until after the pandemic and a return to business as usual.

### **Arrangements for the appointment of deputy and assistant deputy coroners**

43. Under the Coroners Act 1988 it is for the coroner to appoint his or her deputy and assistant deputy coroners, with the approval of the chairman of the relevant council.
44. As part of Phase One and Two ways of working, coroners and local planners should have made arrangements to identify and appoint additional assistant deputy coroners. Nevertheless it may still be necessary to appoint a new deputy, or new or additional assistant deputy coroners at short notice in the event of a pandemic, either to replace other office holders or to deal with a sudden and unexpected increase in workload.
45. To avoid any delay coroners will be empowered to make these appointments without the approval of the council during the Phase Three period. The local authority should, however, be informed as a matter of course.
46. When the powers which authorise Phase Three Ways of Working are revoked, any appointments made by the coroner under emergency legislation will cease. If the local authority wished to retain any of these deputy or assistant deputy coroners, then the chairman of the relevant council should confirm the appointment in the normal way.

### **Greater flexibility for coroners to order post-mortems outside of their jurisdiction**

47. Under the Coroners Act 1988 the coroner may order the removal of the body to any place within his or her own district, or an adjoining district, in order for a post-mortem examination to be carried out. Past experience suggests that these geographical restrictions can cause practical difficulties when there is a sudden increase in caseload in a particular area. It can also make it difficult to procure specialist post-mortems, as specialist pathologists are not available in all parts of England and Wales.
48. At Phase Three of a pandemic, these restrictions will be removed, allowing the coroner to order a post-mortem to be conducted in any suitable facility in England and Wales. This will give maximum flexibility to manage the increased pressure on mortuary facilities, mortuary staff and pathologists.

49. In planning for a pandemic, coroners and local planners will need to consider options for storing bodies and conducting post-mortems on a local or regional level. Part of the planning process will be to assess whether existing facilities and capacity are likely to be sufficient, or whether temporary mortuaries will also be required. The Home Office Framework recommends that all alternatives are fully explored before any investment is made in temporary mortuaries. Greater flexibility on where an inquest can be held and which coroner can hold an inquest
50. Under the Coroners Act 1988 an inquest into a death shall be held only by the coroner within whose district the body lies, and a coroner shall only hold inquests within his or her district. Arrangements for the transfer of cases, and responsibility for the costs of transferred cases, are also governed by the Act.
51. In Phase Three measures will be introduced to give greater flexibility to coroners. The requirement for a coroner to hold an inquest only in his or her jurisdiction will be removed. In addition, the limitation that a case only be heard by the coroner in whose district a body lies (unless transferred) will be removed. This would take away the need for a formal transfer of a case, enabling a more efficient movement of cases if necessary.
52. This will enable a greater level of co-operation between jurisdictions. It would, for example, enable coroners and staff to be co-located at a single base, and the potential efficiencies for workload management created. This may allow a more even spread of cases across a set of coroners, without the need to transfer them from one jurisdiction to another.
53. Another option might be for a monitoring system to be put in place on a regional basis which could distribute cases evenly amongst available coroners.
54. In order for these provisions to be effective, the Local Resilience Forum will wish to co-ordinate the planning process in close liaison with coroners and other services. Agreement will be needed in advance of the pandemic on how plans are to be implemented and work co-ordinated. In particular agreements on the monitoring of numbers, potential transfer of cases and pooling of resources will need to be made.
55. In developing plans, a number of points need to be considered. Suitable accommodation will need to be identified for any option involving the co-location of staff. Accommodation needs to be of a suitable size, and the provision of court space also needs to be considered. Arrangements for the monitoring of numbers, and co-ordination of transfers would also need to be determined and signed up to by all parties. It should also be noted that notification for death registration will need to be sent to the registrar for the district where the death took place.

## **Relaxing the requirements for investigating deaths abroad**

56. Coroners are required to investigate deaths that occur abroad where the body is returned to their jurisdiction and the circumstances of the death are such that they would otherwise be required to investigate if the death had occurred in England and Wales.
57. In the event of an influenza pandemic there is likely to be an increased number of deaths abroad that would need to be referred to the coroner where the body is repatriated. This may be because insufficient evidence of the cause of death is available (even if it is assumed to be influenza) or because the relevant certificates from the overseas authorities cannot be produced.
58. In order to minimise the increased workload that overseas deaths may create, the Government are likely to limit the types of deaths abroad that a coroner must investigate. Coroners will be required to investigate only three categories of deaths. These will be:
- i. If the coroner has reasonable cause to suspect that circumstances arising in England and Wales may have caused or contributed to the death – e.g. medical treatment in England or Wales.
  - ii. If the coroner has reasonable cause to suspect that an act or omission has taken place which, if it had taken place in England or Wales, would be considered murder, manslaughter or infanticide. This will only apply when there is no investigation in the country where the death occurred.
  - iii. The deaths of a member of the Armed Forces whilst on duty abroad.

Coroners will nevertheless continue to have discretion to investigate any other deaths abroad.

## **Increasing a coroner's ability to hold inquests based on documentary evidence**

59. The Coroners Rules 1984 allow for documentary evidence to be submitted where this is unlikely to be disputed, provided there is no objection from an interested person. Were an objection to be made, a coroner must call the witness from whom the documentary evidence has been received.
60. In the event of a pandemic the Government will amend the Coroners Rules so that an objection from an interested party does not necessarily prevent the use of documentary evidence. Coroners will be able to decide, case by case, whether to proceed on the basis of the documentary evidence or whether there are compelling reasons to call the witness.
61. This will enable a more efficient processing of cases. Where only documentary evidence is to be used there will be no need for witness availability to be a consideration in scheduling inquests. It should also enable inquests to be concluded more quickly, meaning a greater number will be completed in a shorter time.

62. In deciding whether to proceed with documentary evidence only, coroners will wish to balance any objections that may have been registered with the need for efficiency. In particular, coroners will need to consider Article 2 requirements in relation to deaths in custody. Of particular relevance will be whether it is necessary to provide the family with an opportunity question a witness in order to provide them with a proper opportunity to participate in the investigation. The Courts have previously held that family participation is not necessarily a compulsory requirement of Article 2.<sup>5</sup>

## Communications

63. Any changes to the coroner system, particularly to the conduct of inquests, will require careful and sensitive communication. It will be important to make clear the reason for the changes and their implications.

64. The Home Office National framework offers further guidance on communications in the event of an influenza pandemic. It notes that local communications will be the first step in providing reassurance to the public, and emphasises a **tell it all, tell it truthfully and tell it quickly** approach. Coroners and local planners should ensure that communications are factored into business continuity plans.

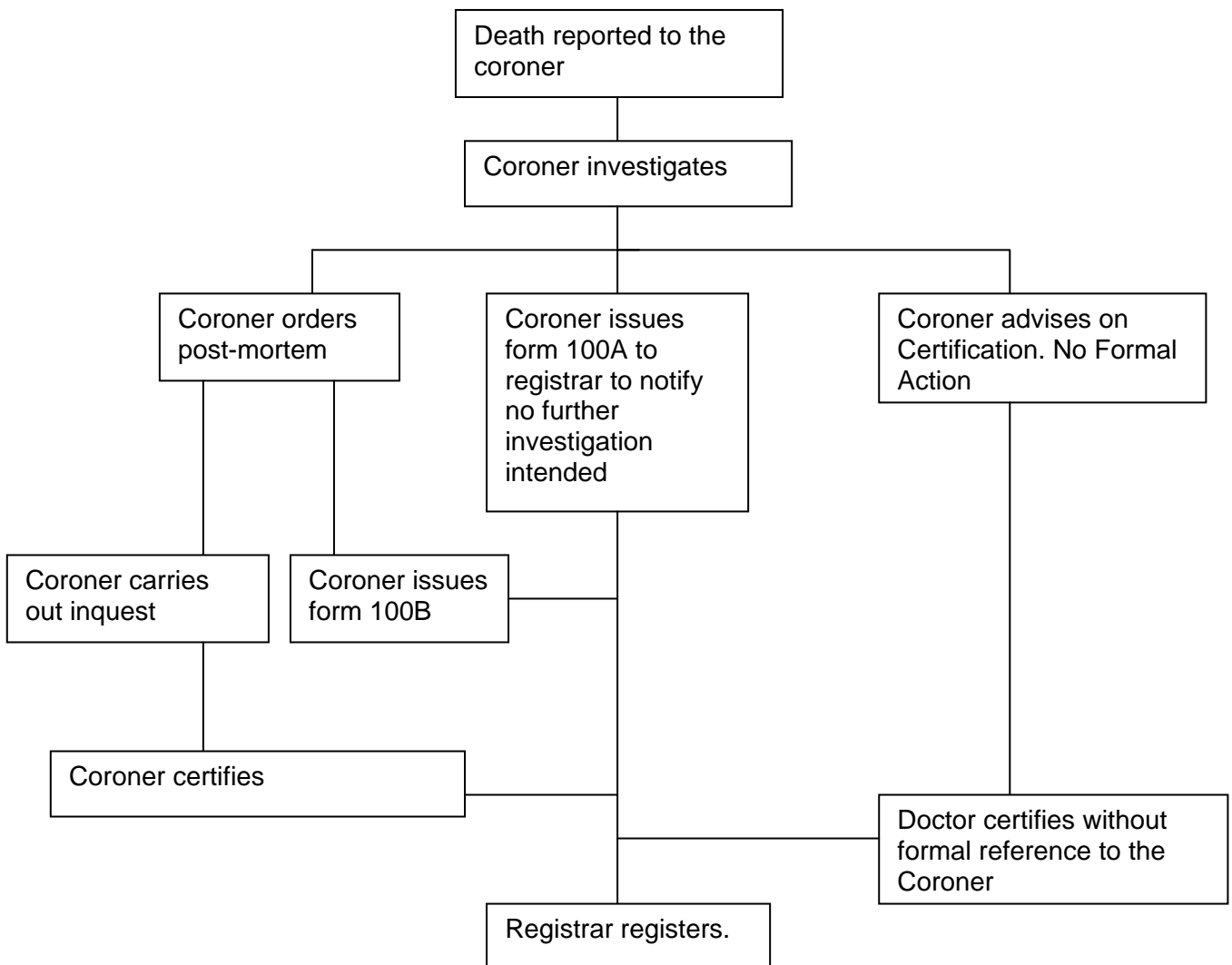
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<sup>5</sup>The requirements of a case will vary with circumstance. For example, an accusation of murder by state agents would call for an investigation of the utmost rigour, whilst a death in custody with no accusation of negligence would bear a different quality. The Courts have also held that a duty to investigate under Article 2 has three aims: To minimise the likely risk of similar deaths in the future; to give the beginnings of justice to the bereaved; and to assuage the anxieties of the public. Fulfilment of the Article 2 obligation requires a flexible approach which is responsive to the facts of the particular case.

## Annex A

1. Deaths are usually reported to the coroner by the police or a doctor called to the death if it is sudden. The local registrar of deaths may also make a referral. Whenever a death is reported, the registrar must wait for the coroner to finish his or her enquiries before the death can be registered.
2. Upon referral, a coroner must consider whether an inquest or post-mortem is required or whether to notify the registrar that they are unnecessary. In considering this the coroner will take into account information relevant to the death of other persons.

**Figure 1: Current system of death certification and investigation**



## Annex B: Determination of whether a post-mortem is necessary

### Pandemic flu – emergency procedure

Name of deceased:

Information from coroner's office:

Has a diagnosis of flu been made? Yes / No

If yes:

- by a doctor? Yes / No

- by another health professional? Yes / No

- by telephone contact only? Yes / No

(in which case attach documentation)

If the diagnosis is sufficiently reliable, no further action is necessary.

Advice from pathologist:

What form did your post mortem examination take?

(naked eye examination suitable if there was a diagnosis of flu)

- external naked eye examination Yes / No

If so, was this consistent with flu? Yes / No

(if no, proceed to full pm)

- blood serology Yes / No

If so, did this diagnose flu? Yes / No

(if no, proceed to full pm)

- closed lung biopsy Yes / No

If so, did this diagnose flu? Yes / No

(if no, proceed to full pm)

|                                  |            |                              |
|----------------------------------|------------|------------------------------|
| Name of pathologist :            | Signature: | Date of limited post mortem: |
| Name of supervising pathologist: | Signature: |                              |

## Contact details/How to respond

Please send your response by 3 September 2008 to:

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### Publication of response

A paper summarising the responses to this consultation will be published within 12 weeks of the closing date for the consultation. The response paper will be available online at [www.justice.gov.uk](http://www.justice.gov.uk)

### Representative groups

Representative groups are asked to give a summary of the people and organisations they represent when they respond.

### Confidentiality

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Ministry.

The Ministry will process your personal data in accordance with the DPA and, in the majority of circumstances, this will mean that your personal data will not be disclosed to third parties.

## **The consultation criteria**

The six consultation criteria are as follows:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
2. Be clear about what your proposals are, who may be affected, what questions are being asked and the time scale for responses.
3. Ensure that your consultation is clear, concise and widely accessible.
4. Give feedback regarding the responses received and how the consultation process influenced the policy.
5. Monitor your department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.
6. Ensure your consultation follows better regulation best practice, including carrying out an Impact Assessment if appropriate.

**These criteria must be reproduced within all consultation documents.**

## About you

Please use this section to tell us about yourself

|   |   |
|---|---|
| <b>Full name</b>  |   |
| <b>Job title</b> or capacity in which you are responding to this consultation exercise (e.g. member of the public etc.) |   |
| <b>Date</b>   |   |
| <b>Company name/organisation</b> (if applicable):   |   |
| <b>Address</b>  |   |
|   |   |
| <b>Postcode</b>   |   |
| If you would like us to acknowledge receipt of your response, please tick this box                                      | <input type="checkbox"/><br>(please tick box) |
| Address to which the acknowledgement should be sent, if different from above  |   |
|   |   |
|   |   |

**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.

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## Consultation Co-ordinator contact details

If you have any complaints or comments about the consultation **process** rather than about the topic covered by this paper, you should contact Gabrielle Kann, Ministry of Justice Consultation Co-ordinator, on 020 7210 1326, or email her at [consultation@justice.gsi.gov.uk](mailto:consultation@justice.gsi.gov.uk).

Alternatively, you may wish to write to the address below:

**Gabrielle Kann  
Consultation Co-ordinator  
Ministry of Justice  
5th Floor Selborne House  
54-60 Victoria Street  
London  
SW1E 6QW**

If your complaints or comments refer to the topic covered by this paper rather than the consultation process, please direct them to the contact given under **the How to respond** section of this paper at page 20.

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[andrew.tucker@justice.gsi.gov.uk](mailto:andrew.tucker@justice.gsi.gov.uk) or from telephone number 020 3334 6387