Changes to Rule 43 of the Coroners’ Rules
Coroner’s reports to prevent future deaths - Explanatory Notes

Background
This rule gives Coroners the power to make reports to a person or an organisation where the Coroner believes action needs to be taken to prevent future deaths and where that person or organisation may have the power to act. The Coroner announces his intention at the end of the inquest hearing. Historically there was no obligation on an organisation to respond or even to act upon the report – though public bodies did often do so.

The recent review of, and consultation on, the role and power of the Coroner revealed strong support for strengthening the power to make reports and to introduce changes to force organisations to respond to the Coroner and for such responses to be put in the public domain.
Interestingly, in the NHS, the Department of Health does not have a single unit with an overview of every rule 43 report received. Ordinarily, reports are sent to the NHS Trust under whose care a person has died and the responsibility of responding to and acting upon the report falls to the individual NHS Trust.

**Why the change?**
The idea is to make sure that lessons are learnt especially when the State is involved with its obligation under the Human Rights Act 1998 to protect life. The main rationale is as follows:

- to give greater prominence and importance to Coroner’s reports;
- to improve public health and safety;
- to ensure organisations consider and respond to reports;
- for the Coroner to inform the families and other interested persons of lessons learnt and changes made to prevent similar deaths in future; and
- to collect information and reports centrally and to share with other Coronial areas so that a potentially opportunity to save lives elsewhere in the country is not lost.
- reports and responses to be filed with the Government (Lord Chancellor) to enable emerging trends to be identified and lessons that might apply at a national level to be highlighted.

**Changes to the law**
The Coroner’s Amendment Rules 2008 became law on 17 July 2008.

Rule 43 is amended in the following way:

- Coroners have a wider power to make reports to prevent ‘any other deaths’ – it is not limited to ‘similar deaths’;
- a new statutory duty is placed on organisations receiving reports from Coroners to respond within 56 days. Failure to respond in time will prompt the Coroner to chase the organisation and continued failure to engage with the Coroner will prompt an adverse report to the Government and general publication;
- there is no obligation to act upon the Coroner’s recommendations but the response must indicate what action has been taken or what is proposed. If no action is proposed an explanation must be given;
- Coroners must share reports and responses with those, including bereaved families, assigned the status of ‘interested persons’. The Coroner may send a copy of the report and response to any other person or organisation with an interest;
- the Coroner must file a copy of his report and the response with the Government (Lord Chancellor);
- the Lord Chancellor may publish the report and response or a summary thereof. The Lord Chancellor may share the report and response to any other person or organisation considered to have an interest; and
• reports and responses will be centrally collated for the first time so that any trends can be identified, monitored and lessons learned can be shared widely.
The Ministry of Justice has set out guidance to Coroners on the application of the new rule 43 and has suggested to Coroners the content and format of rule 43 reports.

**Implications for NHS Trusts**

**To prepare properly for the inquest**
The Coroner will only make a rule 43 report where he has concerns that there is a risk of future deaths occurring. It is therefore important before any serious inquest to consider what action should be or has been taken following the death and for evidence to be placed before the Coroner showing that lessons have been learnt already and changes (if appropriate) have taken place. This will also minimise the risk of adverse publicity.

Consider with your lawyer making representations on rule 43 at the conclusion of the evidence at the inquest hearing.

**To deal with the report appropriately and respond**
Each NHS Trust will need to ensure that responses to reports from the Coroner are prompt and accurate and should be mindful that any response may become public. Procedures must be put in place to make sure that rule 43 letters are identified and that information is collected and action considered. It is suggested that this be a board level responsibility (director of governance) and delegated appropriately within the governance department. Medical staff and other health care professionals will need to be educated on the necessity to respond to requests for information and assistance.

**To agree a procedure with the local Coroner**
It will help if contact is made with the local Coroner to discuss arrangements for handling rule 43 reports. This will demonstrate knowledge and willingness on the part of the NHS Trust to co-operate and will promote good will and a good working relationship with the Coroner.

Much will depend on the local Coroner, but at the very least you should try and agree to whom the Coroner should write in the Trust to make sure reports are not missed along with the format of the response and what to do if the Trust encounters difficulty with the response or time limits.

**To consider internal governance arrangements, procedures and audit.**
You should consider putting together a procedure to handle rule 43 letters to ensure effective responses and demonstrate compliance. In particular consider the following:

• to whom rule 43 reports should addressed within the Trust. Should it be more than one person?
• who will take the lead handling the reports;
• to create a database of reports and responses to demonstrate compliance and action taken. Such information can be demanded / audited by the NHSLA (risk management
• make sure an acknowledgment is sent to the Coroner within 7 days;
• to have a straightforward process to gather information / launch an investigation. Who will take the lead?
• how will any action plan be created and implemented?
• make sure a proper response is formulated and sent to the Coroner – consider whether the Chief Executive or other executive director is the appropriate ‘author’;
• liaise with the Coroner and keep him informed on progress, especially if more time is required. This may be granted if it can be shown a substantial amount of work is needed;
• feeding the response, action plans and any other issues into governance groups (at department and executive level) within the Trust;
• consider whether an annual review of all rule 43 reports and responses should be published to executive governance groups; and
• consider whether the Trust should ‘publish’ its responses and to whom? This might be an important consideration if there is a continuing relationship with relations or if there is an outstanding complaint.

A robust system for handling and responding to rule 43 reports will help the NHS Trust to develop a good working relationship with the Coroner; to minimise adverse publicity and avoid the uncomfortable question as to whether Trusts will face claims in negligence if they fail to implement changes recommended in coroner’s reports, or proposed in their responses, and a further death occurs.

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Legislation
Coroners Act 1988
Coroner’s Rules 1984
The Coroners (Amendment) Rules 2008

Guidance
Guidance for coroners on changes to Rule 43: Coroner reports to prevent future deaths

Useful Links
www.justice.gov.uk
Publications and articles

Jervis on Coroners 2002 Twelfth Edition (and 2 supplements)
Coroner’s Courts – A Guide to Law and Practice, Dorries, 2004
Appendix

The New Rule 43

The Coroners (Amendment) Rules 2008

In force: 17 July 2008

"Prevention of future deaths

43.—(1) Where—
(a) a coroner is holding an inquest into a person’s death;
(b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and
(c) in the coroner’s opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
the coroner may report the circumstances to a person who the coroner believes may have power to take such action.

(2) A report under paragraph (1) may not be made until all the evidence has been heard except where a coroner, having adjourned an inquest under section 16 or 17A of the 1988 Act, does not resume it.

(3) A coroner who intends to make a report under paragraph (1) must announce this intention before the end of the inquest, but failure to do so will not prevent a report being made.

(4) The coroner making the report under paragraph (1)—
(a) must send a copy of the report to—
   (i) the Lord Chancellor; and
   (ii) any person who has been served with a notice under rule 19; and
(b) may send a copy of the report to any person who the coroner believes may find it useful or of interest.

(5) On receipt of a report under paragraph (4)(a)(i), the Lord Chancellor may—
(a) publish a copy of the report, or a summary of it, in such manner as the Lord Chancellor thinks fit; and
(b) send a copy of the report to any person who the Lord Chancellor believes may find it useful or of interest (other than a person who has been sent a copy of the report under paragraph (4)(b)).

Response to report under rule 43

43A.—(1) A person to whom a coroner sends a report under rule 43(1) must give the coroner a written response to the report containing—
(a) details of any action that has been taken or which it is proposed will be taken
whether in response to the report or otherwise; or
(b) an explanation as to why no action is proposed
within the period of 56 days beginning with the day on which the report is sent.

(2) On receipt of a response under paragraph (1), the coroner—

(a) must send a copy of the response to—

(i) the Lord Chancellor; and

(ii) except where paragraph (6) applies, any person who has been served with a
notice under rule 19; and

(b) except where paragraph (6) applies, may send a copy of the response to any
person who the coroner believes may find it useful or of interest.

(3) Except where paragraph (6) applies, on receipt of a response under paragraph
(2)(a)(i), the Lord Chancellor may—

(a) publish a copy of the response, or a summary of it, in such manner as the Lord
Chancellor thinks fit; and

(b) send a copy of the response to any person who the Lord Chancellor believes may
find it useful or of interest (other than a person who has been sent a copy of the
report under paragraph (2)(b)).

(4) A person giving a response under paragraph (1) may make written representations
to the coroner about—

(a) the release, under paragraphs (2)(a)(ii) or (b) or (3)(b), of a copy of the response; or

(b) the publication, under paragraph (3)(a), of the response.

(5) Representations under paragraph (4) must be made to the coroner no later than the
time when the response is given under paragraph (1).

(6) On receipt of representations under paragraph (4), the coroner may decide that the
response should not—

(a) be released in full under paragraphs (2)(a)(ii) or (b) or (3)(b); or

(b) be published in full under paragraph (3)(a).

(7) If paragraph (6) applies—

(a) the coroner must prepare a summary of the response; and

(b) paragraphs (2) and (3) apply to the summary of the response prepared by the
coroner as they apply to the response received under paragraph (1).

Extension of time

43B. A coroner may extend the period of 56 days mentioned in rule 43A(1) (even if an
application for extension is made after the time for compliance has expired)."