Coroner's Court Competences and Toolkit

Evaluation report

June 2024

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BAR STANDARDS BOARD

REGULATING BARRISTERS

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Executive Summary

- In September 2021, in response to concerns raised about standards of practice in the Coroners' Courts, the Bar Standards Board (BSB), the Solicitors Regulation Authority (SRA) and CILEx Regulation Ltd (CRL), with assistance from the Deputy Chief Coroner and a working group, published a set of Competences for practitioners (barristers, solicitors and CILEx practitioners). The competences outlined the skills, attributes and knowledge that practitioners need to be effective in Coroners' Courts.

- A toolkit was also developed, containing resources to raise awareness about how to report concerns about standards in the Coroners' Courts, and help practitioners understand the challenges of practising in inquests and identify the learning and development needs they need to address to meet those challenges. The resources were designed to be practical and suitably high-level as other bodies are better placed to provide thorough technical guides to specific issues or challenges in the Coroners' Courts.

- This evaluation was designed to determine the extent to which the Coroners' Courts Competences and toolkit have met the overarching objectives of the project. Evaluation work started in September 2023, two years after the publication of the resources, to align our evaluation work with that of the other regulators and ensure the resources had sufficient time to impact on practices in the Coroners' Courts. The evaluation focussed on answering the following key evaluation questions:

  - Are the Bar and other stakeholders aware of the Coroners' Courts resources?
  - Are the Bar and other stakeholders using the Coroners' Courts resources?
  - Do the Bar and other stakeholders find the Coroners' Courts resources useful in supporting good practice?
  - Do the Bar and other stakeholders feel that standards in the Coroners' Courts have improved/are improving as a result of the publication of the resources?
  - Has the publication of the resources encouraged the reporting of poor practice to the relevant regulators?
  - Are there other actions that the BSB could be taking to improve standards in the Coroners' Courts?

Key Findings

- The evaluation suggests that awareness of the resources among barristers and coroners is relatively high, although it may be lower among barristers when compared to coroners. Survey results show that among barristers practising in the Coroners' Courts, over 75% of respondents stated that they were aware of the resources. Among coroners, the survey results suggest that awareness of the resources was higher than among the Bar, with over 95% of respondents aware

of them, and that fewer than one in ten had not read or reviewed them personally. However, some felt that awareness of the competences is 'patchy' among practitioners, despite the extensive work that had been carried out so far by the BSB, the Chief Coroner's Office and the other regulators to publicise and raise awareness of the resources.

- The evaluation suggests that the majority of both barristers and coroners who are aware of the resources are using them. Among barristers, the vast majority of those aware of the resources had also read them personally, and two thirds of barristers stated that they would probably or definitely use them personally. Among coroners, fewer than one in ten had not read or reviewed them personally, and a large majority stated that they were already using or would use them in their own work.

- The evaluation suggests that the majority of barristers who are aware of the resources view them as helpful and are using them to inform their work in the Coroners' Courts. The majority also stated that they would recommend them to colleagues. The picture was similar among coroners – a large majority of those who had used the resources felt that they had helped their practice, in particular by clarifying the expected standards in coronial proceedings. Overall, the evaluation suggests the resources are seen as helpful in supporting good practice.

- In terms of the impact of the resources in improving standards in the Coroners' Courts, this evaluation suggests the picture is more mixed. Among barristers, some stated they felt the resources were having an impact on coronial proceedings, whereas others felt the impact had been limited or non-existent, and more needed to be done to address issues in this area. A majority of coroner survey respondents felt that standards in the Coroners' Courts were in need of improvement when the resources were published, and although some felt that standards had improved following the publication of the resources, the majority felt that they had remained the same.

- This suggests that among coroners, many feel that more needs to be done to improve standards – among survey respondents, the most common suggestion made was to raise awareness of the resources themselves, with some responses highlighting that a number of practitioners still seemed unaware of the resources, or that adversarial approaches which were harmful to participants were still an issue. Overall, the evaluation findings around impact are more mixed than the generally positive findings around awareness, use and value of the resources. While the resources are seen by some as having had a positive impact, the majority appear to feel that more needs to be done to address the issues, whether by Parliament, coroners, the legal services regulators, or practitioners themselves.

- Among Round Table participants, the consensus was that the resources were having limited impact in terms of leading to increases in reporting of poor practice, although they were being used by some coroners to highlight where practitioners were not meeting the competences during inquests. However, a majority of

coroner survey respondents stated that they were more likely to report poor practice following the publication of the resources, with several respondents highlighting the fact that the existence of guidelines on the required standards made it simpler to report poor practice and easier to highlight to practitioners when they were not meeting the required standards.

- A number of barrister survey responses suggested making improvements to the resources in the future, either in terms of making further clarifications or adding additional information or resources. Others suggested that actions needed to be taken by stakeholders other than the BSB such as Parliament or coroners themselves. Round Table participants felt more needed to be done to raise awareness of the resources, both among coroners and practitioners. Coroner survey respondents similarly flagged that awareness among practitioners needed to be higher, and several felt that adversarial approaches, which were harmful to participants, were still an issue.

1 Introduction

1.1. The Bar Standards Board (BSB) is the regulator for barristers in England and Wales. The BSB is responsible for:

- Setting the education and training requirements for becoming a barrister;
- Setting continuing training requirements to ensure that barristers' skills are maintained throughout their careers;
- Setting standards of conduct for barristers;
- Authorising organisations that focus on advocacy, litigation, and specialist legal advice;
- Monitoring the service provided by barristers and the organisations we authorise to assure quality;
- Responding to concerns about barristers and the organisations we authorise and taking disciplinary or other action where appropriate.

1.2. Our regulatory objectives are laid down in the Legal Services Act 2007 and are:

- Protecting and promoting the public interest;
- Supporting the constitutional principle of the rule of law;
- Improving access to justice;
- Protecting and promoting the interests of clients;
- Promoting competition in the provision of services;
- Encouraging an independent, strong, diverse and effective legal profession;
- Increasing public understanding of citizens' legal rights and duties;
- Promoting and maintaining adherence to the professional principles;[1] and
- Promoting the prevention and detection of economic crime.

1.3. The Legal Services Act 2007 requires the BSB to regulate in a transparent, accountable, proportionate, consistent and targeted way. We also have a responsibility to base our regulatory activities on risk and take an evidence-based approach to determine the priority risks. To achieve this, we allocate our resources where we think they would be most effective in addressing these priority risks and constantly monitor the market for barristers' and advocacy services.

Background

1.4. In 2016 a report was published by the Right Reverend James Jones at the request

1. As defined in the Legal Services Act (2007), the "professional principles" are (a) that authorised persons should act with independence and integrity, (b) that authorised persons should maintain proper standards of work, (c) that authorised persons should act in the best interests of their clients, (d) that persons who exercise before any court a right of audience, or conduct litigation in relation to proceedings in any court, by virtue of being authorised persons should comply with their duty to the court to act with independence in the interests of justice, and that the affairs of clients should be kept confidential.

of the Government, into the Hillsborough families' experiences[2]. The report includes first-hand accounts of the families' experiences during the inquests and was largely critical of the adversarial approach adopted by some lawyers, as being inappropriate given the grief and trauma of witnesses and families experiencing bereavement[3].

1.5. Following this report, an independent review into serious incidents and deaths in custody, undertaken by Dame Elish Angiolini, was published in 2017[4]. The aim of this report was to examine the procedures and processes surrounding deaths in police custody and included a chapter on the "Coronial System". Again, this was critical of the adversarial approach taken by some lawyers which could sometimes lead to "hostile and insensitive" questioning of family members and witnesses.

1.6. As a result of both reports and their findings, the Ministry of Justice (MOJ) felt that more should be done to improve standards and to ensure that lawyers demonstrate responsible advocacy in the Coroners' Courts, considering the distinct purpose of inquests as opposed to other court proceedings.

1.7. In response to the issues identified, in February 2020, the BSB and the SRA, with assistance from the Deputy Chief Coroner, set up a working group to assist the regulators in considering how they should best develop standards and resources for lawyers who work in the Coroners' Courts, to improve standards of advocacy. CRL later joined the group.

1.8. The purpose of the working group was to consider:

- a set of draft competences which outline the skills, attributes and knowledge that lawyers need in order to be effective in the Coroners' Courts;
- the resources that may be established to assist lawyers in the development of those competences;
- how best to engage with interested parties as we develop our approach;
- how best to communicate any new approach; and
- the methods by which poor practice might be raised.

1.9. As a result of these discussions, four virtual workshops were held in November 2020, comprising:

- UK Government Legal Department (GLD) and NHS Resolution workshop;
- Practitioners workshop (a group of barristers and solicitors who specialise in this area);

2. The report by the Right Reverend James Jones entitled "The Patronising Disposition of Unaccountable Power" can be found here. The Government has responded to the report here.
3. The above report states that the families were "not prepared for what they described as the intensity and ferocity of the approaches taken by lawyers" (page 57 para 2.72)
4. The report by Dame Elish Angiolini entitled "Report of the Independent Review of Deaths and Serious Incidents in Police Custody" can be found here.

- Family workshops – three individual calls with families identified by Inquest who have had personal experience in the Coroner's Court; and
- Coroners' Courts Support Service and the Legal Services Consumer Panel workshop.

1.10. For each workshop, feedback was obtained on the draft competences and proposals for the development of a toolkit. The Deputy Chief Coroner obtained feedback from coroners, and the MOJ also assisted in obtaining feedback from various government departments.

1.11. The key output from this project was the development of a set of proposed competences for practitioners which outline the skills, attributes and knowledge that lawyers need in order to be effective in the Coroners' Courts, along with a toolkit containing resources to address learning and development needs and to meet the challenges of practising in inquests.

1.12. The Competences and the toolkit were published in September 2021, in conjunction with the SRA and CRL, and can be found here. We committed to beginning an evaluation two years after the Competences and toolkit were published to allow time for them to embed within the profession.

2 Methodology

Research Objectives

2.1. The evaluation was designed to determine the extent to which the Coroner's Court Competences and toolkit have met the overarching objectives of the project, which were to improve the standards of practice of those practising in the Coroners' Courts by:

- improving awareness among practitioners of the Coronial system as a jurisdiction which is different from other courts;
- assisting practitioners in understanding what to expect when working in the Coroners' Courts;
- assisting practitioners in understanding and meeting the key competences required in the Coroners' Courts, and
- improving understanding of when and how to report poor performance (and what action the BSB will take as a result).

2.2. The evaluation focussed on answering the following key evaluation questions:

1. Are the Bar and other stakeholders aware of the Coroner's Court resources?
2. Are the Bar and other stakeholders using the Coroner's Court resources?
3. Do the Bar and other stakeholders find the Coroner's Court resources useful in supporting good practice?
4. Do the Bar and other stakeholders feel that standards in the Coroner's Court have improved/are improving as a result of the publication of the resources?
5. Has the publication of the resources encouraged the reporting of poor practice to the relevant regulators?
6. Are there other actions the BSB could be taking to improve standards in the Coroners' Courts?

2.3. The BSB undertook several evidence-gathering exercises to provide indicators for each of the evaluation questions set out above:

- a survey of barristers practising in the Coroners' Courts;
- a round table of key stakeholders;
- a survey of coroners; and
- analysis of web traffic data from the BSB's website.

Barrister Survey

2.4. This collected quantitative and qualitative evidence from barristers around their awareness of the resources, whether they have read/used the resources, whether

they view the resources as useful for supporting good practice, and if they think the BSB should do more to support good practice. This provides evidence from the profession to address the evaluation questions 1, 2, 3, 4 and 6. The SRA and CRL are also surveying their members and we have aligned our questions with theirs, so we have comparable data.

Round Table

2.5. This collected qualitative evidence from the profession and other stakeholders around awareness of the resources, the extent to which those practising in the Coroners' Courts are meeting the required standards, what impact the publication of the resources has had, if the publication of the resources has encouraged reporting of poor practice, and what more the BSB could be doing to improve standards in the Coroners' Courts. This provides evidence both from the profession and other stakeholders around evaluation questions 1-6.

Coroner Survey

2.6. This collected evidence from coroners on standards of practice within the Coroners' Courts, the impact of the resources, whether they have encouraged the reporting of poor practice, and what more the BSB could be doing to support good practice. This therefore provides both qualitative and quantitative evidence from coroners to address evaluation questions 1-6.

Web Traffic Analysis

2.7. This looks at the volume of web traffic/downloads on the relevant documents and web pages that cover the Coroners' Courts resources. This provides a quantitative indicator of the number of views the relevant resources have had and thus provide corroborating information to answer evaluation questions 1 and 2.

Research limitations

2.8. While this evaluation was able to gather the views of both barristers and coroners following the introduction of the Competences, there was no comparative data collection exercise undertaken prior to the introduction of the Competences and toolkit. As such, the evaluation does not include a true baseline comparator to determine equivalent views before the resources were published.

2.9. The response rates for the barrister and coroner surveys were relatively low (fewer than 15% of potential respondents). In addition, the sample was self-selecting rather than random due to the nature of the online survey methodology. As a result, it is impossible to rule out non-response bias,[5] and the profile and experiences of the survey respondents may not be representative of the whole population of coroners and barristers operating in the Coroners' Courts. Instead, they should be

5. Non-response bias occurs when those that respond to a survey are not representative of the population as a whole.

treated as indicative of the experiences of coroners and barristers rather than as a statistically representative sample.

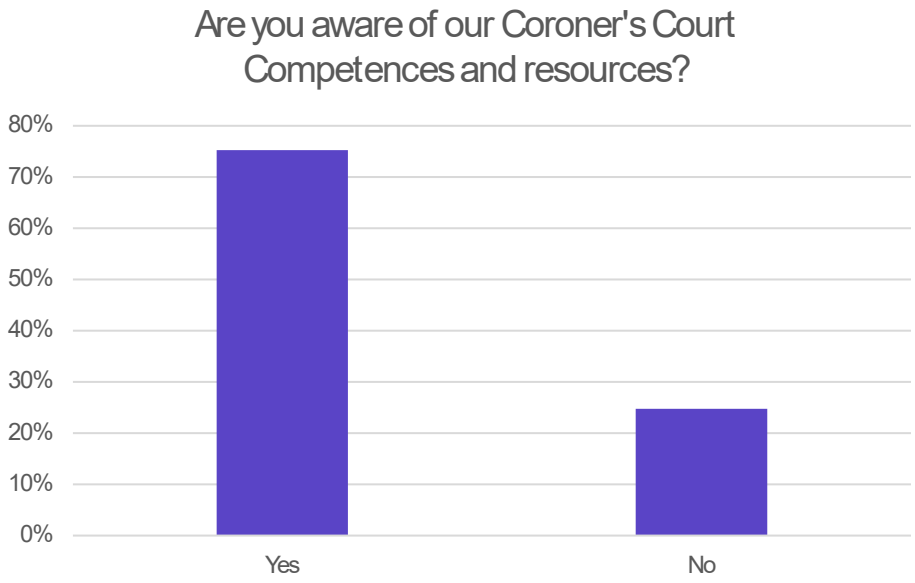
2.10. In addition, this evaluation did not gather evidence from other stakeholders and users of the Coroners' Courts, including witnesses and family members. As such, it provides an indication of the impact that is based on the views of legal professionals rather than the full range of individuals impacted by any changes to the operation of the Coroners' Courts.

3 Research Findings

Barrister Survey

3.1. The survey was sent to barristers practising in the Coroners' Courts to collect feedback and evidence about awareness, understanding, and impact of the resources. The questions were designed to mirror the questions used by the SRA in its own survey about awareness and use of the Coroner's Court resources, and the questions were also used by CRL for its own survey, to enable comparisons between regulated professions. The survey was emailed to 1,666 relevant barristers in November 2023, and received 198 responses – a response rate of 11.9%. The survey questions are included in Appendix One.

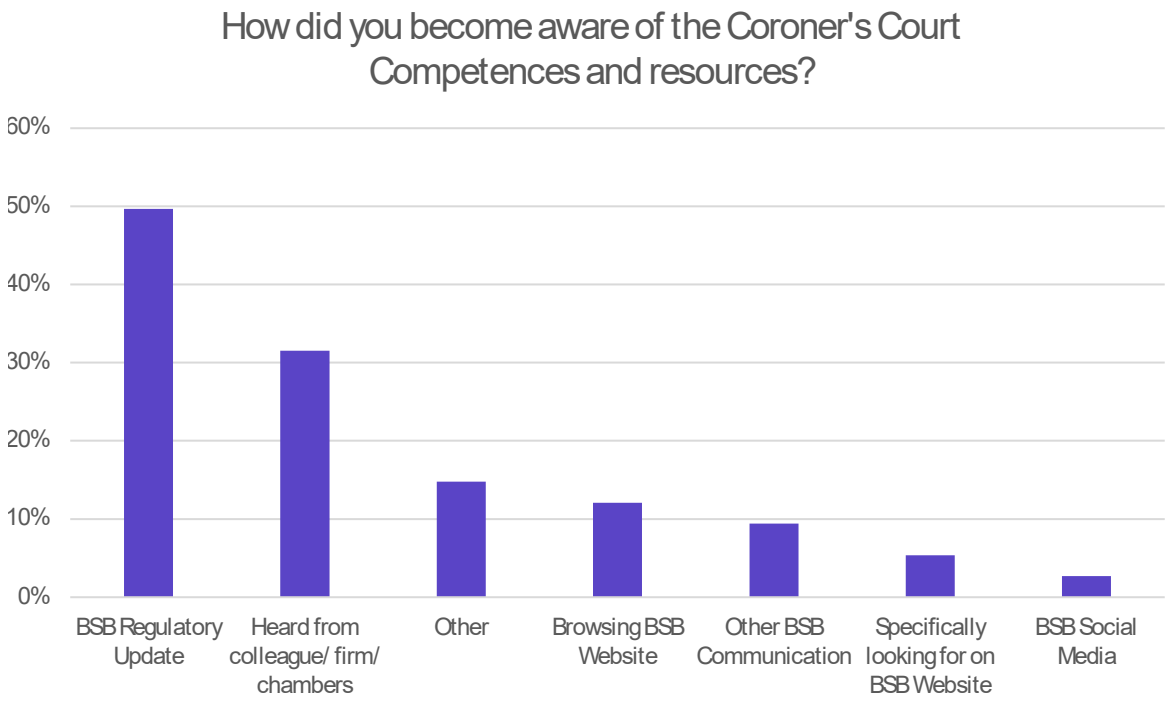
Chart 1



3.2. The majority of respondents were aware of the resources, with 75.3% of respondents stating they were aware of the Competences and resources. However, despite a substantive majority being aware, one in four respondents were not aware that the BSB had published resources for use in the Coroners' Courts.

3.3. This suggests that more can be done to raise awareness among those practising in the Coroners' Courts, given that a substantive minority of barristers the resources are targeted at are still not aware of them, over two years after they were first published.

Chart 2



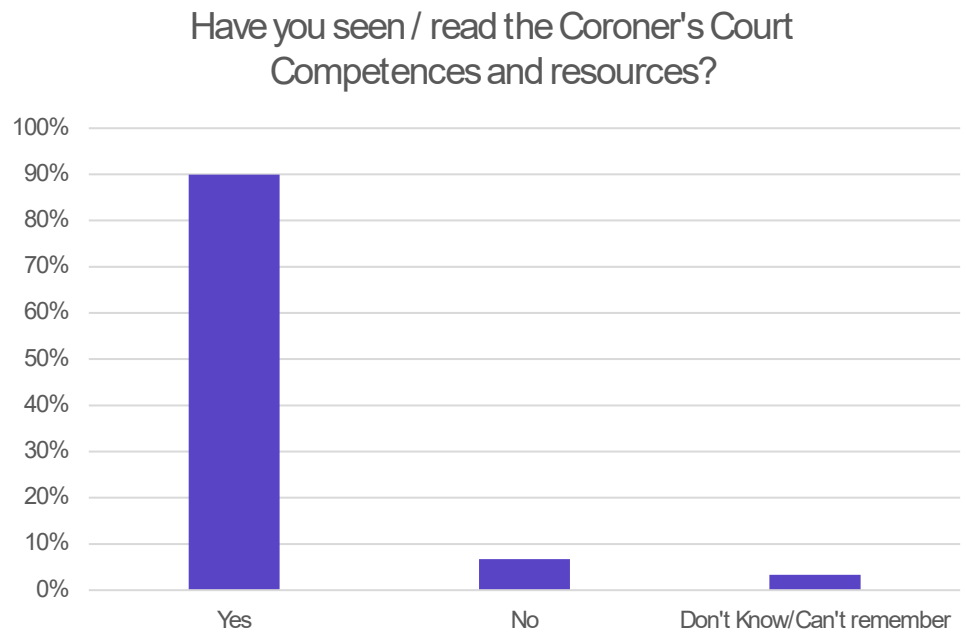
3.4. Respondents who were aware of the resources were asked how they became aware of them (respondents were able to select more than one option for this question). The most common response was that they became aware due to the resources being mentioned in the BSB's Regulatory Update, given by nearly half of respondents (49.7%). Hearing about the resources from a colleague or from their organisation was also common, with nearly one in three respondents stating that they had heard about the resources in this way (31.5%).

3.5. Among the 'other' sources (mentioned by 14.8% of respondents) a number of respondents heard about it from the Chief Coroner's Office, either from their website, email updates or training resources, as part of their work as a coroner. Other responses given were Counsel Magazine, involvement in the initial consultation about the resources, and the resources being mentioned or highlighted by coroners themselves during cases.

Highlighted to me by the Coroner's Society as I am an Assistant Coroner.

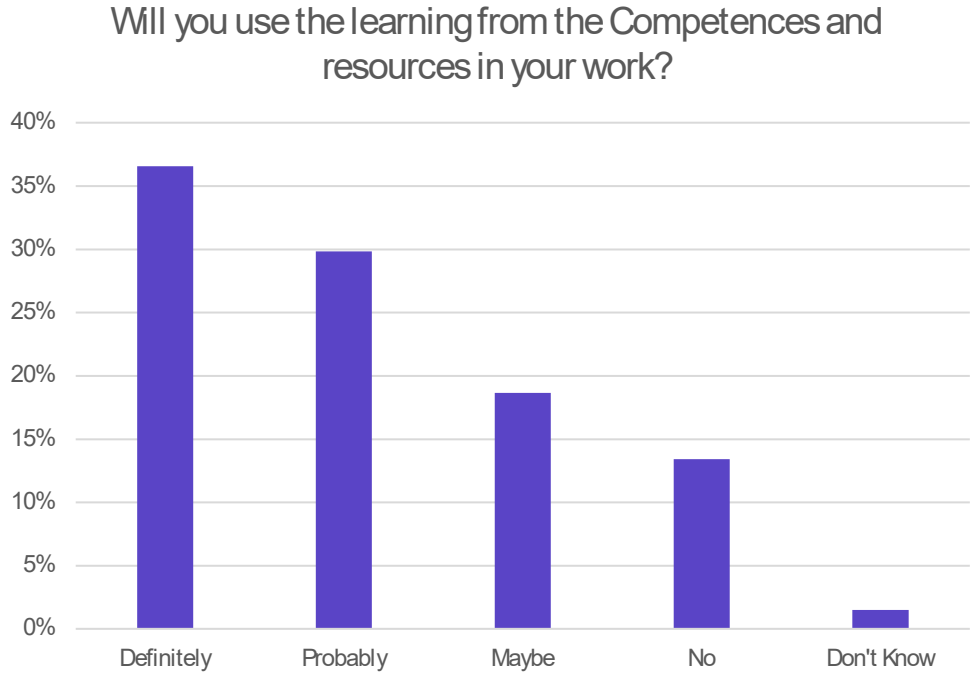
Coroners have been drawing attention to the guidance during hearings.

Chart 3



3.6. Among those who were aware of the resources, the vast majority had seen or read the resources personally (89.9%). Only 6.7% of respondents stated that they had not read the resources themselves. The most common reason given by those who had not viewed the resources personally was that they used alternative learning and development resources around their work in the Coroners' Courts. Other reasons given were that the resources did not contain relevant content for their work, or that they had recently returned from parental leave.

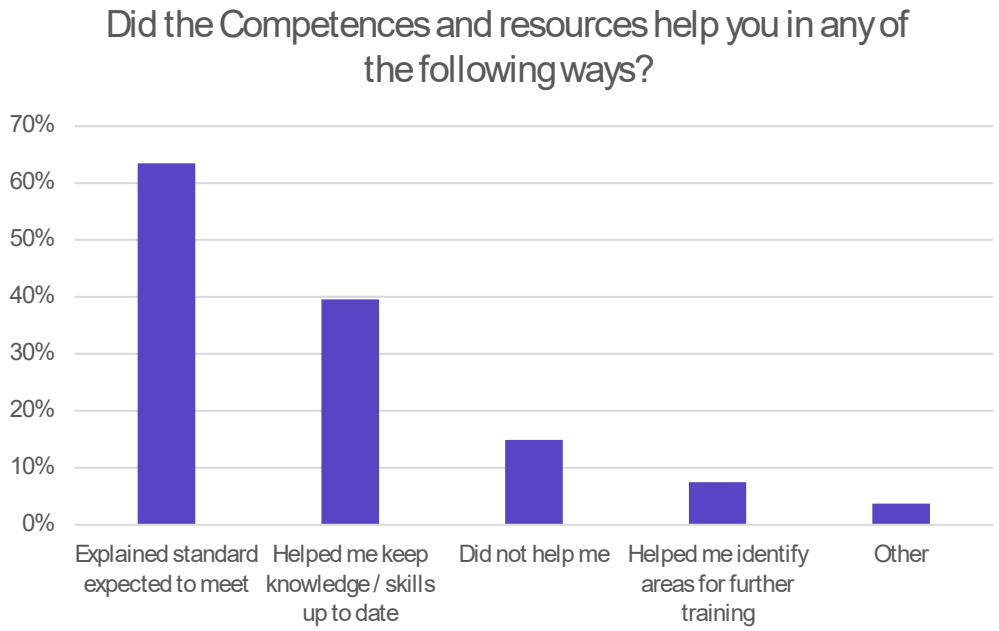
Chart 4



3.7. The majority of respondents who had viewed the resources stated that they would definitely or probably use the resources in their own work. Two thirds of responses

(66.4%) stated that they would probably or definitely use the resources, with a further 18.7% stating they might use the resources. Only 13.4%, less than one in seven responding to the question, stated that they would not use the resources themselves.

Chart 5



3.8. Respondents who had read the resources were asked if they had helped them. The most common response given was that the resources had helped explain the standard they were expected to meet in their work in the Coroners' Courts, with nearly two thirds of respondents stating that the resources had helped them in this way (63.4%). The next most common area mentioned was helping them keep their knowledge and skills up to date, with 39.6% of respondents saying the resources had helped them in this way. Only a small proportion of respondents (7.5%) stated the resources had helped them identify areas for training.

3.9. Other ways respondents said the resources had helped were that they provided those who sat as coroners with clarity on the standards expected of advocates, that it was helpful to have a range of valuable information in a single place, and that it was useful as a learning resource for pupils.

I sit as an assistant coroner - helped me to know what is expected of advocates who appear before me.

Allowed me to refer my former pupil to them for his first inquest.

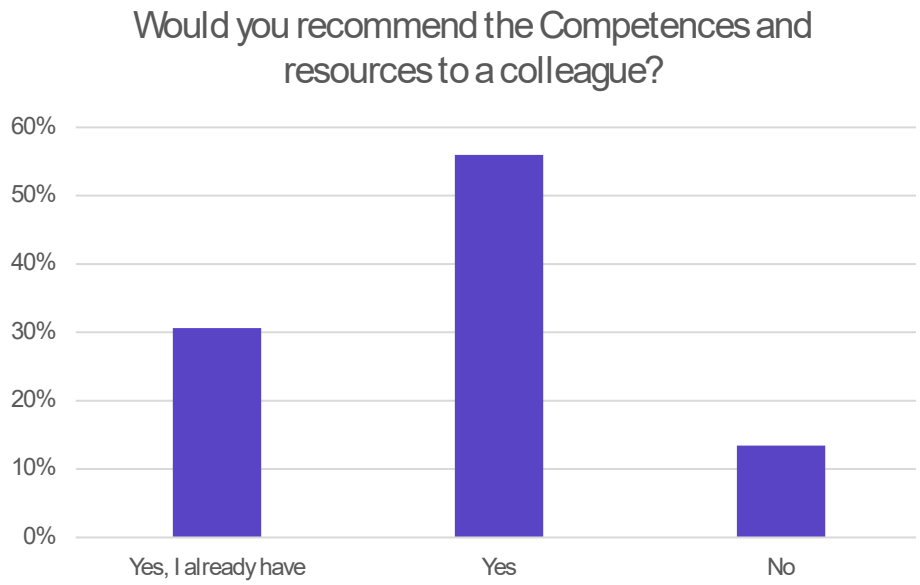
3.10. Some respondents stated the resources had not helped them (14.9%). Among respondents giving this response, the most common reasons given were that the resources were too basic to be of use to them and / or that they already were aware of the information covered. Several respondents who stated the resources were too basic to be of use to them personally said that they believed they would be helpful to more junior counsel or those with less Coroner's Court experience.

The standard is (necessarily) pitched low and I was already familiar with the material covered. I also felt it explained points which are matters of principle but not practice and for that reason I do not consider the resources to present an accurate picture of the actual practice of Coroner's courts.

I have been practising in this area for some time and did not consider it added anything to what I already knew.

Too basic, but I would recommend to a more junior colleague.

Chart 6



3.11. Respondents were asked if they would recommend the resources to a colleague, and a large majority stated that they would do so (86.6%). Over a third of those who stated they would recommend the resources to colleagues said they had already done so.

3.12. Respondents who felt the resources had helped them were asked if there had been any further benefits coming from the publication of the resources. A number of those responding to this question stressed the value of clarifying to advocates that proceedings in the Coroners' Courts should be carried out in a less adversarial way than proceedings in trials, although some stressed that they felt there was still room to do more to address this issue. Other benefits mentioned included prompting respondents to identify training needs, or that the resources were valuable for sharing with others involved in the Coroners' Courts such as clients and voluntary organisations.

For me, it has reiterated the need to have a different approach to advocacy which seeks to minimise the risk of matters becoming too adversarial. In my experience however, many counsel (including those who represent families) still do not keep the competencies sufficiently in mind. Inquests are inherently tragic and many

witnesses (not just families) find them difficult processes. Too adversarial an approach makes for inefficient fact-finding.

The competencies are useful - I have referenced them in Court to encourage others to take a less adversarial stance. However much remains to be done if the culture of the Coroners court is to truly move away from being adversarial and indulging in quasi-blame focus to a properly inquisitorial function.

They have given me a greater awareness of the impact my actions and words may have when representing organisations, particularly upon unrepresented bereaved families.

I use them when I am an advocate, and as a coroner, to ensure other advocates take an appropriately inquisitorial approach to the inquest. I think they are useful in helping shift the culture away from being adversarial. Having the BSB and SRA approval enhances this.

3.13. Some respondents stated that they felt the resources had not had an impact on practice in the Coroners' Courts overall, and one respondent stated they felt that the production of the resources was unnecessary and the BSB should avoid taking actions that may deter barristers from operating in particular practise areas.

It seemed to be a restatement of some fairly obvious principles that we should have been following anyway. It has not transformed the culture or working practices of the Coroner's Court (in my view).

Personally I thought this was over regulation… I was unsure why this particular Court was singled out for a competency resource issue and feared that the BSB would do this for more and more individual / specific court / tribunal systems. Barristers have a wide breadth of practice, over regulation by specific dictate does not assist them in my view. The BSB should be conscious of not setting undue barriers for barristers to practice across different fields of the law.

3.14. Respondents were also asked if the resources could be improved. Some respondents stated that the resources did not need anything further and were already sufficient to help advocates meet the standard required (although some stated that the resources would need to be kept under review and updated as and when further improvements are identified).

No. The basics are there and if everyone applies them life will be better for all.

They are good but almost every resource can be improved. The important thing is to review them regularly.

3.15. However, others made a range of suggestions as to how the resources could be improved. These included suggestions for information to add to the resources (such as further examples, linking to additional resources such as the Chief Coroner's guidance or other relevant publications, or giving further guidance on available resources for new practitioners). Some responses highlighted areas that required addressing by stakeholders other than the BSB, such as coroners themselves, or parliament.

Remind counsel that duty is still to their client - this document makes as appear more like some intervenor. While we have a duty to the court, our duty is also to the client.

They ought in my view to stronger and more explicit about the need for the vulnerability of witnesses to be sensitively handled by all (including family representatives). However, progress will be limited for so long as the dichotomy remains whereby Coroners state that an inquest is not about blame, yet much of every inquest (particularly Article 2 inquests) focusses on failures / serious failures in an adversarial way.

I think Parliament can take a much more positive step to assist the Competences by supporting article 2 of the ECHR the right to life by making Legal Aid available to families of the bereaved. It is one thing developing competencies, Coroners also require updated training. My experience of past hearings, some Coroners were insensitive and unhelpful to bereaved families and I hope there is now a change that is taken into consideration.

More emphasis on the fact that witnesses from organisations may also find the process of giving evidence difficult. They too deserve to be question in a courteous and respectful manner. The inquest is intended to be a fact-finding forum rather than a way of blaming people. Too often some advocates continue to treat witnesses as if they are on trial.

It would be extremely helpful for Coroners to have standards that they are held to. The quality is extremely variable.

Key Findings - Barrister Survey

3.16. Responses to the survey suggest that overall, among barristers practising among the Coroners' Courts, awareness of the resources is relatively high, with three quarters of respondents stating that they were aware of the resources, and the vast majority of those aware of the resources having viewed them personally. However, the fact that one in four of respondents were not aware of the resources at all suggest there is still room for improvement in terms of raising awareness that the resources exist.

3.17. Among those that had viewed the resources, a large majority felt that they had helped their practice, with the most common reason given being that it had helped clarify the standards they were expected to meet in this area of practice, with a significant number of responses also highlighting the value of the resources in terms of helping them keep their skills up to date.

3.18. Among other benefits given, a number of responses highlighted the value in clarifying the fact that Coroner's Court proceedings are supposed to be less adversarial than other Court proceedings. Additionally, the majority of those who had viewed the resources stated that they would recommend them to colleagues. This suggests that the majority of barristers view the resources as helpful and are using them to inform their work in the Coroner's Court.

3.19. Among barristers responding to the survey, some stated they felt the resources were having an impact on Coroner's Court proceedings, whereas others felt the impact had been limited or non-existent, and more needed to be done to address

issues in this area. A number of responses suggested making improvements to the resources in the future, either in terms of making further clarifications or adding additional information or resources, whereas others suggested that actions needed to be taken by stakeholders other than the BSB such as Parliament or coroners themselves.

Round Table

3.20. The online round table event was held on the 11th December 2023 and was attended by seventeen participants – four from the BSB and thirteen other stakeholders including the Deputy Chief Coroner, representatives from the Office of the Chief Coroner, the GLD, the MOJ, the Legal Services Consumer Panel, and solicitors and barristers who work in the Coroner's Court. The round table lasted an hour and a half and the discussion guide is available in Annex 2. Where quotes are included below, the organisation or background of the participant is given to give context.

3.21. When discussing awareness of the resources, a number of participants stated that it was still patchy, both among practitioners and – to a lesser extent – among coroners as well. Participants from the Chief Coroner's Office stressed the efforts that had been made to raise awareness of the resources among coroners – this included promoting it at the annual Chief Coroners conference and promoting it in email communications. The GLD explained that they include it in instructions to counsel, and the MOJ also highlighted that they promote the resources wherever they can. Some participants mentioned that coroners had drawn attention to elements of the resources to participants as part of ongoing cases as well.

I was in front of an area coroner the other day, and the family advocate had been reprimanded. The Coroner stopped proceedings and gave a direction to watch the good practice videos. This was a good way of dealing with it.

Solicitor

3.22. When discussing why some practitioners are not aware of the resources, a number of suggestions were put forward. The fact that Assistant Coroners do not attend the Chief Coroner's annual conference was cited as one limitation of this as a route for raising awareness (although it was highlighted that coroners who attend the conference do attempt to raise awareness among their colleagues, and information on the Competences and toolkit is provided in training materials and mentioned on training days for coroners). Among lawyers, it was mentioned that lawyers from different legal backgrounds may have less awareness of, or understanding of, the issues covered by the competences.

Often you can have barristers from different backgrounds such as litigation, civil jurisdiction, health and safety jurisdiction because most people that practice in the Coroners' Court do different areas of work. I think those that come from a civil litigation

background don't always act in accordance with the competences.

Barrister

3.23. In terms of understanding of – and use of – the resources, participants generally felt that those who were aware of the resources understood them overall. In terms of areas where understanding was more limited, participants particularly stressed dealing with vulnerability. Also mentioned were issues around disclosure, and how this was a particular area of difference in coronial proceedings as opposed to the more adversarial background of some lawyers practising in this area.

There is an issue about non-disclosure to Coroners of relevant material that's within the scope of an inquest and that also has a really big impact on delays that can be brought into inquest. [Disclosure in Coroners proceedings] in itself is a whole different competency, that's unique to an inquisitorial process.

Barrister

3.24. In terms of the impact the resources were having, some felt they were having a positive impact, whereas others mentioned it was hard to tell what impact they were having as, in their experience, they had not noted that the resources were being referred to in proceedings themselves.

3.25. Some participants highlighted that any impact relied on coroners, advocates, and other supporting individuals/organisations being aware of and using the resources, as there should n be any expectation on witnesses, families etc, to familiarise themselves with this sort of information – if they were represented, it should be the role of their lawyer to explain procedures to them and 'hold their hand' throughout the process. If they were not represented, it should be the responsibility of the other practitioners and coroners) to help explain and support them through the process.

I have not had a Coroner refer to the competences or to the toolkit. It very much depends on which coroner you have, on how they deal with this.

Solicitor

I do not feel like it has changed hugely from seeing how coroners behave. I think it has given a route to make a complaint where there hasn't been one before. It is difficult to know how much the competences themselves have made a difference.

Solicitor

I agree with managing expectations, but I think for many families they have a lot to deal with already. It is the lawyer's job to explain to them and not force them to have to necessarily watch videos for people who are not represented.

Solicitor

3.26. When discussing the reporting of poor practice and the extent to which the Competences and resources were supporting this, the majority felt that that there

had been limited impact in terms of increasing the reporting of practitioners for poor practice, and that issues of poor practice were generally being dealt with in a similar way that they were before the resources were published. The BSB also confirmed that their data shows that the number of reports relating to the Coroner's Court remains steady, so there has been no significant increase in the reporting of poor practice in the Coroners' Courts since the publication of the resources.

I think people would say something if someone was below the standards expected. Coroners who would deal with it before the competences, still do deal with it, and I have not heard them mentioning it.

Solicitor

I have never felt the need [to report] simply because [poorly performing advocates] have immediately reacted to anything the coroner has said and have not repeated that advocacy style. For me to report somebody they would need to be continuing, despite having been reprimanded or advised by the coroner to take a different tone.

Solicitor

3.27. Several participants mentioned the challenges of calling out or reporting poor practice. Some barriers mentioned were that a particular approach by an advocate could be because of instructions from the party they were representing and, therefore, it would be unfair to report them, or that coroners or other stakeholders were concerned about reporting poor practice due to the potential impact on someone's career or uncertainty around any consequences for them personally. Additionally, it was felt that reporting of poor practice should be the responsibility of the professionals involved in the process, rather than other participants such as witnesses or family members.

3.28. However, a number of participants felt that the resources – in particular the setting out of the core expectations around competences required – helped both clarify a route to report poor practice if they felt it was warranted and/or to ensure that any report was genuinely based around an advocate failing to meet expectations that had been clearly set out. However, the preference for most was to deal with poor practice in the context of the inquest itself, either by addressing the issue in questioning or in instructions to participants.

I might on behalf of my clients say something along the lines of: this question has been put or I'm slightly concerned about the tone of the question and/or the delivery. And then nine times out of ten, the coroner would then immediately step in and remind them that this is an inquisitorial proceeding.

Solicitor

It is useful to know that we have now got this route, which can make sure that we are focusing on the right things, and that when we do raise something that it will be for the right reasons.

Coroner

3.29. In terms of improvements that could be made to the resources, a few potential areas were mentioned. These mirrored the areas highlighted as still needing improvements – in particular, improving awareness of the resources among practitioners and coroners, including more information about dealing with vulnerability and the risk of retraumatising participants, more done to stress the importance of an inquisitorial rather than adversarial approach in inquests, and including more information around disclosure.

3.30. In addition, there was a suggestion that the resources could make clearer that a failure to meet the competences by practitioners could result in a referral to their professional body, to give the competences more 'bite' and ensure they are carefully considered. Some participants stated that the fact regulators were conducting an evaluation exercise was valuable, as it would help raise awareness of the resources and show that regulators remain committed to this area of work.

Slightly more could be added into the disclosure aspect of the guidance that dovetails with the Chief Coroner's guidance and underpins the importance [of disclosure]

Barrister

Whether more can be said about what that vulnerability or re-traumatisation looks like, and whether more could be put in the competences around re-traumatisation and focusing on what the vulnerabilities are.

Barrister

Is it the guidance from the regulator that [failure to meet the competences] could lead to a potential referral to your professional body? If there is going to be a coroner that makes a referral on the basis that you've not complied with the core competences, then I think it does need to say more.

Barrister

Round Table - Key Findings

3.31. It was agreed that awareness of the competences is 'patchy' with lawyers and coroners, despite the extensive work that had been done so far to publicise and raise awareness of the resources. However, there was a general consensus that where practitioners, coroners, and other key stakeholders are aware of the resources they generally do understand and make use of them.

3.32. In terms of the impact the resources were having, some felt the resources were having a positive impact, whereas others either felt it was hard to tell what impact they were having or felt that they were so far having limited impact. In particular, the consensus was that they were having limited impact in terms of leading to increases in reporting of poor practice (although the resources were felt to be valuable to highlight the expectations for practitioners and therefore set out clearly a route for reporting and what behaviours were considered to fall below the regulators expectations).

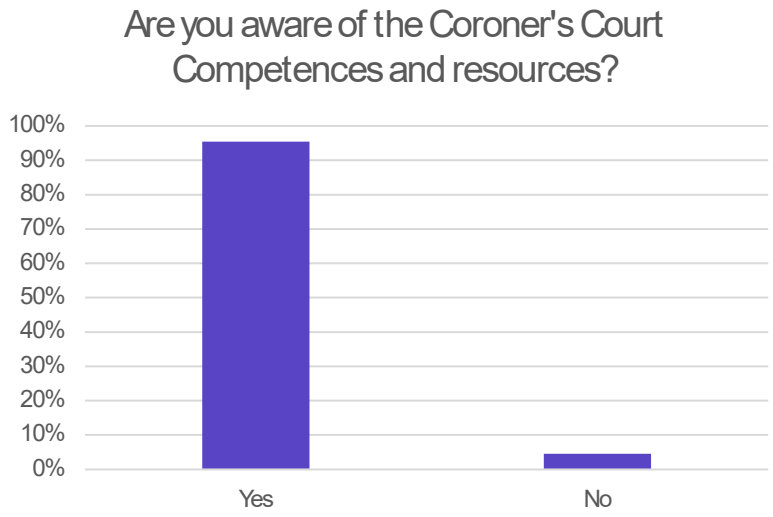
3.33. In terms of what more could be done to drive improvements in the Coroner's Court,

several participants felt more still needed to be done to raise awareness of the resources, both among coroners and practitioners. In addition, specific areas of the toolkit were raised where improvements could be made, in particular around setting out the risks of re-traumatisation, dealing with vulnerable participants, and clarifying expectations on disclosure (and how these differed in inquisitorial proceedings as opposed to adversarial ones). There was also some discussion as to whether it should be clearer that non-compliance with the Competences could result in enforcement action by the regulators.

Coroner Survey

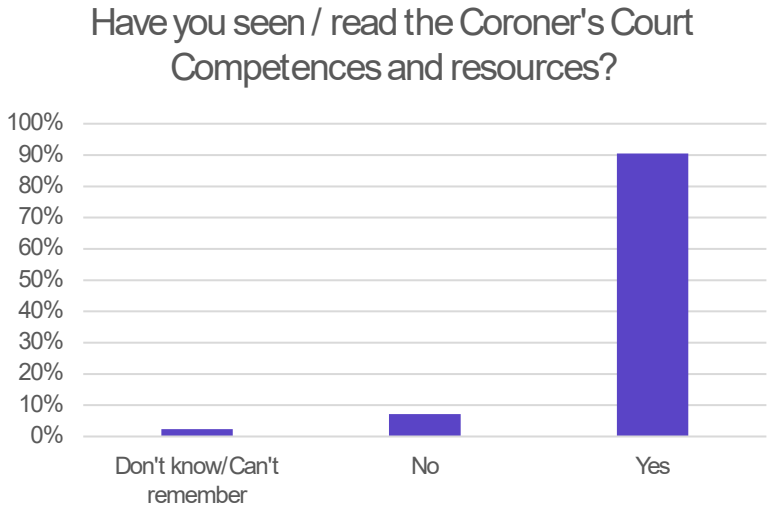
3.34. The survey was sent to coroners to collect feedback and evidence about awareness, understanding, and impact. The questions were designed to largely mirror the questions used in the survey of barristers. The survey was emailed to 305 members of the Coroners Society in January 2024, and received 45 responses – a response rate of 14.8%. The survey questions are included in Appendix Two.

Chart 7



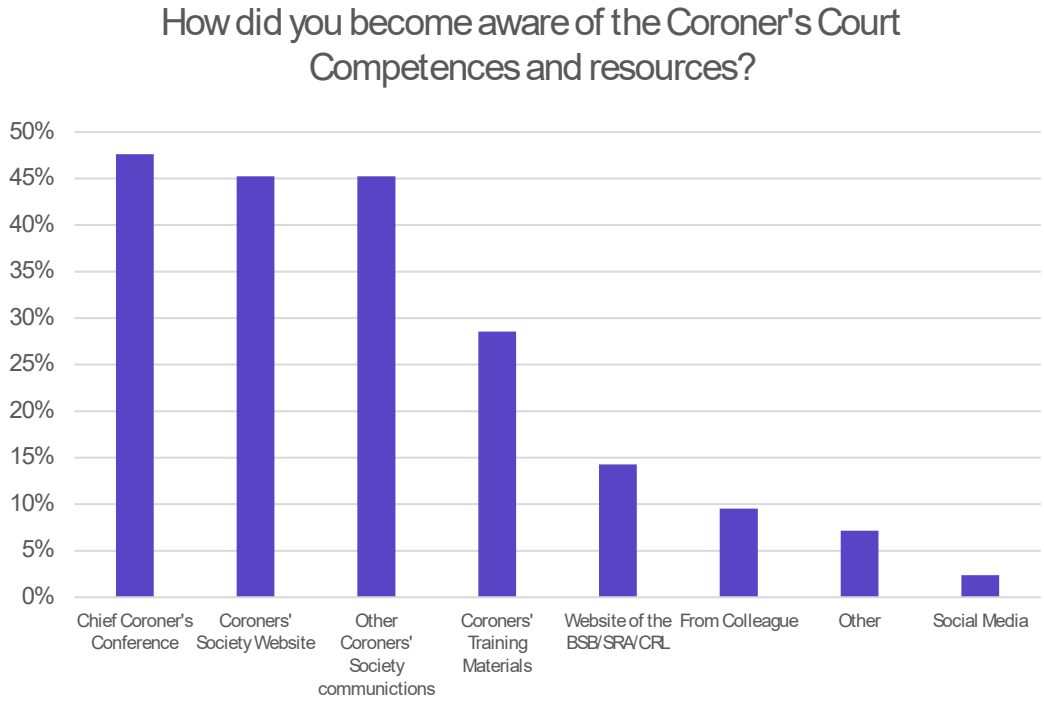
3.35. The vast majority of coroner respondents were aware of the resources, with only two respondents stating they were aware of the Competences and resources. This was substantially higher than the proportion of barrister respondents who were aware of the resources.

Chart 8



3.36. Among those who were aware of the resources, the vast majority had seen or read the resources personally (over 90% of respondents). Only 7.1% of respondents stated that they had not read the resources themselves. The reasons given for not reading the resources were that they had not yet taken or found the time to review them.

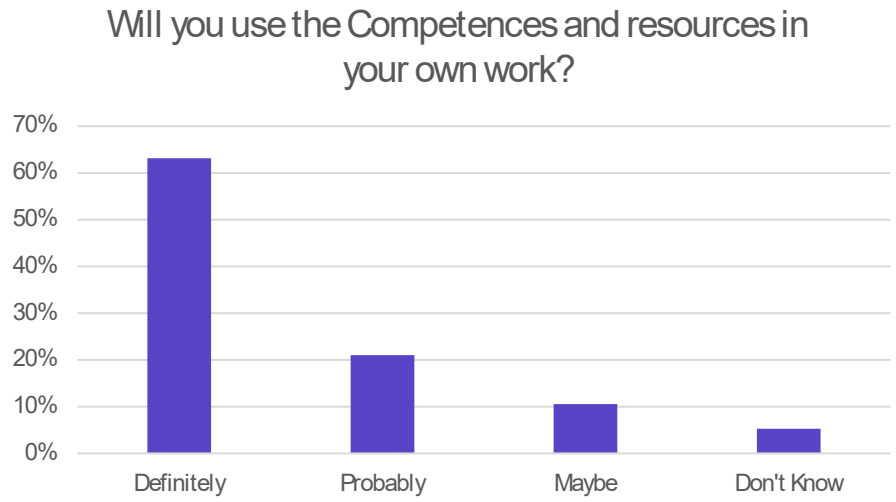
Chart 9



3.37. Respondents who were aware of the resources were asked how they became aware of them (respondents were able to select more than one option for this question). The most common response was that they became aware due to the resources being mentioned at the Chief Coroner's Conference, given by nearly half of respondents (47.6%). A similar proportion heard about the resources from the website of the Coroners Society of England and Wales or the Chief Coroner, or

from other communications from these organisations such as email. Slightly over a quarter heard of them from the coroners' training materials. Some responses also mentioned becoming aware of the resources because they were mentioned in court.

Chart 10



3.38. A large majority of respondents who had viewed the resources (84.3%) stated that they would probably or definitely use the resources themselves. This is a higher proportion than among respondents to the barrister survey – both in terms of the proportion who said that they would definitely or probably use the resources (84.3% compared to 66.4% among barristers) but also in terms of the high proportion who said they would 'definitely' use the resources (63.2% of coroner responses compared to 36.6% of barrister responses). It seems noteworthy that a higher proportion of coroners say they will use the resources personally given that they were primarily developed to support practitioners – this may well be linked to the fact that close to half of coroner respondents said the resources would help them in terms of enforcing the required standards and identifying when to report practitioners.

Cart 11

3.39. Respondents who had read the resources were asked if they had helped them. The most common response given was that the resources had helped explain the standard practitioners were expected to meet in their work in the Coroners' Courts, with over 70% of respondents stating that the resources had helped them in this way. The next most common area mentioned was helping them identify and enforce the required standards, mentioned by half of respondents, and helping provide clarity about reporting those who did not meet the required standards, mentioned by 47.6%. For the two respondents who said the resources had not helped them, they stated it was because they were already aware of everything covered in them.

3.40. When asked about other benefits or impacts from the resources in Coroner's Court proceedings, several participants mentioned the benefit of having a set list of competences to refer practitioners to, particularly when they felt they were exhibiting poor practice, or when they had little or no experience in Coroner's Court proceedings. Some respondents highlighted that more still remained to be done, particularly in addressing inappropriate adversarial approaches by practitioners.

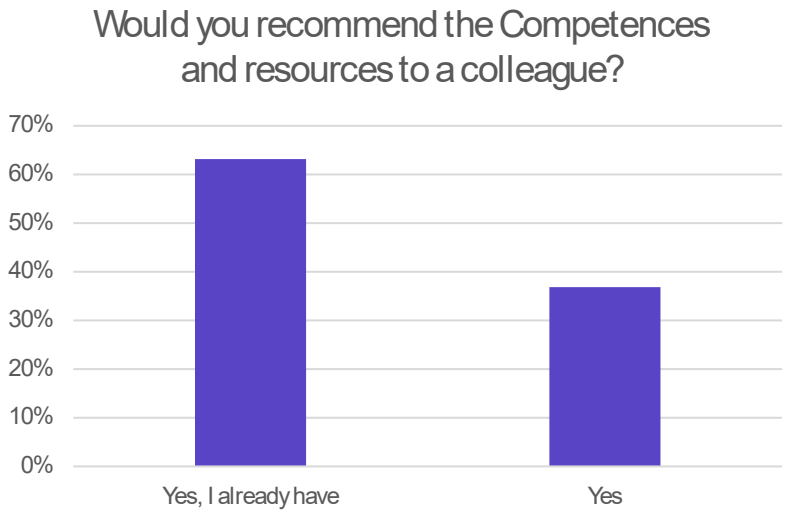
They have certainly given the ability of Coroners to refer advocates to guidance on practice which is a absolute benefit rather than it just being seen as the Coroners opinion that the conduct is poor.

They have been used as a reminder that standards are set out. Despite their existence, confrontation still arises and so that is where reinforcement of standards can defuse a situation.

There is still a material number of advocates/solicitors who treat the coroner's investigation/court hearings like litigation and an adversarial process.

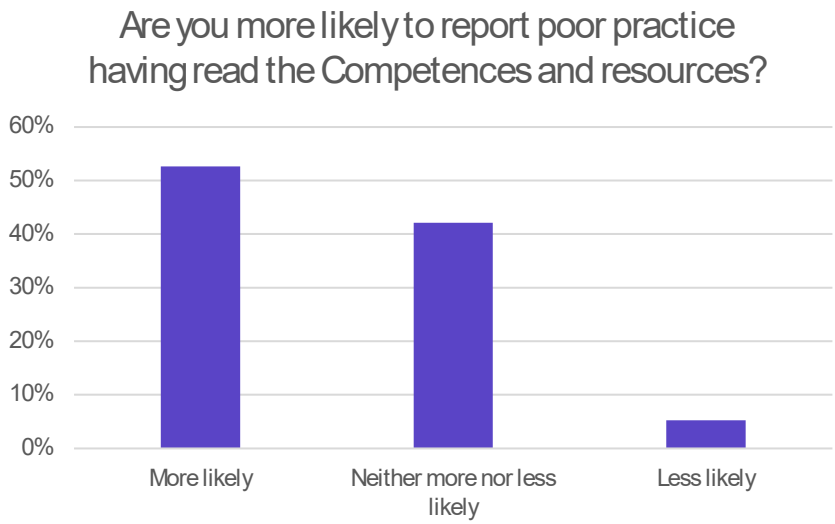
More detailed and robust guidance to all advocates needs to be set out. The impact is harming families and taking up valuable resources in terms of court time.

Chart 12



3.41. Respondents were asked if they would recommend the resources to a colleague, and all responses stated that either that they would or that they had already done so. In particular, it is noteworthy that the majority – close to two thirds – had already recommended the resources to colleagues, significantly higher than the equivalent proportion of barrister respondents (less than one in three).

Chart 13



3.42. A majority of respondents (slightly over half) stated they were more likely to report poor practice by practitioners in the Coroners' Courts following the publication of the resources. However, slightly under half stated the resources had not made a difference to the likelihood of them reporting poor practice, and two respondents stated that they were in fact less likely to report poor practice.

3.43. When asked how the resources could be improved, the most common response given by respondents was that awareness needed to be improved – several responses stated that awareness of the resources was still too low among practitioners, or that individuals felt that the resources did not apply to them. Other suggestions included making them shorter and simpler, using printed resources

rather than videos, ensuring they were reviewed regularly to keep them up to date, and providing more clarity around reporting routes and potential sanctions.

Ensure every practitioner has actually read them as there are still numerous practitioners who are unaware of them or think they do not apply to them.

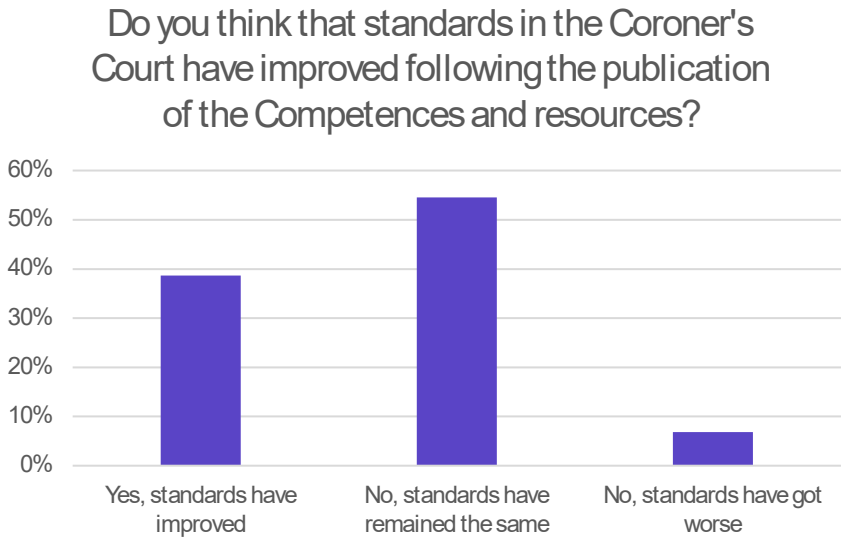
A more simple and succinct toolkit type document that is used in other jurisdictions would be more helpful and I anticipate more would access the material.

A clear link to reporting and indication as to sanction. The Coroners Courts are sadly an area where poor practice reigns - and sadly referring to the toolkit seldom curbs [poor] practice.

Chart 14

3.44. When asked if they felt that the standards of practitioners in the Coroners' Courts were in need of improvement prior to the publication of the resources, a large majority stated that they believed standards of practitioners did indeed need improving – nearly nine out of ten respondents took this view. While this may not be representative of the views of coroners overall, it is striking that such a high proportion felt that improvement was needed.

Chart 15



3.45. The majority of respondents felt that standards had remained the same following the publication of the resources, although a significant minority did feel that standards had improved (38.6%). Only a few respondents (slightly over one in 20) felt that standards had declined since the resources had been published (although it is worth noting that one of the respondents who felt standards had declined felt that they were not in need of improvement prior to the publication of the resources). Given the high proportion who felt standards were in need of improvement, it seems clear that for the majority of coroner respondents there remains work to be done to ensure that standards improve.

Key Findings – Coroner Survey

3.46. Responses to the survey suggest that overall, among coroners, awareness of the resources is high – over 95% of respondents were aware of them, and fewer than one in ten had not read or reviewed them personally. Both proportions were significantly higher than the equivalent proportions among barrister respondents, which suggests that awareness among coroners is likely to be higher than among the Bar.

3.47. Among coroners who had viewed the resources, a large majority felt that they had helped their practice and stated that they would use them in their own work. The most common benefit highlighted was that they clarified the expected standards in coroners proceedings, and around half of coroners also flagged the benefits around enforcing standards and clarity around reporting poor practice.

3.48. All respondents also stated that they had already recommended the resources to colleagues or would do so in the future. This suggests that coroners, as with the majority of barristers, are finding the resources valuable and using them in their work in coroners' proceedings. As with awareness, it is worth noting that the proportions of coroner respondents stating that they would use the resources themselves or recommend them to colleagues was higher than among barrister

respondents. This was reinforced by a number of comments from coroner respondents who flagged that awareness among practitioners needed to be higher, or that some practitioners did not feel that the resources applied to them when practicing in the Coroners' Courts.

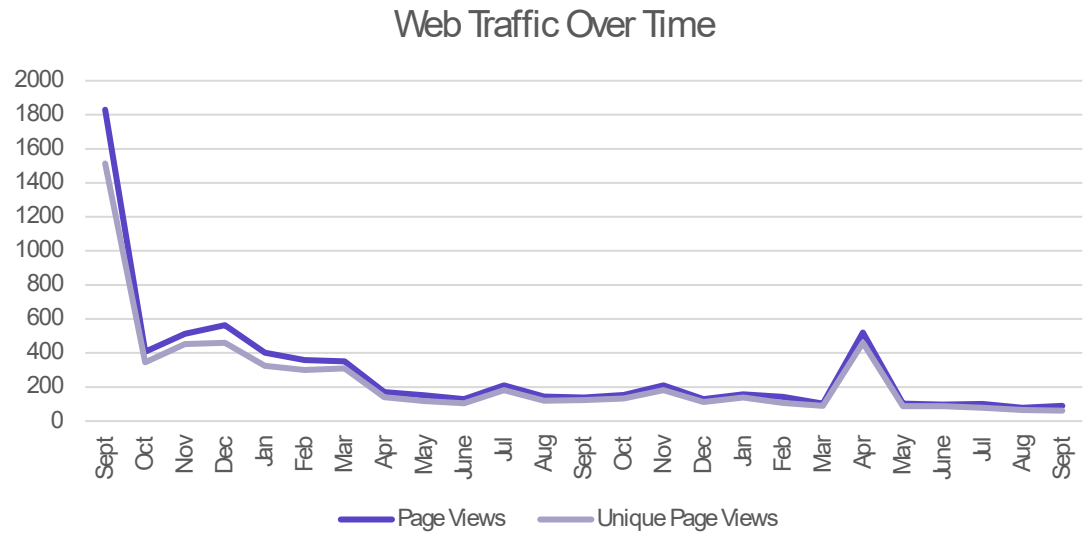
3.49. A large majority of respondents felt that standards in the Coroners' Courts were in need of improvement when the resources were published. However, while some felt that standards had improved following the publication of the resources, the majority felt that they had remained the same. This suggests that among coroners many feel that more needs to be done to improve standards – among survey respondents, the most common suggestion made was to raise awareness of the resources themselves, with some responses highlighting that a number of practitioners still seemed unaware of the resources, or that adversarial approaches which were harmful to participants were still an issue.

3.50. However, a majority of respondents stated that they were more likely to report poor practice following the publication of the resources, with several respondents highlighting the fact that the existence of guidelines on the required standards made it simpler to report poor practice, or that it made it easier to highlight to practitioners when they were not meeting the required standards.

Web Traffic Analysis

3.51. This evaluation also looks at the volume of web traffic for the Coroner's Court resources on the BSB website/downloads on the relevant documents and web pages that cover the Coroner's Court resources. This provides a quantitative indicator of the number of views the relevant resources have had, and therefore both measures engagement with the resources and how this varies over time. Engagement data was taken from google analytics from the BSB's website and YouTube account.

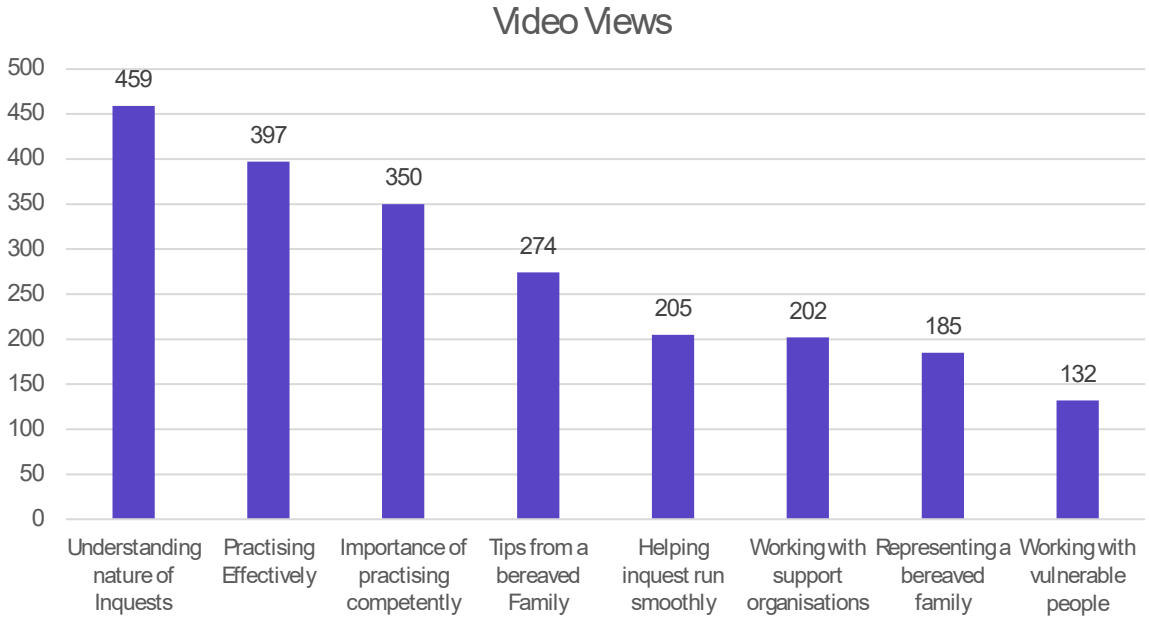
Chart 16



3.52. The chart above shows two years of web traffic data, from the release of the resources in September 2021 until September 2023. It shows both total number of views, as well as 'unique' views (i.e. the number of distinct IP addresses that accessed the relevant webpages, in order to give a more accurate picture of the total number of individuals who viewed the resources, discounting multiple views from the same IP address). The highest number of monthly views were in September, when the resources were first published, and received 1830 total views and 1514 unique views. This compares to over 3000 barristers who practise in the Coroner's Court.

3.53. For the first six months following the September publication (October 2021 to March 2022) monthly views dropped to an average of 432 total views and 365 unique views. After this, monthly views fell further, to an average of 156 total views and 132 unique views for the remainder of the two year period (although there was a considerable spike in engagement in April 2023). This suggests that a relatively small proportion of barristers practising in the Coroner's Court engage with the web resources regularly following their publication (although they may be referring to downloaded documents without referring to the website). Overall, there have been over 6000 unique views of the resources, which suggests that the majority of barristers practising in the Coroner's Court will have viewed the resources at least once.

Chart 17



3.54. The highest number of unique views were for those which covered the nature of inquests, and effective and competent practise for inquests. However, other videos received lower numbers of views, with the lowest being the video covering communicating and engaging with vulnerable people. Given the numbers of barristers working in the Coroner's Court, the view totals suggest that the majority have not viewed the videos, and therefore are not using them to inform their work in the Coroner's Court.

Key Findings - Web Traffic

3.55. Web traffic to the relevant sections of the BSB's website suggests that engagement was relatively high when the resources were first introduced, but has gradually declined since September 2021 when they were first published. Nonetheless, the number of views over time suggest that most barristers practising in the Coroners' Courts have seen the resources, and that there is a low level of continued engagement. However, video views suggest that the majority have not watched the videos provided as part of the resources, with relatively low numbers of total views. The videos covering the nature of inquests, and effective and competent practice in the Coroners' Courts, were viewed more than the other videos.

4 Summary and Conclusions

Are the Bar and other stakeholders aware of the Coroner's Court resources?

4.1. The survey of the Bar suggests that overall, among barristers practising in the Coroners' Courts, awareness of the resources is relatively high, with three quarters of respondents stating that they were aware of the resources, However, the fact that one in four respondents were not aware of the resources at all suggests there is still room for improvement in terms of raising awareness that the resources exist.

4.2. Among coroners, the survey suggest that awareness of the resources was higher than among the Bar, with over 95% of respondents aware of them, and fewer than one in ten had not read or reviewed them personally. Round Table participants felt that awareness of the Competences is 'patchy' with lawyers and coroners, despite the extensive work that had been done so far to publicise and raise awareness of the resources. The BSB's web traffic suggests that online engagement was relatively high when the resources were first introduced, but has gradually declined since then, although there remains a low level of continued engagement.

Are the Bar and other stakeholders using the Coroner's Court resources?

4.3. Among barristers, the vast majority of those aware of the resources had also read them personally. Two thirds of barristers stated that they would probably or definitely use the resources, with a further one in five stating they might use the resources.

4.4. Among coroners, fewer than one in ten had not read or reviewed them personally, and a large majority stated that they were already using or would use them in their own work. As with awareness, it is worth noting that the proportion of coroner respondents stating that they would use the resources themselves or recommend them to colleagues was higher than among barrister respondents. Among Round Table participants, there was a general consensus that where practitioners, coroners, and other key stakeholders are aware of the resources they generally do understand and make use of them.

4.5. Overall, the evaluation suggests that the resources are being used by the majority of both barristers and coroners who are aware of them. The relatively low levels of monthly engagement with the relevant sections of the BSB's website suggest that regular use of the resources online is somewhat limited.

Do the Bar and other stakeholders find the Coroner's Court resources useful in supporting good practice?

4.6. Among barristers who had used the resources, a large majority felt that they had helped their practice, with the most common reason given being that it had helped clarify the standards they were expected to meet in this area of practice, with a significant number of responses also highlighting the value of the resources in

terms of helping them keep their skills up to date. Other benefits included clarifying the fact that Coroners' Courts proceedings are supposed to be less adversarial than other court proceedings. The majority also stated that they would recommend them to colleagues. This suggests that the majority of barristers view the resources as helpful and are using them to inform their work in the Coroners' Courts.

4.7. Among coroners who had used the resources, a large majority felt that they had helped their practice. The most common benefit highlighted was that they clarified the expected standards in the Coroners' Courts, and around half of coroners also flagged the benefits around enforcing standards and clarity around reporting poor practice. All respondents also stated that they had already recommended the resources to colleagues or would do so in the future. This suggests that coroners, as with the majority of barristers, are finding the resources valuable and using them in their work in Coroner's proceedings.

Do the Bar and other stakeholders feel that standards in the Coroners' Courts have improved/are improving as a result of the publication of the resources?

4.8. Among Round Table participants and barrister survey respondents, some felt the resources were having an impact on Coroners' Courts proceedings. However, others stated the impact had been limited or non-existent, and more needed to be done to address issues in this area. Others felt it was hard to tell what impact they were having.

4.9. A large majority of coroner survey respondents felt that standards in the Coroners' Courts were in need of improvement when the resources were published, and although some felt that standards had improved following the publication of the resources, the majority felt that they had remained the same. This suggests that among coroners, many feel that more needs to be done to improve standards – among survey respondents, the most common suggestion made was to raise awareness of the resources themselves, with some responses highlighting that a number of practitioners still seemed unaware of the resources, or that adversarial approaches which were harmful to participants were still an issue.

4.10. Overall, the evaluation findings around impact are more mixed than the generally positive findings around awareness, use and value of the resources. While the resources are seen by some as having had a positive impact, the majority appear to feel that more needs to be done to address the issues, although often the suggestions relate to work needed to be done by others such as coroners themselves, noting the relatively small part that barristers play in coronial proceedings.

Has the publication of the resources encouraged the reporting of poor practice to the relevant regulators?

4.11. Among Round Table participants, the consensus was that the resources were having limited impact in terms of leading to increases in reporting of poor practice (although the resources were felt to be valuable to highlight the expectations for

practitioners and therefore set out clearly a route for reporting and what behaviours were considered to fall below the regulators' expectations).

4.12. However, a majority of coroner survey respondents stated that they were more likely to report poor practice following the publication of the resources, with several respondents highlighting the fact that the existence of guidelines on the required standards made it simpler to report poor practice, or that it made it easier to highlight to practitioners when they were not meeting the required standards.

4.13. Data from the BSB shows that there has been no significant increase in the reporting of poor practice in the Coroners' Courts, and Round Table participants highlighted the concerns that some may have in making reports to the regulators, and that in most cases the preference is for coroners to deal with any issues of poor practice in proceedings themselves rather than reporting (although they feel this is an option in particularly problematical cases).

4.14. As such, it appears that while the resources have had an impact around the objective of improving understanding of when and how to report poor performance, this has not in itself impacted on the level of reporting to the BSB. Evidence from the Round Table suggests that it remains the preference of coroners to deal with issues around poor practice coroners during proceedings, and that the Competences have given coroners more confidence to deal with these issues during proceedings by referencing the standards regulators expect.

Are there other actions the BSB could be taking to improve standards in the Coroners' Courts?

4.15. A number of barrister survey responses suggested making improvements to the resources in the future, ether in terms of making further clarifications or adding additional information or resources, whereas others suggested that actions needed to be taken by stakeholders other than the BSB such as Parliament or coroners themselves.

4.16. In addition, specific areas of the Competences / toolkit were raised where improvements could be made by Roundtable participants, in particular around setting out the risks of re-traumatisation, dealing with vulnerable participants, and clarifying expectations on disclosure (and how these differed in inquisitorial proceedings as opposed to adversarial ones).

4.17. Round Table participants also felt more needed to be done to raise awareness of the resources, both among coroners and practitioners. Coroner survey respondents similarly flagged that awareness among practitioners needed to be higher, or that some practitioners did not feel that the resources applied to them when practicing in the Coroners' Courts, and several felt that adversarial approaches which were harmful to participants were still an issue.

4.18. Overall, the evaluation suggests that the publication of the resources for the Coroners' Courts has been positive – awareness among barristers is generally

high (although coroners in particular feel that there is still scope for improvement), and most of those who are aware of the resources are both using them and finding them helpful at supporting their work in the Coroners' Courts.

4.19. In terms of the impact, the picture is more mixed – while some feel they have had a positive impact, others feel that they have so far made limited difference to the issues they are intended to help address. While there does not seem to have been a notable increase in the reporting of poor practice, the majority of coroner respondents felt that they were more likely to report poor practice following their publication and that they had improved clarity around what should be reported. In terms of what more could be done to drive improvements in the Coroners' Courts, the most common suggestion among both barristers and coroners was to do more to raise awareness, although there were some additional suggestions around improving the resources themselves, particularly in terms of the risks around re-traumatisation and dealing with potentially vulnerable participants.

4.20. The BSB will work with the SRA and CRL to consider the findings of our evaluation and their own evaluations. In doing so, we will consider suggested changes to the resources and explore whether parts of the toolkit need to be expanded or amended, noting the importance of uniformity between the regulators to help ensure consistent, high standards of practice in the Coroners' Courts. Additionally, we will work with the Deputy Chief Coroner and other stakeholders, including the SRA and CRL, to identify and agree on ways to continue raising awareness of the resources among practitioners and coroners.

5 Appendices

Appendix 1

Barrister Survey

1. Are you aware of the Coroner's Court Competences and resources?
Yes
No
[If 'NO' END]

2. [If YES for prev Q) How did you become aware of the Coroner's Court Competences and resources? Select all that apply
Browsing on the BSB website?
Specifically looking on the BSB website
BSB social media
BSB regulatory update
Other BSB communication
Heard from colleague/firm/chambers
Other

3. Have you seen / read the Coroner's Court Competences and resources?
Yes
No
Don't know/Can't remember

4. [If NO for Q3] Please tell us why you have not used the Coroner's Court resources and guidance. Select all that apply
I was not aware of this resource
I did not use the resource because it did not contain relevant content
I have no learning and development needs
I use alternative learning and development resources
Other
[THEN END]

5. [If YES for Q3) Did the Competences and resources help you in any of the following ways? Select all that apply
Helped me keep my knowledge and skills up to date
Helped me identify areas where I need further training
Explained the standard I am expected to meet
The resources did not help me
Other

[If 'The resources did not help me' for Q5] Please explain why the Competences and resources did not help you.
Open Text

6 Will you use the Competences and resources in your own work?
Definitely
Probably
Maybe
No
Don’t Know

7. Would you recommend the Competences and resources to a colleague?

Yes, I already have
Yes
No

8. Please share any further details about any other impact or benefits that the Competences and resources have had in terms of helping you meet the standards expected in the Coroner’s Court.

Open Text

9. Can the Competences and resources be improved to make them more effective in helping you meet the standards expected in the Coroner’s Court?

Open Text

Appendix 2

Online Survey – Coroners

1. Are you aware of the Coroner's Court Competences and resources?
Yes
No
[If 'NO' END]

2. [If YES for prev Q) How did you become aware of the Coroner's Court Competences and resources? Select all that apply
From the website of the Coroners' Society of England and Wales?
Other communication from the Coroners' Society of England and Wales or the Chief Coroner's Office?
From the Coroners' Training Materials?
From the Chief Coroner's Conference?
From the website of the BSB/SRA/CRL?
Social Media?
Heard from colleague?
Other

3. Have you seen / read the Coroner's Court Competences and resources?
Yes
No
Don't know/Can't remember

4. [If NO for Q3] Please tell us why you have not used the Coroner's Court resources and guidance. Select all that apply
I was not aware of this resource
I did not use the resource because it did not contain relevant content
It was not well presented
I use alternative resources(?)
Other
[THEN END]

5. [If YES for Q3) Did the Competences and resources help you in any of the following ways? Select all that apply
Explained the standards practitioners are expected to meet
Assisted me in identifying and enforcing the required standards for practitioners
Helped provide clarity around reporting practitioners for not meeting the required standards
The resource did not help me
Other

6 Will you use the Competences and resources in your own work?
Definitely
Probably
Maybe

No
Don’t Know

7 Are you more likely to report poor practice having read the Competences and resources?
Less likely
Neither more nor less likely
More likely

8. Would you recommend the Competences and resources to a colleague?
Yes, I already have
Yes
No

9. [If Q5 ‘The resource did not help me’] Please explain why the Competences and resources did not help you.
Open Text
TO Q 11

10. Please share any further details about any other impact or benefits that the Competences and resources have had in terms of improving standards of practice in the Coroner’s Court?
Open Text

11. Do you think that the standards of practitioners overall in the Coroner’s Court were in need of improvement prior to the publication of the Competences and resources?
Yes
No

12. Do you think that standards in the Coroner’s Court have improved following the publication of the Competences and resources?
Yes, standards have improved
No, standards have remained the same
No, standards have got worse

[END]

Appendix 3

Roundtable 11 December 2023

Evaluation of the Coroner's Court competences and resources

Objectives of the project

The competences and the toolkit were designed to:

- clearly state the behaviours and standards we expect from practitioners (barristers, solicitors and CILEx practitioners) working in the Coroners' Courts;
- develop resources to help practitioners meet the challenges of practising in the Coroners' Courts; and
- help people report poor practice to us if they experience or witness it.

Areas of discussion for the roundtable

Awareness

Awareness of the competences and toolkit:

Are practitioners and coroners aware of the competences and toolkit?

What more could we do to raise awareness of the standards we expect in the Coroners' Courts?

Understanding

Thinking about the competences:

Within each of the themes – procedure; dealing with vulnerability; communication and engagement; awareness of key organisations - do you think that practitioners understand what is required of them? If not, why not?

Which areas in the competences do you think practitioners have difficulty in complying with? Why is that?

Thinking about the Toolkit themes and format:

Do you think the content and format is appropriate to help practitioners meet the competences?

Do you think anything is missing? If so, what should be included and why would it be appropriate to include it in the Toolkit? (and in what format)?

Impact

Thinking about upholding the standards and the reporting of poor practice:

Do you think coroners are confident in dealing with practitioners who fall below the standards we expect of them in Court? Has this changed as a result of the work we have done in this area?

Are you more confident in reporting poor practice as a result of the competences / toolkit highlighting what is expected of practitioners?

Have you seen examples of poor standards of practice by practitioners that falls short of the standards you think we expect since the competences were introduced? If so, what was done as a result?

What do you think are the major barriers for individuals in reporting poor practice?

Have you ever reported poor practice to a regulator or felt that you should make a report? If you didn't report, why not?

If you did experience poor practice in the Coroner's Court, do you feel that the Coroner addressed this effectively? If so, how?

What more can regulators, coroners and other stakeholders do to encourage reporting of poor practice?

Concluding questions:

Do you think the work we are doing in this area has had a positive impact?

Is there anything else you feel we should be doing as regulators in this area to improve standards of practitioners?