

Response from Action against Medical Accidents to A Consultation Paper by the Fundamental Review of Death Certification and the Coroner services: 'Certifying and Investigating Deaths in England, Wales and Northern Ireland'

Introduction

- 1.1 Action against Medical Accidents (AvMA) is a registered charity established in 1982. AvMA provides advice, information and support services to patients injured during the course of medical treatment both directly and through their advisors. AvMA also works in conjunction with healthcare providers, regulatory and other bodies to try and reduce the number of avoidable accidents and to secure a just and fair system for meeting the needs of injured patients. AvMA was in the forefront of campaigning for the introduction of bodies such as the Commission for Health Improvement and the National Patient Safety Agency.
- 1.2 By the nature of the work undertaken by AvMA, AvMA's response to the Consultation document will focus on cases where failures in medical care have either contributed to or been directly responsible for the deceased's death. These will be referred to as 'medical deaths'.
- 1.3 Through the enquiries AvMA receives through our advisory services including a subscription based service for clinical negligence lawyers, AvMA has considerable experience of the problems faced by individual families with respect to the investigation of medical deaths as well as the limitations of the present coronial system.
- 1.4 Why do we need to reform the coronial system? Some might argue that it would be unnecessarily burdensome to introduce a new system and that with the potential numbers of medical deaths involved and the possible impact this might have on relatives and healthcare professionals, it would be preferable to accept the status quo. However, AvMA has long been concerned that the present coronial system is not working with respect to medical deaths and that families are being denied their right to an explanation, and the public interest in preventing further preventable medical deaths is not being served. AvMA believes that medical deaths should remain within the jurisdiction of the coroner. However, to be effective, the coronial system must be subject to fundamental reform.
- 1.5 Reforming the system for investigating medical deaths would be an important part of the new focus within healthcare provision on patient safety and also for ensuring relatives of the deceased are not left fighting endless battles to obtain an explanation and justice.
- 1.6 It is AvMA's experience that medical deaths have largely been excluded from the inquest process. Where medical deaths have been subject to a coronial inquiry, this has often failed to be more than a superficial inquiry restricted to

the who, where and how questions, the how being subject to a very narrow interpretation. It is apparent that concerns about avoiding issues of blame, limits the inquiry process. To be an effective inquisitorial process, it is going to be necessary to have the freedom to identify failures and establish accountability, if not in relation to individuals, then in relation to the systems within which those individuals work. The criminal courts are rarely the appropriate place for investigating the circumstances surrounding medical deaths but there is a risk that some cases do end up within the criminal courts by default where an individual is identified, rightly or wrongly as culpable. This is not however to suggest that there are not some cases where the actions of a healthcare professional are such that they should be subject to the criminal law but the approach taken under the coronial system needs to be overhauled so that it can better serve the public interest in medical cases.

1.7 We need to overcome the default position of medical deaths being classified as due to natural causes. It is AvMA's experience that, with the exception of a few enlightened coroners, there normally has to be overwhelming evidence against a finding of natural causes for medical deaths to be subject to the full inquest process. This high threshold impacts throughout the process from inaccurate death certification and poor quality of post-mortems through to a preponderance of natural causes verdicts at inquest. An essential change would be to ensure that the inquiry process extends beyond the immediate terminal event to explore the causal chain - the events that may have contributed, either directly or indirectly, to the deceased's death.

1.8 AvMA believes that any system for investigating medical deaths should:

- meet the needs of the bereaved
- involve the family and other individuals with knowledge relevant to the inquiry
- protect the public by identifying unsafe clinical practice or procedures and failures in systems of care
- reduce the risk that dangerous or criminal activity is concealed
- improve the accuracy of death certification
- increase the body of medical knowledge/research and provide a learning tool for healthcare professionals/healthcare managers
- have the power to ensure that where avoidable causative factors are identified, action is taken to prevent a recurrence
- be applied consistently across England, Wales and Northern Ireland

AvMA's experience of the problems of the present systems for investigating medical deaths

- 2.1 AvMA has identified a number of concerns with respect to the present system of investigating medical deaths:
 - a. inaccurate death certification
 - b. failure to identify untoward incident as a causative factor
 - c. failure to report untoward medical deaths to coroner
 - d. the use of 'natural causes' in medical deaths
 - e. reluctance of coroners to investigate medical deaths
 - f. poor quality of post-mortems
 - g. limitations of the inquest inquiry process
 - h. lack of representation and support for bereaved families

Inaccurate death certification

- 3.1 The medical profession are at the front-line of death certification. There needs to be a far greater emphasis on the importance of the death certification process and appropriate training for those involved in certifying death. Research has established that at least 30% of death certificates are inaccurate in that the stated cause of death is incorrect. This in itself demonstrates the low priority attached to the certification process. The elderly are perhaps amongst the most susceptible for the true cause of death not to be identified because deaths are less likely to be classified as 'unexpected' except by a small number of concerned relatives. Unfortunately, such concern is often interpreted/dismissed as being part of the grieving process - displaced guilt or anger.
- 3.2 The accuracy of death certification could be improved in many cases by a review of the deceased's medical records. The low priority given to auditing deaths perhaps reflects a fear of the Pandora's box and that if we look too closely, far more cases of unnecessary deaths will be exposed.
- 3.3 Other health professionals who have knowledge relevant to the death, must have a secure means of reporting concerns. In a recent case, a healthcare professional only alerted the family to a major untoward incident after the burial. In an earlier case, a healthcare professional was subject to sanction by their professional body for whistleblowing to the family about the actions of a colleague.
- 3.4 Additional evidence short of undertaking a full post-mortem should be considered in terms of scans, blood tests, tissue samples etc.
- 3.5 There does have to be a balance between the needs of the family and not making the whole process more traumatic or overly-bureaucratic whilst at the same time ensuring that avoidable medical deaths are not dismissed as 'one of those things'.

- 3.6 An additional safeguard that could be considered would be for an appropriate family member to be asked to confirm to the registrar that they are satisfied with the cause of death as given.

Failure to identify untoward incident

- 3.7 As a consequence of the poor systems that currently exist for accurately recording the cause of death and the fact that the whole issue of adverse events is only now being addressed, deaths caused as a result of an adverse event are rarely recognised and/or reported as such.
- 3.8 In the Chief Medical Officer's report, *An Organisation with a Memory* (June 2000), an estimate of 34,000 preventable deaths was put forward. How many of these are identified during the death certification and audit processes? One would surmise only a fraction. The reasons why these cases are not identified are multiple from a failure to diagnose the patient's condition both prior to and after death to a deliberate attempt to cover up the true facts of the case.
- 3.9 This is set against a background where the whole issue of adverse events has remained a largely hidden problem with no systematic or supportive way of openly addressing medical error. In many cases, healthcare professional may recognise that something did go wrong but would perceive or condone this as 'one of those things'.
- 3.10 For relatives, coroners and other authorities, the deference to the medical profession means that the right questions are frequently not asked or when a relative does raise concerns, these are dismissed. As was found with Shipman and the Bristol Royal Infirmary, the more serious or seemingly outlandish the allegations, the greater the degree of disbelief.
- 3.10 We are now on the threshold of developing a more systematic approach to adverse events although we are still a long way from having effective systems in place for identifying and responding to adverse events on the ground. That requires a significant change in culture together with a recognition of the support and training needs of healthcare professionals. The Commission for Health Improvement is increasingly making inroads in identifying and addressing poor standards and the National Patient Safety Agency is beginning the process of collating information on adverse events. We also have the confidential enquiries although some have proved more effective than others in bringing about significant changes in practice. However, both the NPSA and the confidential enquiries are limited by the very fact of being confidential processes and therefore do not address the individual case or the needs of the relatives.

Failure to report untoward medical deaths to coroner

- 3.12 As indicated above, many medical deaths are not reported to the coroner because they are not recognised as untoward or unnatural deaths. There is also ignorance about the role of the coroner system as well as fear of the consequences of reporting cases. AvMA has seen many examples where deaths which clearly should have been subject to a coroner's investigation have either failed to be reported or if they have, no further action has been taken

following discussion with the healthcare provider. This has been of particularly concern with respect to deaths in the independent healthcare sector.

- 3.13 There needs to be clear guidelines for mandatory reporting. Consideration should be given as to whether it is feasible for accountability for reporting to be placed with a named individual with overall responsibility within that organisation.

'Natural Causes'

- 3.14 A significant factor in the failure of medical deaths to be fully investigated is the use of the term 'natural causes' and its very broad interpretation. AvMA has found that the default position with respect to medical deaths is to assume that death was due to natural causes. In other words, that it was caused by the disease process or was an unavoidable risk of the treatment. The consequence of this is that when cases are reported to the coroner, many are closed following the post-mortem on the basis of a finding of 'natural causes'. All deaths could potentially be ascribed to natural causes if you only consider the terminal event and ignore the causal chain.

Example A

A man in his 40s admitted himself as a voluntary patient to a private psychiatric clinic where he had previously been an inpatient. It was the evening and he was intoxicated on alcohol at the time of admission. A number of drugs were administered including droperidol and a minor tranquilliser. He was then placed in a private room. The following morning he was found dead. The case was necessarily reported to the coroner as the deceased had been in good physical health. A coroner's post-mortem was undertaken and the cause of death was given as hypoglycaemia (low blood sugar). The coroner accepted the pathologist's advice that death was due to natural causes and the case was closed without further investigation. Despite representations, the coroner refused to hold an inquest and the family did not have the finances to challenge his decision. This was clearly a case which warranted further investigation to establish whether more could have been done to prevent this death. It was of importance not just to the family but for the safety of other psychiatric patients.

- 3.15 AvMA has also seen a number of cases where deaths have been reported to the coroner but no investigation has been undertaken because the coroner has accepted the advice of the treating clinicians, without post-mortem, that death was due to natural causes.

Example B

A young man was admitted to a private hospital for major abdominal surgery. He suffered an unrecognised complication and sepsis which led to circulatory collapse. An attempt to insert a naso-gastric tube whilst he was in a collapsed state resulted in aspiration of stomach contents. He suffered severe hypoxic brain damage and died the following day. The case was discussed with the

coroner but he accepted that the death was due to natural causes and the case was not investigated. No post-mortem was performed.

- 3.16 These examples highlight the need for a transparent system for categorising and identifying cases which should be subject to coronial investigation and for this to be clearly communicated to healthcare professionals and the public at large.

Reluctance of coroners to investigate medical deaths

- 3.17 From the cases that have come to AvMA, it would appear that only a small proportion of untoward medical deaths are captured by the present coroner system. AvMA would suggest that the majority of coroners have not perceived medical deaths as coming within their jurisdiction. In Scotland, 20% of Fatal Accident Inquiries relate to medical deaths. This is perhaps because the rules governing FAIs specifically state that deaths caused by medical mishap should be investigated by the Procurator Fiscal. This is less clear under the coronial rules. The Human Rights Act has in very recent times had some impact on the number of untoward medical deaths investigated by coroners but AvMA would want this category of deaths to be specifically included as being reportable to the coroner and subject to inquest where appropriate.

Poor quality of post-mortems

- 3.18 Increasing concern has been expressed by lawyers, doctors, relatives and the Confidential Enquiries with respect to the quality and accuracy of post-mortems. There is particular concern with respect to the use of independent post-mortem services by coroners. Where families have had the resources to arrange a second post-mortem, significant errors and omissions in the original post-mortems have often been found such that the cause of death has not been correctly identified in the coroner's post-mortem. Most bereaved families and probably many professionals would tend to assume that a coroner's post-mortem would be of a high forensic standard. The fact that many post-mortems are of a poor standard is a major concern because it undermines the whole coronial system.
- 3.19 Part of the reason may relate to inadequate funding of pathology services as well as a shortage of specialist pathologists. Concern has been expressed that where pathologists have requested necessary additional tests in order to complete their enquiry, these have not been allowed because the local authority has been unwilling to grant the funding required. This in turn is likely to lead to a general lowering of post-mortem standards. It would be interesting to know how many medical death post-mortems are considered to require a pathologist with specialist skills at the higher fee rate as opposed to the normal post-mortem costing a third of the specialist rate. The evidence of substandard post-mortems would suggest that non-specialist post-mortems are the general rule.
- 3.20 One would also like to know how frequently the pathologist examines the case records at the time of post-mortem. If this were done more frequently either by a pathologist or an appropriate clinician, it would assist in identifying the cause

of death with or without post-mortem and/or ensuring the post-mortem was appropriately targeted. It might also alleviate the need for a full post-mortem in every case if other tests, biopsies, scans etc could be used to confirm the suspected cause.

Limitations of the inquest hearing

- 3.21 Inquests relating to medical deaths frequently prove unsatisfactory because the issues being examined are often too narrow. It is suspected that this partly relates to the general reluctance of coroners to investigate medical deaths but also because of the rules relating to 'no blame' and 'self-incrimination'. In the medical context, it is very difficult to undertake an effective enquiry into the circumstances surrounding a patient's death without individual health professionals coming into the frame. What tends to happen in practice is that when the enquiry leads towards a particular individual, that line of enquiry is either not explored or is restricted by avoidance of questions which point to individual accountability. For the bereaved families, this can mean that they receive a partial explanation with respect to systems failures but issues of accountability are not addressed. Families and the public are left with a somewhat unsatisfactory explanation which skirts around what are sometimes central issues. This is a significant failing under the present system.
- 3.22 Secondly, the quality of the evidence presented at the inquest is often inadequate. AvMA believes that coroners in medical cases should always avail themselves of specialist independent medical advice to assist them in completing their inquiry. It is more normal for the only medical evidence to come from the pathologist and the witnesses who were responsible for the deceased's care. Consideration should be given as to whether a three person panel should sit for medical deaths including a medical and lay representative.
- 3.23 The other significant issue is that of the causal chain and how far coroner's are prepared to examine the circumstances leading up to the death. This in part relates to the interpretation of 'natural causes' but is also a factor in other cases where the inquiry is limited to the terminal event.

Example C

A voluntary patient at a psychiatric hospital was due to be transferred by ambulance back to his local psychiatric hospital. He was a known suicide risk. Due to funding restrictions, the transfer arrangements were changed a few days before the transfer date and he was to be transported by train accompanied by a psychiatric nurse. The partner of the patient offered to accompany the nurse to provide additional cover. On the day of transfer, the partner was advised that the hospital was unable to provide a nurse and that they would provide a taxi to the station and she should accompany the patient by herself on the train journey. She argued against this but ultimately felt she had no choice but to agree to this arrangement. During the course of the journey, her partner jumped from the moving train and was fatally injured. An inquest was held but only the pathologist and train driver were called as

witnesses. The events leading up to the train journey were not examined at inquest. An open verdict was given.

Lack of legal representation and support for bereaved families

- 3.24 It is AvMA's experience that families are often advised by coroners' officers that they may benefit from having a legal representative at the inquest but for many this does not prove to be a feasible option. Whilst exceptional public funding is now available for representation at inquests, the feedback AvMA has received would suggest that this is rarely granted in relation to medical deaths. The costs to the family of privately funding representation can range from a minimum of around £500 to a more realistic figure of £1,000 to £3,000. The result is that many families do not have legal representation. If we are going to place the bereaved at the centre of this process, than adequate funding arrangements must be put in place. It is AvMA's experience that where a family is well represented, this can make a considerable difference to their perception of the usefulness of the inquest and its outcome. Without representation, they become powerless spectators.

Some additional considerations

- 4.1 **Identifying which medical deaths should be subject to a public inquest:**
AvMA believes that medical deaths should remain within a reformed coronial system. With the potential number of untoward deaths resulting from medical care - anything in excess of 36,000 - it is apparent that not every death could reasonably be subject to a full public inquest. On the other hand, it would be unjust and contrary to the Human Rights Act for some families to have the benefit of a full inquiry whilst others are denied any form of investigation and explanation.
- 4.2 There therefore needs to be established a system whereby all untoward medical deaths are subject to enquiry and according to clear criteria, appropriate cases are then referred to a full inquest. This would be in line with the proposals put forward by the Shipman inquiry whereby they have proposed a Medical Coroner and a Judicial Coroner. AvMA believes this is a proposal that should be explored further (see below).

Responding to the needs of bereaved families

- 4.3 Under the present inadequate system for identifying and investigating untoward medical deaths, the majority of bereaved families are probably unaware that their relative's death may have been avoidable. If a more effective system is introduced for identifying and investigating avoidable medical deaths, many more families are going to be presented with information which is going to cause distress and anger and raise concerns about what they should do in response. It will also highlight more general failings within the provision of healthcare above and beyond what is probably perceived as the relatively isolated incidents that currently come within the public domain. This is not to suggest that the best option would be for these deaths to remain uninvestigated but it highlights the importance of being

aware of the potential impact that reform may have and the need to ensure that appropriate support and guidance is made available to bereaved families.

Impact on healthcare professionals

- 4.4 As with bereaved relatives, it is also important to consider the impact on healthcare professionals of more medical deaths being subject to inquiry. The majority of healthcare professionals if involved in an avoidable death are undoubtedly deeply affected by the experience. They may well feel guilt whether or not they could be considered in any way responsible for what has happened. The inquiry process may understandably be perceived as threatening both personally and professionally. However, healthcare professionals may also benefit from having a proper inquiry process in that it should explore all the causative factors above and beyond their own personal role in the events.

Disclosure of documents

- 4.5 Under the present coronial system, access to documents prior to the inquest is often restricted although this does vary between coroners. Families should be entitled to have full access to statements and other documents prior to the inquest.

Witnesses

- 4.6 Families should have the right to request that certain witnesses attend the inquest and where this right is denied, to be able to challenge that decision.

AvMA's Response to Consultation Questions

1. Chapter 1 - Overview

Page 16: Analysis and aims of new services

AvMA would largely agree with the statements set out in paragraph 22. We would extend the aims to specifically state that:

- the quality of the investigation of deaths will be subject to specific standards;
- the system will be sufficiently flexible to allow the enquiry to be tailored to the specific circumstances by which the person came by their death whether it be by due to a rail disaster or medical accident
- the criteria for mandatory reporting to the coroner needs to be expanded to specifically include untoward medical deaths with sub-categories within this. These criteria need to be clearly communicated. Criteria for mandatory inquests in relation to clinical deaths should also be established.
- there need to be clear guidelines and protocols for when an inquest should take place
- the scope of coronial investigations needs to be reformed to ensure that the 'causal chain' is included in the investigation. Without this, the inquest represents an expensive procedure with limited value in terms of protecting the public
- consideration should be given to including the investigation of intrapartum stillbirths within the coronial enquiry process

With respect to 2., one would like to see the coroner have greater power not just to inform but to enforce.

2. Chapter 2 - Death Certification

Page 25, Paragraph 46.

1. Para.25: death certification needs to be given much higher priority than is currently the case as highlighted by the error rate with statutory duties attached and possible sanctions.

Untoward deaths occurring whilst the deceased was under medical supervision generally require a far higher level of suspicion before they are identified than most other untoward deaths and there therefore needs to be more effective and sensitive systems for capturing these cases.

2. Para 27: the Medical Audit Service would be a useful addition although the proposals put forward in the Shipman discussion paper, ('Developing a New System for Death Certification'), for introducing the post of Medical Coroner, takes this a step further and would be a preferred option. The numbers of untoward deaths resulting from medical care would make it potentially impractical for inquests to be held in every case but where the death has been caused or contributed to by failures in medical care, an investigation must be carried out. All families who have lost a loved one as a result of negligent care have a right to have the circumstances investigated. To be effective the proposed Medical Coroner would have to be properly

resourced and be independent of local healthcare providers. The resourcing of this structure both financially and in terms of the professionals to staff it would have to be examined further.

If such a system as proposed by the Shipman Inquiry were working correctly, one would anticipate that far more untoward medical deaths would be identified than is currently the case. One then either has the choice of referring all these to the proposed Judicial Coroner for inquest or trying to filter cases such that a more limited number are subject to an inquest hearing. It is possible that if the findings of the Medical Coroner are accepted in full by the healthcare provider and the bereaved, the matter can be closed, subject to verification by the Judicial Coroner, with recommendations for corrective action etc. Where dispute remains, the case must then be referred on to the Judicial Coroner for consideration.

3. Para 29: as above the preferred model being more in line with the Medical Coroner.

4. Certification for cremation: the three tier system for cremations would appear unnecessary providing there is significant reform and improvement in the current system of death certification and that both burials and cremations are subject to a more rigorous system.

5. Two-tier certification system.

6.& 7. Standard processes for verifying deaths: if other health professionals are to verify deaths, then they should be certified to carry out this function and according to set protocols. Relatives must have trust in the people carrying out this function and be assured that those undertaking this role are appropriately trained to do so. The occasional case that does hit the headlines where live patients have been certified as dead is sufficient to undermine public confidence.

Chapter 3 - Post Mortems. **Page 31, Paragraph 61**

1. As above, the quality of post-mortems is a significant concern and undermines the whole coronial process and would raise serious concerns about the effectiveness of any reforms if the quality of pathology services is not addressed.

AvMA is in general agreement with the issues set out in paragraph 59..

2. Given the problems that currently exist with respect to the quality of post-mortems, setting standards and auditing will be an essential element.

3. It is difficult to comment on this at this stage without more detailed information. However, what AvMA would not want to see is a protocol which is used to reduce post-mortems to an unacceptable level on a cost-cutting basis

ignoring the public interest and rights of the bereaved under the Human Rights Act.

Chapter 4 - The Judicial Investigation of Deaths
Page 37, Paragraph 7

1. Agree. The present system is unpredictable with wide variations between individual coroners in their interpretation of the Coroner's Rules and their role within it. This results in very different approaches being adopted depending on which area the death happens to take place in. There needs to be a system whereby poorly performing coroners can be dealt with and do not remain in office where they are clearly not serving the public interest.
2. Agree.
3. Agree.
4. Agree.
5. -
6. Agree. Coroners should also undertake some basic medical training if they do not have a medical background and training in general forensic issues.
7. Would generally agree but this may present problems in some rural areas unless the coroner is going to cover a very large district which would in itself present problems in terms of accessibility etc. for the bereaved.
8. Agree
9. Unable to comment.

Chapter 5 - The Public Inquest
Page 48, Paragraph 107

1. AvMA believes that deaths caused as a result of a medical mishap or treatment omission should be included as a specific category subject to coronial investigation. Consideration should be given to mandatory inquests in certain categories of medical death. Medical deaths have been largely neglected by the coronial system which is perhaps part of the reason why it has taken so long to identify the quite staggering problem that avoidable medical deaths represents.

One would have to be extremely careful about moving away from holding inquests in certain categories of death. For example, in the case of suicides, as illustrated in the case history above (Example C), many families may report concerns about the circumstances leading up to the person taking their own life. A lack of appropriate medical care or inadequate systems for care in the community is often a contributory factor. It would be very dangerous to exclude these cases from a public inquest.

Reference is made to the other procedures open to families for investigating a relative's death. Civil claims for clinical negligence are

often not open to families where the level of damages is insufficient to satisfy the cost benefit requirements under the Civil Procedure Rules and public funding bodies. Where the family does not qualify for public funding, then legal action may simply be too costly for them to proceed. More importantly, most families, unless dependent on the deceased, are seeking an explanation and accountability rather than compensation and have no desire to take legal action unless that is the only option remaining to them. The NHS Complaints Procedure has consistently failed to meet the needs of patients and relatives and cannot be considered as a viable alternative to a Coronial inquiry.

2. **Inquests and administrative disposal of cases:** the Shipman inquiry proposals for a medical coroner could provide an additional means of investigation short of a public inquest. However, this must include protection to ensure that the needs of the bereaved and the public interest are met.
3. **Verdicts:** AvMA would favour a combination of narrative outcomes and short-form verdicts providing the short form verdicts were appropriate to the type of case under consideration. Verdicts of natural causes and accidental death are frequently used in the context of medical deaths. This frequently fails to reflect the true nature of the causal chain leading up to the death and the fact that had more appropriate treatment been provided, the death could have been avoided.

Example D

An inquest was held into the death of a baby that died shortly after delivery as a result of severe hypoxia caused by a prolapsed umbilical cord. There was clear evidence that there was a significant failure to adequately monitor the mother's and baby's condition during active labour. There was also evidence that had such monitoring taken place, the prolapse would have been detected and the baby's death avoided. The verdict of the inquest was natural causes.

This example illustrates a number of issues. It is probably still the exception rather than the rule that such a case would be subject to a coronial inquiry and public inquest. The coroner in this case was perhaps unusual in that he allowed a fairly full exploration of the care provided during labour whereby the failures in midwifery care were highlighted. However, it also illustrates the failure of the verdict to reflect the causal chain and the evidence that but for the failures in care, this death was preventable.

4. **Support:** AvMA would strongly agree with the proposal that the support of bereaved families is placed at the centre of a reformed inquest process. This support should include ensuring families have access to appropriate advice. It should also be taken into account that in the immediate aftermath of a death, relatives are often not in a

position at that stage to give a full and cogent account of their concerns. It is often only during the following weeks that they are able to articulate their concerns. The processes of grief and anger can sometimes appear to undermine the credibility of the witness and it is important that those conducting the enquiry understand the needs of the bereaved so that important testimony is not lost or dismissed.

5. **Public funding:** as indicated previously, the feedback that AvMA has received would indicate that public funding is extremely difficult to obtain for inquests involving medical deaths. If we are placing the needs of the bereaved more centrally to the inquest process, then funding for representation must be made available. The issue of specialist solicitors is less of a problem with respect to clinical negligence due to the existence of specialist clinical negligence panels and LSC franchises. However, those who are privately paying for representation do still need to be advised of the need to seek advice from a specialist solicitor.

6. **Public Safety Comments:** AvMA believes that the coronial system should have more teeth to ensure that where recommendations are made, the outcome of these recommendations are monitored, and that the appropriate regulatory body is made accountable for ensuring these recommendations are acted upon.

Chapter 6 - Some Issues of Structure and Reporting

Page 49-51

AvMA welcomes the move towards standardising coronial services and reducing fragmentation between the various bodies with a responsibility following a death. Coroners need to work within a supportive structure rather than the apparent isolation that leads to wide variations in standards.

There are benefits to the concept of the local coroner but there are also drawbacks in terms of independence both real and perceived.

As indicated previously, the role of a Medical Audit Service, whilst useful, in monitoring and improving standards of death certification, is probably too limited to provide a second tier investigative structure. The preferred option would be that proposed by the Shipman Inquiry for a Medical Coroner providing this post is properly funded.

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