RESPONSE TO

Coroners and Justice Act 2009, Post Implementation Review 2015

Call for Evidence

CONSULTATION DUE: 10TH DECEMBER 2015

Introduction

1. Action against Medical Accidents (AvMA) was established in 1982. It is the UK patient safety charity specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents throughout the United Kingdom.

2. AvMA offers specialist services to the public, free of charge, across the United Kingdom. This includes a helpline and an individual casework service staffed by legal and medical professionals.

3. In September 2009 AvMA committed resources to providing a specialist pro bono inquest service in England and Wales. The service was officially launched in July 2010. The service aims to find representation for people who have been affected by the death of a loved one where the death occurred in a medical setting.

4. Currently, AvMA has at least 4 members of staff who are committed to undertaking inquest work, along with other duties. All staff involved in the inquest work are highly trained and are qualified as either doctors, solicitors or barristers.

5. The pro bono inquest service has developed so that it now provides advice to between 80 – 100 families each year, including at least 15 inquest hearings as well as pre inquest reviews (PIR). Some of the cases are referred to solicitors especially if there is a potential civil claim. Through our work, we have developed considerable expertise in providing assistance and representation to members of the public at inquests where the death arose in a healthcare setting. It should be noted that the service developed before the implementation of the Coroners and Justice Act 2009. We are therefore in a strong position to make observations on the coronial process in both the pre and post implementation period.

6. Our inquest experience has enabled us to explore core issues pertinent to the patient's death and to draw attention to them as part of the investigative process of the Coroner's court. Our aim is to protect patients by highlighting concerns apparent in a Trust's practice and or procedures and to invite the Coroner to use his/her powers to remedy the failings where appropriate.

7. As an organisation our aims are to champion patient safety and access to justice. Accordingly, where appropriate we invite the Coroner to consider the need for a conclusion to reflect that neglect aggravated the cause of death and to record evidence of systemic failings. We also consider any Action Plans put forward by the Trust and where relevant address the Coroner on the need to make a Prevention of Future Death Report (PFD).

8. AvMA provides specialist support services for legal professionals through our Lawyers Resource Service including the recommendation of expert witnesses. We organise specialist training courses and conferences for health and legal professionals, advice agencies and members of the public.

9. AvMA operates a specialist accreditation scheme and assesses solicitors for eligibility to the panel based on their experience and expertise in clinical negligence. The AvMA panel has been running since the late 1980's and is the longest running clinical negligence accreditation scheme as well as being the first accreditation scheme of its kind. We reaccredit our panel solicitors after 5 years to ensure that they are maintaining standards, both the original application for accreditation and reaccreditation process require solicitors to submit case reports. As a result we have access to over 200 case reports annually.

10. The case reports ask for a number of pieces of key information. For example: when the solicitor first had contact with the client, when the letter of claim was sent, when the letter of response was received; when proceedings were issued; when the case settled. Applicants are also routinely asked about their experience of the coronial system as it relates to deaths in a healthcare setting. The information collected not only enables us to assess a candidate but also provides us with a keen sense of the difficulties commonly encountered by claimant solicitors in progressing cases in the civil courts and/or in the Coroner's court.

AvMA's Response to the Consultation

11. AvMA has confined its responses to questions where we feel able to comment based on our experience and information available to us through our services.

Executive Summary of AvMA Recommendations

12. **Greater recognition that the bereaved should be at the centre of the process:** This should be more than just lip service, there should be increased notice for hearings and less refusal by Coroners to take into account counsel's available dates

13. **Greater emphasis to be put on the duty of Trust's and Hospital's to disclose all documents which may be relevant to the inquest to the Coroner at the earliest possible opportunity.** Overall Trusts seem to be very slow and or reluctant to disclose documents and this results in adjournments which in turn gives way to unnecessary costs being incurred. We would comment that generally the Coroner's office is usually quite good at disclosing their own documents such as the post mortem report, expert reports and witness statements.

14. **More information for the bereaved about what they are entitled to receive by way of documents** – they have to ask for disclosure, it isn't volunteered. It is true that some families don't want to see the documents but for many others they simply don't know they have to ask or that they are entitled to ask. It may be that if the Guide were more widely available this option would be better understood (see comments below).

15. **Greater access to information for the bereaved**: "The Coroners Investigations: a Short Guide" (4 page document) and the "Guide to Coroner's Services" (57 pages) published last year – None of the clients coming to AvMA were aware of the existence of these documents.

16. **Greater parity in the court room**: In healthcare cases it is still typical for the Trust to attend with counsel and representatives from the Trust as well as the witnesses while the family are often unrepresented

17. **Better dissemination of the learning points from Inquests** to all Hospitals not just the one at the centre of the investigation in question. Better follow up for Action Plans.

18. **Specialist healthcare Coroners**: It is AvMA's view that inquests arising out of a death associated with healthcare would be improved if Coroners received specific training in healthcare or had a clinical negligence background.

19. **Provide Coroners with power to impose sanctions**: The inquest process would also benefit if Coroners had the power to impose sanctions on Trusts or Hospitals that failed to provide disclosure in a timely manner.

QUESTIONS

Guide to Coroners Services

Did you receive a copy of the Guide to Coroners Services? If you received the Guide, did it help you understand the process of investigations and inquests? Why or why not? Did you feel the Guide's standards were met? If not, which standards did you feel were not met in your case?

20. **Comments:** Of the 80 – 100 cases we have been involved in over the last 12 months none of the team dedicated to inquest work can recall any situation where clients approaching us were already aware of the existence of the guide. To this extent the public is no better off now than it was before the implementation of this Act in July 2013. However, AvMA staff considers the contents of the Guide to be very useful. It is our view that greater emphasis should be put on the need for Coroner's officers to provide copies of this document to the family or at least make families aware of its existence when they initially write to families.

The release of bodies and post-mortem examinations: If you experienced a delay in the release of a body, did you receive an explanation from the Coroners' office? Were you satisfied with the explanation for the delay? If you requested a less invasive post-mortem examination, were you satisfied with the Coroner's service? Why or why not?

21. **Comments:** Generally, this provision has not caused any difficulties in practice and it is not a usual cause for concern. We have experienced one case where one family wanted to have a second post mortem but was unable to find a pathologist to assist. As a result, the body was not buried for several weeks.

22. We have also come across the situation where members of the public would like the Coroner to order a post mortem but this step is not taken. The usual reason for this is that the Coroner considers the death to be brought about by natural causes and does not consider it necessary to hold an inquest. There can be dispute about whether the death was due to natural causes or not and this could be better explained in the short guide which simply says: *"If a Coroner decides that an investigation is necessary, a pathologist will normally carry out a post mortem examination of the body".*

23. If the intention is that the Guide will be more widely and readily available in the future then then we would suggest that the short Guide includes reference to the fact that the Coroner does not have to carry out a post mortem if he or she considers that there is sufficient evidence to suggest that the death was due to natural causes.

24. We are not aware of any cases where the family requested a less invasive post mortem but this was refused.

Disclosure of information: If you requested any information or documents during an investigation, was this during or after the investigation, or both? Did you receive information as a result of the request? Were you satisfied with the information you received? If you had to pay a fee for disclosure, do you feel the fee was reasonable?

25. **Comments:** In general terms the current system is more effective than the pre July 2013 system as parties are clearer about the family's entitlement to receive documents having requested the same. However, considerable difficulties with disclosure persist in relation to both the Trust refusing to disclose some/all documents to the Coroner at the outset.

26. When analysing this response we have looked at the cases handled by us and given particular consideration to matters such as: How many clients come to us with documents already disclosed to them? How many families were aware that they are entitled to the documents if they requested them? We have also had regard to whether Coroners are routinely asking for medical records and or serious incident reports (SIRs) or equivalent documents and are prepared for handling an inquest where the death occurred in a healthcare setting.

27. To illustrate the level of misunderstanding that persists over the duty to disclose we refer by way of example to a case we were recently involved in, referred to as *"C"*. The case involved a one day old baby who owing to a congenital defect required an operation to correct Oesophageal Atresia (OA) and Tracheo-Oesophageal Fistula (TOF). The baby died during the procedure.

28. In the case of "C", AvMA wrote to the Coroner enclosing the client's signed form of authority to provide documents and liaise with us on behalf of the client. The Coroner refused disclosure until counsel had been instructed. AvMA objected on the basis that this was not necessary or in accordance with the rules. However to save time and given that counsel had been identified the Coroner was given details of the counsel who had been instructed. However, the Coroner insisted that he would only give disclosure directly to Counsel and not the AvMA representative.

29. The case of "C" was eventually referred to the head Coroner for that area who subsequently took over the case. Once that happened matters did improve and we did receive a call from the head Coroner apologising for the difficulties encountered. Full disclosure was then made to AvMA. However, this example illustrates the fact that some Coroners remain confused about when and in what circumstances disclosure should be made.

30. We have several examples of hearings having to be adjourned because documents requested were not made available in time for the hearing, this is despite the fact the documents were requested well in advance of the hearing date. In those cases, we gave clear reasons why the documents were relevant and necessary to complete the inquiry. This approach results in unnecessary expense to all involved, not least the court itself.

31. Our pro bono service relies on the good will of counsel and the fact that barristers take time out of their diaries to undertake inquest work. It is very frustrating for all parties involved in providing the service to encounter adjournments especially where this outcome has been flagged up in advance to the Coroner. This approach does not put the bereaved at the centre of the process.

32. We have also encountered difficulties with healthcare providers not providing relevant documentation to the Coroner at the outset or to the family when the specifically requested same. In one of our cases, we made specific enquiries of a Trust as to the existence of a SIR. We were told that no such document had been completed. Subsequently during the Inquest hearing itself, it became apparent that a SIR did exist and that it had been disclosed to the Coroner who referred to it. The SIR had simply not been disclosed. It was only midway through the inquest hearing that the family had confirmation that a SIR did exist.

33. This case raises two issues. Firstly the lack of candour by the Trust in failing to meet its obligations to disclose to the Coroner and family at the earliest possible opportunity, all documents which are likely to be relevant. Secondly, the Coroner's failure to disclose the SIR to the family when it came into her

possession. This was a case where the family had made it clear they wanted access to relevant documentation.

34. In another AvMA case of *"F"* where we had provided assistance to the client very early on, few documents had been disclosed to the client or ourselves. However late on the Friday afternoon before the Monday when the inquest was due to commence, we received a large number of papers. AvMA sent counsel's written submissions requesting an adjournment in order to consider the papers. We were told by the Coroner's officer to *'turn up with an open mind'*. On Monday morning, counsel for the family made submissions which simply repeated the written submissions sent on Friday afternoon, at that point the Coroner agreed to adjourn the hearing. This decision could and in our view, should have been taken on the Friday afternoon to avoid expense being incurred.

35. In our experience, most families if not all are unaware that they are entitled to request disclosure of documents from Coroners. It is also our experience that families do not recognise and or understand that they are entitled to additional documents if the court is relying on the same. There is clearly a correlation between this situation and a lack of information being made available by the court to the bereaved at the outset; not least the availability of the Guide to the Coroners Court. Not all families are proactive in seeking disclosure. Whilst it is accepted that many families would find it too distressing to see the documents to be relied upon at the inquest, ignorance of their entitlement to see the relevant papers upon request appears to be a greater bar.

36. The vast majority of clients who approach AvMA for assistance from the pro bono inquest service do not have documents in their possession. Those who do approach us with documents rarely have anything more than the post mortem report and some witness statements. It is often the case that there appears to be a lack of open communication between the Coroner and the family in relation to what documents/reports do actually exist. In part this may be due to the fact that Trusts and Hospitals are often very slow and or very reluctant to disclose documents and when they do it is in piecemeal fashion.

37. Leaving aside the not insignificant difficulties with Trusts/Hospitals failing to provide timely disclosure of relevant documents to the Coroner, there does appear to be a general failure on the part of Coroners to appreciate how significant the medical records are in healthcare related deaths. It is AvMAs view that the medical records are key to providing evidence of the broader clinical picture as well as being an important source of information relevant to identifying issues with medical care and how the deceased died. The medical notes enable appropriate witnesses to be identified and to be called in advance of the inquest to give evidence or to prepare a witness statement.

38. In the case of “S” this was particularly pertinent as the death involved a vulnerable adult who had cerebral palsy. The family had set out their particular concerns with the care provided to their relative immediately before her death but despite this the Coroner had not requested any medical records from the Trust.

39. AvMA believes there is a case for healthcare deaths to be dealt with by a Coroner who has particular experience in this area.

40. It is our experience that Coroners have varying degrees of knowledge and or expertise in this area and consequently fail to appreciate how complex and niche inquests following deaths in a healthcare setting are. We have encountered Coroners who do not know what a CTG trace, Syntocinon or a NEW score is.

41. We have also experienced cases where the Coroner has not appreciated the significance of the existence or otherwise of a SIR or equivalent document. Given that background it stands to reason that there is more chance of a Coroner not being able to identify important issues. This has an adverse effect on the family who then have less confidence in a Coroner who has little knowledge of the medical terminology/issues.

42. It is AvMA’s view that inquests arising out of a death associated with healthcare would be improved if Coroner’s received specific training in healthcare or had a clinical negligence background.

43. The inquest process would also benefit if Coroners had the power to impose sanctions on Trusts or Hospitals that failed to provide disclosure in a timely manner.

Inquest recordings: If you requested a copy of a recording (audio or transcript) of an inquest, did you receive the recording? Were you satisfied with the recording (audio or transcript) you received?

44. **Comments:** Generally this appears to be satisfactory however in the case of “S” the client requested the recording of a PIR in order to remind the Coroner of an issue that was agreed upon at this hearing. The recording however could not be found. In another case of “P” the client requested a copy of the recording of a PIR only to be told that on that day the recording equipment was not operational.

That the bereaved and other IPs are notified of the inquest within 1 week of arrangements’ being made or any changes to the arrangements being made:

45. **Comments:** We are unable to ascertain from our data the extent to which at least one weeks’ notice is being given. However, Coroners do appear to be

listing Inquests at very short notice. The need to list the inquest is often driven by the Coroners focus on having the case heard within the first 6 months following the death and at the latest within 12 months following the date of death.

46. AvMA recognises that there are benefits with having Coroners working to a timetable, however this should not overshadow the fundamental purpose of the inquest which is for the Coroner to be in a position to carry out a full and fearless investigation into how the deceased came about their death.

47. Some examples of the situations we have encountered are identified below:

- The case of *"Str"* the deceased passed away on 4.10.15, the inquest was listed for 9.12.15 and client informed of this date on 24.11.15. It is very difficult to assist client at such short notice.

- The case of "*Grm*", the deceased passed away on 15.6.15, the inquest was listed for four days commencing 5.11.15; the client was notified on 23.10.15. Again this allowed a very short period of time period for the client to prepare and secure representation.

- The case of *"Grly"* was a case where the death occurred in 2002, the inquest was listed for 7.12.15, the client was only made aware of the hearing date on 16.11.15.

48. Listing cases with little or no warning creates a number of problems. It is often the case that important documents such as medical records have not been obtained. It can also make it very difficult for families to secure representation. Some Coroners are more amenable to listing a case with counsel's availability in mind than others. We have set out some of the responses we have received from Coroners when requesting that they take into account counsel's availability. The quotes set out below have been taken from six different cases:

- The Coroners officer stated: "*the Coroner 'doesn't take counsel's availability into account' and alternative representation has to be sought by AvMA"*

- Even where the Coroner is given counsel's dates to avoid prior to the listing we are told it *'wasn't essential for Counsel to be present'*

- Even where the Coroner is more amenable to taking into account counsel's availability we were told that, the "Coroner *would take the dates into account however they were not essential"*

- In another case the family were not available to attend the final Inquest hearing as they were travelling to New Zealand. The Coroner stated that it was not necessary for the family to be present.

- In the case of *"P"* the Coroner was very accommodating and took into account the fact that the family were in France for a period of time and the birth of the client's grandchild.

- In another case of *"C"* the Coroner was amenable to holding the inquest into the death of child when the bereaved mother discovered she was pregnant.

49. AvMA fully supports the aim to get inquests heard more quickly and proximate to the death. However the pressure on the Coroner to have an inquest heard within 6 months and certainly within 12 months otherwise the case has to be reported to the Chief Coroner (CC) causes difficulties and does result in cases being listed for hearing before the investigation is complete.

50. Although there is a view that families do not need representation at an inquest because the system is inquisitorial rather than adversarial, it is also the case that Trusts and or Hospitals are invariably represented. It is our view that the process should be a level playing field. If the Trust and or Hospital is represented then the Coroner should respect the family's right to be represented and make every effort to accommodate counsel for the family's availability.

51. It is our experience that a grieving family is often not ready for an investigation into how their loved one died within 6 months from the date of death; their grief can prevent them from accessing the process as fully as they might otherwise do. It can also result in an inquest date being fixed before investigations are complete, including SIR. This can result in the family perceiving that the inquest has been rushed and a less than fulsome inquiry has taken place.

Flexibility of location for inquests and post mortems which many now be held anywhere in the UK:

52. **Comments:** AvMA has no experience of this issue.

Out-of-hours availability: If you tried to contact a Coroner outside normal office hours, why was this? Were you able to speak to the Coroner's office outside of normal hours? Were you satisfied with the response you received to your contact?

53. **Comments:** AvMA has no experience of this issue.

****END****

Prepared by: Lisa O'Dwyer

Position Held: Director Medico – Legal Services

Address: Action against Medical Accidents (AvMA), Freedman House, Christopher Wren Yard, 117 High Street, Croydon, CR0 1QG.

E-mail: lisa@avma.org.uk

Telephone: 020 8688 9555

Date: 10th December 2015

About you

Please use this section to tell us about yourself

Full name	LISA O'DWYER
Job title or capacity in which you are responding to this call for evidence (e.g. member of the public etc.)	DIRECTOR MEDICO-LEGAL SERVICES
Date	10TH DECEMBER 2015
Company name/organisation (if applicable):	ACTION against MEDICAL ACCIDENTS (AvMA)
Address or email address	Freedman House, Christopher Wren Yard 117 High Street, Croydon
Postcode	CR0 1QG
If you have had experience with coroner services, which coroner area(s) have you dealt with?	
If you would like us to acknowledge receipt of your response, please tick this box	☑ (please tick box)
Address to which the acknowledgement should be sent, if different from above	

If you are a representative of a group, please tell us the name of the group and give a summary of the people or organisations that you represent.

SEE INTRODUCTION FOR DETAILS