avma
action *against* medical accidents

RESPONSE TO MINISTRY OF JUSTICE (MoJ) CALL FOR EVIDENCE IN THEIR REVIEW OF LEGAL AID FOR INQUESTS

30th August 2018

Brief Introduction to AvMA

1.1. Action against Medical Accidents (AvMA) was originally 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.

1.2. AvMA offers specialist services to the public, free of charge. AvMA's specialist services are its Helpline, pro bono inquest service and advice and information services.

1.3. AvMA's pro bono inquest service was set up in 2010 and has been running for 8 years. We provide advice and assistance to about 125 people per annum and arrange representation at the inquest hearing for between 8 – 15 people each year depending on the length of the hearing and complexity of the case

1.4. AvMA only takes on inquests where the death occurred in a health care setting or against the background of medical services provided including deaths involving mental health and primary care issues.

1.5. Our response to this review of legal aid for inquests is based on our experience of healthcare inquests only, we are not able to comment on other areas such as the experience of families following a death in police custody.

1.6. The demand for our services invariably outstrips what we can supply and has increased, not diminished in recent years. The demand for our services is fed by the lack of availability of public funding for inquests.

2. Executive Summary

2.1. Through our work we have observed how the public are driven by the need for the truth about what has happened in relation to an incident or a death and to ensure that lessons are learned so that future mistakes are prevented.

2.2. The inquest is potentially a powerful forum that can to some extent fulfil this need, its importance to the public cannot be underestimated. However this can only really be achieved where families are represented by advocates who know how to manage large volumes of material; know what documents are required and can be requested and can argue competently for the inquest hearing to widen its scope where appropriate.

2.3. Families tell us that they find the inquest process overwhelming. They are often fearful of the inquest's legal status and the medical and legal language used; they are anxious about the process in particular whether they will be able to communicate their concerns to the coroner.

2.4. Our pro bono inquest service exists to provide representation to families at health care inquests. Whilst there is exceptional funding for inquests the public will only be able to access it if they meet the exceptional funding criteria. The criteria are exceptionally hard to satisfy and the majority of families are not eligible for it; in our experience the funding is rarely made available at healthcare inquests.

2.5. By contrast, it is our experience that hospitals and NHS trusts are invariably represented at healthcare related inquests. By contrast, families will generally be unrepresented. By way of illustration, when HM Coroner Andrew Haigh (the Staffordshire Coroner) gave evidence to the Mid Stafford Inquiry he estimated that eight out of ten families were not represented at inquests

2.6. Families tell us they find the process very difficult to manage as lay people. A fact that is made more difficult because they are grieving for the death of a loved one.

2.7. For the inquest hearing to truly offer a full, fair and fearless investigation there needs to be equality of arms between the parties. NHS Trusts are invariably represented at the inquests we are involved in, they are public bodies but they do not have to satisfy any exceptional funding criteria.

2.8. Coroners tell us that it makes a huge difference to them and the nature of their investigations when a family is represented. This is due to the fact that there is considerable evidence to be considered not least complex and healthcare specific issues such as the deceased's medical notes; hospital procedures/guidelines/protocols, serious incident reports which may be relevant to the death to be considered. Coroners tell us that given their own workloads it is often not possible for them to be familiar with all of the papers and issues that may be relevant to the death. Where families are represented properly this representation can make a significant difference.

2.9. We have included five case studies in support of our experience and have expanded on the comments made in the executive summary in our response.

Questionnaire

Question 1: Do we need to make any changes to the existing financial means assessment process to make it easier for applicants to complete? If so, please suggest prospective changes.

The financial restrictions should be removed altogether for individuals where the death occurred or was potentially caused or contributed to by a public body. AvMA's pro bono inquest service only deals with providing assistance to individuals whose loved ones have died in a healthcare setting, in practice this is often although not always NHS hospitals.

NHS hospitals invariably attend inquests fully represented by counsel and/or a specialist healthcare solicitor or legal advisor; they do not have to justify the use of public funding to secure representation, the bereaved family of a deceased person should not be in any different position.

To ensure a level playing field, the financial requirement imposed when applying for legal aid funding for inquests must be removed altogether. There is no financial eligibility test for NHS hospital trusts when they organise their representation. This test is burdensome for a bereaved person; equally the obligation to show that there is no other means of funding available to them is an intrusive and unfair obligation.

Families are not attending an inquest because they choose to, they are attending because the statutory criterion for holding an inquest has been met – whether an inquest is held or not is outside of their control. It is difficult to see why they should have to meet the cost of participating in the inquest out of their own pocket.

Even though the LAA have discretion to waive the financial eligibility test this is not always exercised and even when it is, it can be a lengthy process waiting for that discretion to be authorised. The merits test is onerous enough, the means test only adds to the burden on the bereaved.

Question 2: Do we need to make any changes to the current legal help process where a waiver is being sought? If so, please provide suggested changes.

The application for legal help is separate to the application for legal aid and only covers advice, assistance and preparation for the inquest it does not cover advocacy. This means that those preparing the case are unable to attend a pre inquest review hearing (PIR) and be paid for it. The importance of a PIR should not be underestimated, it can be pivotal to obtaining full and correct disclosure, attendance of relevant witnesses, appointment of an independent expert and that the scope of the inquest can be properly considered.

Coroners do not always give much notice as to when the PIR is to be held, there is not always sufficient time to obtain legal aid for advocacy.

Whilst the LAA can consider whether the financial limit test should be waived the application and decision making process around this decision is time consuming. As referred to above, it is not always possible or practical for the application to be made in time for a PIR and coroners have little scope for adjourning PIRs or hearings to accommodate the needs of the LAA to process an application of this nature.

There should at the very least be the opportunity to offer legal aid retrospectively to cover the cost of attendance at PIRs and hearings and preparatory work that needs to be done.

There should be one application form that covers preparatory work and advocacy regardless of whether a waiver is sought or not. The waiver requires arguments on Article 2 which are not always forthcoming at the beginning of the inquest and can often only be determined at the end of the inquest once the coroner has heard all of the evidence.

Question 3: Are you aware of any cases where it would have helped to have had a lawyer assisting the bereaved family at the point at which a coroner is making a decision to trigger Article 2?

Article 2 arguments in healthcare inquests are invariably complex and coroners frequently ask for written submissions on the points being raised. It is unrealistic and grossly unfair to expect a lay person to be able to tackle these issues on their own.

The reality is, most lay people don't know what an Article 2 inquest is, and the complex nature of European law and the Human Rights Act is such that it requires a lawyer or experienced advocate to make the necessary submissions.

AvMA provides advice, assistance and representation in about 100 cases per annum. We try and prioritise those cases where the deceased was particularly vulnerable, for example where they had learning difficulties; where the life of an infant or young person has been lost; elderly care and those with mental health difficulties.

Many of the cases referred to us have had Article 2 issues which a family or lay person would not be able to identify. Even when AvMA and counsel raise systemic failings as being relevant to engaging Article 2 we are increasingly experiencing what appears to be a trend in coroners saying they will revisit the submissions at the end of the inquest once all the evidence has been heard.

Question 4: Are you aware of any cases where there have been difficulties in establishing whether Article 2 has been triggered? What sorts of cases are these?

Healthcare inquests can be complex, not just because of the medical evidence but also because the question of whether there was, is or continues to be a systemic failing within the hospital trust is often a question of fact. Often, the facts cannot be determined until all the witnesses have given their evidence, as a consequence it is not always possible to identify whether Article 2 has been engaged at the outset.

However, it is also the case that in many instances where the Article 2 issue is parked at the outset, the evidence goes on to demonstrate that omissions/failings are proven or conceded. Where the inquest has not been declared an Article 2 inquest the coroner will then go on to give a non-Article 2 conclusion. This can be very unsatisfactory not just from a wider public interest point of view but from the grieving family's point of view as conceded failings and or criticisms and or identified failings are not found to be reflected in the non-Article 2 conclusion.

See the attached case study 2 "JP" which sets out a number of complex facts and issues which the lay client (the deceased's partner) who not only suffered the bereavement but was left to care for two young children would not have been able to manage without representation. You will note from paragraph 8 of the case study that the coroner initially rejected submissions around Article 2 at the PIR stage however the coroner changed their mind and subsequently on day 6 of the hearing agreed that Article 2 had been engaged.

See also the attached case study 5 "Baby W" where submissions were made on Article 2 but the coroner side stepped declaring the inquest an Article 2 inquest at any point during the inquest hearing.

Question 5: If yes to question 4, what impact have these difficulties had on the bereaved family's experience of the proceedings and the legal aid application?

The failure to declare an Article 2 inquest in healthcare cases at the outset means that families are often outside of the scope of legal aid from the outset.

Exceptional funding is only available on two possible grounds: first that advocacy is required under Article 2 ECHR into the death of a member of the individual's family. Second, where the Director identifies that there is a wider public interest determination in relation to both the individual and the inquest and that representation is likely to produce significant benefits for a class of person other than the applicant's family.

Where there is reluctance or unwillingness by a coroner to declare an Article 2 inquest at the outset then families are generally unlikely to satisfy the first exception for funding. The second exception is a high bar and is rarely considered appropriate in healthcare related inquest cases.

Question 6: Are you aware of any cases where an applicant has applied for and not been awarded legal aid for legal representation for a case where Article 2 has been triggered? Please provide details.

None of the cases we run would satisfy the exceptional funding criteria. See our response to question 5 above.

Question 7: In your experience, is Article 2 ever triggered in cases where the death has not occurred in state custody or state detention? If yes, please can you include details on these types of cases.

Yes. See response to question 4 above and the case study 2 "JP" attached.

During a healthcare inquest issues may arise that involve a healthcare provider's procedures, for example, whether they provided suitable facilities or failed to provide adequate staff or an appropriate system of operation. These are examples of issues that are likely to arise if a healthcare provider's procedures are said to be inadequate due to systemic failings.

There is an inescapable problem with arguing systemic failings in health care cases as this is often a question of fact which can only be determined upon hearing the witness evidence. It is often the case that those facts only become apparent during the inquest hearing and not before as legal aid is not retrospective it essentially means that the family has been prevented from accessing the funding required by them.

For the process to be fair, LAA funding should be made available in circumstances where Article 2 is at least arguable in healthcare inquest cases and the financial test should be removed.

Question 8: Where applications for legal help and/or legal representations are refused, does the LAA give clear reasons for this decision?

Not applicable to us. The highly restrictive nature of legal aid income and merits test for exceptional funding for inquests is such that generally our clients are not eligible for legal aid.

In practice if clients do secure funding it is through a Conditional Fee Agreement (CFA) – the CFA will pertain to the civil claim which if successful will enable the legal representatives to recover that part of their inquest costs that relates to the civil claim. A CFA will only be offered if there appears to be a reasonable prospect of bringing a civil claim, given that this assessment takes place at an early stage and pre inquest lawyers are naturally circumspect about the whether they can offer a CFA. Lawyers also have to weigh up the proportionality principle when deciding to take a case on.

In practice most families are either represented pro bono, pay for legal services which is very expensive (£5 - £10,000 would be typical) and therefore out of the reach of a great many families, or are unrepresented at the proceedings.

Question 9: Are there any ways in which the LAA can provide greater clarity regarding their decision-making?

Yes, by giving examples of the type of cases that would fall within the scope of wider public interest. The expression of "wider public interest" is a nebulous phrase that means little in practice. What one person considers being in the wider public interest may not necessarily be shared by another.

Arguably a healthcare inquest where a prevention future death report appears likely might be considered to be in the wider public interest given that NHS hospitals are used by the majority of the British public.

Question 10: In your experience, have there been inquests where Article 2 is not engaged that have met the criteria considered by the Director? Please provide details.

No comment.

Question 11: Is the current definition of 'wider public interest' in the context of the granting of legal aid for inquests easy to understand? If not, please suggest areas for improvement.

See our response to question 9 above.

We would suggest that where it would appear that submissions in relation to a Prevention Future Death (PFD) report are likely to be arguable this should satisfy the wider public interest point at the outset. In practice PFD's will only be made towards the end of the hearing or when the coroner is delivering his/her conclusions and is in possession of all of the oral and documentary evidence and information that is relevant to the investigation

Question 12: Are you aware of any inquests that have been awarded legal aid through the ECF scheme under the 'wider public interest' determination? If so, please can you provide details of these cases.

No

Question 13: Do you think that families are still able to understand and engage with the proceedings in cases where they are not legally represented at the inquest? Please provide reasoning for your response.

No. AvMA has never supported the view that families are able to understand and engage with the inquest proceedings in cases where they are not legally represented; we have not changed our position on this. This fact was one of the catalysts for AvMA setting up our now well established Pro Bono Inquest Service.

The argument that families do not need representation at inquest because the process is inquisitorial as opposed to adversarial is fatally flawed; the inquest is still a legal process where complex arguments on Article 2, systemic failings and neglect frequently arise.

The following bullet points will illustrate our reasoning for this:

- Lay people are often shocked by the death of a loved one, it can take them considerable time to come to terms with the loss and manage their grief. Many find it hard to make sense of the loss especially where the cause of death is unknown. Despite this Section 8 Coroner's Inquest Rules 2013 says the coroner must hear the inquest within 6 months of the deceased's death. In many cases the insistence on listing such cases so quickly can bring added distress and bewilderment to grieving families.

- Many people have never been involved in a legal process – perhaps the most common experience is buying a property and even then not everyone experiences this. As a result there is often a fundamental lack of understanding about what has triggered the process – some families believe they are implicated in the death; this can often be the case where a family member has been the nominated carer for the deceased.

- Lay people find it difficult to understand issues around the purpose and scope of the inquest. The purpose is essentially to find out "who" the deceased was and critically "how" the deceased came about their death and when and where the death occurred. The fact the coroner has considerable discretion in making his or her decision is another factor that lay people find difficult to reconcile.

- Where the scope of the inquest is widened the coroner may look at "how and in what circumstances" a person died. The scope of the inquest will depend on legal arguments around key cases such as Jamieson (***R v HM Coroner for North Humberside & Scunthorpe [1995] QB1***) Middleton (***R (Middleton) v HM Coroner for Western District Somerset and another [2004]***) as well as others and legislation such as ECHR and Human Rights Act when it comes to Article 2. It is a travesty to suggest that lay people should be able to tackle arguments of this nature on their own.

- In healthcare inquests there are certain key documents that should be requested for disclosure, including the medical notes. The nature of medical notes is such that a level of medical knowledge is required to understand and interpret them; a review of the medical notes requires an understanding of what documents you should expect to see – it would be unrealistic to expect a lay person to know to look for a MEWS score, a prescription chart, test results, it is even more unrealistic to expect them to be able to interpret them correctly without assistance.

- Other documents that should be requested include things like the post mortem or the hospital trust's guidelines and/or policies on a particular area of medicine or procedure; serious incident reports are meant to be shared with the family but in practice this does not always happen and the reports are not always prepared. When matters of this nature occur then it takes someone of experience to draw them to the coroner's attention and to request sight of the relevant documents.

- Although the Coroners (Inquest) Rules 2013 give family members (who are declared properly interested persons) the right to access documents which the coroner decides are relevant for disclosure they have to know to ask for the documents. The documents are not disclosed to them as a matter of routine. If you don't ask, you don't get. If you don't know you have the right to ask, you have little chance of obtaining the documents. If you don't have access to the relevant documents you cannot be expected to participate in the process in any way or in any meaningful way.

- The inquest process relies on legal terms like disclosure, redacted documents; pre inquest review hearings. Even at the end of the process the coroner findings are set out in his/her "determinations" and "conclusions" and regardless of the evidence those conclusions cannot be framed in a way that connotes civil or criminal liability on the part of a named individual. AvMA makes no specific criticisms of the terms in use but would highlight that such language can serve to alienate families, representation makes this less likely to happen.

- The coroner has the power to make a prevention of future death (PFD) report if she/he having heard the evidence has a concern that there is a risk of deaths in the future and that action needs to be taken to reduce or eliminate that risk. It is often of critical importance to grieving families that they get answers to their questions about their loved ones death but also that any failings associated with that death are addressed so other people do not have to experience the same grief and suffering as they have. Submissions on the need for a PFD need to look at all of the evidence and need to be carefully crafted, the representative should not make submissions on the facts but neither can they be made in a vacuum – this is not a job for a lay person who does not have the experience of managing evidence especially where oral evidence is pertinent as is often the case.

- Identifying relevant witnesses: relevant witnesses often only become apparent from a careful review of the medical records, and/or serious incident report, and/or witness statements. There is a particular skill to identifying the witnesses that are key to a coroner's inquiry and being able to rationalise why they are key – as opposed to inviting the coroner to call every possible witness. The reason why some witnesses are more relevant than others is often more apparent to those use to representing at inquest than a lay person.

- Other complex areas include the recognition that the coroner should be invited to appoint his/her own independent expert or experts; in healthcare cases this will usually be a medical expert. See the attached case report number 2 "JP" and case study 5 "Baby W" where AvMA instructed experts

- The above point is particularly relevant when considered in the context of any Action Plan that a trust might submit – Action Plans are often produced for the sole purpose of persuading a coroner that they do not need to make PFD. In such cases it is necessary to call the maker of the Action Plan so the Coroner can be satisfied that the actions identified have been executed and if not, why not. It is also the case that Action Plans are often not substantial enough and upon careful review or examination of the author of the Action Plan it becomes apparent that do not avoid the need for a PFD report. If a PFD report is required then lay people are generally not best placed to make the relevant submissions, experienced advocates are.

- Coroners have also told us that given the number of inquest cases they have to deal with (for some this is circa 500/annum) it is not possible for the coroner to have the same depth of knowledge about a case as an advocate. When families are represented they are put in a position where the chances of exploring relevant issues that might otherwise have been missed is increased and in turn this increases the likelihood of a full, fair and fearless inquest investigation being undertaken.

- Moreover, there is a real issue about equality of arms. If a public authority such as an NHS Trust is able to be represented then it is only right that a grieving family is also represented. Calls for an equality of arms have been made by the former Chief Coroner (Sir Peter Thornton) and the Bishop Liverpool in his review of Hillsborough: "The patronising disposition of unaccountable power"

- The importance of the inquest to a family should not be underestimated. For many families this is the first opportunity to get answers from an independent and impartial forum, up until this point most of the investigations whether the serious incident report or the complaints process will be conducted by the same trust and possibly the same staff who were responsible for providing care to the deceased. The coroner may see the family or at least individual members as key witnesses – this is not a status many, if any, of them will have experienced prior to the inquest hearing. Where families feel failed by the trust's own internal processes, the coroner's court offers an opportunity for their voices to be heard and their concerns to be taken seriously. Families need to have the opportunity to make the most of this opportunity especially as many will not be eligible for or will choose not to bring civil proceedings in clinical negligence.

Question 14: In your experience, how could we ensure that available legal aid funds provide the most value to bereaved families going through the inquest system?

The financial eligibility test needs to be removed altogether.

The merits test for satisfying exceptional funding must be widened to include eligibility for cases where there are strong prima facie grounds for demonstrating the potential for one of the following being likely to be triggered:

(i) The hospital trust is being represented
(ii) That Article 2 may or is likely to be satisfied on the grounds of systemic failings
(iii) Neglect is arguable
(iv) Where causation is an issue
(v) A PFD is likely to be required and/or that the trust's action plan is not likely to be satisfactory
(vi) A jury is required
(vii) Specialist knowledge is required for example medical knowledge and or expert medical evidence is likely to be necessary
(viii) Where the papers are voluminous and cannot reasonably be expected to be marshalled by a lay person
(ix) Where the case can demonstrate real issues around the care provided to the deceased.
(x) Where examination in chief and cross examination of witnesses is required.
(xi) Where submissions on conclusions are required

Question 15: In your opinion, do inquests where the state has legal representation meet the criteria used to determine the need for a financial means test?

Hospital trusts make their own arrangements with their own legal providers or arrangements are made through NHS Resolution.

AvMA has previously seen legal framework agreements prepared by the NHS Litigation Authority which shows that NHS legal panel firms are subject to stipulated hourly rates in inquest cases. The NHSLA did require that a firm obtain prior authority for funding at inquests but authority would be granted if a claim for compensation was likely.

Legal framework agreements are difficult to obtain and we have not seen any agreements since NHS LA rebranded itself NHS Resolution in April 2017. It is our understanding that NHS Resolution is a trading name and that the framework agreements are likely to stand until the next tendering by NHS Resolution for legal services. This needs to be verified by MoJ who are likely to experience less difficulty in obtaining the relevant information.

AvMA has never provided representation to a family in circumstances where a hospital trust was unrepresented.

AvMA has seen what appears to be the option for trusts to consider three tiers of representation: (i) in house legal (ii) NHS Resolution panel solicitors (iii) barristers. Invariably the trust will have a legal representative attend a Pre Inquest Review hearing or the first part of a part heard inquest and form a view on the complexity and severity of the issues raised, having assessed the case they then have the freedom to instruct counsel of their choice. Unlike families who are represented under AvMA's pro bono inquest service the trust are able to instruct quite senior counsel. The nature of AvMA's pro bono service is such that we tend to have fairly junior counsel provide representation to families.

Question 16: In your experience, at inquests where both the state agents and the family have legal representation, does the family receive the required level of support and representation from their legal representative to enable them to understand and properly participate in the proceedings? Please give examples where possible.

Yes. Please see the five case examples attached.

The AvMA pro bono inquest team was pioneered by myself in 2010 and continues to be headed by me – I am a qualified solicitor who had in excess of 15 years in private practice as a specialist claimant clinical negligence lawyer before coming to AvMA. I have a team of four full time specialist caseworkers who are dedicated to providing assistance to families who have lost a loved one in a healthcare setting. My team comprises three doctors (one of whom is dual qualified as barrister another of whom is in the process of completing the Legal Practice Course to qualify as a solicitor). I also have another qualified former solicitor who had 4 years in private practice as a claimant clinical negligence lawyer before coming to AvMA.

The AvMA Inquest team is very experienced with the inquest process and managing a family's fears and expectations. The preparation is marshalled by the individual caseworkers running the case and cases are prepared to the highest standard, including submissions to the coroner on relevant witnesses, expert evidence and so forth. The leading sets of clinical negligence chambers work with us to provide pro bono advocacy services to our clients. AvMA and counsel's motivation for working in this way is to ensure that families feel supported at the inquest, that the coroner does carry out a full and fearless inquiry into the death and that the family's questions are answered so far as is possible.

Overall it is about creating a level playing field in a legal forum that is addressing the most serious and devastating outcome for any individual – their death.

Our other key aim is to ensure that where failings associated with the deceased's death are identified, these are addressed either through challenging Action Plans or PFD reports.

Case study 1 - AC (a minor): The mother had given birth to twins, one of whom died shortly after birth. The deceased child had a life limiting genetic condition and underwent surgery to maximise chances of survival. Sadly, the child did not survive the surgery and the mother was told everything had been done to help her, the mother believed this until she subsequently received a high level report into her child's death, the report was sent to her 7 months after her child had died and she was not expecting it. At this point the mother sought advice from AvMA and it subsequently became evident that the paediatric anaesthetist and the paediatric surgeon were at odds with one another on the facts. The coroner's inquest lasted 5 days, a PFD was issued and a Regulation 28 report.

Case study 2 - JP: Please see paragraph 7 which identifies the seven main issues we sought to address at the inquest. Paragraph 8 of that case study sets out what difference representation made to that family. Paragraph 9 of the case study identifies particular obstacles that had to be overcome in that case, these included an alteration of the medical records to show a different time; the Trust's delay in finding relevant witnesses; the Trust seeking to avoid the relevant witness from preparing a written witness statement.

Case study 3 - GR: The deceased fell from a ladder and came into the hospital for surgery to evacuate a subdural haematoma, he died in hospital from a completely unrelated condition – a massive gastro-intestinal bleed and acute duodenal ulcer. The inquest was originally listed for 2 hours with 2 witnesses in attendance, one of whom was the pathologist the other the deceased's wife. Following AvMA's involvement and representation there were 4 PIR hearings and a 2 day inquest hearing. Some of the complications included the fact that the trust had failed to even carry out their own serious incident report – this is despite the fact that the case met the triggers for such an internal investigation. The coroner made a finding of neglect in this case.

Case study 4 - JS: Illustrates how legal representation enabled the family to ensure the coroner enforced the PFD report he made at the inquest despite discrete correspondence from the trust after the hearing that a PFD was not necessary. We refer to the (ix) submissions made by counsel to ensure enforcement of the PFD and to demonstrate that the trust legal representatives were acting outside of the Coroner's Act, rules and regulations and without authority.

Case study 5 - Baby W: Paragraph 26 identifies the issues we attempted to address on behalf of the family at the inquest. Paragraphs 20 – 21 illustrate the feelings of the family when they tried to represent themselves at the PIR in April 2017 – they were "overwhelmed" by the process. The serious nature of the inquest is reflected in the fact that it moved from a 2 day inquest to a 5 day inquest to accommodate the 13 live witnesses we were able to demonstrate were relevant to the inquiry. The inquest hearing was hampered by the finding that the communication and documentation in the case was suboptimal.

We further refer to the bullet point set out in response to question 13 which points to the fact that coroners have told us off the record that they rely on legal representatives acting for family's to draw their attention to key facts and issues of concern that they may have missed owing to their own lack of time and workloads

Question 17: For cases where the bereaved family has legal representation, do you feel their lawyer(s) are effective in representing the family's interest? Please give examples where possible.

Yes. Please see our response to question 16 above.

For the avoidance of doubt we believe that effective representation of a family at inquest is determined by families being represented by advocates, lawyers and others who have the relevant expertise to represent them.

AvMA considers that families who have lost a loved one in circumstances where the death may have been caused and/or contributed to by the healthcare provided should be represented at inquest by a specialist who has experience in this specialist field of work. It does not follow that because a representative has experience of deaths in police custody they would be suitable to represent at a healthcare inquest.

Question 18: In your experience, what impact does the number of lawyers representing the state have on the experience of the bereaved family?

We refer to the comments made by the family in the case study 5 " Baby W" who used the term "Overwhelming". It is not so much the number of lawyers involved as parity between the parties and the family having confidence in the representation they have.

However, there are occasions when the number of representatives does have a bearing such as the case study 1 "AC" where the paediatric anaesthetist and the paediatric surgeon were subsequently each separately represented, the Trust continued to be involved – that meant that if we had not provided representation to the family they would have been attending the inquest each day facing 3 separate sets of lawyers. It is easy to understand why this would have been a daunting experience especially in the context of a family which is having to come to terms with the death of an infant child and the circumstances of the child's death being misrepresented at the outset.

What families need and want is equality of arms. They want their own voice and they want to feel as though they are part of the process which looks into how their loved one died.

Question 19: In cases where there are multiple lawyers representing the state, would the family benefit from receiving information about the role each one plays, and the type of legal position they are assuming? Please give examples where possible.

I doubt that additional information about the roles of each of the representing lawyers will make any difference to a family who themselves remain unrepresented. That information is unlikely to make any difference what so ever, it won't enable them to feel any more equal to the represented parties. Unrepresented families are already coming to terms with a legal process, a death, grief the legal language and trying to make sense of any documents they have, another leaflet is unlikely to offer any reassurance, comfort or confidence.

Question 20: Can you provide any examples of cases where a lawyer has adopted an inappropriate advocacy style or approach? If so, was the lawyer representing the state or the bereaved family?

Generally there is mutual respect among healthcare lawyers. There are times when representatives for the trust might show a lack of compassion and/or overlook the fact that the bereaved family are in court but this is not usual. When this happens the coroner is often quick to dampen down any lack of respect shown by an advocate.

We refer to the attached case study 4 "JS" in which the trust's advocate took the approach that they could persuade the coroner to withdraw a PFD by making representations to him without including the family and or their legal representatives. The coroner was intending to act upon the trust's advocates representations when counsel for the family made the valid submissions set out at paragraph 5 (i) – (ix) of that case study. Without the family's advocate undertaking this step the trusts advocate looked likely to persuade the coroner to withdraw his position on the need for a PFD. We consider this behaviour to be underhand and severely prejudicial to the integrity of the coroner's investigation and the purpose of the inquest process.

In one case we were involved in the advocate for the general practitioner took a family member (daughter of the deceased) down a totally inappropriate line of questioning. That advocacy style and approach caused great unnecessary distress and served only to bully and intimidate the witness; it was an approach that was eventually halted by the coroner but should never have been tolerated in the first place.

Question 21: Do you consider that the MoJ Guide meets the needs of bereaved people? If not, what do you suggest?

We consider the MoJ Guide to be useful and have a link to it on our website however there is a real problem in bringing the Guide to the attention of the bereaved. In our experience the vast majority of people seeking advice from our pro bono inquest service have never even heard of the Guide let alone been referred to a copy of it.

Question 22: Have you found any other information useful? If so, please can you give details.

Clients tell us that they consider the AvMA inquest leaflet to be very helpful: https://www.avma.org.uk/?download_protected_attachment=Inquests-into-deaths-following-medical-treatment.pdf

Question 23: What else do you think could be done to support bereaved families better throughout the inquest process?

One size does not fit all with bereavement; some people want to talk about their loss and experience others do not want to talk at all. It would be helpful if counselling were routinely available especially as the many families find the inquest process traumatic. Generally, we believe that a family that has good, experienced representation will find the processes fairer, more probative and independent than those who do not have good or any representation.

Many people who have been properly represented at inquest find a certain catharsis once the conclusion has been reached.

Question 24: Is there anything else you would like us to consider?

The preamble to this consultation acknowledges:

"For bereaved families hearing how their loved ones died can be traumatic and the search for answer can be challenging"

"However, that search to find out what happened is important in helping the bereaved to understand and make sense of their loss as well as ensuring that there is proper accountability"

Paragraph 2 of the executive summary says:

"Inquests should be conducted in a way that families are able to feel confident that they can:

a. Understand the timeline and scope of proceedings;

b. Participate in the proceedings;

c. Have access to legal advice and legal representation if required; and

d. Feel properly supported throughout the process. "

We would not disagree with any of those comments but would emphasise that this is not what happens in practice. In healthcare related inquests families are only represented if they are willing and able to bring a civil claim in clinical negligence (not everyone wants to have to do this) in which case they may be eligible for funding under a conditional fee agreement (CFA); alternatively they may pay for representation but this is expensive and outside of the reach of most families; or they represent themselves (where they feel able, in practice this is the minority of lay people) or where they can obtain pro bono representation.

There needs to be parity between the parties when it comes to obtaining legal representation, if the healthcare provider has representation then the family should be eligible for representation. The financial test for exceptional funding is onerous and unfair, there is no equivalent requirement for financial eligibility for other healthcare bodies whether public bodies or otherwise.

It goes without saying that a lay person with no legal education or background in healthcare related issues will require legal advice and representation if they want it; however what they require and what they actually get are two different matters. The exceptional funding requirements are difficult to fulfil and as explained the Article 2 issue is often avoided or fudged by the coroner so that it is not actually addressed either at the outset or at all.

Without appropriate legal advice and representation families do not feel supported and the scope and remit of the process is never fully understood. As we stated at the outset the importance of the coroner's inquest to a family who is looking for answers and accountability, cannot be overstated. That can only be achieved by a representative who is familiar with the process and who is able to manage and understand the evidence and papers typically disclosed and relied upon in a healthcare related process.

The inquest process would benefit from having specialist and designated healthcare coroners who understand the need to read and review the medical records; is unafraid of criticising an internal report whether a Serious Incident Report (SIR) or equivalent; is prepared and confident enough to challenge a trust which puts forward an Action Plan either by understanding the purpose of the document and/or by calling the maker of the plan to explain it.

It is also important to recognise that those representing family's should be recognised as doing a job equal to that which advocates for an NHS trust or other health care organisation do. It follows that advocates should be paid equally for the work they do, that means the same hourly rate as opposed to one receiving commercial rates and the other receiving legal aid rates of pay. This is about equality of arms between the parties to the inquest.

Thank you for participating in this call for evidence exercise.

Review of Legal Aid for Inquests – MoJ call for evidence: 30.08.18

Baby AC (deceased) – Case study 1

The Facts

- AC was one of twins born prematurely with a life limiting condition – Edwards Syndrome. The condition gives rise to a number of complications including cardiac congenital abnormalities. It is a life limiting condition.

- AC was born with Oesophageal Atresia – **OA** - (when the upper part of the oesophagus does not connect with the lower oesophagus and stomach) and Tracheo Oesophageal fistula – **TOF** - (when there is an abnormal connection between the upper part of the oesophagus and the trachea or windpipe)

- AC underwent surgery to ligate the TOF and possibly repair the OA. Prior to the surgery, the Consultant Paediatric Anaesthetist arranged for AC to undergo tests which confirmed that she had cardiac congenital abnormalities. The anaesthetist advised the Paediatric surgeon and added that it was suspected that AC may have a difficult airway.

- During the surgery the Paediatric surgeon announced his intention to perform a rigid bronchoscopy prior to ligating the fistula. The procedure is not uncommon in such circumstances but as it requires removal of the breathing tube (endotracheal tube) and given that the paediatric anaesthetist had concerns about the patency of AC's airway the anaesthetist urged the surgeon to consider alternative procedures which would not require removal of the endotracheal tube

- Although the decision to remove the endotracheal tube is usually the surgeons it is relevant to note that the surgeon in this case had failed to attend the team debriefing session prior to the surgery commencing – all the anaesthetists were there, as was the surgical registrar. When the surgeon entered the operating theatre he was advised of the team's preference not to carry out a rigid bronchoscopy.

- The anaesthetist pointed out to the surgeon that ACs larynx could not be visualised and this was highly suggestive of the fact that if the airway was lost following removal of the endotracheal tube re-intubation would be extremely difficult if not impossible.

- The surgeon proceeded to examine AC without anyone there to hold the endotracheal tube in place to prevent dislodgment. As expected, the endotracheal tube became dislodged, the surgeon was unable to reintubate. A tracheostomy tube was eventually inserted by the ENT surgeon but by this point attempts at re-intubation had resulted in bilateral pneumothoraces and intraabdominal bleeding.

- The bleeding became life-threatening with poor cardiac output and difficulty ventilating. AC passed away.

- These facts were eventually identified in the High Level Investigation (**HLI**) report but not until 7 months after ACs death.

- The facts came as a shock to the family who had understood that AC had died as a consequence of her airway having been lost & that everything had been done to try and save her.

- ACs parents approached AvMA following receipt of the HLI

Background to the Inquest

- Originally the inquest hearing was fixed for end 2014. Following representations from AvMA this was adjourned

- Initially we had some difficulties obtaining disclosure from the coroner's officer – the officer was under the impression that disclosure could not be given despite the client's clear signed, form of authority. Following on from that the Officer would only give disclosure to counsel direct. Eventually, the coroner stepped in and disclosure was provided to us in accordance with the regulations.

- There were several PIH's during which the conflict between the paediatric anaesthetist and the paediatric surgeon became apparent. The coroner advised that those parties should become PIP and seek their own representation

- Coroner instructed 3 independent expert witnesses to help her investigate

- Inquest originally fixed for 2 full days at end 2015 – The anaesthetist and the surgeon both continued to be represented by the Trust. Coroner adjourned the hearing because of the continued conflict – the Trust was invited to pay the family's wasted costs of attending this hearing – they refused! Adding insult to injury.

- The inquest hearing resumed March 2016 – listed 5 days

- The coroner carefully explored issues around the communication between the clinicians regarding the surgical plan (ie rigid scope vs flexible scope vs no scope) and the difficulty that would be faced if Amelia's airway was lost, the absence of certain equipment in theatre and the events which led to the endotracheal tube becoming dislodged.

CONCLUSION: 'natural causes' with a short narrative acknowledging that the suregone had failed to minimise the risk of loss of intubation by not guarding the endotracheal tube in a ventilated baby. She also found there had been a breakdown in communication by staff in theatre on the 28th of March 2014.'

- **PREVENTION FUTURE DEATH REPORT** (Regn 28): The coroner wrote to both the Department of Health and the Trust regarding the issue of grading of airways by neonatologists and anaesthetists. Currently both specialities use different systems to classify airways.

- Although this issue was not causative in Amelia's death the Coroner is not restricted to matters causative of the death when considering whether or not to make a Preventing Future Death Report.

- **PARAGRAPH 37, GUIDANCE SHEET 5**: REPORT TO PREVENT FUTURE DEATH: **"Where the duty to make a report does not arise, but the coroner wishes to exceptionally draw attention to a matter of concern arising during the investigation (including the inquest), the coroner may choose to write a letter expressing that concern to the relevant person or organisation'.** The Coroner in AC expressed an intention to write a letter addressed to the Chief Executive Officer of the Trust regarding three areas of concern:

    1. Concern that the morbidity and mortality meetings by the Paediatric Anaesthetic department were not minuted.

    2. Dissatisfaction with the explanation of the use of the word 'outcome' in the HLI. The report gave the impression that in some point in the future Amelia would have died due to her Edwards' Syndrome and therefore any issues with her care did not impact on the clinical 'outcome'. The family were also concerned about the insensitive nature of this wording.

    3. A mandatory requirement for all Paediatric Surgeons to attend the team debriefing prior to surgery. The Coroner requested further clarification as to how competing commitments of Surgeons are being dealt with.

While it is very difficult to ever categorise the outcome of an Inquest in positive terms especially when it involves the death of a baby, the family were nonetheless pleased that a Regulation 28 report (in particular addressed to the Department of Health) and a separate paragraph 37 letter had been issued. They have found some comfort in knowing that AC's legacy may well avoid deaths of other babies in similar circumstances.

Review of Legal Aid for Inquests – MoJ call for evidence: 30.08.18

JP (Dec'd) – Case study 2

Condition

The deceased was a 42 year old male who lived with his partner and two young children. JP had previously been working in finance in the city however was made redundant from his job. For a few years he had received support from his GP for alcohol dependency and anxiety originally associated with his redundancy. He found it difficult to engage with specialist community alcohol services.

SEQUENCE OF EVENTS:

1. In August 2014 JP decided to detox from alcohol at home without seeking prospective medical advice. Two days into his detox, he developed symptoms of major alcohol withdrawal.

2. GP prescribed some medications in an attempt to control symptoms via a phone consultation

3. JPs Condition continued to deteriorate. Auditory and visual hallucinations. An ambulance was called and he was taken to X Trust A&E department where he was given a 'green' triage category (ie to be seen within two hours)

4. JP self-discharged 90 minutes after arrival and before medical assessment. Searches were undertaken

5. Subsequently JP's body was located approximately 1 mile from the Trust next to a dual carriageway.

6. Post Mortem: TOXICOLOGY: cause of death was alcoholic ketoacidosis which was as a result of major alcohol withdrawal.

7. **Main issues**
   - (i) **Potential failings by JP's GP** to recognise that he was hallucinating and whether a telephone assessment was adequate when he had symptoms of major alcohol withdrawal
   - (ii) **In A&E failure to have an acute alcohol withdrawal policy** particularly given that that this is quite a common presentation (the Trust as a result of JP's death now have such a policy in place)
   - (iii) **Failure to correctly triage JP** (failing confirmed by the A&E expert and 2 other nurses giving evidence)
   - (iv) **Failure to recognise the urgency** associated with acute alcohol withdrawal and its symptoms.
   - (v) **The Triage Nurse was agency** and the Trust should not allowed her to be in this position as she was not familiar with the Trust's triage system

(vi) **Failure to adequately advise JP** on the risks associated with self-discharge by the nursing staff

(vii) **Failure to call the police** until well over an hour after JP left the A&E

(viii) **Failure to adequately pass on information to the police about JP's condition**. (During questioning the police search strategy advisor gave evidence that had they known he was suffering from acute alcohol withdrawal and the risks associated then his 'risk' category would have been higher)

8. **How did AvMA's work in providing representation to the family make a difference to the Inquest and the family?**

- Initially the Coroner had not identified any potential failings by JP's GP. Counsel identified potential failings and GP was given PIP status.

- In order to further explore any potential failings by JP's GP and in his A&E care AVMA instructed experts in general practice and A&E medicine to provide a pro bono report which was very helpful for Counsel but also helpful in providing some answers for the family.

- As a result of these reports Counsel was then able to make submissions on the Coroner formally instructing his own expert in A&E medicine at one of the PIRs. The Coroner finally agreed to this and the Coroner's expert report was supportive with the expert finding that JP was triaged incorrectly.

- At the first PIR the Coroner had initially stated that he was not minded to list it as an Article 2 inquest but would keep the matter open. Following submissions made on the 6th day of the inquest the Coroner stated that he found Counsel's submissions quite convincing.

9. **Problems encountered with the Trust**

- **Amending medical records** – When JP self-discharged the nurse in charge of A&E spoke to JP's sister who demanded that she call the police as there was a concern over JP's welfare given his mental state, the poor weather and the fact he did not have his phone with him. This nurse at some point called the police to commence the search for him. This record was disclosed at an earlier PIR – the copy provided showed that the entry was not timed. Subsequently the police disclosed documents including this entry which showed that the entry was timed. An inspection of the original document showed that a time had originally been entered.

- **The timing of the call to the police** was a relevant issue as the family had maintained the trust had delayed calling the police. The timed entry supported that concern. In the witness box the nurse who made this entry vehemently denied altering the records.

- **Delay in locating the witnesses**: From the first PIR January 2016 we had consistently asked for the triage nurse to attend to givbe evidence. Right up until the week before the first three days of the hearing in May 2017 the Trust

were adamant that they were unable to identify the nurse in question as she was a bank nurse. We were notified a week before the inquest that they had found the nurse in question

- **Evidence:** Having found the nurse the trust then sought to rely on the nurse's oral evidence only. There was no plan to obtain a statement. AvMA of course respectfully requested that the Coroner ask the Trust for a statement from her ASAP. a statement was delivered up at 4 pm on the day before the hearing.

- **Tenacity:** Families are not best equipped to maintain pressure on coroners to enforce their rights. An advocate will. The coroner's powers in any event are often inadequate for the purposes of enforcing their own orders and ensuring compliance with timetables.

- In this case it took the trust **18 months to find a witness.** The family would have had to identify and deal with the issue of **falsified medical records.** There was **persistent delay in the disclosure of documents**. **Families are unable to instruct independent medical experts** (don't have the technical knowledge and experts don't take instructions from them)

- **Families often complain that it is not the Coroner driving the investigation – it is the Trust**.

Review of Legal Aid for Inquests – MoJ call for evidence: 30.08.18

GR deceased – Case study 3

The Facts

- GR was an active 75 year old man. No previous medical history of note other than taking NSAID (Naproxen) for osteoarthritis.
- He also took Omeprazole (a proton pump inhibitor) prophylactically to counter the possible effects of Naproxen causing a gastric bleed.
- He had been taking these medications regularly for 7 years prior to his admission to hospital and managed his condition well.
- In October 2012 he fell from a ladder and sustained a head injury. He was taken to Kings College Hospital where he underwent a left sided mini craniotomy to evacuate a subdural haematoma. He showed improvement post operatively although had to undergo a repeat procedure on 13th November following which he was diagnosed with C difficile.
- Shortly afterwards GRs wife noticed that he was passing black, tarry stools and that his abdomen had become distended. On several occasions she brought this to the attention of the clinical staff but did not receive a satisfactory answer.
- The symptoms continued and GRs wife asked on a number of occasions for confirmation that GR was receiving his omeprazole along with his Naproxen – she was fobbed off
- GR continued to deteriorate and Mrs GR was told in early December that the hospital staff suspected GR had sustained a gastric bleed. Again, she drew attention to the fact that GR should be on Omeprazole whilst taking Naproxen. Nothing was done to allay her concerns.
- On 4th December GR became haemodynamically compromised with hypovolemic shock. Later that day he suffered a cardiac arrest and sadly died.

The issues:

- When Mrs GR came to AvMA she had been given a date for the inquest hearing. The case had been fixed for
  - 2 weeks time
  - Listed for a full hearing where only 2 hours had been allowed
  - Only two witnesses had been called – the pathologist and Mrs GR
  - The coroner had not disclosed any documents to her

- AvMA wrote seeking an adjournment and requesting copies of the documents – it was clear the coroner had not obtained the medical records. Our request was refused.

- Mrs GR explained to AvMA that she believed that GR had the hospital had given GR his Naproxen but they had failed to administer the antacid, Omeprazole. The fact that GR was not eating had compounded the effect of the Naproxen.

- Mrs GR also had copies of Hospital complaint correspondence that showed that the trust's response to her concerns had not been taken seriously – the trust advised that GR died to the CDiff infection.

- **HOWEVER** - The post mortem report when disclosed showed that cause of death was due to a massive gastrointestinal bleed, and an acute duodenal ulcer!

- AvMA arranged for Mrs GR to be represented at the initial hearing. The coroner converted that hearing to a PIH and ordered disclosure of the medical records and other documents.

- AvMA also asked the trust for a copy of their SIR – they said an SIR was not necessary and did not prepare the report.

- In fact there were 4 PIH in this case.

- During the course of one of the PIHs the Coroner said he expected a SIR and this was eventually carried out by the Trust.

- The coroner appointed his own independent expert - gastroenterologist

- The inquest hearing took place in 2015 (2 years after the original date was set). Instead of 2 hours, the hearing lasted 2 days.

- **CONCLUSION**: The hospital were not aware that GR was receiving Naproxen until after the GI bleed. The use of a PPI (Omeprzole) was never considered. The failure to prescribe the PPI amounted to 'neglect'.

Review of Legal Aid for Inquests – MoJ call for evidence: 30.08.18

JS deceased – Case study 4

The Facts

- JS admitted to SR Hospital with hip pain following a fall at another centre. Subsequently a hip fracture was diagnosed the cause was cancer of unknown primary.
- Several weeks later JS underwent a hip replacement operation. The surgery was uneventful.
- JS had a complex medical history which was well managed. In particular he suffered from severe obstructive sleep apnoea (OSA) which meant that when he was asleep the muscles in his neck relaxed and obstructed his airway which would stop him breathing.
- JS also suffered from obesity hypoventilation syndrome (OHS), (a combination of obesity and daytime hypercapnia (increased levels of carbon dioxide in arterial blood)).
- As a result of OSA and OHS, JS had excessively slow or shallow breathing due to low levels of oxygen in his blood.
- To manage his OSA JS used a Continuous Positive Airway Pressure (CPAP) machine (this is a mask he would wear when asleep and which exerts positive end expiratory pressure (PEEP) to keep the airway open).
- JS had been successfully managing both conditions through use of the CPAP machine for 3 years.
- Shortly after JS' hip replacement surgery and after being placed on a Ward JS was heard snoring. JS' CPAP machine was not with him despite his having taken it into hospital when he arrived.
- Around this time JS suffered a respiratory arrest from which he never regained consciousness. His CPAP machine was never located. JS died.

The Issues

- How and when was the CPAP machine lost?
- Why, had staff on the ward who were familiar with JS not realised that he had been asleep without his CPAP machine?
- Conflicting information being given following the respiratory arrest about JS treatment and prognosis.
- The medical notes flagged potential concerns with use of Morphine, which can be a respiratory depressant, against a backdrop of OSA/OHV.
- Rationale for removal of the nasal cannula.
- The trust had undertaken a serious untoward incident report identifying that a bedside handover should have taken place. The nurse who has transferred JS maintained that a telephone handover occurred but none of the other nurses recalled it.

- Given that the evidence was that JS had eaten lunch prior to his arrest there was a question over whether he may have choked on food. This was corroborated to some extent by the allegation that during resuscitation efforts food debris was found in JS mouth."

- The trust maintained that cardiac dysrhythmia was a potential factor in JS's death

- The hearing lasted 2 days and evidence was heard from 2 consultants in intensive care medicine, the ward matron, 2 nurses present at the time of the arrest, a consultant anesthetist, a consultant in general medicine, the pathologist and 2 other witnesses.

- There was no system for setting up and enforcing the use of medical equipment brought in by a patient on arrival at the ward.

Conclusions

1. The Coroner made a Prevention Future Deaths report in relation to ensuring that whenever there is a transfer from one department to another, not just HDU or intensive care, the equipment must be put in place and in the possession of the person using it and made available to them as a matter of priority, even over lunch.

2. The Coroner commented "On the Public Record; I convey to the family the dignity they brought to the inquest; the thoroughness of preparation of medico-legal issues; and the spirit in which they raised those issues deployed through their advocate and AvMA. No one could have asked for more than the assistance provided by Ms. Wood [Counsel] and that Ms. Wood had from AvMA."

   Trust's behaviour: It is notable that most of the witnesses from the trust expressed their sorrow, either when giving evidence or outside the court room, which was important to the family.

3. Following the conclusion of the inquest the hospital quickly made further changes to their ward to ward transfer document so that a computerised box is checked confirming that all essential equipment is available, checked and ready to use.

4. However, after the inquest but before the PFD was published the trust attempted to avoid the coroner's PFD report by making ex-parte representations in writing to the coroner that because of the steps already taken by the trust a PFD was no longer required. Neither the family nor AvMA were party to these representations which only came to light some 2 months following conclusion when the Coroner wrote to the family to say he would no longer be doing the PFD report, because it would be otiose. There was no invitation for the family to make submissions of their own.

5. In response Counsel on behalf of the family made submissions to challenge the Coroner's decision to withdraw the PFD report. Counsel for the family submitted that:

   (i) Once a duty under S 7(1) has been engaged, as it was at the inquest, there was a duty to make the PFD report and there is no discretion or scope for retrospective withdrawal.

   (ii) The sending of letters to the Coroner's Office following conclusion of the inquest is not recognised as part of the procedure under the 2009 Act or at all.

(iii) he Chief Coroner's Guidance number 5 applies to the inquest, not to letters sent after the inquest has concluded. Furthermore the Guidance cannot over-ride the duty under the Act.

(iv) It was plainly accepted that the steps taken by the trust before the inquest and prior to the Coroner indicating he was making a PFD report to avoid equipment being lost were inadequate because further steps were taken after the PFD was made.

(v) The basis of the request to withdraw the PFD was not because the PFD was made in error but because the trust had complied with what would have been written on the PFD.

(vi) In any event the decision in R (Dr Siddiqui and Dr Paeprer-Rohricht) -v- Assistant Coroner for East London suggests that, even if the PFD report were made in error in absence of the full facts, the decision to make a PFD cannot be challenged, at least not by Judicial Review and, by analogy, not by informal correspondence sent after conclusion of the inquest.

(vii) Informal letter sending after the inquest has concluded and without the knowledge of other interested parties is not consistent with transparency in the coronial process.

(viii) Taking such letters into consideration sets a dangerous precedent and offends the finality of the inquest.

(ix) There are procedures that must be followed to challenge the decision of the coroner, neither of which were followed here.

6. The Coroner responded quickly, taking on board the representations made on behalf of the family and the PFD report was duly provided.

7. The family would not have been in a position to secure a PFD in the terms obtained or enforce the coroner's PFD report without representation by counsel or AvMA.

Review of Legal Aid for Inquests – MoJ call for evidence: 30.08.18

Baby W (deceased)- Case study 5

Condition

Baby W was born in May 2016. The mother's 3rd child and an unremarkable pregnancy. Spontaneous labour and birthing plan followed which included a birthing pool. Spontaneous delivery with good APGAR scores 9(1), 9 (5).

Baby dies shortly after birth. The issue centres around the failure of staff at Z trust to identify a baby who was in respiratory distress and clearly deteriorating and to arrange transfer to a tertiary unit in time.

Facts:

1. Meconium noted in the birthing pool at the time of delivery but focus is on APGAR scores
2. 20 minutes after birth baby noted to be grunting, tachypnoeic, high respiratory rate
3. 5 minutes later, baby vomits meconium. Neonatal intensive care unit called.
4. Referred to neonatal unit for stabilisation: placed in an incubator and oxygen administered
5. Further reviews occurred overnight on an hourly basis when baby was fed. Baby's oxygen requirements continued to increase. Observations were not recorded on a NEWS chart. NO formal medical review undertaken
6. 0720 Neonatal advanced nurse practitioner (ANP1) handed over to ANP2
7. 0900 a doctor reviewed baby with the benefit of chest x ray (ordered by ANP2) which showed "hazy lung fields". The doctor diagnosed mild respiratory distress.
8. 11.30 baby showing increased distress and agitation
9. 12.45: baby's breathing increasingly laboured, respiratory rate had risen, blood gas results such that the decision was taken to place baby on high flow oxygen (81/min oxygen)
10. 1335: need for oxygen increased, distress and agitation continued
11. 1410: a doctor reassured parents but does not appeared to have examined baby
12. 1530 – 1730: Respiratory distress continued [NO OBSERVATIONS RECORDED AFTER 1730]
13. 1800: Doctor 2 alerted and escalated the case to the consultant on call
14. 1830: baby intubated and surfactant administered. Deterioration continued, situation worsened and baby hand bag ventilated

15. 2110 A doctor at the H contacted a mainland tertiary referral centre – first contact!

16. 2200 decision made to transfer baby to mainland. Transfer actually took place 0345, arrived at mainland tertiary unit 0512. Baby continuing to deteriorate throughout this time

17. Shortly after arrival as a result of profound hypotensive and bradycardic episodes a decision made to stop active treatment. Baby extubated and died in his mother's arms

The Documentation:

18. Post Mortem:Main findings:

- Meconium present in some alveoli with other changes consistent with meconium aspiration syndrome;
- Features of pulmonary vasculature consistent with clinical findings of pulmonary hypertension;
- Large, acute, Intraventricular haemorrhage.
- On the balance of probabilities cause of **death stated as: 1a Acute intraventricular haemorrhage**

19. Serious incident investigation: **Independent** review on the basis that this was a neonatal death where survival would have been anticipated. Report concluded:

- There was a delay in recognising the baby's deterioration by all staff both nursing and medical; This allowed Baby to deteriorate to a point whereby it was "***difficult to retrieve the situation";***
- This was compounded by "suboptimal" documentation and communication;
- There was a failure to follow transport referral guidance;
- It's also "possible" that the staffing structure and "geographical limitations" may have had a bearing on the outcome.
- Failure to provide timely review of baby
- Members of the staffing team were confused about which tertiary centre to contact.

The Family:

20. Initially contacted AvMA March 17. Wanted information on inquest process but felt representation was unnecessary

21. April 2017: family attended PIRH alone. Came up against a wall of representation from Trust. Family were "**Overwhelmed"** so Post PIRH contacted AvMA again for assistance and we offered representation.

The issues:

22. **INQUEST HEARING** fixed for 2 days in August 2017. Converted to a PIRH in September, family represented when request for additional disclosure of statements and witness attendance made. Hearing moved to 5 days to accommodate 13 live witnesses

23. **ARTICLE 2: COUNSEL** for the family instructed to argue that Art 2 is engaged owing to the Trusts systems failing to protect life. Particularly with regard to the systems in place to provide:

    (i) Adequate or appropriate systems of documentation or record keeping

    (ii) Escalation of care, contact with tertiary units and transfer

    (iii) Adequate staffing levels

24. **The coroner never actually declared whether this case was an Article 2 investigation or not.**

25. **AvMA obtained an independent pro bono expert report**: Our expert says transfer of baby ought to have been contemplated and initiated at an even earlier stage than that suggested in SIR

26. **ISSUES FOR FAMILY**:

    (i) The main issue of concern for the family was whether their baby's death could have been avoided.

    (ii) The family didn't dispute the finding of meconium aspiration syndrome and persistent pulmonary hypertension of the newborn.

    (iii) The family were seeking to establish whether the interventricular haemorrhage could have been identified and treated successfully by the teams caring for Baby W.

LEARNING LESSONS: PREVIOUS SIMILAR CASES:

27. Same trust, another baby who died in December 2015. The inquest concluded earlier this month (2017) and a finding of: Gross systemic neglect made. The SIR prepared in this case also referred to the death of a third baby details of which were disclosed to the coroner but not to the family on the grounds that the "facts were not alike".

Tactics:

28. In this case, the trust conceded breach of duty and causation and issued a Pt 36 offer in July 2017. The family did not seek advice and accepted the offer – the costs of the inquest were not covered by the Trust even though they were well aware of the ongoing proceedings.

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 exercise (e.g. member of the public etc.)	Director Medico-Legal Services
Date	30th August 2018
Company name/organisation (if applicable):	Action against Medical Accidents (AvMA)
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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.