Action against Medical Accidents response to the Consultation on proposals to reform Fatal Accident Inquiries legislation

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. Our work with patients and their families feeds directly into our policy and campaigning.

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

AvMA's Experience of working with bereaved families

4. AvMA had for a long time recognised the need for specialist support for families that had lost a relative where it was suspected failures in medical treatment may have contributed to the death. In September 2009 AvMA committed resources to providing a specialist pro bono inquest project in England and Wales; the project was officially launched in July 2010. The project 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.

5. AvMA deals with approximately 100 medical inquest cases a year providing pro bono representation at inquest hearings in approximately a third of these cases. Through this work, AvMA has developed considerable expertise in providing assistance and representation to members of the public at inquests where the death arose in a healthcare setting.

6. The inquest project has ensured that for those we are able to assist, there is a more level playing field for bereaved families. But for our pro bono service the bereaved would more often than not go unrepresented and unable to have their concerns properly heard

and thereby limiting the effectiveness of the inquest process in preventing future deaths. For bereaved families, knowing that the inquiry process will help prevent another family suffering a similar loss is often essential to coming to terms with what has happened.

7. We believe it is essential that the needs of bereaved families are placed at the centre of the FAI process and that they are supported as active participants as opposed to passive observers. The consultation makes little reference to how this might be achieved and in so doing, ignores the contribution that families can make to the Fatal Accident Inquiry process and in preventing future deaths.

8. There have been a number of recent examples in Scotland of hospitals where excess deaths have been identified which have been associated with concerns about substandard or unsafe care. This would indicate that a proportion of these deaths may well have been preventable if earlier intervention had taken place. In reforming Fatal Accident Inquiries, questions need to be asked about why the number of Fatal Accident Inquiries that takes place is so small relative to the potential number of avoidable deaths in healthcare settings and what is required to ensure that the early warning signs are detected and preventative action taken at the earliest possible stage. There is enormous potential for Fatal Accident Inquiries to improve patient safety if the system is made sufficiently sensitive to identify those cases that may signify a more deep seated systemic problem and where further investigation is required.

9. This starts with the death certification process and the extent to which the causal chain leading up to the ultimate cause of death is included within the investigation. If one takes the example of an elderly person admitted to hospital from a nursing home with bedsores who subsequently dies having developed sepsis leading to respiratory and cardiac arrest, it is quite plausible that this could be certified as natural causes and not be subject to a FAI. This is more likely if a less experienced doctor is responsible for the certification process. However, if a FAI were undertaken, it might reveal that this patient was in fact one of a series of patients admitted from this nursing home with bedsores and other evidence of seriously substandard care and which would indicate the need for immediate intervention.

10. Families involved in a medical death can often provide vital testimony that will not be found in the medical records and this is why it is so important that they are supported in having their voice heard. The participation of bereaved families should be laid down in statute. Without that input from the families, a significant number of avoidable deaths are at risk of being overlooked with the result that no action is taken to address the underlying problems that were causative of the death.

11. As set out in our response to the consultation, one of the key concerns is around delay before the FAI takes place. In addition to the impact that delays have on the bereaved as well as those directly involved in the death, it also means that there is a significant risk that the opportunity to prevent further deaths in the interim is lost.

AvMA's response to the consultation

12. In completing our response, AvMA has drawn upon the experiences of our members in Scotland as well as AvMA's experience of providing a specialist inquest advocacy service for bereaved families. Whilst our inquest service currently operates in England and Wales, our experience of working with families and the type of advice and support needed as well as the importance of an effective investigation in preventing future deaths is common across all jurisdictions within the United Kingdom. We have confined our response to questions 9 to 24 and in respect of deaths relating to medical care or 'medical deaths'.

AvMA's response to questions 9-24

Q9. Do you agree with Lord Cullen's view that "it is plainly not practical or realistic to make it mandatory that an FAI must open within a certain period of the date of the death of the deceased…because of the diversity and potential complexity of the cases" which may mean that an incident is not properly investigated?

No. Delays in completing FAIs is amongst the concerns most commonly observed and reported. We therefore believe that there should be enforceable deadlines incorporated into the legislation. Where there is good reason why a deadline cannot be complied with, full reasons should be given and for the progress of the case to be monitored thereafter to ensure adequate resources are allocated to the inquiry to ensure further delays are minimised.

Following the Coroners and Justice Act 2009 and the Coroners (Inquests) Rules 2013, inquests are expected to be held within 6 months of being reported to the coroner or as soon as practicable thereafter and any inquests taking longer than 12 months have to be reported to the Chief Coroner.[i] Whilst 6 months may well be seen as too short a period to allow a full and proper investigation in a complex FAI case, there is a need for a statutory timetable and for there to be central monitoring to ensure avoidable delay is kept to a minimum. These deadlines must take into account the needs of bereaved families and the difficulties they may well face in accessing affordable specialist advice but protracted investigations will ultimately do the families a disservice and potentially risk further deaths occurring.

An important part of minimising delays is ensuring that the service is adequately resourced and that both procurator fiscals and sheriffs have the training and support to enable them to undertake their roles in the most efficient and effective manner.

Q10. Do you agree that preliminary hearings should be held to help speed up the process of FAIs?

Agree. This is an essential part of moving the process forward in terms of determining the scope of the FAI, disclosure of evidence, identifying witnesses and setting the timetable.

Q11. Will having pre-hearing meetings of experts speed up FAIs?

In principle this should assist in narrowing the issues. However this is dependent on obtaining full and open disclosure of relevant documents and other evidence and the

instruction of experts with the appropriate expertise for the particular case. The latter is particularly important in the case of medical deaths where the process of identifying and instructing the appropriate medical expert is often not straightforward given the increasing number of sub-specialties within medicine. This requires medical understanding and knowledge. This reinforces the need for specialist training for procurator fiscals with access to specialist advice.

In the case of medical deaths, there is the added complication that the experts the procurator fiscal will be relying on to provide expert evidence will be commenting on the actions of colleagues within the relatively small medical community within Scotland. There is inevitably a need for caution to be exercised to ensure the objectivity and independence of such opinions where with the best will in the world, objectivity may be unconsciously undermined. There will be circumstances, for example where there are only a small number of specialists, where it is going to be necessary to seek opinions from outside the jurisdiction.

Q12. Will hearing some business in sheriffs chambers help speed up FAIs?

Not within our knowledge to comment.

Q13. Do you agree the proposal of permitting the submission of statements to the sheriff in advance of the FAI?

This would be acceptable provided the family had a right to ask for additional questions to be asked and also in determining the witness to be called in evidence. It is important that the statements are made available to families at an early stage. Statements should not be substituted as evidence for important witnesses.

Q14. Should the sheriff principle be able to transfer the case to a different sheriffdom if this is thought appropriate and if it may speed up the holding of the FAI?

We would support this approach but it would be essential that if the case is to be transferred to a different sheriffdom, it is to a sheriff with the appropriate expertise to deal with the case e.g. for medical deaths, to a sheriff who has training and experience in dealing with these cases. It would be important that the alternative venue remained accessible for the family. There may on occasion in relation to medical deaths be a benefit in transferring to a different sheriffdom to avoid any risk of local prejudice.

Q15. What impact do you think the proposals to speed up FAIs will have on you, your organisation or community?

The speeding up of FAIs would allow families to get answers and closure more quickly and this is important as lengthy delays prevent families from being able to come to terms with their bereavement. It is also important for those directly involved in the death that they do not have the FAI and any subsequent legal action hanging over them for any longer than is necessary. The earlier the FAI takes place, the more likely it is that witnesses' recall of events will still be sufficiently fresh to form the basis of a cogent inquiry.

In addition, given that an important function of both inquests and FAIs is the prevention of future deaths, any unnecessary delay may result in further avoidable deaths. However

speed should never be at the cost of a full investigation. A cursory investigation is not worthwhile and undermines the purpose of the FAI process.

Q16. Q17. Do you think that all FAIs in Scotland should be held in three bespoke, dedicated centres?

As indicated above, there are clear benefits to having dedicated centres with a team of lawyers who are specifically trained in the area in question e.g. if it is a hospital death the Fiscal or person presenting the FAI must have clinical negligence experience and be familiar with medical terms .

Q19. Should it be mandatory for all FAI determinations, subject to redaction, to appear on the SCS website and be fully searchable?

Yes. Particularly in relation to medical deaths, sharing this information will assist in the prevention of future deaths.

Q20. Do you think that sheriffs should instruct the dissemination of their recommendations (if any) to the parties to whom they are addressed and any appropriate regulatory bodies?

Yes. It is important that lessons are shared as well as where appropriate ensuring preventative action is taken and/or enforced. These details should be collated centrally. In the case of medical deaths, all FAI findings should be reported to the relevant regulators which would include such bodies as Healthcare Improvement Scotland, the Royal Colleges, professional regulators and where appropriate, other regulators across the United Kingdom.

Q21. Do you agree that parties to whom sheriffs' recommendations are addressed should be obliged to respond to the sheriff who presided over the FAI indicating what action had been taken? This would be on the basis that those parties would not be obliged to comply with the sheriff's recommendations, but if they have not complied they would be obliged to explain why not.

We would strongly agree that parties should be obliged to respond to sheriffs' recommendations e.g. if the Sheriff indicates certain changes should be made, the Health Board should be required to report to the Sheriff within a certain period following the determination indicating what they have done in respect of the recommendations.

However, this does not go far enough in terms of ensuring action is taken. There needs to be enforcement powers attached to those recommendations and that failure to act upon the recommendations will result in sanctions.

Q22. What impact do you think that the proposals regarding sheriffs' recommendations will have on you, your organisation or community?

In the case of avoidable medical deaths, this will improve patient safety and help to prevent future harm. An important part of this is disseminating lessons to all relevant healthcare providers and instituting changes to practice where this is indicated.

Q23. Do you agree that the existing arrangements for legal aid for bereaved relatives at FAIs should remain?

The current arrangements for legal aid for bereaved relatives are inadequate and need to be extended to ensure families have access to advice and representation at FAIs. It is certainly AvMA's experience that where families have access to advice and representation, this enables them to be motivated and active participants, and to support the inquiry process. This in turn can help ensure a full and proper inquiry takes place given that one of the key motivations of families is to prevent future deaths.

Q23a. If you answered "no" to question 23, in what ways would you change the arrangements for legal aid for bereaved relatives?

There is a view that legal aid is unnecessary in FAIs because procurators fiscal represent relatives, but – as pointed out in the consultation document - this is not strictly the case. The procurator fiscal's role is not to represent the relatives, nor is there an obligation to act in their best interests. It is important that the bereaved family has access to a lawyer experienced in dealing with FAIs. Many Fiscals are not experienced and it is vital that relatives have a voice. There is no facility to recover costs in a FAI in any subsequent court action and this is an access to justice point that must be addressed for those who cannot get legal aid.

One suggestion is that the arrangements for legal aid for bereaved relatives could be modelled on the Inquiries Act 2005. Under the terms of this Act, the chairman of a public enquiry receives funding applications from those people who wish to be represented. If there is a concern that counsel to the inquiry is unable properly to represent the participant, public funding can be awarded. In the same way, the power to award public funding for bereaved relatives should lie with the sheriff, following an application to the sheriff from the bereaved. Any recommendations for funding from the sheriff should be binding on the Scottish Legal Aid Board.

Contact details:

Liz Thomas
Action against Medical Accidents
Freedman House
Christopher Wren Yard
117 High Street
Croydon
Surrey CR0 1QG
Email: policy@avma.org.uk Tel: 020 8688 9555
Website: www.avma.org.uk

[i] http://www.legislation.gov.uk/uksi/2013/1616/pdfs/uksi_20131616_en.pdf