RESPONSE TO

CORONER REFORM: THE GOVERNMENT'S DRAFT BILL

SEPTEMBER 2006

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INTRODUCTION

Action Against Medical Accidents (AvMA) is an independent charity which promotes better patient safety and justice for people who have been affected by a medical accident. A "medical accident" is where unintended harm has been caused as a result of treatment or failure to treat appropriately. This includes where the care has been negligent but does not necessarily mean that it was. AvMA believes that whatever the cause of a medical accident, the people affected deserve explanations and support. There is a wider public interest in that we all need to know that the necessary steps will be taken to prevent similar accidents being repeated.

AvMA have almost 25 years' experience of supporting those affected by medical accidents, including bereaved families involved in the coronial process. AvMA maintains close links with specialist solicitors and patient safety groups nationwide. As a result of our shared experiences we are uniquely placed to make informed comment and recommendations with a view to improving the current system and improving patient safety.

AvMA have long been concerned about the inconsistency of approach by Coroners and in particular, a reluctance to investigate deaths which have occurred whilst the individual was under medical care. As a result, opportunities to improve patient safety have been lost. There is widespread agreement by users and providers of the coronial system that reform is needed and in particular that there needs to be a national structure offering consistency and accountability underpinned by adequate funding and specialist training.

The Coroners' Charter and the reforms suggested are to be welcomed. However unless very significant extra resources are made available it seems unlikely that the structure proposed will deliver the promises made in the Charter and the opportunity to make the system fit for purpose and therefore improve patient safety will be lost.

SUMMARY

Overview and Key concerns:

- A better service for bereaved families will not be delivered unless there is an adequately resourced national Coroners service
- A fully accountable and consistent service cannot be provided whilst funding and the system of appointment remains in the hands of local authorities.
- A dedicated medical officer should be appointed for each area to support the Coroner.
- A professional qualification should be established for Coroners' officers and in the case of medical deaths each area should have a Coroner or a deputy and at least one coroners' officer trained in the specialist investigation techniques required in such deaths.
- All deaths should be reported to the Coroner who could then determine those deaths to be investigated.
- The importance of the post mortem examination should not be overlooked and the standard of post mortem examinations needs to be raised.
- Tissue and organs should not be disposed of until any enquiry has been completed.
- Where the Coroner suspects that a failure to provide medical treatment in the UK or that treatment purchased oversees by the NHS may be relevant to the death the Coroner should be under a duty to investigate in addition to those cases where medical treatment may have resulted in a death oversees.
- Minimum standards of accommodation to hold inquests should be specified and only in exceptional circumstances should Coroners travel to inquests in rural areas.
- The grounds for appeal and the list of interested parties are appropriate and should not be reduced but there should be a hierarchy of interested parties.
- There is a clear need for legal representation in relation to medical deaths and the availability of financial support in such cases should be extended.
- In the interests of improving patient safety, there be a positive duty placed on the Coroner to lodge details of any criticisms/recommendations with the National Patient Safety Agency and the Healthcare Commission so that a national database can be constructed and any necessary interventions made.

1. STRUCTURE AND FUNDING OF THE CORONIAL SERVICE

1.1 General comments

The proposals to allow the system of recruitment and appointment and direct financing of Coroners by local authorities will lead to continuing inconsistencies in the service offered from region to region.

It is vital that a national Coroner service is established with Coroners, their deputies, officers and medical officers employed centrally to ensure that all those involved in the Coronial system reach a minimum standard and that sufficient financing for the service as a whole is guaranteed.

The Judicial Appointments Commission should conduct the appointment of Coroners. The current system of appointment is incompatible with the aims of the new Coroners service as local authorities main priorities may well be related to budgetary concerns.

1.2 Investigations in Relation to Treasure

AvMA welcome the proposals to ensure that treasure be dealt with by Coroners specifically appointed for that task thus allowing for separate training and expertise for Coroners investigating deaths.

1.3 Medical support for local coroners

It is proposed that there be a Chief Medical Assessor who will provide support to the Chief Coroner. However the Home Office Position Paper Proposals to appoint at least one medical examiner per area have been abandoned.

It is proposed that there will be a financial allowance made to local Coroners to purchase ad-hoc medical expertise.

Although it is intended that all Coroners will be legally qualified but be offered some medical training, they will undoubtedly require considerable medical support in the context of medical deaths. A failure to provide a dedicated medical officer to support the local Coroner will mean that such evidence and information may be provided by a doctor employed by or having links with local healthcare providers and impartiality will be difficult. Alternatively, the Coroner will need to seek medical expertise out of area and this will prove costly and fail to develop expertise locally.

If the Coroner is given a capped budget to obtain such expertise, as outlined in the proposal, the Coroner is unlikely to have sufficient funds to meet all of the requirements for medical advice and there is a further possibility that monies allotted for medical expertise will be expended on other areas of need.

A failure to provide a dedicated medical officer in each area will also reduce the opportunity of improvements to public health and safety as a dedicated medical officer could supervise collection and analysis of data and make appropriate recommendations to notify those who may be in a position to either investigate further or take positive steps to improve public health/patient safety.

It is also noted that it is suggested that limited post-mortems are performed and again medical expertise would be required to assist in deciding how limited that post-mortem should be.

Any proposed changes to the death certification system would also require the input from a dedicated medical officer in the locality.

1.4 Coroners officers

The importance of the role of the Coroners' officers should not be overlooked. They are the first point of contact for the bereaved.

They should be offered the opportunity of a professional qualification guaranteeing a minimum standard. Such training should include specialist training in dealing with the bereaved, how to apply the legislation, basic medicine, investigation techniques and the standard of evidence to be produced at the inquest.

1.5 Medical deaths and the need for specialist training.

AvMA believe that further training should be given as a minimum to either the Coroner or one of his deputies per region and to a minimum of one Coroner's officer per region in the specialist investigation techniques and information required in respect of medical deaths.

This should be over and above the basic qualifications required for Coroners' deputies and their officers.

2. DEATH CERTIFICATION

2.1 General comments

There is no good reason to continue the system of separate systems of certification for burial and cremation provided adequate post mortem examinations are undertaken in appropriate cases.

2.2 Duty to Notify

AvMA would suggest that all deaths should be notified to the Coroner and there be a positive duty placed on doctors and the police to notify the Coroner of any deaths.

The assessment as to whether or not the deaths should then be investigated could then be screened by properly trained Coroners' officers with recourse to the medical officer where appropriate and a final decision as to whether or not there should be an investigation be authorized by the Coroner. In the majority of cases this would be a matter of routine.

This would avoid inconsistency in approach between a doctor deciding whether or not the Coroner should be notified and would also avoid the potential difficulty of a Coroner being unable to investigate a death unless he has been notified of the death.

It would ensure that the collation of information regarding trends etc. be carried out centrally and the information collected in respect of all deaths rather than those that require investigation.

3. INVESTIGATION OF DEATHS

3.1 Post mortem examinations

At the present time, there is inconsistency in the quality of post-mortems performed by pathologists. A thorough and detailed post mortem may be needed to establish the relevant facts in a medical death and it may be the only means of ascertaining the precise cause of death. Without this information the opportunity to learn from medical mistakes could be lost and patient safety compromised.

The Chief Medical Assessor proposed by the draft Bill could oversee the training and quality of all pathologists to ensure that there is a minimum standard.

Present difficulties with the recruitment of pathologists and the monies currently available to fund Pathologists should not lead to the conclusion that there should be a reduction in the number of post-mortems performed.

The decision to proceed with the post-mortem is made before the investigation is undertaken. The need to determine the requirement for a partial post-mortem or a complete post-mortem in cases under investigation may lead to important evidence being overlooked and vital evidence may be lost.

Any decision to perform a limited post-mortem should ideally be made by the Coroner in consultation with a medical expert.

3.2 Retention of human remains

AvMA agree that retention of the body prior to burial/cremation should be for as short a time as possible.

However if tissue and organs are disposed of within 40 days other than in exceptional cases, this may lead to the destruction of tissue prior to the investigation and the inquest being completed.

It is suggested that there should be a presumption that all tissue is retained until completion of the inquest unless there are good reasons for its earlier disposal.

There should however always be a full explanation given to the family as to what tissue/organs are being retained and why.

The bereaved should also be offered the opportunity of donating appropriate tissue for medical research purposes if appropriate.

3.3 Deaths outside the United Kingdom

AvMA have no objection to the broad principle that the Coroner need not be under a duty to investigate deaths outside the UK unless the Coroner suspects that

circumstances arising in England and Wales may have caused or contributed to the death.

The explanatory notes indicate that such a case may be where the deceased received medical treatment in England or Wales and the Coroner believes that death may be linked to treatment received in the UK. This should specifically include where the Coroner suspects a failure to provide medical treatment in the UK may be linked to the death.

As patients may now be sourcing NHS funded medical treatment overseas and therefore the medical treatment and the death may take place oversees it should be specifically stated that the circumstances arising in England and Wales should include NHS funded medical treatment overseas which may be linked to the death.

4 THE INQUEST

4.1 Provision of accommodation

It is noted that the draft Bill proposes an obligation on the local authority to provide suitable accommodation for the Coroner to hold an inquest.

At the present time, inquests are held in a variety of locations from hotel rooms, council chambers, medical museums to purpose-built courts.

The use of suitable facilities for the Coroner to conduct inquests is essential to protect the interests of the bereaved.

In the past, inquests have been delayed as a result of a failure to have suitable accommodation available. The accommodation offered is often inappropriate in the circumstances. This can lead to unnecessary distress on the part of the bereaved and lead to inefficient handing of inquests by Coroners and their officers.

In many locations, there is inability to access basic office supplies taken for granted in civil and criminal courts, for example photocopiers and stationery.

It has been suggested that in rural areas, it would be appropriate for Coroners to travel to be closer to the bereaved. Although this may be advantageous to the bereaved in that they will have less traveling time, this is an inefficient use of the Coroner's time and would lead to greater delays in providing inquests as suitable accommodation is sought and it may mean that the services required by the bereaved could not be delivered in a professional manner.

We would therefore suggest that other than in exceptional circumstances the Coroner holds inquests in designated centres and that the Bill specifies the minimum standards for the accommodation to be provided.

4.2. Inquests to be held in public

It is in the public interest that inquests take place in public, not only to inform the public and improve patient safety but also to ensure that there is trust in the inquest system.

Clause 41 makes it clear that inquests should be held in public unless there are exceptional reasons for excluding the public.

It should be made very clear in the draft Bill that 'exceptional circumstances' should be drawn very narrowly and the wider public interest should take precedence.

The 1984 rule requiring inquests to be held in public where there is a necessary safeguard to national security should be retained.

5. APPEALS & INTERESTED PARTIES

5.1 Grounds for appeal

The grounds for appeal are appropriate as listed in the Bill and should not be limited.

The possibility of reviewing a Coroner's decision in for example the investigative process before the inquest takes place could lead to a better quality of investigation and ultimately inquest. If the system and training is working correctly it is unlikely to be widely used, if it is not working it will provide a means of quality control, lacking in the current system.

It will be more cost efficient to appeal at the time the decision is taken rather than wait until the inquest process has been concluded and avoid the need to revisit the investigation and avoid the risk of an inquest having to be re-heard.

It is in the public interest (particularly in medical deaths) that as full an investigation takes place as possible and restricting the decisions which can be appealed could lead to public mistrust of the system.

Based on AvMA's experience of working with bereaved families and the experience of specialist solicitors working in this area, it seems extremely unlikely that in medical deaths relatives would use the appeals process as a method of venting their anger towards a member of the team that looked after the deceased as suggested by the BMA.

5.2 Interested Parties.

The widening of interested parties is welcomed and is appropriate. However, there should clearly be a hierarchy of interested parties with those having a personal connection to the deceased taking precedence over those with a commercial interest in the outcome of the inquest.

Sadly there are those who may die without family and it is appropriate that in such circumstances a long-standing friend could act as advocate for the deceased.

6. CORONERS CHARTER

AvMA welcome the proposals to set out guidelines and standards to make it clear what service bereaved people can expect and to promote better contact between them and the Coroner's staff.

However, the draft Bill seems unlikely to deliver the promises contained in that document. The lack of resources, appropriate training and a consistent approach throughout the country will mean that a patchy service will be offered to the bereaved as is the case at present.

In the case of medical deaths, there is a particular need for legal representation for the bereaved at inquest.

At a time of greatest vulnerability, the bereaved will be faced at inquest by a healthcare provider who is legally represented and has technical expertise available not only to assess the evidence given at inquest but also have technical input into the preparation and investigative process prior to inquest.

Although public funding is available in certain circumstances for representation at inquest, this is of extremely limited applicability and the discretion to allow public funding is rarely exercised at the present time. The availability of financial support for representation at Inquests should be extended.

7. IMPROVEMENT IN PATIENT SAFETY

Although AvMA support the aims of the Charter it believes greater steps could be taken to place a positive duty on the Coroner to report any concerns to the appropriate authority or body for appropriate action or further investigation.

There should be a system by which the Coroner is notified of the outcomes of any investigations of any action by the authority or body concerned.

At present, there appears to be reluctance on the part of Coroners to make any comments in narrative verdicts which are in any way critical to avoid the suggestion that a finding in relation to civil or criminal liability has been made.

It should be made clear that critical findings should be recorded as a matter of public interest.

There should be a positive duty placed on the Coroner to lodge details of any criticisms/recommendations with the National Patient Safety Agency and the Healthcare Commission so that a national database can be constructed and any necessary interventions made.