RESPONSE TO JUSTICE COMMITTEE'S CALL FOR EVIDENCE ON THE CORONER'S SERVICE

CONSULTATION CLOSES:2nd SEPTEMBER 2020

Introduction

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

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

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

4. Currently, AvMA has at least 3 members of staff who are committed to undertaking inquest work, along with other duties. All staff involved in the inquest work are highly trained and are qualified as either doctors or lawyers.

5. AvMA has been routinely collating responses to questions posed in our Inquest New Client Form since January 2019; it is part of the AvMA Inquest application process that all beneficiaries seeking assistance from this service are expected to complete the new client form. 53 new client forms received during the period January to November 2019 were analysed by AvMA on 14th November 2019. The analysis was aimed at identifying how much information and knowledge beneficiaries typically had about the healthcare inquest process and other investigative steps when they came to us. We have referred to the analysis as the "AvMA 2019 analysis" and where appropriate refer to our findings as part of the evidence contained in this response.

6. The pro bono inquest service has developed so that it now provides advice to between 80 – 100 families each year, including committing to up to 10 inquest hearings as well as pre inquest reviews (PIR). Some of the cases are referred to solicitors especially if there is a potential civil claim. Through our work, we have developed considerable expertise in providing information, assistance and representation to members of the public at inquests where the death arose in a healthcare setting. The views expressed within this document are based specifically on our experience in healthcare related inquests only.

Summary of key points made:

7. Unevenness of the coroner's service: The service has benefited from the appointment of a Chief coroner, first appointed in 2013. The appointment has had a unifying effect on the coroner's service but there is room for improvement. There are still inconsistencies in the service which need to be addressed. Details of those inconsistencies are set out in the body of this response.

8. Ways to strengthen the coroner's role in prevention of avoidable future deaths: Coroners need greater powers to impose penalties on interested parties who fail to deliver up all relevant information, investigations and statements at the earliest opportunity. The coronial service needs

improved information technology, infrastructure, funding and collaboration with other organisations to ensure that both responses to Prevention of Future Death reports and actions proposed by relevant interested parties in Action Plans submitted to the coroner are monitored and policed to ensure that changes to the system are implemented and consistently reviewed. A national coroner's service could have a significant role to play to roll in disseminating learning from local hospitals and make that information available nationally.

9. Fairness in the coroner's service: Where a public body has access to legal representation, information, and advice the same should be made available to a family as a matter of right. There will never be equality of arms and therefore fairness in the coroner's service unless and until this happens.

AvMA's Response to the Consultation

1. The extent of unevenness of coroner services, including local failures, and the case for a National Coroners Service

1.1. AvMA's pro bono inquest service aims to provide support to families across England and Wales. This nature of our experience means that we can state with confidence that the coroner's service is inconsistent, and the local failures vary from one coroner's area to another.

1.2. The coroner's service has undoubtedly benefited from the appointment of a Chief Coroner in 2013. The Chief Coroner has endeavoured to unify the coronial system by introducing more consistency in local services, this has been introduced in a number of ways. Key amongst these is ensuring that coroners now receive regular training. The Chief Coroner's Guidance notes have also been an effective way of communicating expectations and standards to coroners and this has been helpful.

1.3. However, inconsistencies in the way in which coroner's handle healthcare inquests continue to be as marked now as ever. The Coroners Service suffers from a lack of access to appropriate information technology and adequate national funding and these issues must be addressed if this important service is to ever address the factors that give rise to an uneven coroner's service and local failures.

1.4. The following paragraphs provide examples of some of the inconsistencies we routinely observe.

1.5. A central tenet of the coroner's service is that the grieving family/loved ones are to be at the centre of the process, the variation in how this is applied is evident in several ways. For example, the amount of notice families are given of a forthcoming inquest hearing or pre-inquest review hearing (PIRH) is very variable. It is not unusual for AvMA to receive enquiries from the public seeking assistance from our service a very short time before the inquest hearing commences. Our beneficiaries report that they approached us as soon as they received notification of the inquest hearing date, this is often less than 14 days before the hearing is due to commence.

1.6. AvMA's experience is that when beneficiaries do contact us early in the process, for example as soon as they are told an inquest is going to be opened and we ask the

coroner/coroner's office to communicate directly with us on behalf of the family that reasonable notice of the PIRH and/or inquest hearing date is given.

1.7. At section 5.6 of "A guide to coroner services for bereaved people" (The Guide) which is a Ministry of Justice (MoJ) publication it says: ***"The coroner's office must tell you the date and time of the inquest and where it will be held within a week of fixing the inquest. The coroner's office will take into account your views on the date and time of the inquest wherever possible."*** The experiences reported to us by our beneficiaries suggests that this approach is not applied consistently and that families are rarely contacted to ask their views on whether the date and time of the hearing is convenient for them.

1.8. Section 5.6 of The Guide also says that interested persons can expect to receive three monthly updates on how the case is progressing. In our experience, that rarely happens in practice.

1.9. Section 4 of The Guide deals with whether an interested party needs a lawyer. The Guide says: ***"You do not need to have a lawyer to attend or participate in an inquest…You may want to get legal help for an inquest hearing if other interested persons are represented, for example if the state of a public body has legal representation at the inquest".*** In our experience there is real variation in the way this message is communicated. Some coroners encourage families to obtain their own legal representation whereas others question the family over this in a way that appears to be aimed at dissuading them from seeking legal advice even when other interested parties such as hospital trusts will be represented.

1.10. In our experience even where families have sought advice from AvMA and we in turn have been able to organise pro bono representation from counsel for them, coroners do not consistently consider dates of pro bono counsel's availability. Pro bono representation is difficult to arrange, where coroner's fail to take account of that counsel's availability it jeopardises the family's ability to secure that representation. By contrast, we have experienced situations where say the trust's counsel's availability has been given due consideration. The perception is that a hospital trust's need for representation is greater than a family's need for representation.

1.11. Information provided to interested parties, especially families, needs to be clear and consistent especially when it comes to explaining matters such as what a pre inquest review hearing (PIRH) entail. Coroners and or their officers should explain to families that they could potentially benefit from legal representation/advice at a PIRH particularly where matters such as the engagement of Article 2 European Court Human Rights (ECHR) are concerned. Families should also be made aware of the importance of these hearings for making submissions on witnesses to be called and requests for document disclosure. Some families do not know that they can make submissions on witnesses to call.

1.12. Families should be invited to have access to all available documents prior to any PIRH so they can consider the contents of the documents and be in a position to at least request particular witnesses to attend the full inquest hearing.

1.13. Families need to have sufficient notice of any such PIRH to have time to seek legal advice and to review any disclosure in preparation for the hearing. In AvMA's

experience where we are involved at an early stage with assisting a family generally sufficient notice of PIRH is given. As described in paragraph 1.5 above, in practice we are often contacted by families who have received last minute notice. AvMA is often unable to assist families who receive short notice of the PIRH hearing date as we do not time to properly review any available documents prior to the hearing.

1.14. AvMA suggests that a standard leaflet on PIRH be produced. The leaflet should set out what the family can expect at a PIRH, and the sort of things they may want to consider requesting for example documents which have not been disclosed to date, request for certain witnesses to attend etc. The coroner's officer or similar person can then be responsible for ensuring the leaflet is distributed to families prior to the PIRH. It should be straightforward to ensure that all Coronial jurisdictions make the standard leaflet available across England and Wales. It is AvMA's understanding that some jurisdictions already have this in place such as the one used by the Coroner in Cambridge.

1.15. There are also great inconsistencies between the facilities available to families. Some courts have rooms where the family can prepare prior to the hearing, others do not. Some courts have access to the Coroner's Support Service, an organisation which provides emotional support for families which can be very helpful for grieving families, particularly when they have no representation. AvMA does recognise that funding is an issue here however it is a point that should not be underestimated as it is important to respect the family's dignity at such a difficult time.

1.16. The way in which coroners approach evidence gathering and disclosure of evidence remains inconsistent. In some jurisdictions medical records are not requested at all by the coroner. AvMA considers that coroners being asked to conduct a healthcare inquest should as a minimum be expected to consider the core medical records of the deceased – these documents are a significant source of information on how the deceased came about their death. The medical records are also an important way to identify potential witnesses to be called as well as issues to be explored – the medical records are a crucial piece of evidence in any healthcare inquest.

1.17. AvMA's 2019 analysis shows that almost a third of families (31%) did not know they could request copies of their loved one's medical records. The same analysis showed that 35% of clients coming to us did not know they could request copies of any statement or other documents being relied upon during the hearing.

1.18. There are also great inconsistencies in the way Serious Incident Reports (SIR) are disclosed and admitted into evidence. Some Coroners will not admit an SIR into evidence at all whereas most Coroners rely on SIRs quite heavily. Some Coroners will not hold a PIRH until the SIR is disclosed whereas others will proceed without it. It is AvMA's view that SIRs can be quite helpful for the family and the Coroner along with any statements made to compile the SIR. It may be relevant to the Coroner's enquiry and assist with witness identification and to assist the Coroner with making any potential PFD.

1.19. It is also AvMA's view that if a family is informed that an SIR is underway then no PIRH or inquest should be listed until the family and the Coroner have time to read and consider the SIR report. AvMA's 2019 analysis demonstrates that, 52% of our clients did not know whether the Trust had prepared an SIR. The analysis also showed that

where a SIR had been prepared 64% of our clients had not received a copy of it and 81% did not know they could write to the trust and request a copy of the SIR.

1.20. AvMA considers it imperative that any internal investigative reports, witness statements etc produced by the Trust should be made available to the coroner in a timely manner. AvMA believes that Coroners should have the power to impose penalties (for example a financial penalty) for a trust's persistent delays and or failure to disclose relevant documents. AvMA has assisted with a number of cases where trusts have taken inordinate time to produce a report and or other documents which has then delayed the inquest process significantly, this has a detrimental impact on not only the Coroners service but on the family and the bereaved.

1.21. There is an inconsistent approach regarding witness evidence at hearings. Some Coroners seem to take the view that it is acceptable to call witnesses to give evidence on behalf of another treating clinician. For example AvMA assisted the family of RK where the Coroner initially agreed to the trust's submission that the matron could give oral evidence on behalf of all of the nursing staff working on the shift where the deceased suddenly deteriorated. The matron was called to give evidence despite never caring for or even meeting the deceased. AvMA successfully argued that this hearsay evidence could not be acceptable with the Coroner agreeing to call the attending nurse whose care was in question.

1.22. In another example, AvMA assisted in the case of JP where the Trust tried to argue that they could not identify a triage nurse who was on duty in A&E because she was an agency nurse. After months of chasing the Trust on this and disbelief that a rota could not be produced for the evening in question the Coroner in this case threatened to summons every single nurse from the agency used by the Trust to identify the nurse in question. The trust was subsequently able to identify the agency nurse in question and arrange for her to attend to give evidence. These differing approaches highlight the inconsistent approach when it comes to witness evidence.

1.23. There are also great inconsistencies when it comes to instructing independent expert witnesses. Some Coroners are very amenable to instructing an independent medical expert (sometimes even several experts) whereas others are not. AvMA does understand that there are budget constraints but given the complexity of medical inquests and the fact that Coroners who are solely medically trained are no longer recruited to the Coroners service this is a serious concern. In place of instructing an independent expert some coroners have asked a clinician from the same trust to provide an opinion on the care provided by another colleague, almost in the capacity of an expert witness. This not only lacks impartiality but also puts the clinician in question in a difficult position having to potentially give evidence that is not favourable to their colleagues and employer. Other Coroners do not accept this.

1.24. AvMA has more recently noticed great inconsistencies in the way that Article 2 of the ECHR is applied. Some Coroners will rule that Article 2 is triggered at the start of proceedings whereas others will wait to hear all of the evidence before making a ruling. This can have great implications for families particularly in terms of obtaining funding for legal representation. There are also inconsistencies on the application of the legal tests. Some Coroners declare that Article 2 is triggered if there is an arguable case (in our view, this is the correct approach) whereas others make an assessment as to whether there was an actual breach.

1.25. There are also inconsistencies when it comes to the issuing of an agenda prior to Pre-Inquest Review Hearings (PIRHs). Following ***Brown v Norfolk, [1] (2014) EWHC 187 (Admin)*** the Chief Coroner recommended that an itemised agenda be disclosed to all interested parties along with the Coroners preliminary views on each item. Some of the items include but are not limited to the final witness list and who is giving oral evidence, whether article 2 of the ECHR is engaged, whether the Coroner should sit with a jury, whether an expert should be instructed, the scope of the inquest (ie the major issues to be explored in the case), the likely date and duration of the inquest, who should be given interested person status and whether any further documents need to be obtained and disclosed.

1.26. In our experience, coroners all too often fail to give their provisional view on the agenda item listed. Families should not only be given this list of items but should be given a note of the Coroner's preliminary views on each item, this is valuable to a family as it enables them to manage their expectation in advance of the hearing and where appropriate be prepared to invite the coroner to take a different approach. The coroner's provisional views should be given on matters such as who he/she thinks should be called as live witnesses, preliminary views on whether article 2 is arguable etc.

1.27. It is AvMA's experience that when the coroner does produce an agenda, more often than not it consists of a simple list of agenda items with no accompanying note from the Coroner. This is extremely unhelpful for the family and in preparing for the hearing. It is AvMA's view that it should be standard across all jurisdictions that the Coroner's preliminary views should be circulated with the agenda in advance of the hearing in accordance with ***Brown v Norfolk***.

1.28. AvMA repeats its previous call for specialist coroners who have expertise and experience in dealing with healthcare issues to be designated coroners in healthcare inquests.

2. The Coroner Service's capacity to deal properly with multiple deaths in public disasters

2.1 AvMA does not have any experience in multiple deaths in public disasters.

2.2 It might be argued that multiple deaths involving Trusts such as those at Shrewsbury and Telford and more recently East Kent could be defined as public disasters. In that context, AvMA questions the ability and capacity of the Coroner's service to identify trends following on from multiple deaths that occur over a period of time in certain departments within Trusts and to take action once such trends have been identified.

3. Ways to strengthen coroners' role in the prevention of avoidable future deaths

3.1 The coroner needs authority and support to chase organisations against whom a Regulation 28 prevention future death report (PFD) has been issued.

3.2 The coroner should not have to accept replies that suggest, for example a trusts own review does not support the need for additional changes.

3.3 It should also be made clear that once a PFD has been issued by the coroner, the trust or other third party body cannot make an application for the PFD to be dismissed without serving notice on all parties to the proceedings. AvMA previously assisted the family of the deceased in a case where a PFD was issued by the Coroner at the conclusion of the inquest proceedings. The PFD was addressed to the Trust. Following the inquest hearing further correspondence passed between the coroner's office and the trust/their legal representatives without the knowledge of the family. That correspondence resulted in the Coroner resiling from his decision to make the PFD which the court had originally found it had a duty to make pursuant to Schedule 5 of the Coroners and Justice Act 2009. By chance, the family learned of the trust's approach and AvMA was able to write to the Coroner and challenge this decision. The Coroner then quite rightly re-instated the PFD.

3.4 AvMA has assisted a family in another case where despite assurances given by the trust at the inquest hearing that changes were underway there was no evidence that those changes were in fact being implemented. The Coroner therefore chose to issue several PFDs to ensure that such changes were enacted as swiftly as possible. The Coroner also commented that issuing these reports affords other organisations the opportunity to learn lessons, an approach that AvMA shares whole heartedly.

3.5 In AvMA's view there needs to be independent monitoring and policing to ensure that preventative action offered up by a trust in their Action Plans and/or in response to a coroner's PFD are actioned. Perhaps there should be a direct pathway where the coroner provides an independent body such as the CQC with a copy of their PFD and a trust's response to it, so the CQC can check and if necessary police whether details of the response have been implemented.

3.6. Similarly, where trusts head off the need for a PFD to be made by producing an appropriate Action Plan, the coroner should have power to send this to the CQC to enable the CQC to check that the Action Plan has been fully implemented when they next inspect the trust.

3.7. A national coroner's service could have a significant part to play in ensuring that learning from healthcare cases is shared nationally. This gives trusts the opportunity to learn from each other's mistakes and avoid fatal outcomes either entirely or put in place procedures to mitigate similar systemic or other failings.

3.8. AvMA also believes that the coroner's role in preventing avoidable deaths would be strengthened if the coroner's service were able to disseminate patterns, trends and persistent themes identified at a local level nationally. PFDs form a vital part of this however some form of 'red-flag' system would be just as important to protect the public at the earliest opportunity if a trend is identified. For example, AvMA provided advice and support to the family of HR where the Coronial investigation unearthed a number of systemic issues in the Trust' obstetric department. Following this inquest, several other baby deaths came to light which then resulted in a formal public inquiry being launched. If a 'red-flag' system was implemented, it could have identified such trends at an earlier stage and potentially prevented more deaths from occurring.

3.8 AvMA is also aware of another Coronial jurisdiction where the Coroner identified many baby deaths at a hospital trust. This Coroner then contacted the trust and requested that all neonatal deaths be reported to the Coroner's office, not just those

that appeared unnatural. Although the Coroner in this case made this recommendation the Coroner does not have the statutory authority to do this. AvMA would therefore welcome giving Coroners more statutory powers to protect the public and where appropriate, penalise trusts who do not comply with requests such as these or who do not introduce changes following the coroner's PFD report.

3.9 AvMA recognises that funding the coroner's service is an issue and this will have to be addressed if change is to be introduced. The coroner's service would greatly benefit from improved IT services in order to identify trends. However, we also consider that the coroner's court is a comparatively inexpensive and effective forum for carrying out independent investigations. When those investigations are carried out well by confident coroner's experienced in healthcare matters it has the ability to offer impartial, robust and effective conclusions that can improve patient safety by reducing harm.

4. How the Coroner Service has dealt with COVID 19

4.1 In our experience the coroner's service has dealt with the COVID 19 crisis well. We consider that the national leadership of a Chief Coroner and his use of guidance notes has been instrumental in ensuring this is the case.

4.2. AvMA is fully supportive of the need to offer partial remote hearings but that the coroner should be influenced by representations made by the family as to why actual or partial remote hearings should not go ahead.

4.3. The approach has been successful as there appears to have been a willingness to recognise the importance of the family being able to participate in the inquest process. There has also been a willingness to accept that not all families have access to or experience of IT which makes remote or partial remote hearings possible.

5. Progress with training and guidance for coroners

5.1. There has been some progress with training and guidance for coroners. The fact that there are still inconsistencies around important issues such as disclosure of documents, suggests that more needs to be done.

5.2. However, it is still the case that not all coroner's put the family at the centre of the coronial process, many coroners are more preoccupied with reducing their caseloads, trying to get cases heard within 6 – 12 months, than ensuring for example that a case is ready for a full, fearless investigation.

6. Improvements in services for the bereaved

6.1 Generally, there have been little or no improvements in services for the bereaved. Not all coroner's adjourn hearings and consider counsel for the family's availability. This is problematic particularly when representation is offered pro bono.

6.2 The facilities available to the bereaved at the coroner's court are variable. Some courts still do not have a room for the family to take respite in.

7. Fairness in the Coroner Service

7.1 Knowledge, advice and information: Families are still unclear about what documents they can see or can request and the importance of certain processes such as PIRH. For there to be equality and fairness in the coroner's court families must be made aware of what is available to them. Without that, families do not have equal access to information and therefore cannot consider the evidence in advance, neither are they able to prepare to ask questions arising from the information available.

7.2 Disclosure: There needs to be improved disclosure of all documents in the trust's possession which may be relevant to the inquest to the Coroner at the earliest possible opportunity. Overall Trusts seem to be very slow/reluctant to disclose documents and this results in adjournments which in turn gives way to unnecessary costs being incurred by families, many of whom are not able to afford it. Coroners need improved and greater powers to enforce this.

7.3 The bereaved must ask for disclosure, it is not volunteered. It is true that some families do not want to see the documents but for many others they simply do not know they have to ask or that they are entitled to ask. This needs to be addressed to make proceedings fairer.

7.4 Representation: none of the families who approached AvMA had a solicitor who was able to act for them during the inquest hearing. For there to be improved parity in the court room families should be able to access legal representation. In healthcare cases it is still typical for the Trust to attend the inquest hearing and any PIRH with counsel and legal representatives while the family are usually unrepresented. There will never be fairness in the coroner's service unless and until this situation is remedied.

7.5 Funding: We know that funding is available for NHS Trusts to pay for legal representation at inquests although it is difficult to obtain precise figures for the amount of funding available for each healthcare inquest. A figure of about £5,000 per healthcare inquest has been referred to although we are unable to verify that sum. We refer to research conducted by Julie's Mental Health Foundation who submitted a Freedom of Information Request to 53 mental health Trusts in England asking how much they spend on lawyers at inquests in the financial year 2017-2018. Responses from 26 of the Trusts revealed that £4 026 787.45 was spent on legal representation. In the same year. By contrast, the Legal Aid Agency paid a total of £117 968 towards fees for legal representation at inquests for families following the death of a relative in contact with mental health services.

7.6 AVMA is also aware that each Trust has a pot of funding available to spend on instructing panel firms for inquests. It is often our experience that when panel firms reach the limit in their funding that they cease being as active in the case.

7.7 Although legal aid is available, in practice it is very difficult to get and this contributes to there being inequality of arms. Despite the MoJ's response to the "Call for evidence in a review of legal aid for inquests" in 2018, there have been no substantive changes to the availability of legal aid.

7.8 To improve access to legal aid funding for inquests, the financial restrictions should be removed altogether for individuals where the death occurred or was potentially caused or contributed to by a public body. 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.

7.9 Even though the LAA have discretion to waive the financial eligibility test this is rarely exercised and even when it is, it can be a lengthy process waiting for that discretion to be exercised.

7.10 It is frequently argued that as the coroners court is inquisitorial, not adversarial it is not necessary to have legal representation. That is not what most families experience. AvMA asks: if the non-adversarial nature of the coroner's court is such that families do not need legal representation then why do public bodies such as an NHS Trusts have access to funding for representation?

7.11 The reality is families are faced with an unfamiliar and formal forum where complex legal arguments on matters such as whether Article 2 European Court Human Rights (ECHR) has been triggered or not.

7.12 The complex nature of these arguments and the accompanying case law is such that coroners will frequently ask for written submissions on the points being raised.

7.13 It is therefore unrealistic and grossly unfair to expect a lay person to be able to tackle these issues on their own without representation. The committee need to be mindful that these families are often struggling to come to terms with the loss of a loved one, invariably they will not have any legal knowledge, they may not have a professional background or training, they may not have had any involvement with any legal of formal process previously. They are then faced with having to manage information from the coroner and understand how to access the inquest process in a meaningful way.

7.14 As referred to above, Section 4 of The Guide published by the MoJ recognises that families and other interested parties "***may want to consider getting help for an inquest hearing if other interested parties are represented, for example if the state of a public body has legal representation at the inquest".*** There is an urgent need for resources to be made available to make access to specialist advice for families going through the inquest process a reality. AvMA is a small independent charity who provides what advice, assistance, and representation we can but invariably demand for our service outstrips what we can supply, and many families go without representation. Our service is not funded, we offer advice and assistance on a pro bono basis. For the coroner's service to be fair there needs to be equality of arms and that starts with fair and equal access to funding, legal advice, information and representation.

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