Inquests into deaths following medical treatment

Inquests only take place when someone has died. This leaflet focuses on providing information about what happens when an inquest is opened when someone has died following medical treatment – for ease we refer to this as a 'medical inquest'.

You may also find the Ministry of Justice's (MoJ) Guide to Coroners and Inquests helpful.

Contents

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Key areas covered in this guide

The inquest

The inquest is an investigation into how the deceased came about their death. The coroner is not allowed or expected to make any finding relating to liability or negligence – the allocation of blame is for the civil courts, not the coroner's court.

See more: "What is an inquest?" on page 2

The inquest process

It is not the coroner's job to make findings in relation to blame or negligence; in fact they are not allowed to make such findings. However, sometimes information comes to light which indicates that the standards operated by a healthcare provider fell short of what was reasonably expected.

See more: "The inquest process" on page 4

The post mortem

The post mortem does not have to take place in the same area as where the coroner sits. Wherever the post mortem takes place the coroner must know the circumstances in which the body is kept.

There are two types of post mortem: one is invasive and involves opening and examining the body internally; the other is far less invasive and relies on evidence available from a CT or MRI scan.

See more: "The post mortem" on page 4

The pre-inquest review (PIR) hearing

These are hearings which are often held before the main inquest hearing. They are procedural only and no evidence is heard. These hearings help the coroner manage what needs to be done before the main inquest hearing, for example documents or statements to be provided by the IPs and identifying the witnesses to be called to give evidence at the inquest hearing.

See more: "What are pre-inquest review (PIR) hearings?" on page 8

What is an inquest?

The inquest is an investigation into how the deceased came about their death. The coroner is not allowed or expected to make any finding relating to liability or negligence – the allocation of blame is for the civil courts, not the coroner's court.

What is the coroner's job?

The coroner's job is limited to finding out the answers to the following four questions:

i. Who the deceased was

ii. How he or she died

iii. When the deceased came about their death

iv. Where the deceased came about their death

In practice the investigative nature of the inquest can mean the coroner's hearing may run to several days or weeks, depending on the number of witnesses the coroner needs to call, the number of interested persons and the complexity of the case.

Most medical inquests take between one and five days. However, it is also not unusual for the coroner to carry out some initial investigations and then have a "paper hearing", that is, he or she does not call any witnesses to give evidence.

Coroners will often put limits on how far they will go back into the medical records. Their focus is on the very narrow question of: **how** did the deceased come about their death? Sometimes families feel the cause of their loved one's death is rooted in care provided several years earlier.

Families can feel very disappointed if a coroner refuses to go back much beyond the days leading up to the death. However, the coroner has considerable discretion and that discretion gives them the power to set tight boundaries around the issues to be investigated.

Once the coroner has established that their duty to open an inquest has been triggered they must ensure that their investigation is full, fair, practical and effective.

When is an inquest called?

Given the number of deaths that occur throughout England and Wales, coroners are allocated to work in a particular area. Each area has its own senior coroner as well as coroners and deputy coroners. Coroners are answerable to the Chief Coroner who is the head of the service.

Usually, the coroner can only consider holding an inquest if the body of the deceased is in their area.

The coroner has a duty to investigate a death if he or she has reason to suspect that one of the following circumstances applies:

i. The deceased died a violent or unnatural death

ii. The cause of death is unknown

iii. The deceased died while in custody (for example prison) or in state detention (for example, in a mental health hospital run by the NHS)

What happens if the coroner is not sure whether the duty to investigate arises?

There may be times when the coroner is not sure whether the duty to investigate the death arises. In those cases the coroner can:

i. Make preliminary enquiries. The coroner can then decide as a result of those enquiries that no investigation is required because the duty to investigate has not in fact arisen. One example of this might be where the post mortem shows that the death was due to natural causes.

ii. Following their preliminary enquiries decide that they are satisfied that the duty to investigate does arise and an inquest hearing is required. One example of this might be where the post mortem shows that the cause of death was due to natural causes but the coroner's inquiries show that other factors, such as neglect, contributed to the death.

What are preliminary enquiries?

Preliminary enquiries are whatever enquiries the coroner considers necessary in order to satisfy him/herself that their duty to investigate has been triggered. For example, the coroner can ask for a post mortem examination (sometimes referred to as a coroner's post mortem) and/or can obtain documents that they believe will help them identify whether the duty to investigate the death arises. The coroner may also call a pre-inquest review hearing (PIR), although is not obliged to – see **page 8** for more information on PIRs.

A post mortem report may give the coroner new information to help decide whether a fuller investigation is required. For example, if the post mortem shows that the deceased died as a result of natural causes and there is no other information to suggest that the death was violent or unnatural then the coroner **must** discontinue the investigation and inquest.

What happens when the coroner decides not to proceed with an inquest?

Where the coroner discontinues an investigation because they are satisfied the duty to investigate does not arise, the coroner must then **record** the cause of death and **notify** the next of kin or personal representatives of the deceased using a prescribed form (Form 2).

The inquest process

It is not the coroner's job to make findings in relation to blame or negligence; in fact they are *not allowed* to make such findings. However, sometimes information comes to light which indicates that the standards operated by a healthcare provider fell short of what was reasonably expected.

If you are thinking about bringing a claim in clinical negligence, the inquest can provide useful information that may assist in you succeeding against the healthcare provider.

Litigation, like the inquest process, can be a very stressful experience. Unlike the inquest process, you decide whether you want to bring civil proceedings and sue the healthcare provider – you don't have to take this step if you don't want to.

Opening the inquest

Once the coroner is satisfied that his or her duty to investigate the death has been triggered, two things should happen:

i. The inquest should be opened as soon as practicable.

ii. The coroner must attempt to inform the deceased's next of kin of their decision.

The coroner should only have one person as the point of contact with the family.

Having opened the inquest, the coroner will then usually adjourn the hearing to allow additional time to carry out further investigations.

Under Section 8 of The Coroners (Inquests) Rules 2013 the coroner **must** complete an inquest within six months of the date he or she is made aware of the death, or as soon as reasonably practicable after that date.

Any inquests which have not been completed within 12 months of the date of death must be reported to the chief coroner.

All inquest hearings and pre inquest hearings must be held in public.

The post mortem

The post mortem does not have to take place in the same area as where the coroner sits. Wherever the post mortem takes place the coroner must know the circumstances in which the body is kept.

There are two types of post mortem: one is invasive and involves opening and examining the body internally; the other is far less invasive and relies on evidence available from a CT or MRI scan.

There are some difficulties with post mortems by way of scanning:

i. Scanning techniques for post mortem are not available in every area of the country

ii. Scanning techniques are not always appropriate, for example if a toxicology and/or histology report is required.

iii. Where scanning techniques are used, the family of the deceased or next of kin will be expected to pay a fee.

iv. Scanning techniques may not avoid the need for a more invasive post mortem. Following receipt of the scan results, the coroner may decide that the more invasive type of post mortem is required after all.

Coroners will take into account a family's religious and cultural needs, but these needs do not override the coroner's discretion. **Ultimately, the coroner will decide whether post mortem by way of scanning is appropriate.**

The coroner may ask for specific tests to be undertaken on the body. For example, the coroner has the right to ask for a toxicology report. A toxicology report will require blood or other samples to be taken and tested for things like alcohol and/or drugs (including prescription drugs) present in the deceased's body. Another report commonly requested by coroners is a histology report. A histology report will mean that organ and/or tissue samples of the deceased might be examined in more detail.

A coroner's post mortem is independent and carried out by a suitable medical practitioner

When will the body be released for cremation or burial?

Once the post mortem process has concluded the coroner is required to release the body for cremation or burial as soon as possible.

The coroner can only authorise burial or cremation once they are satisfied the body is no longer needed for the purposes of their investigation.

How can I be involved in the inquest?

The government's view is that you do not need to be legally represented at the inquest. The rationale behind this is that this is an inquisitorial process, which means it focuses on investigating how the deceased came about their death. In this respect the inquest differs from the civil court which is adversarial. However, the reality is that very often the NHS trust providing the treatment will be represented by a lawyer, even if you are not.

For non-lawyers, who are unfamiliar with the inquest process and trying to cope with grief and the shock of losing a loved one, the thought of representing yourself can be understandably daunting.

AvMA does have a pro bono inquest service and we may be able to assist you. However, we are unable to guarantee representation and do not have the capacity to provide representation to everyone who seeks help from us.

Legal Aid may be available for representation, although in practice public funding is very difficult to obtain and is rarely awarded. See **page 9** for more information on inquest funding.

How can I improve my chances of participating in the inquest?

If you have questions about how your loved one died there are several steps you can take to improve the way in which you are involved in the inquest:

i. Make sure the coroner identifies you as an interested person (IP):

Section 47 of the **Coroners and Justice Act 2009** makes it clear that an interested person (IP) is someone the coroner recognises as having sufficient interest in the investigation to participate above that of the general public.

Some relationships are recognised under the Act as having IP status, for example if you are a spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half-brother or half-sister of the deceased, you are highly likely to be considered an IP. As noted above, normally the coroner's office will only communicate with one family member in order to avoid duplication.

It is important to note that IP status covers a much wider group than family members and can include insurers, doctors, trade union representatives and others.

AvMA's advice: *To ensure that you are able to participate in the inquest you should let the coroner know as soon as possible that you consider yourself to be an IP.*

ii. Obtain copies of the deceased's medical records:

This can be quite time consuming and difficult in practice and a fee is payable. However, the medical notes are important as they should set out what the deceased was being treated for; the medication prescribed, how and when it was given; what tests were ordered; what tests were carried out and the results of those tests.

It will also contain information about assessments carried out, decisions made, documents and any correspondence passing between medical professionals. Unfortunately, coroners do not always obtain copies of the records in a medical inquest, so it is usually helpful for the family to request a copy themselves.

See AvMA's self-help guide on obtaining copies of the medical records at **www.avma.org.uk/guides**

iii. Ask the coroner or their officer for disclosure of the documents

What does the term disclosure mean?

Put simply, the term "disclosure" in this context refers to your entitlement as an IP to have access to the documents that the coroner intends to refer to during the inquest hearing. In practice this means that the coroner will provide you with copies of the documents – these will often be sent to you electronically as an email attachment.

The coroner's rules around disclosure are set out in Section 13 of **The Coroners (Inquests) Rules 2013**.

What sort of documents can I expect to receive?

Documents which are covered by this rule include:

- Post mortem report
- Any other report provided to the coroner during the course of the investigation. For example, if you have used the hospital complaints process

you may have been given a copy of a Serious Incident Report (SIR) or similar document.

- Any other document which the coroner considers relevant to the inquest. This might include things like witness statements from the treating medical staff
- Disclosure extends to information which is held in other mediums such as CCTV footage or photographs as well as paper documents

What does redaction of documents mean?

When the coroner discloses documents he or she is entitled to redact (black out) some of the information contained in the document. This will usually happen if the information relates to third parties who are not connected to the inquest in any way – an example of this might be the name of another patient.

Does the coroner have to disclose all documents?

The short answer to this is no. There are certain circumstances when the coroner does not have to, or is not allowed to disclose documents. For example:

- Some documents have a particular status of their own which means they may not be disclosed to anyone other than the coroner. For example, investigation reports which may be carried out by the Healthcare Safety Investigation Branch (HSIB) have separate legal protection on disclosure; this means that even if these reports are made available to the coroner, the coroner will be unable to make the reports available to IPs.
- The coroner may not be able to disclose reports where the consent of the author or copyright owner cannot be obtained.
- The coroner does not have to disclose documents where he or she believes the request for disclosure is unreasonable.
- The coroner is unable to disclose documents where criminal proceedings are contemplated or commenced
- The coroner does not have to disclose documents they consider to be irrelevant to the investigation.

How does disclosure help me?

The disclosure of documents is an important step in making you aware of any issues that may not have been brought to your attention before now. Disclosure of the documents can help you in the following ways:

- The information contained in some of the disclosed documents may provide answers to some of the questions you have about how your loved one died.
- The information may prompt you to ask further questions.
- The information may help you identify early on the questions and issues you want the coroner to explore at the inquest hearing. It will give you the opportunity to sit down and write out your questions in advance, you can then send those questions to the coroner **before** the inquest starts so the coroner is aware of your concerns and can consider them further.
- Equally, if you do have legal representation, it can also help to ensure that your advocate is aware of your concerns.
- The documents may also help you identify people who you think will help the coroner with their inquiry. These are potential witnesses who may be able to establish how, when and if appropriate, where the deceased came about their death
- Some of the documents may contain information which causes the coroner to look very carefully at the evidence. It may even prompt the coroner to widen the scope of the inquest to look at **how and in what circumstances** the deceased died. (see **"What is an Article 2 inquest?" on page 11**)
- The information available thorough disclosure may give rise to concerns that future deaths may occur as a result of some of the practices and or procedures operating at the trust.

AvMA's advice: *If you do want to see the documents the coroner is relying on, you must **ask** for them. The documents will not be sent to you automatically.*

Once you have asked the coroner for the documents, he or she must provide them to you "as soon as is reasonably practicable."

*To be on the safe side, request the documents verbally **and** in writing.*

iv. Draft your own statement for the coroner.

Many families find this a really helpful way of setting out their recollection of events and explaining any concerns they have about the how their loved one died.

Families are often with their loved one in the final days and hours of their death, they witness events and have discussions that they feel may be relevant. Where this happens then a statement should be written by the person who had the conversation or witnessed the event.

There may be several family members who saw or heard different things at different times – each of those family members should prepare their own statement rather than a single statement for the whole family. This allows the coroner to understand which events each family member witnessed and consider whether to call any of them to give evidence in person at the inquest. The statements should then be sent to the coroner.

AvMA's advice: *If you do write a statement and send it to the coroner for consideration, make sure you keep a copy. The same advice goes for every family member or friend who writes a statement for the coroner's consideration.*

I've never written a statement before, how do I do this?

The coroner will not expect families to provide formal, legal statements. If you don't have representation or any form of assistance we suggest that you keep the statement as short and as simple as possible. The following are some suggestions which you may find helpful:

- Give the statement a heading: something along the lines of "Statement for the coroner in the inquest of [name of the deceased]" will be perfectly acceptable
- Make sure you include your name and address
- State your relationship to the deceased, eg brother/sister/spouse/partner
- Try and keep your paragraphs short
- Number your paragraphs if possible
- Give a little bit of background to set the scene
- Quickly get to the issue of concern
- Say why you think the issue is relevant to how your loved one came about their death
- Set out the questions about the death you would like the coroner to consider
- If possible type the statement although the coroner will accept handwritten statements if you don't have access to a computer
- Don't worry about spelling, grammar and other such matters
- If you are not confident enough to type the document then you can get someone else to do it
- Number each page of the statement
- Sign and date the statement. Remember, the person who signs the statement should be the person who is named in the statement.

You should keep in mind that any statements, letters or other documents that you send to the coroner may be circulated to the other IP(s) at the coroner's discretion. If you do not want the coroner to circulate a document, you can ask that it be kept confidential, but the coroner does not have to comply with this request.

v. Write to the coroner suggesting possible relevant witnesses to attend the hearing

If as a result of looking through the medical records and disclosed documents you believe there are individuals who will be able to help the coroner say how the deceased died then you should write to the coroner identifying the person you are suggesting be called.

If possible, when you write to the coroner you should

- Identify the name of the potential witness. If you do not know their name, outline the date/time and nature of their involvement in your relative's care (it may be possible to identify them from the medical records) or ask the healthcare provider to find their details.
- Set out in one or two lines why you believe the proposed witness is relevant to the coroner's investigation.

AvMA's advice: *If you do write to the coroner suggesting witnesses, you need to be aware that you can only suggest that an individual attend as a witness. You cannot compel the coroner to call the person or people identified by you as relevant.*

What are pre-inquest review (PIR) hearings?

These are hearings which are often held before the main inquest hearing. They are procedural only and no evidence is heard. These hearings help the coroner manage what needs to be done before the main inquest hearing, for example documents or statements to be provided by the IPs and identifying the witnesses to be called to give evidence at the inquest hearing.

PIR hearings can be quite wide ranging and include discussions around the scope of the inquest (this may involve legal issues) and identifying the likely date and venue for the full hearing.

Coroners should set out in advance what they want to discuss at these pre hearings by setting an agenda. If the coroner has set a date for a PIR you should write to him or her before the hearing and ask for a copy of the agenda.

There may be more than one PIR prior to the full inquest hearing.

The inquest hearing: important facts to note:

- The full hearing is part of the coroner's investigation into the death.
- The hearing will be in public.
- The coroner must inform the next of kin or personal representative of the deceased and any other IPs as soon as practicable of the date, time and place at which the resumed inquest is to take place.
- Usually, the coroner should give at least one week's notice of the hearing date.
- Coroners are required to make a recording of the inquest hearing proceedings and any pre inquest review hearings. After the inquest the recordings should be available, although a fee may be payable.

The coroner's findings

The inquest conclusion

After the coroner has heard all the evidence and the inquest hearing has concluded the coroner must complete a form **"Record of an inquest"** (Form 2).

The coroner must set out their conclusions on this form. The conclusion must not be framed in a way which appears to determine questions of civil liability or criminal liability on the part of a named individual.

Conclusions may be very short, and in cases of medical inquests may typically include one of the following (please note this is not an exhaustive list):

i. Natural causes

ii. Stillbirth

iii. Suicide

iv. Narrative conclusions

Longer conclusions will accompany inquests which are intended to be Article 2 compliant – see **page 11**

The coroner's determination

This sets out the coroner's findings in relation to **who** the deceased was and **how**, **when** and **where** they came about their death

The statutory findings

The conclusion and determination are required by the register of Births & Deaths Registration Act 1953

What is a narrative conclusion?

As referred to above, there are a number of conclusions the coroner can arrive at, most of which speak for themselves. A narrative conclusion can be short or long. The short version will often recite basic factual findings made by the coroner, although should not use language that suggests findings relating to civil matters. For example, the coroner should not use words like "negligent" or "liable," they can use words like "neglect" which has a very specific legal meaning.

If an 'Article 2' inquest (see **page 11)** is held then the coroner must give a narrative conclusion. Narrative conclusions in Article 2 inquest cases tend to be longer and more detailed. They will set out any failings of the hospitals management or internal systems (systemic failings).

Funding for inquests

Can I get funding for representation at or before the inquest?

There is very little funding available for inquests. The government takes the view that, as the inquest process is about an investigation rather than finding out if someone has been negligent there is no need for families to be represented.

The coroner cannot make an order for costs to be awarded. This means that if you do pay for a barrister or solicitor to represent you, you will have to pay their fees. The coroner will not order that those costs be repaid to you at the end of the inquest, regardless of what the coroner's conclusion is.

Conditional Fee Agreements (CFA)

For more information on CFAs please see AvMA's self-help guide on understanding legal costs for medical negligence claims at **www.avma.org.uk/guides**

CFAs are essentially contracts which clients and solicitors enter into to cover the costs of any civil proceedings (in this context, a CFA will usually be for work carried out to prove a clinical negligence claim).

A CFA can cover advocacy and investigations into the inquest. However, CFAs will only help you if you intend to bring civil proceedings in clinical negligence against the healthcare provider.

You should enter into the CFA as soon as possible after the coroner has confirmed the inquest is to be opened.

If you are then successful in proving your civil claim in clinical negligence, then all or part of the costs of the inquest may be recoverable from the other party. For your inquest costs to be recoverable, your solicitor **must** show that the costs incurred at the inquest are costs of or incidental to the civil claim.

Is legal aid available for inquests?

Legal aid funding for inquests may be available although in practice it is rarely granted.

To get legal aid funding you have to show that you satisfy the financial means test (this can be waived in exceptional cases) **and** the circumstances of your case fall into one of two situations:

The first situation is where the coroner has stated that the inquest is an Article 2 inquest (see **page 11**) and funding is deemed necessary for the family to be able to participate effectively in the inquest.

The second situation is where it can be shown that the inquest is addressing issues which are said to be "of wider public interest".

What does wider public interest mean?

In this context "wider public interest" is where it can be shown that the inquest is likely "to produce significant benefits for a class of person other than the individual and the members of the individual's family"

AvMA's advice: *In practice, legal aid is rarely granted for representation or investigation of inquests. For more information about public funding for inquests, please see the* **Lord Chancellor's Guidance**.

Where costs are recovered, it is far more usual for this to be as a result of a client entering into a CFA with a firm.

AvMA's advice: *If you do go to a firm of solicitors we urge you to use an AvMA accredited solicitor. Please see below for more information on accreditation.*

Accreditation

Any solicitor can offer legal services for clinical negligence, but clinical negligence is a complicated and specialist area of work.

There are several clinical negligence schemes around, including AvMA's own AvMA Panel accreditation.

What makes the AvMA Panel Accreditation scheme so special?

AvMA set up the first accreditation scheme over 30 years ago. We are the longest running scheme of its kind.

Solicitors who have attained AvMA Panel accreditation have demonstrated three key competencies, these are:

i. A level of expertise in clinical negligence law

ii. Experience in undertaking clinical negligence litigation on behalf of clients (as opposed to healthcare providers)

iii. An awareness of the importance of client care.

AvMA's Advice: *If you are seeking independent legal advice from a solicitor on a clinical negligence matter, make sure they are an AvMA accredited lawyer; you will be able to tell this if the solicitor is displaying the following logo:*

Or visit AvMA's Find a Solicitor service at **www.avma.org.uk/find-a-solicitor**.

Other frequently asked questions

Is a jury required for an inquest?

Since 2013 an inquest must be held **without** a jury, although there are limited exceptions to this. The exceptions are:

i. Where the coroner in their discretion thinks there is sufficient reason to hold an inquest with a jury

ii. A jury must be summoned where the deceased died while in custody or state detention, eg mental health hospital, **and** the death was violent **and/or** unnatural **and/or** of unknown cause

iii. A jury must be summoned where the death resulted from an act or omission of a police officer in the execution of their duty

iv. A jury must be summoned where the deceased died as a result of an accident, poisoning or disease which must be reported to a government department or inspector

A jury can be comprised of a minimum of 7 people and no more than 11 people all of whom are called from the electoral register. If you consider that a jury is necessary, you should inform the coroner at an early stage.

What is an Article 2 inquest?

Families attending the inquest of a loved one may hear the coroner or other parties involved in the process refer to an "Article 2" inquest. There are often difficult and complicated legal arguments about whether an inquest is an "Article 2 inquest". Sometimes you will hear people ask whether "Article 2 is engaged" and, if it is, whether the inquest itself is "Article 2 compliant".

Please note: *This note is not intended to be anything other than an outline of what Article 2 means in the context of an inquest.*

Article 2, refers to Article 2 of the European Convention Human Rights (ECHR); Article 2 is sometimes referred to as the "right to life". However, it is a difficult area which involves looking at whether the United Kingdom as a member of the European Union has in place a sufficiently adequate framework of laws and procedures that will, so far as is reasonable, protect life.

Article 2 requires that members of the European Union, which includes the UK, have in place a process that will enable them to investigate whether the framework of laws and procedures employed to protect the lives of their citizens is adequate. The coroner's court is one of the forums or processes used by the UK to fulfil the Article 2 requirement to investigate. There are other ways the UK might fulfil that duty to investigate, for example the civil courts.

During the 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.

A coroner does **not** have to decide at the outset whether an inquest is an Article 2 inquest; he or she can make that decision part way through the inquest process or at the end of it.

If the coroner does make the decision that an inquest triggers an Article 2 investigation at the start of the inquest process, this may assist you in obtaining legal aid. Please see **page 9** for more information on public funding.

An Article 2 inquest will only be triggered if the death occurred in a state-run organisation. The NHS is a state-run organisation and, as such, Article 2 inquests might be triggered if the death occurred as a result of care provided by the NHS. By contrast, an Article 2 inquest will **not** be held in cases where the death occurred as a result of care provided by a private healthcare organisation.

What is a prevention of future death report?

A prevention of future death (PFD) report can only be made by a coroner after he or she has considered all the documents, evidence and information that they consider to be relevant to the investigation.

The coroner has a duty to make a PFD report when their investigation gives rise to 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.

A PFD enables the coroner to identify weaknesses in a healthcare provider's practice or procedure so they can come up with a plan to address those weaknesses. The overall aim of a PFD is to prevent other deaths occurring in the same or similar circumstances at that healthcare provision, thereby making the care safer for the public.

The coroner only has to state that action has to be taken. The coroner does not state what the action to be taken should be.

The coroner issues the PFD report to any persons or body who the coroner believes has the power to take such appropriate action. The coroner also has to make sure a copy of any PFD is sent to the chief coroner. The chief coroner may publish summaries of these reports and the responses.

The coroner must receive a response to their PFD within 56 days, although this time limit can be extended. The response must include details of any action taken or to be taken to address the coroner's concerns and include a timetable. The coroner's involvement ends on receipt of the response and they do not, for example, monitor whether any actions have been taken or whether they are effective.

However, it should be noted that the response can state that **no** action is proposed but there must be a clear explanation of why this is the case.

What is an action plan?

Healthcare providers do not like having PFD reports made against them. Very often they will try and avoid the need for a coroner to make a PFD report by producing their own action plan.

Action plans are more difficult for families to follow up and ensure that the recommendations contained are implemented.

Action plans are not published or forwarded to the chief coroner in the same way PFD reports are.

A coroner can criticise an action plan if they believe it is lacking in content or if the coroner believes the action plan has overlooked an important issue; the coroner may even call the author of the action plan to attend the inquest hearing to answer questions about the plan.

A coroner may still make a PFD report even though the trust has produced an action plan. For example, if the coroner does not think the action plan is thorough or comprehensive enough then they may issue a PFD report to cover the issues the action plan fails to deal with.

What does neglect mean?

A finding of neglect is **not** a standalone conclusion; it can only be tagged on to one of the statutory conclusions.

Neglect is a finding and should not be considered as the main cause of death.

In the context of coronial law a finding of neglect has a strict legal meaning. Where a coroner does make a finding of neglect, it **does not** mean there has been negligence but it does mean there has been a level of fault which justifies the finding.

A finding of neglect will be made in circumstances where there has been a **gross failure** to provide **basic** medical attention to someone who was in a dependent position – dependent position suggests a particularly vulnerable person. The vulnerability may arise as a result of their age (either very young or elderly), illness or incarceration (perhaps detained under the Mental Health Act).

A gross failure is more than just a failure and is difficult to define; whether a failure is gross or not will depend on the actual facts of each case. Examples of treatment which might amount to neglect might include where there has been a failure to provide adequate nourishment or liquid, or basic medical care such as simple checks.

How can AvMA help me?

If the coroner is investigating your relative's death, we can provide information that may assist you in preparing for the inquest.

We may also be able to arrange legal representation by a barrister on a pro-bono basis, although we can't guarantee representation. Pro-bono representation means that you will only be asked to cover the cost of the out of pocket expenses, for example, the travel costs associated with attending the hearing(s).

We will need to see copies of the relevant documents (post mortem report, medical records, any documents disclosed to you by the coroner's office and any correspondence passing between you and the healthcare provider and/or the coroner's office) in order to assess how we can assist you.

If you would like help from our inquest service, please complete a **new client form** and provide copies of the documents as far in advance of the inquest as possible. Our diary is usually very busy, and it is more difficult for us to assist if we are contacted at short notice.

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You can help make healthcare safer and fairer for all

Our vision is a simple: **People who suffer avoidable medical harm get the support and the outcomes they need.** This vision is underpinned by four objectives, we believe, will transform trust in the NHS and healthcare generally and significantly cut the cost – financial and human – which is incurred annually in settling legal claims as well as dealing with the human costs associated with traumatic medical injuries and death. Our four key objectives are:

- To expand the range of communities we serve and so enabling more people experiencing avoidable harm to access services from us that meet their needs
- To empower more people to secure the outcomes they need following an incident of medical harm, whilst providing caring and compassionate support
- To eliminate compounded harm following avoidable medical harm
- To have the necessary diversity of sustainable resources and capacities to deliver

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The **charity** for **patient safety** and **justice**

AvMA is the charity for patient safety and justice. We provide specialist advice and support to people when things go wrong in healthcare and campaign to improve patient safety and justice.

For advice and information visit
www.avma.org.uk

Or call our helpline
10am-3.30pm Monday-Friday
(03 calls cost no more than calls to geographic numbers (01 or 02) and must be included in inclusive minutes or there can be a cost per minute)
0345 123 2352

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