RESPONSE TO JUSTICE COMMITTEE'S NEW INQUIRY INTO THE CORONER'S SERVICE TO EXAMINE PROGRESS SINCE 2021

CONSULTATION CLOSES:15th January 2024

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. Our evidence is based on our experience of inquests which arise as a result of deaths where acts and/or omissions in healthcare provision may or have caused or contributed to the death. We do not provide advice and information on any other type of inquest and our evidence is therefore confined to our experience of healthcare inquests.

5. AvMA's healthcare inquest service typically operates with 3 caseworkers who all work part time on the pro bono inquest service, the remainder of their time being taken up with other AvMA duties. All staff involved in the inquest work are highly trained and are qualified as either doctors or lawyers.

6. Since January 2019 AvMA has been routinely collating responses to our Inquest New Client Form questionnaire; all of our inquest clients are invited to complete the questionnaire. We routinely analyse information we receive from the public to identify how much they understand and know about the inquest service.

7. In responding to this call for evidence we have analysed the public's responses to the questions posed on our Inquest New Client Form for the period 2020 – 2023 inclusive. A full analysis of the data and findings can be seen here: AvMA Inquest Statistics 2020 – 2023

8. The pro bono inquest service has developed so that it now provides in person advice to more than 70 families each year, including representation for about 8 inquest hearings as well as pre inquest reviews (PIR). Additionally, advice is given on our helpline as well as through our designated inquest service.

9. AvMA has a policy of referring inquest cases to experienced solicitors who have demonstrated expertise in clinical negligence claims by being accredited by AvMA and admitted to the AvMA Panel. Not all families wish to bring a legal claim, those who do have traditionally been able to secure legal representation at the inquest on the back of there being a civil claim.

10. The Justice Committee is asked to note that following the Government announcement in September 2023 that it intends to follow through with introducing Fixed Recoverable Costs (FRC) for lower value clinical negligence claims (to include fatal claims) by April 2024 more than 80% of specialist solicitors currently providing representation at inquests will be forced to withdraw from this service. AvMA surveyed specialist lawyers on their response to FRC in October 2023 details of that FRC survey can be found here: AvMA's 2023 FRC Questionnaire responses

11. Specialist lawyers are clear that bringing a low value civil claim where someone has died under a FRC regime will not be commercially viable and they will cease to take on this work including providing representation at inquests. AvMA has repeatedly called for fatal claims and claims involving protected parties to be excluded from the proposed FRC regime.

Summary:

- There has been little progress in placing the bereaved at the heart of the coroner's service. AvMA's data shows that more than half the public involved in healthcare inquests are unaware they can obtain copies of the postmortem report. More than two-thirds are unaware they are entitled to copies of the documents the coroner relies on at the inquest hearing.

- It remains the case that NHS trusts are invariably represented at inquests while families are not. Although there have been changes to the funding criteria for legal aid, the merits test remains the same – it is very difficult to satisfy the merit criteria for legal aid Exceptional Case Funding.

- As a consequence, families are not able to secure representation at the inquest hearing unless they pay for it themselves which is cost prohibitive for most people or if they can secure representation off the back of a civil claim for negligence. The latter situation is severely under threat because of the Government's commitment to introduce a regime of Fixed Recoverable Costs (FRC) for low value clinical negligence claims. There is no level playing field for families involved in healthcare inquests.

- For the reasons set out in our response to Question 1 and 2 below, AvMA does not consider there has been any meaningful progress in placing bereaved families at the heart of the coroner service. There continues to be inequality of arms at healthcare inquests.

- The inquest process has the potential to be a powerful independent forum, it has demonstrated its effectiveness on many occasions. The learning which can and does come out of the inquest process remains largely lost. The Prevention Future Death (PFD) process and Action Plans submitted by Trusts are important tools for preventing the same issues from happening again to other families, but they are not meeting their potential for change.

- The PFD reporting process remains difficult to search. That means that common themes and red flags about the state of hospitals are still not readily identifiable.

- The fact that there is no national oversight mechanism to police and monitor the change promised by the response to a PFD report or set out in an Action Plan means that a rich seam of learning is going unchecked. There is no way to identify the extent to which the response to a PFD report or Action Plan is being implemented. That is a loss for the public safety both regionally and nationally.

- Much more needs to be done to effect meaningful change and to ensure that lessons identified by the coroner through the inquest process are acted on. There is a long way to go before there is equality of arms in the inquest process for families involved in healthcare inquests.

The Committee invites evidence on:

1. **What progress has been made towards the goal of placing bereaved families at the heart of the Coroner Service?**

   Bereaved people who are interested parties (IP) have rights which are mainly set out under the Coroner's (Inquest) Rules 2013, they include: Being notified of the post mortem report; Being advised of the date, time and place of the inquest hearing within one week of the coroner setting the date of the inquest hearing; the right to be involved in the inquest procedure including cross examining witnesses and seeing written evidence.

   Where an interested person (IP) requests disclosure of a document held by the coroner, the coroner must provide the document or a copy of the same or make it available for inspection as soon as reasonably practicable. This is subject to their being no restrictions on disclosure as set out by the Coroners (Inquest) Rules. Documents which the coroner considers relevant to the inquest should be disclosed.

   Any member of the public who requests assistance from AvMA's pro bono inquest service: https://www.avma.org.uk/help-advice/inquests/ must complete an Inquest New Client Form: https://www.avma.org.uk/help-advice/inquests/inquest-form/

   AvMA asks a number of questions on the Inquest New Client Form as a means of gauging how much information and understanding of the inquest process members of the public have when they first approach us. The information set out below is based on data we have received and analysed from 2020, 2021, 2022 and 2023 – a year runs from 1st January to 31st December.

   71 members of the public completed the Inquest New Client Form in 2020; 95 people completed the form in 2021, 74 in 2022 and 75 in 2023. The responses to the questions have been fully analysed for each year, ***details of this analysis can be found at the link included at paragraph 7 of our introduction above.***

   The analysis shows that in 2023, 41% of people seeking help from AvMA's pro bono inquest service knew they could ask the coroner for a copy of the postmortem report, compared with 44% in 2020. This suggests that there has been a small increase in the public's awareness of their right to the postmortem report.

Our data also demonstrate that in 2023, 39% of the public who came to us for help knew they could ask the coroner for copies of any statements or documents being relied upon at the inquest hearing. By contrast, our 2020 statistics show that 32% of people coming to us knew they could ask for documents being relied upon in the hearing.

This also suggests that while there has been a small increase in the number of people who are aware of their right to request disclosure, it is not significant. On balance, it might be reasonably concluded that not much has changed since 2020 and there has at best been minimal improvement.

The responses strongly indicate that less than half the public involved in an inquest are aware that they can obtain a copy of the post-mortem report and worse, less than one-third of people are aware of their entitlement to copies of documents the coroner relies in at the inquest hearing. In turn, it might be concluded that at least two-thirds of families attending healthcare inquests are unable to properly participate in the proceedings and are therefore not being represented or being placed at the heart of coroner's service.

The Justice Committee's recommendation was that "*We encourage the new Chief Coroner to strengthen guidance and training on disclosure and pre inquest reviews, emphasising to coroners that bereaved people should be told about their rights to documents early in the process"*. Our data suggests that there has been no substantive improvement in the public understanding of their right to disclosure. This may be linked to the continued challenges for families looking for advice, information on the coronial process and representation at inquests – please see also response to question 2 on public funding below.

The analysis of AvMA's New Client Form responses appears to corroborate that there is a continued lack of access to support for the Interested Party throughout the inquest process. AvMA's analysis of its data demonstrates that this is a major concern for ordinary members of the public facing an inquest. In our New Client Form questionnaire, AvMA pose the question ***"What particular concerns do you have about the inquest process?"*** the most consistent response was "***having to deal with a legal process without support"***. In 2020 this was a concern for 58% of the public, in 2021 this was a concern for 52% of the public, in 2022, 55% and in 2023, 59%.

2. **What progress has been made by the Government in implementing those of the Committee's earlier recommendations which it accepted in September 2021?**

Disclosure documents: On the committee's recommendation that bereaved people be clearly advised and the process for obtaining evidence explained to them, at paragraph 9 of the Government's response they said that it would encourage the new Chief Coroner to strengthen guidance and training on disclosure.

The Government also relied on the Guide to Coroner's Services for Bereaved People as "going some way" to meeting the committees concerns and said that the Chief Coroner was to provide a "detailed response to this recommendation".

AvMA is aware of the Chief Coroner's Guidance note 44 on disclosure, published on 13.09.2022: https://www.judiciary.uk/guidance-and-resources/guidance-no44-disclosure/ and drafted to provide practical advice to coroners including disclosure to interested persons at a timely stage of the investigation and when requested by the public.

It is difficult to assess the extent to which this Guidance note has improved the public's understanding of the disclosure process. The note makes clear reference to the Justice Committee's report of 27.05.2021 (see paragraph 10 of the note) and would therefore appear to have been drafted in direct response to the recommendation.

AvMA does refer to its analysis of data (link at paragraph 7 of the introduction) and draws attention to its response to question 1 above and notes that the public's awareness of being able to obtain a copy of the post-mortem report, in 2020 and their awareness in 2023 is not significantly different, similarly on the public's entitlement to receive copies of the documents relied upon during the inquest hearing. AvMA considers that these figures suggest not much has changed to improve the public's understanding and ability to access the inquest process.

We add that in our experience we would not expect the public to be aware of the existence of the Chief Coroner's Guidance notes, let alone know where to look for that information. AvMA's data is evidence that there has been little substantive change in the public's awareness, in conclusion the Government's reliance on the Guidance and the Chief Coroner's practice note has made no material change to the public's understanding of their rights. Informing the public of their rights to access information at inquest would likely require a different approach to providing clarification or restating the position in the Guidance Notes.

Duty of Candour: The committee noted that health and social care bodies were failing to fulfil their duty of candour to bereaved people during coroner's investigations and inquests. They recommended that the Coroners Rules should be amended to make clear that the duty of candour extended to the Coroner's Service and that consideration be given to a duty of candour applying to all public bodies.

The statutory duty of candour for healthcare professionals was introduced under the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 20* requires that healthcare providers must act in an open and transparent way when a notifiable safety incident has occurred. The duty is to notify the relevant person, provide reasonable support and to keep a written record of the incident, often referred to as a Duty of Candour letter.

The written account should be a true account containing all the facts the health service body knows about the incident as at the date of the notification. It should set out what further enquiries into the incident the health service body believes are appropriate and include an apology. Written notification must be given or sent to the relevant person setting out details of any enquiries to be undertaken. The duty requires that details of the results of any further enquiries be provided.

AvMA's own statistics show that in healthcare inquest cases alone very few members of the public are aware of the statutory duty of candour or the obligations under it. In 2020, 13% of the public knew about the duty of candour, 2 % of them were in receipt of a duty of candour letter. In 2023, 27% of the public were aware of the duty of candour, 3% had received a duty of candour letter. While the awareness of a statutory duty of candour has improved, the evidence that healthcare providers are complying with this duty by providing written notification in the form of a duty of candour letter is unchanged, there has been no improvement or progress in this regard.

The Government referred to Bishop James Jones report ("The patronising disposition of unaccountable power") saying it was committed to responding to that report including recommendations on the duty of candour. Bishop James' report was published in November 2017. On 6th December 2023, more than six years after its publication the Justice Secretary, the Rt Hon Alex Chalk KC MP gave an oral response to Parliament on the report: [https://www.gov.uk/government/speeches/hillsborough-charter-is-legacy-of-victims-families.](https://www.gov.uk/government/speeches/hillsborough-charter-is-legacy-of-victims-families)

The Government's response to the duty of candour recommendation was to say that it would be "Considered alongside the Government's response to Bishop James' report" (p8 Govt response). The Government has failed to provide a written response to Bishop James report.

Non-means tested legal aid for inquests: The recommendation was that ***"The Ministry of Justice should by 1 October 2021, for all inquests where public authorities are legally represented, make sure that non means tested legal aid or other public funding for legal representation is also available for the people who have been bereaved".***

In the Justice Secretary's statement of 06.12.23, he said ***"that proper involvement in an inquest will in appropriate cases mean that bereaved families should get legal representation, especially when the state is represented".*** No meaningful change has been implemented which would alter or improve a family's ability to secure legal aid, Exceptional Case Funding (ECF) in a healthcare related inquest.

While it would appear to be the case that the financial eligibility considerations for Legal Help and ECF have been made easier, the applicant must still discharge the merits test. The financial means test for Legal Aid's Exceptional Funding rules was removed in January 2022 and in September it was removed for legal advice.

Eligibility for legal aid requires families to satisfy not only a means test, but a merits test too. The merits test is satisfied only if at least one of two available grounds are shown to exist. They are either there is to be an Article 2 inquest and/or where the Legal Aid Director finds there is a "wider public interest determination" in relation to the individual and the inquest.

To satisfy the public interest determination the bereaved applicant must be able to show that the inquest into their loved one's death ***"is likely to produce significant benefits for a class of person, other than the applicant and members of the applicant's family"***.

Satisfying the merits test in a healthcare inquest is difficult because Coroners are often unable to declare the inquest investigation falls under Article 2 until they have heard some or all of the evidence. The coroner's finding on Article 2 is frequently delivered at the time they give their conclusion.

The fact that legal aid is not retrospective means that a declaration at the end of the inquest hearing will not assist the properly interested person because they cannot show that legal aid funding is available for the advocacy at the outset.

There is no definition of what amounts to public interest for the purposes of the Exceptional Funding determination. While it might be thought that securing a Prevention of Future Death (PFD) report could reasonably be considered to produce benefits for a wider class of person, it is not clear that this will meet the legal aid requirements of public interest. In any event, coroners will invariably hear all of the evidence before they consider whether a PFD is required or not. A PFD is usually made following the coroner's conclusion, as legal aid is not retrospective it would be difficult to demonstrate the merits test in advance of the coroners making the PFD report.

In practice not much has changed, Exceptional Funding is exceptionally difficult to secure. It should also be remembered that legal aid is not retrospective and therefore must be secured before the inquest hearing commences.

There needs to be at the very least a focus on ensuring a level playing field by making public funding available for families faced with an inquest "***where public authorities are legally represented".*** It is clear that a legally represented public authority is not part of the ECF merits test, it does not feature as part of the eligibility requirements for securing legal aid.

In September 2023, the government announced plans to introduce a scheme of Fixed Recoverable Costs (FRC) for low value clinical negligence claims to be effective in April 2024. Cases where the death was caused or substantially contributed to by failings in healthcare (fatal claims) will be caught by this regime. The levels of remuneration under the FRC scheme are so low that AvMA's own survey from October 2023 confirms that 89% of the firms currently providing representation at inquest while investigating a clinical negligence claim will cease to do so (see Link to FRC Questionnaire at paragraph 10 of the introduction)

Other than legal aid funding or paying privately for representation (the cost of which is prohibitive for most families) representation at inquest on the back of a clinical negligence claim is another way a family can hope to achieve representation at inquest and therefore some sort of equality of arms in the coroner court. Instead of supporting this by excluding all fatal claims from a FRC regime, the government has sought to cut off this route of access to representation. AvMA repeats its previous calls for government to exclude all fatal claims (not just stillbirths and neonatal deaths) from this FRC regime.

From a healthcare inquest perspective, there is no sense of any commitment from Government to promote equality of arms at inquests between the bereaved and public bodies. It is AvMA's experience that the NHS trust is invariably represented at inquest while

the family is not, there is no indication that the Government has any intention of changing this.

AvMA refers to the case of the *Inquest touching the death of baby Harry Richford*. This inquest was heard by the Assistant Coroner in Kent in 2020, Derek Richford (Harry's grandfather) was an Interested Party. The inquest was heard over about three weeks, legal aid was not available and but for pro bono representation from counsel the family would have been unrepresented. The importance of that inquest cannot be overstated, the effect and impact of the inquest was to open the door to the public inquiry into East Kent Maternity NHS Maternity Services. Mr Richford would likely be faced with the same difficulties regarding representation today as he was in 2019 and 2020, that in itself is shameful.

The Justice Secretary says that he seeks "***to further understand the experiences of these individuals"***. It is difficult to see what other evidence the Government needs hear to understand the experience of individuals. Bishop James' report drew on the experience of individuals and this committee heard oral evidence from individuals when it first took evidence on the Coroners Service back in 2020, the Justice Committee drew on those experiences in writing its report and making its recommendations in May 2021.

Coronial investigation of stillbirths: It was recommended that the Ministry of Justice should publish proposals for reform to give coroners new power to investigate stillbirths. Those reforms have not been published. There has been no progress at all in this regard.

The Government's response was to defer to the Department of Health and Social Care "*leading on a range of initiatives to improve maternity reviews and investigations of stillbirths, neonatal and maternal deaths and brain injuries that occur during labour".* However, the Department of Health is unable to set out proposals to give coroners power to investigate stillbirths, that can only come from the Ministry of Justice.

Maternity Neonatal Safety Investigations (MNSI) came into being in October 2023. MNSI is a reincarnation of the previous Health Safety Investigation Branch (HSIB) maternity investigations which has been operating since April 2018, it is not new. It has now been cast as an Arms Length Body hosted by the CQC but the process of investigation and the criteria for investigation remain as before.

While MNSI and its predecessor (HSIB Maternity investigations) do investigate stillbirths, neonatal, maternal deaths and brain injuries that occur during labour, their aim is to improve patient safety.

MNSI has no authority to investigate how and in what circumstances a baby died and while they may incidentally address that issue in some aspects of their investigation, it is not the aim of the MNSI investigation. Accepting that some aspects of an MNSI investigation may be relevant to the coroner's investigation, it is not a substitute for a coronial process.

Further, while MNSI can make recommendations for change it cannot mandate change. MNSI cannot investigate any case where gestation at the time of labour was less than 37 weeks. It

cannot investigate cases where there was no labour, for example where there was a planned caesarean section.

The Government refers to the Department of Health and Social Care and the Ministry of Justice publishing a joint response to the consultation on stillbirths, that response has not been published yet.

Funding for improving accessibility to PFD reports: While the Government did not accept this recommendation it rejected it on the basis that they were to work with the Chief Coroner to consider appropriate resources required to deliver this. It is not clear what work, if any has been undertaken between the Government and the Chief Coroner to ensure PFD reports and the responses to them are appropriately catalogued and accessible.

Improved accessibility to PFD reports should make searching for similar fact PFDs easier, similarly identifying the NHS trust involved in the inquest. In turn, this would provide a more accessible indication of the breadth and type of problems that have contributed to deaths in NHS and healthcare settings. An improved process (if done in the right way) could offer a cost-effective way to glean considerable learning and offer an opportunity to provide nationwide as opposed to just regional learning for all trusts and healthcare providers.

3. **Given that the Government has rejected the Committee's recommendation to unite local coroner services into a single service, what more can be done to reduce regional variation and ensure that a consistent service operates across England and Wales?**

   Uniting the local coroners services into a single service is the obvious way forward. It may be that reliable information technology and a uniform approach to case management might also help to reduce regional variation especially if there was an expectation that coroners shared information and learning with each other over that network.

4. **Whether more can be done to make the best of the Coroner's Services role in learning lessons and preventing future deaths. In particular (a) are Coroners across England and Wales making consistent use of their power to issue Prevention of Future Death (PFD) reports? And (b) could the way PFD reports are being used to help prevent future deaths be improved?**

   As to (a), it is not possible for AvMA to tell if coroners across England and Wales are making consistent use of their powers. Improved accessibility to PFD reports might help identify this.

   As to (b) AvMA again refers to its response to Question 2 above and the section on funding for improved accessibility to PFD reports. Easier access to PFD reports should make it far easier to identify common themes and problems operating in trusts not just in one geographic region but nationally.

   It also has the potential to act as red flag where a trust has significant problems which need further investigation. It is possible and likely that coroners from the same jurisdiction are hearing the same or similar issues being raised about the conduct, processes, and procedures of their local trusts. This information can be lost if the cases are heard by different coroners

and Assistant Coroners even within the same jurisdiction. Improved accessibility to PFD reports might improve this.

PFD reports are potentially a powerful tool for improving public services, especially healthcare services, they could be more effective if there was a National Oversight Mechanism (NOM) which followed up, policed, and monitored whether the recommendations and changes set out in Action Plans and PFD reports were being implemented or not. Currently, there is no means of following up whether the actions promised by a trust have been implemented or not. PFDs and Action Plans are only powerful if that follow up exists and that penalties can be imposed for trusts (or public bodies) which fail to act on the PFD or Action Plan.

However, AvMA also considers that considerable learning can be derived from Action Plans which are produced by the NHS trusts. Those Action Plans frequently head off the need for the coroner to make a PFD report and are potentially powerful documents as the trust recognises its own failings and offers solutions to prevent them happening again. AvMA recommends that Action Plans should be logged and recorded in the same way PFD reports are.

As the Chief Coroner's Guidance note number 5 points out:

"PFDs are vitally important if society is to learn from deaths….And a bereaved family wants to be able to say: 'His death was tragic and terrible, but at least it's less likely to happen to somebody else.' PFDs are not intended as a punishment; they are made for the benefit of the public…..PFDs should be intended to improve public health, welfare and safety. They should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect."

A National Oversight Mechanism should have a significant part to play in ensuring that changes are implemented which demonstrate learning from inquests, that learning can ensure that lessons are shared nationally. This would give 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.

AvMA refers to another independent charity, INQUEST and their established campaign for a National Oversight Mechanism which we fully support: https://www.inquest.org.uk/no-more-deaths-inquest-launches-its-campaign-for-better-follow-up-to-life-saving-recommendations

5. **How are Coroners responding to the requirements of faith burials and funerary practices, especially in relation to early release of bodies and provision of non-invasive autopsies? Is there a consistent and satisfactory approach across England and Wales?**

   AvMA is not able to comment on this in any meaningful way.

6. **Whether there is evidence that inquests are taking too long to be completed, and if so why, and what can be done in response.**

AvMA's view is that the requirement that healthcare inquests are completed within 6 months and failing completion within 12 months be reported to the Chief Coroner is too onerous. Many healthcare inquests require evidence to be heard from healthcare professionals, or for the court to appoint independent experts to give evidence.

AvMA has been involved in several inquests which had originally been set down for a short hearing date but when we have been able to support the family we can show that the hearing time allowed is inadequate and would not allow the coroner to hold a full and fearless inquiry.

While there is clearly a need for inquests to be held as soon as possible, this should not be the overriding concern; the main priority must be for the inquest to be a full and proper investigation about how the deceased came about their death. This also increases the chances of issues in the healthcare provided being identified and for action to be taken to address those issues increasing the use of the inquest being able to contribute substantially to improvements in patient safety.

7. **Whether the Coroner's service has recovered from the challenges of the Covid-19 pandemic, and what lessons can be drawn from it?**

   Given the unique nature of the pandemic, AvMA's view is that the Chief Coroners approach and management of the inquest process during lockdown and social restrictions was sensible and effective.

   The main lessons learned include how inquests and pre inquest review hearings can be held remotely and partially remotely to good effect where coroners have access to reliable wifi and IT systems. Care does not to be taken to ensure that remote and partial remote hearings are safely conducted, and more guidelines need to evolve to safeguard this. It is imperative that the family agrees to the remote process and a remote process should only be used if the family are able to fully participate remotely.

   Post pandemic we have seen fewer remote hearings and PIRs.

8. **Whether there are any other changes to the way the Coroner Service operates that could be made to improve its effectiveness.**

   We refer to our answers at Question 2 on improved accessibility to PFD reports and to question 4 above on the introduction of a National Oversight mechanism.

Lisa O'Dwyer
Director Medico-Legal Services Action at against Medical Accidents (AvMA)
15th January 2024