Ministry of Justice
Call for Evidence: Post-implementation review of the coroner reforms in the Coroners and Justice Act 2009

A response by the Association of Personal Injury Lawyers
December 2015

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation with a 25-year history of working to help injured people gain access to justice they need and deserve. We have around 3,400 members, committed to supporting the association's aims and all of whom sign up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives and academics.

APIL has a long history of liaison with other stakeholders, consumer representatives, Governments and devolved assemblies across the UK with a view to achieving the association's aims, which are:

- To promote full and just compensation for all types of personal injury;
- To promote and develop expertise in the practice of personal injury law;
- To promote wider redress for personal injury in the legal system;
- To campaign for improvements in personal injury law;
- To promote safety and alert the public to hazards wherever they arise;
- To provide a communication network for members.

Any enquiries in respect of this response should be addressed, in the first instance, to:

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Introduction

We agree with the Government's aim of making sure that bereaved people are at the very heart of the coroner system. We are concerned, however, that the reforms in several respects, do not achieve this aim. While some of the reforms have been successful, such as the appointment of the Chief Coroner, coroner services still vary in quality. Compliance with artificial time limits seems to have taken precedence, with disclosure occurring at the last minute, and inadequate and rushed reports being provided by hospital trusts in order to comply with the deadline for the inquest hearing. The intent behind the new procedure is to put injured people at the heart of the process, and this cannot be achieved if the quality of investigation deteriorates in order to comply with artificial deadlines.

Guide to Coroners Services

Despite the government's aim to put bereaved people at the heart of the coroner process, it is clear that there is still reluctance for bereaved families to obtain legal advice. A common occurrence is for disclosure not to occur until the very last minute, and this causes relatives to panic about the impending inquest, and they then seek legal advice at this late stage. The literature provided to bereaved people (including the Guide to Coroner Services) continues to maintain that a solicitor is not necessary, and bereaved people are therefore left bewildered and unsupported. This is deeply unsatisfactory.

At 8.12 of the Guide to Coroner Services, it is stated that "in most cases, you will not need to instruct a solicitor to represent you at an inquest". There is no mention of solicitors before or after section 8.12. Leaving bereaved people without advice and support at an already extremely distressing time is unacceptable, and there are many instances where a solicitor will be vital. There is evidence, for example, that coroners are still reluctant to listen to the family and take on board very real concerns. In one example, an APIL member had to challenge a decision not to hold an inquest. The coroner decided not to hold an inquest as the death was originally ruled as due to natural causes. The family explained their concerns about medical treatment, but the coroner declined to change her mind. Once solicitors were instructed, the hospital trust provided a report and correspondence was produced accepting failings in care, and an inquest was opened. If the family had not been so persistent and had not contacted solicitors, there would not have been an inquest. At the conclusion of this particular inquest, the coroner issued a regulation 28 report on preventing future deaths, so this clearly demanded an investigation. It should be made clear to the bereaved person or family that they are entitled to be legally represented throughout the process. The other parties will more than likely have legal representation, leaving bereaved relatives vulnerable and without support.

In addition to leaving the bereaved family with no-one to guide them through the process, an uneven playing field will be created. The other side will almost certainly be represented by counsel at the inquest. For cases involving hospital trusts, there may be two or even three counsel, provided by both the Medical Defence Union and NHSLA, and then nobody to represent the bereaved family. Simply, the key to inquests is the examination of events and utilising them as a learning opportunity. Failure to provide the family with the tools to do this makes an inquest a pointless exercise.

More generally, members report that they have not yet had a client who has mentioned being told about the Guide to Coroners Services by the coroner's office. In fact, clients often know very little at all about the inquest process until they contact a solicitor. This suggests that the Guide needs to be more widely publicised and accessible, if it is to be of any use, and again demonstrates the importance of solicitors being involved in the process.

Disclosure

Members have not reported any issues with coroners refusing to disclose documents, however disclosure of documents is often slow and last minute, and the implementation of disclosure also varies from coroner to coroner. A main criticism of the reforms is that the artificial time limits – requiring an inquest to be completed within 6 months - imposed to "put the needs of bereaved people first" are actually having the opposite effect. Coroners often seem to withhold disclosure until they have compiled all the documents they consider to be relevant. However, that often means the following:

- Post mortem reports not being disclosed even to hospitals until the final bundle meaning internal investigations and medical witness statements may be compiled in ignorance of the medical cause of death. It is our view that post mortem reports should be immediately disclosed to all interested parties. Some but not all coroners follow this practice. Unrepresented relatives should be expressly notified that the PM report is available if they wish to see it.
- Reports by hospital trusts or investigations ordered by them can be rushed or incomplete and therefore not particularly helpful.
- Time limits being used tactically by hospital trusts. Hospitals appear to be disclosing documents at the 11th hour, leaving bereaved relatives with no opportunity to have them analysed. There are incidents reported of medical witness statements of fact simply not being provided at all.
- Documents dated months previously are suddenly received all in one day close to the time limit.
- The investigation and inquest are often not as thorough as they should be. Bereaved families want to know that the inquest has been carried out properly, and not that it has been rushed to comply with artificial time limits.
- Expert evidence not being sought because there is simply no time or being sought at the last minute reducing the pool of suitable available experts and leading to experts reports being served midway through or at the end of the inquest giving no opportunity for factual witnesses to be questioned on issues raised in them or leading to those witnesses already having given evidence being recalled.

It is obviously not advantageous for the inquiry to drag on, and the requirement to keep the bereaved family informed of progress is to be welcomed. But it is clear that in some circumstances it is simply not feasible to have an inquest within six months. Our members report that it is seldom if ever that relatives concerned about the circumstances of their loved one's death and faced with a choice between a thorough investigation and a prolongation of the process, or an abbreviated process and early inquest choose the latter.

We recommend that there should be greater use of pre-inquest hearings (PIHs) and that coroners should not feel they will be penalised if as a result of late disclosure or incomplete investigations a date originally set for the inquest is instead utilised as a PIH.

Inquest recordings

We welcome inquest recordings and in our experience the small fee charged is reasonable and cheaper than a transcript. Some members have suggested, however, that it is not made clear enough that a recording of the inquest can be obtained for a small fee. It appears that when interested parties make enquiries with the court regarding transcripts or inquests. Many people are unaware of this alternative option and think they can only obtain a recording of the inquest by paying for a transcript.

There have been instances of technical difficulties which have meant that some evidence has not been recorded. Care must be taken to ensure that recordings are successful. Members also report that it can take a long time to finally receive a recording of the inquest, despite the fact that there is no longer a requirement for a written transcript. It is unclear why these delays occur, and this is unsatisfactory.

Contact with coroners

The quality of communication between coroners and interested parties varies from coroner to coroner. Often, coroners' offices are under-resourced and this can lead to only reactive communication, requiring interested parties to chase should they need further information or updates. This can be a problem particularly if the bereaved family is not represented by a solicitor, as they will not know that they are required to chase up the coroner for information. Again, the bereaved family may feel unsupported and bewildered by the process and lack of forthcoming information.

To ensure consistency across England and Wales, we suggest that a service level agreement should be put in place to ensure that coroner's office must call back within a certain amount of time/must respond to letters within a certain amount of time.

Other general comments

Prevention of future death reports

A further important and effective reform has been the publication online of prevention of future death reports. These set out matters of concern and action that should be taken to prevent future deaths in similar circumstances. The reports are a powerful tool and are effective in holding the people responsible for the death to account, thus are a consolation to the family. Whilst there is still room for improvement, with limited use and dissemination of prevention of future death reports at present, members suggest that they are starting to have an impact on future practices.

Determinations

There has been a move to short form and narrative conclusions after an inquest. The Coroner's Guidance No. 17 actively discourages lengthy conclusions. Paragraph 35 states that "long narratives should not be given, they achieve neither clarity nor accessibility in that form". We believe that this is very much to the disadvantage of bereaved relatives. Longer

determinations are helpful to the bereaved family, as they can see the detail and the way that the coroner has considered the evidence and arrived at the conclusion. Even if the conclusion is not what they originally hoped for, the details and the knowledge that the coroner has careful considered what happened, can provide them with closure.

Detailed conclusions are particularly useful as it is increasingly difficult for a bereaved family to obtain funding to pursue a civil claim and to determine what happened to their loved one through the civil claims process. Often, the inquest is going to be the best step to obtaining proper accountability. It is a particularly powerful tool to enable the family to obtain answers about poor care and the events that led to the death of their loved one. The family is often uninterested in claiming civil compensation; they simply want detailed answers as to what happened. For the Government to insist only on short conclusions is a retrograde step, and certainly does not put bereaved people at the heart of the coroner process.

Expert evidence

The use of expert evidence by coroners is often erratic. There is no clear encouragement, at present, for the coroner to obtain expert evidence where there are complex issues. Instead, it is common place for the coroner to use doctors from the trust in question – even though there is a clear conflict of interest. Use of own trust doctors is unacceptable for the families, and if the family is not represented, the coroner is likely to agree to this on costs savings grounds. This is yet a further demonstration of the necessity of legal representation within the coroner process. If a death occurs at a hospital, the coroner will arrange for the post mortem to be carried out by a pathologist other than the one employed at or connected with that hospital, if a relative asks the coroner to do so and if it does not cause an undue delay. This should be common place practice across all cases and apply to all practitioners, not just pathologists.

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