FORMAL RESPONSE

to the Ministry of Justice's consultation on

THE STATUTORY DUTY FOR DOCTORS AND OTHER PUBLIC SERVICE PERSONNEL T0 REPORT DEATHS TO THE CORONER WITH A VIEW TO IMPROVING THE CURRENT SYSTEM AND IMPROVING PATIENT SAFETY.

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Introduction

About AVMA

Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK 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, and succeeded in bringing about major changes to the way that the legal system deals with clinical negligence cases and in moving patient safety higher up the agenda. The legal reforms of Lord Woolf in the clinical negligence field and the creation of agencies such as the National Patient Safety Agency and the Healthcare Commission have followed after years of campaigning by AvMA.

AvMA is proud of the key role it has played in making clinical negligence a specialism within legal practice. It continues to accredit solicitors for its specialist panel (without membership of AvMA's or the Law Society Panel a law firm is not entitled to a clinical negligence franchise) and promotes good practice through comprehensive services to claimant solicitors.

AvMA have long been concerned that there should be reform of the death certification process as a whole. In particular, AvMA have been of the opinion that all deaths should be notified to the Coroner and that there should be a positive duty placed on doctors and others to notify the Coroner of any deaths.

AvMA remain concerned about the quality of the information provided to the Coroners in the present system in relation to medical deaths and would favour sanctions against those who deliberately mislead or withhold information relating to deaths.

AvMA believe that if the bereaved are to fully participate (even at the stage of reporting a death) they require access to independent representation and advice in the more complex cases.

SUMMARY

Overview & Key Concerns

- AvMA are concerned that there may be an under-reporting of deaths and would favour a system of reporting all deaths to the Coroner.
- The Coronial system should be better resourced to enable proper and consistent investigations into deaths.
- The category of those under a duty to report a death to the Coroner should be widened.
- In widening the list there is a danger of a lack of accountability and AvMA suggest that a 'responsible person' (analogous to Health & Safety legislation) should be appointed for each organisation or the individual in the case of an independent practitioner.
- If the list approach to reporting deaths is to be favoured it should be strengthened to ensure that all types of medical deaths are included.
- In complex cases the bereaved should have access to advice and representation in the public interest
- To willfully or deliberately fail to report a death should be a criminal offence.
- AvMA would favour a sanction being introduced for deliberately or willfully submitting a misleading or inaccurate report of the circumstances surrounding a death.
- Sliding scales applied offences offer neither certainty nor transparency for either the professional or the bereaved.
- If a system of second scrutiny death certification is to be introduced, it needs to be properly resourced, independent and more than a simple rubber stamping exercise.
- We question the decision to abandon the consultation criteria to reduce the period of consultation particularly over the summer period as the proposals are very different to those initially proposed.

Requirement for doctors and other public service personnel to report cases to Coroner.

Q1. Are these the right types of public service personnel who should be given a statutory requirement to report a death to a coroner? If not, who else should be placed under this duty and why? Are there authorities on this list who do not need to be?

You have indicated that it may be advisable to extend the types of public service personnel who should be given a statutory requirement to report a death to a Coroner to include prison governors and registrars.

We have no views as to whether or not Fire Service personnel should be added to the list of those required to report.

However, we do think it important that the statutory duty should apply to other medical staff as well as hospital doctors and general practitioners, as listed, to include nursing staff, midwives, locum doctors, dentists, psychiatrists and the designated paediatrician with responsibility for informing relevant professionals of unexpected deaths in childhood.

We also agree that this should be extended to mental health facility managers, immigration removal centre managers, care home managers and owners and ambulance service personnel and that if one person reports a death to a Coroner it should discharge the duty of all.

We note that it is not proposed to add the funeral industry to the statutory list although they will be encouraged to bring concerns. We believe that either the funeral industry should be added to the list of those who should report cases to the Coroner or the Coroner is given power to act on such concerns from either the funeral industry or others without the death otherwise being reported.

AvMA agree with previous commentators that it is difficult to train medical practitioners to recognise the types of deaths to be reported. However we do not believe this difficulty will be completely removed under the new proposals and we remain of the view that it would be far more effective if all deaths were reported to the Coroner. If the Coroner and his staff were properly resourced it would enable them to undertake this task. The Coroner could identify the deaths which warranted further investigation rather than attempting to train all such potential personnel.

Shipman highlighted the need to collate information relating to deaths and provided the Coroner were to be properly resourced, we feel it would be more appropriate for this to be dealt with independently of the primary care trusts as envisaged by the system of second scrutiny of all death certificates.

There are a number of deaths which should clearly be reported to the Coroner and these will be reported without difficulty. However, concerns arise in the grey areas where it is

not clear whether or not a report should be made or where the personnel with a duty to report may have been or could be implicated in the circumstances surrounding the death. We believe it would be far more cost effective to train those engaged in the coronial system to make these distinctions rather than attempting to train all personnel who may have a duty to report.

AvMA are concerned that in the widening of those under a duty to report a death there is a lack of accountability in that no one person has the specific duty to report.

We would suggest that one named person per organisation has the ultimate duty to report although this could be discharged by any other person reporting the death. This could be for example the Chief Executive of an NHS Trust, the Managing Director of a company operating a nursing home or each individual in respect of health practitioners operating privately or in a surgery. This would be analogous to the 'responsible person' in Health & Safety legislation.

Proposed list of deaths which should be reportable to the Coroner

Q2. Do you believe the proposed list of reportable deaths to the coroner is workable, effective and proportionate?

We agree that Coroners have an important role to play in public protection and to save lives.

We note that the proposals are that a death will be reportable in the following circumstances:

1. Death resulting from self harm and neglect.
2. Death resulting from neglect or abuse where there is an established duty of care by a public authority, other organizations and individuals.
3. Death occurring during or shortly after a period of detention.
4. Death caused or contributed to by the police's conduct.
5. Deaths relating to Employment.
6. Death resulting from lack of care or appropriate treatment, defective treatment and adverse reaction to prescribed medicine.
7. Death of a child.
8. Deaths where there a violent crime is suspected.

9. Sudden and Accidental Death.

10. A death which is the subject of significant concern or suspicion.

11. Where the death has not been certified.

12. A death which may have been caused or contributed to by a specified disease or condition.

13. Deaths associated with childbirth or termination of pregnancy.

We agree that the proposed list of reportable deaths to the Coroner is workable and proportionate but we are concerned as to whether or not it will be effective as we are not clear as to whose judgment will be required to ensure that a death falls into a particular category for example, No. 6 'death resulting from lack of care or appropriate treatment, defective treatment and adverse reaction to prescribed medicine' seems to be suggesting that this must be a medical judgment and we would suggest this should be extended in the same way as per paragraph 10 to include a concern by any family member, any member of the public and any healthcare or other professional with knowledge of the death. As family members may be involved in the reporting process they should have access to advice and information in the more complex cases. The decision as to whether or not a death is fully investigated have wider significance than the immediate family, as can be seen from Shipman, the Bristol Heart inquiry and other high profile cases. The proper investigation of death is in the public interest.

Q3. Are there any additional circumstances not mentioned in the proposed list where you believe there should be a statutory duty to report a death to the coroner?

AvMA are also of the view that paragraph 6.1 '*a lack of care or appropriate treatment, defective treatment and/or failure appropriately to treat on the part of the doctor or other health professional'* should specifically state that this category would include an omission or a failure to offer medical or surgical treatment and a systemic failure in addition to a lack of care or failing to treat appropriately.

Q4. Are there any circumstances where deaths are reported to the coroner unnecessarily? If yes, please specify. (Please do not mention deaths occurring outside of England and Wales in this section.)

AvMA do not believe there are any circumstances where deaths are reported to the Coroner unnecessarily.

Q5. Do you agree that the 14 day rule is arbitrary and unnecessary? If not, what length of time limit would you suggest?

Although we accept that there are different ways of delivering health services, we would be concerned if doctors could certify a death if they had not seen the patient within a reasonable time limit. We make no comment as to whether 14 days is more

appropriate than any other time period but we do feel the time period should be reasonable.

We also think that it is appropriate that the doctor does view the body after death as although it may have limited diagnostic value, it cannot be correct that a doctor can certify death without having seen the body and identified that there are no apparent inconsistencies with the type of death being certified.

Sanctions against doctors and other public service personnel who fail to discharge their duty to report a death to the Coroner

Q6. Do you believe that a deliberate or wilful failure to discharge this duty on the part of a doctor or other public service professional should be dealt with as a criminal offence as described? We would be interested to hear any reasons behind your views.

AvMA believe that deliberate or willful failure to discharge the duty should be dealt with as a criminal offence. This may be limited to the 'responsible person' as outlined earlier. The standard applied would then be that of the criminal standard of beyond reasonable doubt. Whilst we accept that this may lead to a cautious approach on the part of professionals, we are of the opinion that the deliberate or willful failure to report deaths of the categories listed is serious enough to warrant this. It would also ensure compliance. We believe that this should prevent any attempt to bring pressure to bear on those who otherwise would report a death, particularly in relation to medical deaths.

This would only relate to deliberate or willful failure to report and therefore would not be appropriate where a simple mistake has been made in failing to report a death.

AvMA are also concerned as to the quality of the information to be reported and there should be a sanction for deliberately or willfully submitting a misleading or inaccurate report of the circumstances surrounding a death. We believe this would be a matter more appropriately dealt with by the employers code of conduct and the relevant professional body.

Q7. Do you agree that the most appropriate sanction is through the employer's code of conduct and the relevant professional regulatory body? Again, we would be interested to hear any reasons behind your views.

AvMA do not agree that the most appropriate sanction for failure to report a death is through the employer's code of conduct and the relevant professional regulatory body although this may be appropriate if a sanction for deliberately or willfully submitting a misleading or inaccurate report of the circumstances surrounding a death were to be introduced.

We agree that in circumstances where a simple mistake in failing to report a death has been made rather than a willful or deliberate omission then this may be dealt with by the relevant professional regulatory body. If for example there have been repeated mistakes the relevant professional body may feel it appropriate to offer training and rehabilitation or to look at the conduct of others in relation to that error arising if for example there had been a failure relating to supervision or setting or implementing of policy. If a criminal act

has been committed then the regulatory body must deal with the individual in the same way it would if the individual had been found guilty of any other criminal act.

AvMA do not believe that there should be a sliding scale. A sliding scale creates uncertainty for both the medical professional and the bereaved. It cannot provide an open and transparent system for determining culpability as standards cannot be laid down to cover every situation.

Q8. Do you believe that these sanctions will fit with the Government's White Paper, "Trust Assurance and Safety - The Regulation of Health Professionals in the 21st Century"? If not, please give your reasons.

Deliberate and willful failure to report a death is serious enough to warrant a criminal sanction and must be viewed accordingly by the body and the high standard would be applied.

Proposed improvements to the process of death certification

Q9. Do you foresee any practical difficulties arising from the introduction of a second scrutiny of death certificates and the list of reportable deaths?

We are concerned that the medical examiner attached to the clinical governance team in a primary care trust would not be truly independent. We suggest that it may be more appropriate to have the medical examiner report directly to the Coroner or alternatively that they would be appointed as a pool of medical examiners rather than attached to a particular primary care trust so that there could be openness and transparency and effective resourcing.

It does not seem that a thorough review could be carried out on every death and we therefore query how detailed a review would be carried out and whether this would simply be rubber stamping exercise unless concerns were raised at the time. We see there is a real practical difficulty arising from the introduction of a second scrutiny of death certificates in that considerable resources would be required to carry out the work effectively.

Referral Process

Q10. Do consultees agree with the principles which will inform a reporting system?

It is impossible for us to comment on the referral process as sufficiently detailed information has not been provided as to how this will proceed.