action against medical accidents

Registered charity Number 299123

FORMAL RESPONSE

To the Ministry of Justice's consultation on

Coroner reports to prevent further deaths: proposed amendments to Rule 43 of the Coroners Rules 1984

AvMA
44 High Street
Croydon
CR0 1YB.
Web: www.avma.org.uk

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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.

Introduction

Although the evidence relating to the number of preventable deaths arising from medical accidents is disputed it is certainly a significant figure. The National Audit Office Report, "A Safer Place for Patients" indicated that 10.8% of patients experienced an adverse incident of which half (5.2%) were preventable. These adverse incidents contributed to death in 8% of cases.[1]

AvMA believe that the coroner could play an important part in highlighting concerns and potentially saving lives. However research shows[2] that rule 43 is not widely used by the majority of coroners.

To some extent Rule 43 has been used effectively in the past in areas other than medical accidents: for example local coroners alerting local authorities to accident black spots to enable better lighting, improved signage, traffic calming schemes etc.

In recent years some coroners have used Rule 43 to try to bring concerns to the attention of hospital trusts and others but this practice is not widespread. In our experience, although some Trusts met the challenge and changed procedures others did not and some did not even reply to the coroner.

Research has shown there is a lack of clarity in both structure and function in the handling of and learning from coroners' recommendations[3]. The research also demonstrated that there were concerns expressed by those within the Trust to the level of knowledge and understanding of the coroner. AvMA believe that with the increased level of investigation into deaths where article 2 is engaged there should be recognition

[1] National Audit Office. A Safer Place for Patients:Learning to improve patient safety HMSO 2005
[2] Ireland:The report of Fundamental Review. Cm 5831. London HMSO 2003
[3] Tanya Claridge, Gary Cook, Richard Hale: Organisational learning and patient safety in the NHS:an exploration of organizational learning that occurs following a coroners Report under rule 43Clinical Risk volume 14 January 2008

of the value of the information obtained by the coroner in the course of his or her investigation.

It has long been a concern of AvMA that, even when information is obtained at inquest that could potentially save lives, there is no positive duty placed on the coroner to share this information with others who may find this of benefit and no evidence that this information is shared on a voluntary basis.

Whilst we appreciate that there is a need for anonymity for individuals in organisations to encourage them to make full and frank responses, this anonymity should not be extended to the organisation itself particularly organisations that are public authorities as defined by s.6 of the Human Rights Acts 1998. Public authorities have a positive duty to prevent death and should welcome the opportunity to share information and to consider opportunities to improve patient safety.

A further extension to this principle could be considered for the independent sector health and social care providers.

AvMA welcome this consultation and the opportunity to ensure that positive public benefit results from private tragedy.

SUMMARY

Overview & Key Concerns

- AvMA are pleased to note the Government initiative to widen the scope for coroners to make reports and to consider a means by which the reports are made effective.

- AvMA have long been concerned at the under use of Rule 43 and believe a positive duty should be placed on coroners to consider making a Rule 43 report in each case and in each case where a public authority is involved to record his or her reasons for not making such a report

- AvMA are concerned at the failure by many organisations to respond to Rule 43; a failure to respond by a public authority should be punishable by a fine.

- AvMA believe it is essential that reports should be widely available and that there should be a central source of information. We believe that all reports and responses should be lodged with the Chief Coroner and that a positive duty to lodge Rule 43 reports and responses should be put on the coroner. Such reports should then be made available on the Chief Coroner's website once this is in existence.

- To be effective and to ensure maximum benefit from a system there must be clear reporting lines and accountability. It would be impracticable to ask coroners

to follow up any responses to Rule 43 reports but this duty could and should be placed on the appropriate health and social care regulators.

- The Chief Coroner should have a duty to ensure that the appropriate regulatory bodies for the health and social care sectors, including the Healthcare Commission (and its successors), strategic health authorities and Monitor as well as the National Patient Safety Agency (and its successors) receive reports.

- A statutory duty should be placed on the regulators to follow up Rule 43 reports and responses to ensure that remedial action is put into practice.

- If it could be demonstrated to coroners that a Rule 43 report was effective and resulted in a beneficial outcome, coroners may be encouraged to make Rule 43 reports.

MAKING CORONER REPORTS

Question 1: Do you agree that a coroner should have power to make a report, even when it was not announced at inquest?

Yes, we agree that a coroner should have the power to make a report even when it was not announced at an Inquest.

The primary purpose of a coroner's report should be preventing any death based on any evidence available to a coroner. AvMA believe that correctly used, such reports have the potential to save lives. We believe the requirement to announce the intention to prepare a report at an inquest is an artificial hurdle that should be removed.

RESPONDING TO CORONER REPORTS

Question 2: Is the time limit for a response about right? Should there be a greater sanction, and if so what, than "naming and shaming" for a failure to respond to reports?

AVMA believe the time limit of 56 days for the responsible person to respond in writing is about right.

AVMA believes that there should be a greater sanction for a public authority (as defined by s6 of the Human rights Act) for failing to respond to a Rule 43 report.

As public authorities have a duty to protect life, a failure to even respond to a Rule 43 report should be punishable by a fine.

If a public authority does not propose any remedial action, they should be required to give their reasons and explain their reasoning for failing to react and also face a fine if they do not give any such reason.

We believe there should be naming and shaming of organisations which fail to respond to reports but not individuals within those organisations. This should be made as public as possible.

SHARING AND PUBLISHING CORONER REPORTS AND RESPONSES

Question 3: Do you agree with the general principle that coroner reports and responses should be shared with interested persons and relevant organisations?

AvMA agree with the general principle that coroner's reports and responses should be shared with interested persons and relevant organisations.

However this information should be made available to the public. We presume that the Chief Coroner is likely to have a website and this would seem to us an appropriate place for this information to be displayed in full but with complete anonymity for individuals in an organisation.

Other interested parties such as specialist charities should be able to register for e-mail alerts as indicated in response to Question 7.

Question 4: Can you think of any circumstances when it would be inappropriate to share reports and responses in this way?

As previously stated there should be individual anonymity for those involved and for the bereaved if they request it but we would reject any suggestion that there be any circumstance in which the information should not be publicly available in respect of organisations.

Question 5: Do you agree with the proposal for coroners to copy their report and any response to interested persons and to the Lord Chancellor? If not, how else could we ensure that these people receive this information?

AVMA believe that coroners should send a copy of their report and any response to interested persons and also to the Chief Coroner as well as the Lord Chancellor. However as indicated in response to Question 7, there should be wider distribution of the material by the Chief Coroner, rather than the coroner concerned.

AvMA do think it important that the information be made publicly available example as outlined in our response to Question 7.

Question 6: Do you agree that only a summary of reports and responses should be published?

We do not agree that only summary of reports and responses should be published.

PRODUCING A REGULAR BULLETIN

Question 7: How could coroners and/or the Ministry of Justice disseminate lessons learned more widely and more effectively?

To be effective and to ensure maximum benefit from a system there must be clear reporting lines and accountability.

In respect of medical deaths, the Chief Coroner should have a duty to ensure that the following are copied into reports:-

- the National Patient Safety Agency (and its successors)
- the Healthcare Commission (and its successors) who regulate the independent health and social care sectors
- strategic health authorities who hold primary care trusts, acute trusts, mental health trusts and ambulance trusts to account
- Monitor who regulate foundation trusts
- other organisations with a specialist remit such as the Medicines and Healthcare products Regulatory Agency where appropriate

A statutory duty to follow up reports and disseminate information should be placed on all of these organisations.

This principle should be extended to deaths which arise from other circumstances.

It would be impracticable to ask coroners to follow up any responses to Rule 43 reports but this duty could and should be placed on the regulators. They have the power to take appropriate action.

We believe that coroners and the Ministry of Justice could disseminate lessons learned more widely and more effectively in respect of medical deaths by making sure that reports in respect of medical deaths are also made available to other organisations with an interest, for example relevant charities who could register their interest.

This could be done by means of email alert rather than a paper based exercise. If the coroner lodged the report and responses centrally with the Chief Coroner, this could be initiated by the Chief Coroner's office.

TRAINING AND GUIDANCE

Question 8: Is there any particular information you think it would be useful to include in induction and in-service training provided to coroners?

Induction and in-service training provided to coroners would need to be carefully designed to enable coroners to appreciate not only when it is appropriate to submit a report but also the style and the types of actions that could be requested.

We believe that new Rule 43(4) should also be extended to include the requirement of the coroner to lodge the report with the Chief Coroner.

Re paragraph 43b, we think that guidance should be given to the coroner as to the circumstances in which extensions of time may be granted and suitable periods of time. However, we do not think this should form part of the coroner's rules.
There would also need to be legislative amendment to put a duty on the Chief Coroner to send reports to the regulators and legislative change to force regulators to act on reports received.

DRAFT AMENDMENTS TO THE CORONER'S RULES

Question 9: We would welcome general comments on the proposed amendments to the coroners Rules 1984, and on the way that these would work in practice.

Question 10: Do you think that the proposals set out in this paper will i) help coroners to make more effective use of these reports and ii) help to prevent future deaths? Are there any other matters you would like us to take into account?

The coroner should be placed under a positive duty to consider making report at the conclusion of each inquest to encourage greater use of Rule 43 amongst coroners.

AvMA believe that training must be given to coroners to enable them to make effective use of Rule 43.

We believe that appropriately used such reports and responses may prevent future deaths.

Anecdotally, there is evidence that very similar matters appear before the same coroner in respect of very similar medical deaths and no steps are taken to prevent future occurrences or the interested parties are not informed of any such steps being taken,

Question 11: What is the estimated unit cost to the coroner of making a report?

Not within our remit.

Question 12: What is the estimated unit cost to the relevant person/ organisation of responding to a coroner's report? (This is separate to the cost of remedial action.)

Not within our remit but the importance of saving lives means that resources should be targeted at making sure that the lessons are learned out of any death.

Question 13: What is the estimated unit cost to coroners of copying reports and responses to interested persons and the Lord Chancellor?

Not within our remit but we believe that greater use of IT and the internet generally would reduce costs.

Linda Lee
Lawyers' Service Manager
AvMA
44 High Street
Croydon
CR0 1YB

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