FORMAL RESPONSE

To the Ministry of Justice's consultation on

DRAFT CHARTER FOR BEREAVED PEOPLE WHO COME INTO CONTACT WITH A REFORMED CORONER SYSTEM.

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

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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.

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 wholeheartedly support proposals to deliver a better service for bereaved families. AvMA has many years experience of advising and supporting families bereaved as a result of a medical accident and has practical experience of the difficulties faced by families coping with the complexities that arise in the majority of medical deaths. The majority families want an explanation as to how their relative died but also want to ensure that lessons are learned and that deaths arising from similar circumstances are prevented.

Although the proposals for change may simplify the process to some extent, as can be seen from the Charter, the issues and the decisions to be made by the Bereaved in exercising their rights are far from simple. Based on our experience, it seems likely that the Bereaved will increasingly require support and assistance throughout this process.

Overview & Key Concerns

- AvMA's concerns fall into two categories those relating to the draft Charter itself and the implementation of the Charter.
- The Charter does not explain or guide the bereaved as to how the Coroner will identify an appropriate next of kin.
- The family appears to have no input into the Coroner's decision to report to an organisation which may have the power to prevent future deaths
- The national minimum standards set by the Chief Coroner should specifically state that minimum standards should be set in relation to all deaths potentially resulting from medical accidents and those deaths where Article 2 is engaged.
- AvMA remain concerned that inadequate funding will lead to the service standards not being met and therefore believe that local authorities should be held accountable for any failure to meet the standards. Inadequate resources should not be accepted as sufficient reason for any failure to meet standards.
- Steps should be taken to notify families where a death is not reported to a Coroner to inform them of their right to notify the death to the Coroner.
- Booklets and explanatory leaflets should be made available to explain to families how they act on their rights.
- All disclosable documents should be made available to families not just those selected by the Coroner to be used at the Inquest.
- A duty should be placed on local authorities to provide a private room for families prior to an inquest.
- The possibility and availability of legal representation should be raised in the draft Charter.
- Funding needs to be made available to provide legal advice and specialist support and assistance in this process

Response to the Consultation

AvMA welcomes the intention to deliver better service for bereaved people and have considered the draft Charter for bereaved people at appendix A of the consultation document.

However, AvMA do have concerns about some aspects of the draft Charter and have more general concerns about its effectiveness and implementation once the wording has been finalised.

1. Comments on the Illustrative draft June 2008

Appropriate next of kin

Throughout the Charter, reference is made to the 'appropriate next of kin'.
Appropriate next of kin is defined as 'the person identified by the Coroner as the main contact point to receive information' and at paragraph 4 page 8 there is reference to the "most appropriate next of kin" as the person who should be notified as to the arrangements at the outset. Presumably, although it is not made clear, the person notified initially may not be the person the Coroner identifies as the point of contact for later information to be communicated to.
The Charter gives no guidance given as to who the most appropriate or appropriate next of kin will be in such circumstances and on what basis he will make any such decision. It seems possible although not specified that it a Coroner may decide that in some circumstances there may be more than one appropriate next of kin.

Based on our experience of inquests and the complex nature of the modern family, AvMA feel some guidance should be given as to who is likely to be the appropriate next of kin in such circumstances. AvMA are aware that the suggestion of a hierarchy was rejected but we still feel that this leaves a great deal of uncertainty which may cause difficulties and conflict for the bereaved.

We can identify a number of situations where this would cause considerable difficulty both for the bereaved and for the Coroner in trying to establish who the appropriate next of kin is and to make appropriate decisions.

It is not uncommon in our experience for differing family members, for example parents of deceased, ex partners with children from the deceased, current partners)although not in a long established relationship) to expect that they should be the person consulted by the Coroner. It is not uncommon for differing family groups to refuse to communicate and a decision to select one family member over another may lead to a family group being excluded from the process.

We also query whether the Coroner's choice of appropriate next of kin should be capable of appeal to the Chief Coroner in circumstances where decisions will be made by reference to the most appropriate next of kin.

Reports to prevent future deaths

At paragraph 25, page 10, it appears that the Coroner will decide whether the evidence he or she has heard should lead to a report being made to an organisation which may have power to take action to prevent deaths in the future, without reference to the family.

AvMA would prefer that the family have a right to request such a report being made or at the very least have the opportunity to make representations to the Coroner. Where a Coroner refuses to agree to take such action, we would suggest that a right of appeal to the Chief Coroner should be established for a Coroner's refusal to agree to a report being made to any such organisation.

In AvMA's experience, there was sometimes a perception by the bereaved that some Coroners were unwilling to exercise their powers under Rule 43 particularly where the family believes the Coroner had an ongoing relationship with the organisation as for example in the case of hospitals and hospital deaths.

Any such right to make a representation or right to appeal a decision should be stated in paragraph 25.

Other responsibilities of the Chief Coroner

At paragraph 44, the Chief Coroner is stated as being responsible for setting national minimum standards across a range of Coroner functions. It states that there should be specific standards in relation to particular types of deaths or suspected deaths. We would suggest that a category of death which should be mentioned specifically would be that which relates to any death arising from a medical accident.

Medical accidents are of particular importance because there is a considerable potential for preventing loss of life in the future. All too often, in our experience, such deaths are not investigated to a sufficient extent, to enable lessons to be learned from the medical

accident or to inform the Coroner as to steps he or she could take to ensure that duch deaths are prevented in future.

Where it appears that one or more persons acting on behalf of the state are, or may be, in some way implicated in a death (whether by their actions or ommissions), the state is under an obligation under Article 2 of the European Convention on Human Rights[2] to initiate an effective public investigation by an independent body.

Where such deaths occur, the Coroner must determine whether or not Article 2 is engaged and must ensure that there is an effective public investigation as the limited ambit of a traditional inquest is insufficient for this purpose.

Where Article 2 is engaged (which would extend beyond medical deaths, such as deaths in mental hospitals but also to deaths in custody, deaths in prison), the Chief Coroner should lay down specific standards to address Article 2 deaths and this should be explained in simple terms to the bereaved in the Charter.

Although we accept that not mentioning the category does not prevent the Chief Coroner from setting national standards, the importance of these categories of deaths would be recognised and highlighted as an area which needs to be addressed urgently.

2. General concerns regarding the implementation of the Charter

When a death is reported to the Coroner

AvMA remain concerned that the Charter will be ineffective unless Coroners are given extra resources to ensure that they can meet the service standards set out in the Charter.

We note that at a number of instances, such standards are to be offered “where reasonably practicable”.

For example, at paragraph 4 page 8 it is stated that when a death is reported to the Coroner, the Coroner or Coroner’s officer will contact the most appropriate next of kin, where known and where possible, within one working day.

We would welcome a definition of “where possible”. It appears to us that although it is entirely possible that next of kin may not be located, the most likely reason why this standard will not be met will be that there are insufficient resources to enable the Coroner to notify the appropriate next of kin within one working day and we would specifically request that lack of resources should not be acceptable as a reason for not meeting this or any other standard.

It is not clear how these rights will be enforced and what the penalties will be when these standards are not met.

From the outset AvMA have been concerned by the refusal to agree to a national service centrally funded.

We would recommend that it should be the local authorities whose Coroners do not meet these standards that should be held to account, as we suspect that failures will mostly occur due to a lack of resources being made available to a Coroner.

Right of a family to report a death to the Coroner

Although we note that a family member has a right to report the death to the Coroner personally, we are not sure how this information will be conveyed to the bereaved as they will not have any contact with the Coroner's office and the normal system to alert them to this possibility.

Is it intended that the burden should be placed on the police officer or doctor notifying the family of the death or the person certifying the death? It occurs to us that although this duty could be placed on the person registering the death, this may be conveyed to the family far too late for appropriate action to be taken by them.

How to appeal to the Chief Coroner

AvMA would hope that the draft Charter will be accompanied by a series of booklets which will explain in more user friendly detail how the Bereaved may exercise the rights set out in the Charter.

For example, how they may appeal to the Chief Coroner and also, where a pre-inquest review is held, what sort of representations a family may make to the Coroner about how the inquest is held etc.

Inquests – documents

At paragraphs 18 and 19 of the Illustrative draft, it is made clear that all relevant documents to be used in an inquest will be disclosed free of charge and in advance of an inquest which is a welcome step forward.

However, there may be documents that have been obtained by the Coroner which he or she chooses not to use at the inquest. Such documents may not be covered by any of the exemptions which would not permit disclosure, for example national security. AvMA would suggest that either all of the documents be made available to the family and/or

their advisors and if this is not possible, for a schedule of all the documents not disclosed to be provided to the family at the same time as the relevant documents are disclosed so that the family have the opportunity to request specific documents should they so wish.

Inquests – private room

At paragraph 21 of the Illustrative draft, 'wherever possible an appropriate private room will be provided for bereaved relatives when they attend an inquest'.

Our experience at inquests around the country is that not all inquests are held in venues where this is possible.

The original draft Bill suggested that there should be an obligation on local authorities to provide suitable accommodation but this has been removed.

AvMA believe that privacy for the family to prior to the inquest and the opportunity to have confidential discussions with their advisors is extremely important.

AvMA suggest that a positive duty to provide a private room is stated in the draft and that lack of provision of resources by a local authority should not provide sufficient reason for the lack of a private room at an inquest for the family.

LEGAL REPRESENTATION

The Bereaved Charter does not make reference to the right to independent legal advice and representation whether funded by legal aid, legal expenses insurance, privately or pro bono.

We feel this should be stressed particularly for inquests of considerable complexity such as those involving medical deaths.

It was originally envisaged that public funding would be available for representation at complex medical inquests following the decision in R (Khan) v Secretary of State for Health which determined that State had an obligation under Article 2 of the European Convention on Human Rights to provide funding for representation of the deceased's family at an inquest into a complex medical death. However this decision has been interpreted very narrowly

As reported in the Times (August 13 2008) only one in three requests to receive exceptional discretionary funding is granted.

In 2005-06, the latest figures available, 75 requests for funding were made and only 25 granted. Where deaths in custody occurred, funding was easier to obtain, and 58 out of 88 requests were granted.

AvMA would hope that pressure be brought to bear on the Lord Chancellor and the Legal Services Commission to extend the availability of legal aid in complex medical inquests

There is also a need for specialist help and support at inquests which goes beyond the scope of many of the schemes which are currently in existence at a minority of Coroners courts in England & Wales at the present time. Although AvMA acknowledge that many Coroners and their officers do try to explain to the Bereaved the process, they do not have the resources to give all of the support required or have the specialist knowledge to appropriately advice the Bereaved in relation to medical deaths.

Linda Lee
AvMA
44 High Street
Croydon
CR0 1YB