Legal issues and challenges for the coroner

in inquests where medical care may be criticised.

AVMA 15th May 2018

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When is medical cause of death is natural?

- Medical decisions as whether reportable
- Interpreting the MCD. Errors. GVHD.
- How to fairly understand family and medical concerns
- When is autopsy required
- Proper instruction of pathologist
- What is extent of investigation
- How to explain law when discontinuance and redirect concerns

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When is death involving a medical intervention unnatural at **opening stage**?

- Difference between MCD and coroner conclusion
- Scientific opinion on whether cause is natural
- Statutory interpretation of "unnatural"
- Legal contexts of prima facie unnatural death being natural – unexpected, Falls and OAFS
- Legal contexts where prima facie natural death may be unnatural – *Touche*
- The use of IPs attending an Opening Hearing

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When is death involving a medical intervention unnatural at **inquest**?

- Legal contexts where prima facie unnatural death may be natural
  – *Benton*
  implications for emergency interventions
- Legal contexts where prima facie natural death may be unnatural
  – *Touche*,
  - contributory causes
  - new evidence
- When is narrative useful?

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Case Law

- *Touche* applies only if prima facie natural
- Only *possibility* of neglect needed to trigger s1 duty *(Bloom)*
- Circumstance needs to be of some significance *(Terry)*
- No need to enquire into every possibility *(Harris)*
- Circs that shorten life even by a few days are significant *(Longfield Care Homes)*
- Threshold for determining if interventions make the death unnatural may be lower than cases where the alleged failure is an omission; may require expert *(Canning, cf Bicknell, Bloom)*
- Public interest is an important consideration in determining scope, even in *Jamieson (Plymouth)*

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When is PIRH useful?

- Demystifying medical language and thinking: building trust with IPs
- When contested evidence, complexity, family concerns not allayed, when key evidence available
- The determination of scope and A2 submissions. *Rabone* *Fernandes*
- Value of identifying key issues
- Matching IP expectations and fears about blame with court role
- Specific Directions, cross disclosure
- Representation and Assisting unrepresented IPs

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Disclosure

- Timeliness and use of Schedule 5 Orders
- Difficulty in interpreting medical records.
- Inspection
- Pagination
- Court - Identification of issues or witnesses
- Use of websites and intranets
- Role of SUIs/RCAs/Death Reviews – when called in evidence

When is neglect in play and how is it best ascertained?

- Explaining what is neglect
- Evidence on causation
- Evidence on a failure of basic medical care
- Time frame
- Care in directions
- Evidence may lead to PFD report

When is independent expert required?

- When failure/causation needs resolving in potential neglect
- Credibility and accountability of medical witnesses
- Clarity on precise expertise required – which specialty
- Using / Instructing IP experts
- Independent medical expert instructions
- Avoiding calling/ AV link

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The inquest

- Briefing families
- Preparing clinicians
- The order of witnesses – when PM first, releasing clinicians
- Questioning to issues – how much latitude?
- Focusing on causation
- Submissions. Reality of Cor Rule 27.

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Coroner's Conclusions

- How extensive summing up of evidence
- How much should evidence be cited in directions?
- When to use questionnaire
- Inconsistency in Box 3 and 4
- Short form v. narrative.
- Suicide
- Extent of *Galbraith plus*
- Contributory matters / PFD matters

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Variations in Coronial Approaches

- Handling witnesses
- Distinguish variations that are significant from trivial
- Identify underlying reasons for variation
- Is consistency is legally necessary? Does flexibility assist IPs?
- Case mix; Jurisdictional stats combine different coroners
- Be aware of the different resourcing and operational issues
- Ensure any challenge is ripe
- Cite case law. When to quote peer practice

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Opportunities for promoting efficiency and understanding between health and court

- Annual consultative meeting with NHS Trusts and Registrars
- Formalised reporting form and processes
- MoUs
- Joint coroner- pathologist case reviews
- When recusal needed
- Supporting and informing coroner's case officers
- Extra-judicial role in lectures and discussions

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The particular challenge of medical cases

- Professional – lay communications
- Avoiding mistrust developing. Transparency.
- The coroner's court: means of securing closure, springboard for civil claim or opportunity to prevent litigation?
- The predisposition to blame
- Cultural denial of death and the need for better preparation

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