Introduction

Tania is a clinical negligence solicitor with 20 years' experience of representing patients and families in claims and at inquest. From her involvement in hundreds of inquests she shared a number of themes she considers vital to ensuring investigations are full and fearless, as well as tips and insights on how to communicate with bereaved families.

The importance of the investigation to a family

Families seeking legal representation at inquest often want a number of outcomes:

- Answers about how their loved one has died because they don't understand what happened and often have many unanswered questions.
- To prevent recurrence and "stop it happening to others"
- To get an acknowledgement of harm/wrongdoing.

Families can struggle to understand the limits of the Coroner's remit which is to answer 4 questions about the Deceased, namely who they were and where, when and how they died. Inquests are a fact finding process and blame or liability are not a part of the Coronial system. Sometimes it can be difficult for families to accept the limitations of the inquest process.

Communication

Effective communication with the bereaved family is key:

- Duty of candour.
- Positive family engagement at all stages. Remember the family knew the Deceased best – invite them to contribute and listen to them.
- Be open and transparent in your investigations. Provide a written explanation as soon as possible and a true account of what happened in written and oral evidence.
- Timely communications and disclosure. Don't leave any admissions or disclosure until the last minute as families can see this as an ambush which creates lack of trust.
- If a decision is made not to proceed with an investigation, explain why.

Introduction

As Tania said, what the family really want are answers and it is critical that we ensure families understand the purpose and expectations of the coronial process. Healthcare providers have an ongoing relationship with the family and it is imperative that those relationships are preserved and that trust is not broken, and that families feel they are part of the process.

Managing expectations and understanding of different investigatory processes

The Duty of Candour and complaints process all feed into the relationship with the family who may be involved in a number of different processes in addition to an inquest in the aftermath of a traumatic event, e.g. a complaint or an internal or external investigation as well as the inquest.

It is important to ensure families understand the respective remits and complexities of each of those different processes and what each one will address, remembering that it is likely they have no experience or understanding of the various investigations and what each aims to address. The most vulnerable of families will find it hardest to understand and to get the answers they seek.

Transparency and openness

NHS Resolution has done a lot of work around the Duty of Candour and ensuring that all healthcare staff are open with the family and lines of communication are transparent. Being able to be open with the family regarding cause of death is key. Admissions that come as a surprise to the family as part of a lengthy claims process where any problems with care have previously been denied are not well received and break the trust between the family and the organisation.

You can find NHS Resolution's resources on the duty of candour here and here (saying sorry) and lots more resources in the Faculty of Learning here

Keeping the family informed

It is really important to

- Inform the family in a timely manner regarding developments.
- Inform the family that it is normal for the organisation to have legal representation at inquest.
- Think about the use of language; legal language is often challenging.
- Think about how you refer to the deceased in front of the families - use their name.

Impact on healthcare professionals

Where there is an unexpected death the impact on families is great, but it is also significant for healthcare professionals who have experienced traumatic events and are now part of the investigatory process. NHS Resolution have addressed this in our Being Fair reports Being fair and Being fair 2

Ensure that investigatory processes are fair and consistent and in place for all staff. It is recognised that this improves culture and allows staff to be open and transparent.

Compassionate conversations

This applies to families and staff. Consider whether the system gets this right when multiple processes are underway. How do we have those conversations in a compassionate way to ensure that families understand and that everyone is supported?

Practical realities

Thank you for inviting me to talk about how we can improve communications with families at inquests. Apart from anything else, it enables me to offer some brief reflections on the place of the bereaved within the inquest process.

It is, I think, difficult to understand the judicial investigation of unnatural deaths in England and Wales in isolation from the wider death certification and registration system with which it interlocks.

All civilised peoples, past and present, have accepted that the living owe a posthumous duty to care for the dead. So important is that duty that it gives rise to a concomitant obligation on the state to do what it can to enable the living to discharge it. Care for the dead is one of the most deeply rooted human impulses. It has always been recognised as possessing a moral, and not merely utilitarian, dimension. As William Gladstone once put it:

"Show me the manner in which a nation cares for its dead and I will measure with mathematical exactness the tender mercies of its people, their respect for the laws of the land, and their loyalty to high ideals."

More recently, in 2006, the Commons select committee for Constitutional Affairs expressed the same principle with great clarity, albeit in less flowery language:

"The death certification and investigation systems have essential

What about reports for the prevention of future deaths, or ‘PFDs’? After all, if the inquest is, to use Lord Burnett’s words, “an inquisitorial and relatively summary process”, how do PFDs fit into such a scheme? The starting point is that PFDs are a relatively recent addition to the armoury of coroners. They are very important and can achieve a great deal when properly used, but the prevention of future deaths is not the primary function of a coroner’s investigation.

Last year, I had the privilege of attending a surgical audit and quality meeting at a hospital in the North of England. I believe I am the first Chief Coroner ever to have done so. I found it a fascinating and instructive exercise. One point that came across very strongly to me was that there seems to be a strong sense among medical professionals that being issued with a PFD is something to be avoided, as if it were a source of disgrace. I hope I was able to convince the doctors I met on that occasion that it is nothing of the kind.

Until comparatively recently, as you all know, the coroner’s obligation ended with the answers to the four statutory questions: ‘Who, when, where and how’. For the past few decades, however, the coroner has had an ancillary jurisdiction, in cases where he or she believes that action should be taken to prevent the recurrence of fatalities, to make a written report for the prevention of future deaths.

The Coroners and Justice Act 2009 sought to make that process more robust by converting what had previously been a power into a statutory duty. The current legislation provides that where anything revealed by a coroner’s investigation gives rise to a concern that circumstances creating a risk of other deaths will occur in the future, and, in the coroner’s opinion, action should be taken to prevent such circumstances or eliminate or reduce the risk, the coroner must report the matter to a person who the coroner believes may have power to take such action.

I think it is important to keep in mind that although the provision is a mandatory one, so that we can properly speak of a duty, rather than a mere power, to issue a PFD report, the statutory criteria giving rise to the duty are not quite as sharp-edged as we might be tempted to assume. In particular, the duty only arises where “in the coroner’s opinion” action should be taken.

That necessarily imports a significant subjective element – the coroner’s opinion – into the process. In the recent case of *Dillon v HM Assistant Coroner for Rutland and North Leicestershire*, the High Court explained that:

“The coroner must act rationally in coming to the opinion held, but different coroners could reasonably come to opposite opinions on the same facts without either being wrong to do so. In other words, there is no single, objectively correct answer to the question raised by the second criterion in any particular case.”

It follows that the statutory duty to make a PFD report may arise in one case and yet not do so in another, even where the underlying facts are practically indistinguishable.

That is how the courts have interpreted the statute as enacted by Parliament. Now the reason I mention this point is that we need to recognise the limitations of reports to prevent future deaths. While such reports are important, they are not and never have been, a core element of the coroner’s jurisdiction. They are ancillary to that jurisdiction

Given the relatively narrow limits of the coroner's investigation, it is scarcely surprising that the ancillary duty to make reports to prevent future deaths is equally summary in nature. The Act of Parliament specifies next to nothing about their content. For that, we must turn to the official guidance issued by successive Chief Coroners, which explains that a PFD report must, first, state the coroner's concerns and, second, say that in the coroner's opinion action should be taken to prevent future deaths. Put another way, it is a recommendation that action should be taken, not what that action should be. It is neither necessary, nor even appropriate, for a coroner making such a report to identify the necessary remedial action. As Lady Justice Hallett once put it, "the coroner's function is to identify points of concern, not to prescribe solutions."

It remains a fact that the public and those to whom PFD reports are addressed can sometimes entertain unrealistic expectations of PFDs or regard them as sources of public opprobrium. I'm sorry to say that some coroners may themselves have contributed to this by occasionally straying close to, or even beyond, the proper limits of the process, either by attempting to make specific recommendations or by indulging in language that is not, perhaps, quite as temperate as judicial proprieties dictate. Of course, the High Court supervises the work of the coroner judiciary by way of judicial review; the recent case of *Dillon* that I mentioned above provides an example of that supervision in action. But attempts to expand the scope and aims of PFDs beyond their proper statutory limits are counterproductive. That's because they can give rise to an incentive for those who might wish such reports to be issued, as well as for those to whom they might be addressed, to attempt to litigate the question whether there should be a PFD and, if so, what it should contain. That ought not to happen. The decision whether to issue a report is entirely a matter for the coroner, who is under no obligation to consult interested persons, although he or she will usually do so as a matter of courtesy.

Equally, hospital trusts and other organisations, and those who represent them, need to understand that the purpose of a PFD report is not to criticise or humiliate. It is to draw attention, without recommending any specific solution, to the existence of possible learning points. That is something to welcome in the public interest, not to seek to avoid as if it were some kind of badge of dishonour.

Let me turn to another practical topic. The primary responsibility for ensuring that there is proper communication with families is that of the coroner, although lawyers who appear at inquests are bound by their own professional codes of conduct, including, of course, the legal regulators' inquest 'toolkit'. By sympathetically explaining the process to interested persons and witnesses, coroners and lawyers can do a great deal to manage expectations and thereby ensure that the inquest remains faithful to its true, inquisitorial purpose.

It is easy for legal professionals to forget that an inquest may be as daunting for medical witnesses as it is for others, including even bereaved families. At every stage of the hearing, therefore, coroners and lawyers should do what they can to put interested persons and witnesses, including professional witnesses, at their ease. The calming effect of a few kindly words of reassurance should not be underestimated. A senior consultant once told me that he turned up full of foreboding at a coroner's court where he was due to give evidence but, on hearing the coroner's reminder that the process was inquisitorial and not about assigning blame, he immediately felt his nerves settle and was filled with interior peace.

1. How does the Coroner decide who should be called to give evidence?

In my experience often the author of reports/Root Cause Analysis forms is called. This is often a senior member of the ward team (but not always). This person has valuable details on the incident, the learning and any progress already made locally with improvements since the incident occurred. There are occasions when this person does not have to hand expert subject matter information that would be supportive for families/the corner to have during an inquest. Is there scope in having more than 1 witness to ensure there are people there who were close to the patient and the incident but also others that may have information of organisation response changes/the ability to more widely share information discussed?

Answers:

- There is certainly nothing wrong with having more than one witness even though they may cover the same area or material.
- However, what witnesses are called is case-specific and depends entirely on the questions that arise.
- It is about balance. There is a risk of calling too many people increasing the pressure on both the organisation in relation to who is available and families when organisations attend with too many people.
- Internal report authors tend to give an overview even though they may not have had any individual involvement in that particular case. This provides reassurance to the coroner and family as to whether any difficulties have been identified and the steps taken in relation to the prevention of future deaths.
- There is no limit on the number of witnesses the Coroner can call. If an organisation or a family's representative is concerned that there are gaps in the evidence it is usual to write to the Coroner to identify that and any Interested Party can make submissions on the witness list.

2. Consistency between Coroners

How can we improve consistency between coroners? In our area there is good communication between the regional coroners and with the child death review services. However colleagues elsewhere have a much more challenging time which is a shame. The work we do to review deaths should be complementary and can avoid duplication and also the potential of misinterpreting medical information. We are keen to collect as much information to help the coroner because ultimately we want to know the answers to the same questions and help the families, causing as little distress as possible.

Answers:

- Good communication is always desirable.
- Consistency is promoted but that does not extend to seeking to achieve uniformity or trying to interfere with judicial decision making. It is inevitable that there will be different ways of doing things across different jurisdictions.
- No formal guidance to the country as a whole would be of any value as, by its nature, it would have to be too vague and general.

And a related question regarding **supervision of Coroners and training requirements** **(continued overleaf)**

- Coroners are independent judges and cannot be "supervised" in the way that perhaps some might be tempted to assume.
- They are answerable to the higher Courts and challenges to their decisions are made through appeal or judicial review under the judicial system.
- It is not appropriate for example for one Coroner to check the work of another because that would be unconstitutional.
- Misconduct is dealt with by the Judicial Conduct Investigations Office (JCIO).
- Coroners do not have CPD like some other professions.

Answer: (continued)

- The policy behind the law is a matter for policy makers and the Chief Coroner cannot comment on this.
- Inquests cannot be conducted by email, they have to be - in the formal sense – hearings.
- However, it is possible to conduct inquests entirely on the documents without the need to call oral evidence. At Paragraph 23, the Guidance expressly states that "*Coroners should consider whether it would be appropriate to conduct any inquest in writing, or admit written evidence under rule 23, to avoid the family going through the stress of an in-person hearing".*

Resources

Toolkit for advocates who practise inquest law

Chief Coroner's Guidance No. 44: Disclosure

Chief Coroner's Guidance No. 41: Use of 'Pen Portrait' Material[1]

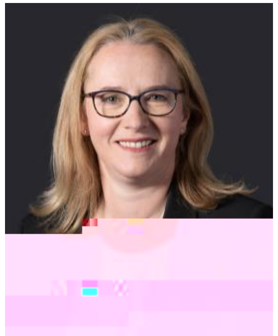
Browne Jacobson have produced a range of resources to help organisations and witnesses involved in the inquest process, which are available all free of charge on our website here. For more information on giving evidence please see our see our Inquest Guide for Clinical Witnesses and the range of resources including our Mock inquest training video and other inquest resources, which are all free of charge on our website.

To watch NHS Resolution's inquest films click here

To register for future Shared Insights sessions and access notes of all previous sessions free of charge visit our Shared Insights Hub.

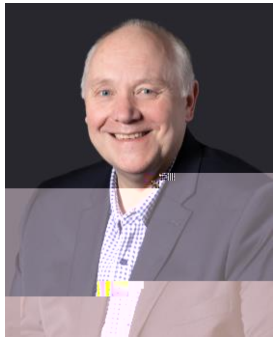
How we can help

- Our specialist team can support you and your staff through the inquest and litigation process. Please do get in touch with Nicola.Evans@brownejacobson.com or any member of our inquest team to discuss how we can help.
- We can also provide advice and support to help with the transition to PSIRF and ensure that PSII reports are prepared and written to a high standard.
- Areas we can help you with include:
  - Deep dives of claims/inquests to assist with identifying your risk profile.
  - Support and training in relation to drafting PSIIs (or Serious Incident Reports during the transition to PSIRF) to ensure that they are clear and effectively communicate findings which are based on the evidence and linked to appropriate areas for improvement and developing safety actions.
  - The documentation and storage of records produced in respect of responses other than PSII.
  - Training on other areas relevant to PSIRF including statement writing and duty of candour.



Lorna Hardman
Partner

+44 (0)115 976 6228
lorna.hardman
@brownejacobson.com



Simon Tait
Partner

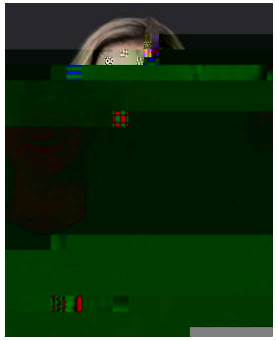
+44 (0)115 976 6559
simon.tait
@brownejacobson.com

Damian Whitlam
Partner

+44 (0)3300452332
damian.whitlam
@brownejacobson.com

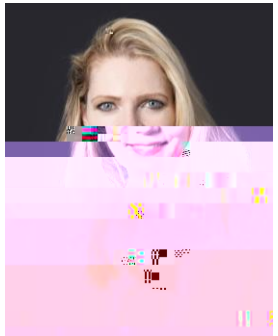
Nicola Evans
Partner

+44 (0)330 045 2962
nicola.evans
@brownejacobson.com



Rebecca Fitzpatrick
Partner

+44 (0)330 045
rebecca.fitzpatrick
@brownejacobson.com



Heather Caddy
Partner

+44 (0)330 045 2516
heather.caddy
@brownejacobson.com