Shared Insights
Coroners' Question Time

Chair:

Nicola Evans, Partner, Browne Jacobson

Panel:

Mr Zak Golombeck - Area Coroner for Manchester City

Miss Louise Pinder - Assistant Coroner for Derby and Derbyshire

Miss Rachel Spearing - Assistant Coroner for Hampshire, Portsmouth and Southampton

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Introduction

This session focussed on two areas:

1. Disclosure and the Chief Coroner's recent guidance on disclosure
2. PSIRF and implications for presenting organisational learning at inquests.

We were pleased to welcome our panel,

- Mr Zak Golombeck - Area Coroner for Manchester City
- Miss Louise Pinder - Assistant Coroner for Derby and Derbyshire
- Miss Rachel Spearing - Assistant Coroner for Hampshire, Portsmouth and Southampton

Disclosure

The Chief Coroner has recently published GUIDANCE No 44 to provide practical advice for Coroners on both stages of the disclosure process:

1. Obtaining disclosure (the first stage) and
2. Providing disclosure to IPs at a timely stage of the investigation process (the second stage).

Of particular interest is **Paragraph 4** of that guidance – which provides an example of wording Coroners could use when ordering Interested Persons to provide disclosure:

I direct that: (i) By [date] all Interested Persons, having conducted reasonable and proportionate searches, must assure the Court in writing that all potentially relevant documents identified by their searches have been disclosed to me; and (ii) By [date] all Interested Persons must indicate with precision and in writing any suggested shortcomings in disclosure made to them (within the scope of the Inquest).

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Fundamental points Trusts and organisations need to remember about disclosure

The panel considered whether Paragraph 4 creates a new legal obligation for Trusts?

- In short – no. Procedural justice has always existed in inquest proceedings. Paragraph 4 is a calibration of general principles that have always existed.
- It ensures disclosure is given the importance that it requires and deserves: in both straightforward and complicated inquests.
- This is a reminder to Coroners that it is important to set out case management points and give directions.
- It is hoped this will reduce delays in the inquest process resulting from issues regarding disclosure, and provide continuity and consistency across different jurisdictions, for the benefit of Coroners and all Interested Persons.
- This is an opportunity to streamline, develop good practice and improve the quality of disclosure across the board.

Key points to remember about disclosure:

1. There is a distinction between disclosure to the Coroner and disclosure to the public and other Interested Persons. Disclosure should properly be regarded as a two stage process.
2. The first stage is disclosure to the Coroner only.
3. In the first stage, the Coroner should request all reports or other material which he/she believes to be relevant for the purpose of assessing the scope and content of the inquiry. It is for the Coroner to determine what is relevant. GUIDANCE No 44 states (Para 3e) that unless there are exceptional circumstances the Coroner should attempt to obtain disclosure by agreement. However, if the documents are not forthcoming then the Coroner has the power to issue a **Schedule 5** notice to compel a Trust to provide a written statement or produce any documents which are relevant to the investigation.
4. The second stage is disclosure by the Coroner to the Interested Persons.
5. In the second stage, once documents have been presented to the Coroner it is for the Coroner to consider whether there can and should be onward disclosure to Interested Persons (IPs). In doing so, the Coroner must bear in mind Rules 13 and 15 on disclosure.

Rule 13 of The Coroners (Inquests) Rules 2013 is the starting point: it states that *'where an interested person asks for disclosure of a document held by the coroner, the Coroner must provide that document or a copy of that document, or make the document available for inspection by that person as soon as is reasonably practicable'*.

Rule 13 expressly states that this applies to the Post Mortem Report and any other report that has been provided to the Coroner during the course of the investigation.

Rule 13 is, however, subject to Rule 15 of The Coroners (Inquests) Rules 2013, which states that 'a Coroner may refuse to provide a document or a copy of a document requested under Rule 13 where:

a) there is a statutory or legal prohibition on disclosure;

b) the consent of any author or copyright owner cannot reasonably be obtained;

c) the request is unreasonable;

d) the document relates to contemplated or commenced criminal proceedings; or

e) the Coroner considers the document irrelevant to the investigation.

Where a document is deemed irrelevant, this simply means irrelevant to the scope of the inquest.

This should provide some comfort that certain documents may be disclosed to the Coroner and remain with the Coroner only i.e. where the Coroner decides the documents do not need to be disclosed/are irrelevant or contain third party, confidential or sensitive information such that the public interest in non-disclosure outweighs the benefits of onward disclosure. An example might include Safeguarding Adult Reviews. The Coroner will consider submissions prior to making onward disclosure – this is considered further in the Worcestershire Case.

Disclosure - Panel discussion

Is it anticipated that a direction under Paragraph 4 will become commonplace in all inquests?

- Good communication over the years between the Coroner and hospital Trusts mean that written directions like this may not be necessary. Principles of mutual co-operation already exist.
- They might be used for example in particular cases where the disclosure is more piecemeal, multifaceted or problematic.
- Where **Paragraph 4 is used**, it is designed to assist the disclosure process and provide transparency about what has been requested and what steps have been taken to look for those documents. Whilst it might seem onerous, it doesn't change the principles of disclosure that already exist.

Should we just disclose absolutely everything to Coroners?

- It is important to strike the right balance. Disclosure of lots of documents that are not relevant could be unhelpful to the inquests process as the system will be slowed down. Coroners do not have the resources available to wade through bundles of irrelevant documents.
- Communication between the Trust and the Coroner's office is key.
- Request clarification if the scope of what is required is not clear.
- Coroners can give specific direction as to what is required in terms of context and content of disclosure.
- A covering letter setting out what searches have been undertaken can help the Coroner to understand the extent of the disclosure material and how it has been found. Equip the Coroner with information to navigate and manage any potential issues that arise to quell or quash any suggestion of conspiracy or cover up of documents.
- Remember there is an ongoing duty of disclosure if further documents are located later. This can be the case particularly where records are stored electronically in various different pockets/systems and further documents are discovered after primary disclosure has been provided. Be alive to new documents being created as part of an investigation process.
- Whilst dealing with disclosure thoroughly may take more time at the beginning of the inquest process it is likely to be of benefit later.
- It may be that the PIRH is utilised more to deal with disclosure e.g. if the issues are narrowed at the PIRH so the disclosure is narrowed.
- If organisations are aware of an electronic document which is central to an inquest, do an audit of that now to obtain information regarding when it was drafted, when it was updated etc.

Does the panel have any thoughts on what the implications will be for organisations or individuals who provide the written assurance under Paragraph 4 …. What is the likelihood of sanctions if new documents come to light after the assurance has been provided?

- This will be for individual Coroners to decide. The panel felt that sanctions would only be used in exceptional circumstances but different Coroners may take different approaches.
- Communication, transparency and openness are key.
- If there is evidence of intentionally withholding documents or insufficient focus on a particular document then sanctions may be considered. These can include a fine or imprisonment in exceptional cases.

Practical steps and Top Tips on disclosure

What practical steps can health and care organisations take to mitigate the risk of sanctions:

- One practical difficulty is that documents are often stored in different places and on different systems – consider taking steps to centralise storage of documents as much as possible.
- The inquest handler should keep a running table setting out the detail of searches performed (parameters, where has been searched, date, who by) to help keep track of steps taken to track down relevant documents. Remember the scope of an inquest can change during the process so it would be useful to be able to look back at the extent of the searches carried out. This would also be useful for disclosure obligations should litigation arise.
- If you intend to make submissions under the Worcestershire Case that documents are sensitive and should not be disclosed to the other IPs, provide the Coroner with a schedule which clearly identifies the documents you agree should be disclosed to the other IPs and those which you submit should not.

The Panel's Top Tips regarding disclosure

- Give your attention to disclosure early in the inquest process. Take the time to search for and locate the relevant documents at the outset.
- Thoroughness over speed.
- Don't be afraid to ask for an extension if you need more time for the search to locate relevant documents – make sure you explain why the extension is required.
- Don't be afraid to seek clarification from the Coroner – if you are not sure what documents the Coroner wants, ask.
- Openness and communication with the Coroner are key.
- Do not forget you have an ongoing duty of disclosure. If further documents are found following primary disclosure, deal with them in the same way using disclosure principles.
- When providing disclosure, provide a clear concise letter setting out what searches you have carried out and why (with the scope of the inquest in mind) and listing the documents you enclose by way of disclosure. It will help the Coroner a lot if you organise the documents and disclose these clearly labelled and organised – rather than disclosing a large number of disorganised documents in a "document dump".
- If you have identified documents which you are not disclosing, tell the Coroner what you have found and why you are not disclosing these e.g. they are not relevant to the death.

PSIRF and implications for presenting organisational learning at inquests

Amelia Newbold and Sian Quirk
Browne Jacobson LLP

PSIRF - Patient Safety Incident Framework - potential impact on inquests

We had a previous Shared Insights session on PSIRF in November 2022. You can read the note from it here. It sets out the background in detail.

Transition to PSIRF, which replaces the Serious Incident Framework, is due to be completed by Autumn 2023.

- Under PSIRF some incidents will still merit or mandate an investigation report, a Patient Safety Incident Investigation Report (PSII). This will include all deaths which fall in the Learning from Deaths criteria.
- However, in some cases there will be a different learning response such as a case review, MDT, Swarm Huddle or an After Action Review. The output from the relevant response will need to be shared with the Coroner and Trusts will need to think about the best way to document all the relevant information.
- Inquests and litigation processes are separate. Witness statements are not recommended under PSIRF and should be collected outside the learning process. Under PSIRF, organisations are also not expected to make judgments about cause of death and organisations may need a separate position statement on causation for the Coroner.

- The Coroner's duty under Regulation 28 remains the same.
- However, for Trusts, preparing for inquests is likely to require a different approach (in terms of disclosure and evidencing organisational learning. Trusts may need to consider:
  - How will the PSIRF learning responses and associated documentation be centrally collated/stored for disclosure purposes?
  - How will Trusts ensure accuracy of notes of huddles etc and ensure that all staff, especially junior members of a team have a voice in the process and agree with what has been documented?
  - How will this evidence or organisational learning be presented to the Coroner? You will need to consider who should present this and whether a separate organisational learning report or Position Statement is required, exhibiting the documents generated by the PSIRF learning response.
  - It may be useful for Trusts to engage with your local Coroner to plan for how you will deal with disclosure of documents generated by PSIRF learning responses and present evidence or organisational learning once the new Framework has been implemented.

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PSIRF and implications for presenting organisational learning at inquests

Panel Discussion

The panel considered that:

- The Coroner's duty in relation to Prevention of Future Death Reports remains the same. Coroners have a duty not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths. If something is revealed by the Coroner's investigation which gives rise to a concern that there is a risk of future deaths then the Coroner's statutory duty to make a PFD Report will be triggered.
- Coroners will therefore continue to seek the same assurance from Trusts that there has been organisational learning and Trusts will need to provide evidence that effective steps have been taken to address any risk of future deaths.
- How that evidence is presented is a matter for the Trust. Learning evidence should be provided to assure the Coroner that learning points have been identified and there is a plan (and ownership of that plan) to put things right. How this evidence is presented is a matter for the Trust –if the Coroner is not assured by the evidence then the duty to issue a PFD Report will be triggered.
- Trusts should identify a witness to give evidence about the learning and on causation.
- A position statement may be helpful on causation.
- PSIRF will not change things for Coroners but it will change things for the Trust in terms of the framework they will need to work within when learning from incidents and deaths.

How we can help

Our specialist team can support you and your staff through the inquest and litigation process.

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.

Resources

For more information on PSIRF and supporting guidance go to the NHS England website

If you are not already a member of the NHS Patient Safety Futures Forum you can become a member by emailing NHSps-manager@future.nhs.uk

For useful inquest resources, see our Inquest Guide for Clinical Witnesses and Mock inquest training video and other resources, which are all free of charge on our website.

Finally, there are still spaces available on our next Mock Inquest Training Course , which starts in March 2023.

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