Shared Insights

Improving communication with families through the inquest process

The Chief Coroner His Honour Judge Thomas Teague KC

Simon Hammond, NHS Resolution

Tania Harrison, Irwin Mitchell

Nicola Evans, Browne Jacobson LLP

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Introduction

We were thrilled to jointly host this extended Shared Insights session with NHS Resolution and Irwin Mitchell.

We were delighted to welcome our extremely experienced panel of speakers:

The Chief Coroner His Honour Judge Thomas Teague KC

Simon Hammond, Director of Claims Management at NHS Resolution

Tania Harrison, Partner at Irwin Mitchell, who shared her experiences as a Claimant lawyer and brings the family's perspective.

And Chair, Nicola Evans, Partner at Browne Jacobson.

The panel discussed practical steps that organisations can take to improve communication with families throughout the inquest process and shared their insights from each of their different perspectives to help shape and inform best practice in this area.

This was followed by a question and answer session with the panel addressing questions submitted by delegates.

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The family's perspective

Tania Harrison, Partner, Irwin Mitchell Solicitors

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.

Investigations and requests for information have an impact on all involved and it can be a natural reaction for clinicians to be defensive. From the family's perspective, clinicians should:

- Record in writing what happened as soon as possible after an incident.
- If you are called to give oral evidence, be prepared. Read all o the papers and make sure you can answer detailed questions confidently, clearly and honestly.

The family's perspective (continued)

Tania Harrison, Partner, Irwin Mitchell Solicitors

- Give clear and honest answers. Try to avoid being defensive, if you don't know the answer to a question then say so.
- Be transparent. Lack of transparency can result in a breakdown of trust in the process. Families appreciate honesty.
- Some conversations will be difficult but sharing the information with families will rebuild trust.
- Remember that the family will be in the court room with you at the inquest so think about how to interact with them on the day and avoid a polarised situation in the courtroom.
- Be sincere and open. Make eye contact with the family and express condolences. An expression of sympathy is not an admission of liability.

Tania gave examples of inquests she has been involved in where there had been delays in communication and lack of transparency, including last minute changes in position and witness evidence, which had a negative effect on families' trust in the process and on their relationship with the healthcare providers going forwards.

Top Tips:

1. Put the family of the Deceased at the heart of the investigation
2. Listen to the family
3. Communication - keep regular contact with families and give realistic timeframes. If there are potential delays, let the family know.
4. Be compassionate e.g. don't hold meetings in the ward where the loved one died. Offer condolences.
5. Be open and transparent from the start
6. Accountability – this is not about blame, it is about improving and evolving. If there have been errors it is about making improvements.
7. Learn and evolve
8. Early resolution . This can help rebuild trust.

NHS Resolution's perspective

Simon Hammond, Director of Claims Management, NHS Resolution

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.

NHS Resolution's perspective (continued)

Simon Hammond, Director of Claims Management, NHS Resolution

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

There are lots of resources are out there for staff:

- Practical videos
- Training sessions on being a witness
- Browne Jacobson's Mock Inquest course
- Guides for clinicians for example on what happens if you are asked to give evidence or write a statement for the Coroner.

Many of these resources are targeted at clinicians and professional witnesses. The Coroner's Service have produced a Guide to Coroner Services for bereaved people.

Consider how can health and care organsations share information with families in the best way and provide these resources which could help reduce hostility and remove the "them and us" feeling, as well as managing families' expectations of the various processes.

Impact on healthcare organisations

We recognise that the coronial process puts significant pressure on health care organisations. There is a fine balance between the need for inquests and the impact on resources. Be open and transparent about the expectations and what can realistically be done to assist with the Coroner's investigations. The last thing the family want is a part heard inquest hearing due to information being incomplete or people not being able to attend.

Improving communications with families through the inquest process

The Chief Coroner His Honour Judge, Thomas Teague KC

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 roles, providing each person who dies with a last, posthumous service from the State; they serve families and friends by clarifying the causes and circumstances of the death; and they contribute to the health and safety of the public as a whole by providing information on mortality and preventable risks to life."

That neat summary makes explicit the organic connection between the coroner's inquest and the death certification system and correctly situates the deceased at the heart of both. It provides us, I think, with a suitable starting point from which to explore the position of bereaved families.

While the posthumous duty of the living to care for the dead explains and lends dignity to the right of the bereaved to be involved in coronial investigations, it also helps to define the proper limits of that involvement. Over the last ten years, my predecessors and I have repeatedly spoken of a duty to put families at the heart of the inquest process. Such a duty, however, cannot exist in a vacuum. It presupposes the existence of a prior duty to put the deceased at the heart of the process. In other words, the centrality of the bereaved is contingent upon the centrality of the deceased, whom the bereaved may be said to represent. It does not, for example, confer a free-standing right to raise whatever issues bereaved families might wish to explore for their own purposes. The ultimate justification for keeping them at the heart of inquests is that it enables them to speak on behalf of the deceased, whose own voice would not otherwise be heard. That is why I have always preferred to say that it is the deceased, *and by extension* the bereaved, who should be at the heart of each inquest.

As a general rule, the interests of the deceased and those of the bereaved will align. However, that is not always so. Sometimes, for example, families fall out among themselves. There may be a long-standing history of past estrangement between the family and the deceased, perhaps leading relatives to adopt a position that is at odds with the known views of the person who has died. In such situations, it is the court's duty to the deceased that will prevail. The focus of any inquest must always be on the person who has died.

Improving communications with families through the inquest process (continued)

The Chief Coroner His Honour Judge, Thomas Teague KC

If what I have just been saying implies certain limitations on the scope of the involvement of bereaved families at inquests, it also provides a principled reason for keeping them at the heart of the process. Just as the medical practitioner treats not an illness but a patient, so the coroner's inquest touches not a corpse but the death of a person. Only the bereaved family can legitimately claim the right and duty to speak on behalf of that person.

In my view, it is this posthumous duty owed to the deceased by the family and the state that ultimately explains and justifies the inquisitorial method of the coroner's inquest and protects families against the risk of being marginalised. When the proceedings acquire a more adversarial character, the focus is liable to be diverted away from the deceased, where it properly belongs, and channelled instead into a debate between competing disputants. In short, there is a risk that the inquest might end up as yet another form of litigation.

The organic connection between the registration and investigation of deaths to which I have referred helps to explain the summary nature of the inquest process. In so doing, it incidentally provides a sound basis for the policy of the law in relation to faith burials. This is an area where coroners have to take decisions with the utmost sensitivity and respect for the deeply held convictions of those who, on religious grounds, require prompt burial of their deceased relatives and friends. That is not to say that coroners must automatically prioritise a faith death over others, but it does mean they should take faith interests into account when making those decisions.

Now, the 2009 Act makes it clear that a coronial death investigation is designed to provide answers to four statutory questions, namely who the deceased was and when, where and how the deceased came by his or her death.

Where the enhanced duty of investigation arises under Article 2 of the European Convention on Human Rights, the coroner or jury must examine the wider circumstances in which the death occurred, but even then, they cannot express an opinion on any topic other than the four statutory matters to be ascertained. So, the attribution of blame forms no part of the coroner's role. Indeed, as we all know, the 2009 Act expressly prohibits inquest determinations from being framed in such a way as to appear to determine any question of civil liability or any question of criminal liability on the part of a named person.

These straightforward principles were reinforced a year or two ago by Lord Burnett in the well-known case of *Morahan*:

*"An inquest remains an inquisitorial and relatively summary process. It is not a surrogate public inquiry. The range of coroners' cases that have come before the High Court and Court of Appeal in recent years indicate that those features are being lost in some instances and that the expectation of the House of Lords in *Middleton* of short conclusions in article 2 cases is sometimes overlooked. This has led to lengthy delays in the hearing of inquests, a substantial increase in their length with associated escalation in the cost of involvement in coronial proceedings. These features are undesirable unless necessary to comply with the statutory scheme."*

The coroner's role is not to adjudicate but to investigate. And the summary nature of the investigation implies a need for expedition. The coroner's inquiry must be sufficient but need not be exhaustive. As Lord Burnett made clear, an inquest is *"not a surrogate public inquiry".*

Improving communications with families through the inquest process (continued)

The Chief Coroner His Honour Judge, Thomas Teague KC

It is important to respect the inquisitorial nature of an inquest. You sometimes hear references to “cross-examination” taking place at inquests. Forgive me if I seem to be pedantic, but there is no such thing as cross-examination in the context of an inquisitorial jurisdiction. How can there be if there is no “examination-in-chief”? The coroners’ procedural rules speak only of “examination”. I’m afraid I even get a bit edgy about references to the “standard of proof”. After all, there is no *burden* of proof. It would, I think, make greater sense if we were to speak of a ‘level of certainty’ or, if you prefer the language of Lady Arden in the case of *Maughan*, a “degree of conclusivity”.

The reason we don’t have a burden of proof, or examination-in-chief or cross-examination, or a ‘playing field’ (level or otherwise), or ‘equality of arms’, is that there are no ‘parties’ to an inquest, as there are in other court proceedings. An inquest is not a field of conflict. Instead, those with an interest in the outcome of a coroner’s investigation come together to help the coroner discharge his or her duty to the deceased.

We all need to do what we can to make putting the deceased and their families at the heart of the process a practical reality, and not just a meaningless slogan. I’m afraid that is not how the bereaved always see things. To some families, an inquest can seem a remote process, conducted by lawyers they could not possibly afford on behalf of large organisations intent only on avoiding reputational or financial damage, a process in which those most profoundly affected by the death are squeezed towards the margins. Of course, some inquests are unavoidably contentious. But it is not the function of a coronial investigation to assign blame or to serve as a vehicle for those who wish to resolve disputes or air extraneous grievances.

That’s why I strongly support the new toolkit for advocates who practise inquest law or who aspire to do so. The toolkit is an important document issued by the legal regulatory bodies and is designed to ensure that the inquisitorial ethos and method are properly respected in inquest proceedings. The toolkit reminds us all that:

“Unlike most court proceedings, inquests do not decide responsibility or guilt, because they are limited to finding out the facts of a person’s death. This important difference means that you need to adapt your style of communication and engagement to the purpose of inquests. In doing so, you should think carefully about whether or not the style of advocacy and questioning that you use in other court proceedings would be appropriate to use at an inquest”.

Tania has rightly pointed out that families often hold information of great potential value to the coroner. That’s another reason for involving them closely in the process. Two recent pieces of guidance illustrate this. One is the guidance relating to pen portraits. I said earlier that an inquest touches not a corpse, but the death of a person. All the more reason, therefore, to encourage families, where they wish to do so, to provide material by way of a pen portrait of the deceased. And families can’t participate effectively unless they receive prompt disclosure. Whether they are represented or not, as another new guidance note makes clear, they should be provided with disclosure as early as possible. I also encourage coroners to explain the process fully, so that unrepresented families are not left feeling excluded.

Improving communications with families through the inquest process (continued)

The Chief Coroner His Honour Judge, Thomas Teague KC

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

Improving communications with families through the inquest process (continued)

The Chief Coroner His Honour Judge, Thomas Teague KC

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.

Improving communications with families through the inquest process (continued)

The Chief Coroner His Honour Judge, Thomas Teague KC

In recent years, coroners have done a great deal to make inquest hearings less intimidating and disruptive for all concerned, including medical professionals. Although each case is different and the decision is one for the individual coroner, clinicians should not generally be required to give oral evidence at all unless it is really necessary for them to do so. In appropriate cases a coroner may allow a witness to give evidence remotely, but I should like to caution against the abuse of this facility (which is not in any sense a 'right' of the witness).

Clinicians are, of course, very busy people. They correctly assign the highest priority to the treatment of their patients, yet attendance in person at an inquest also demands high priority, for medical professionals have an integral and important role to play in the discharge of the state's posthumous duty to the dead. However great the temptation to plead pressure of work as a kind of trump card in support of an application to give evidence remotely, it should not be forgotten that the clinician's physical presence in court can produce a remarkably powerful healing effect, perhaps even to the extent of persuading the family that everything was indeed done that could have been done. Such reconciliation is far less likely where the family sees only a 'talking head' on a remote monitor. There will be some cases, therefore, in which the benefit of personal attendance will outweigh any accompanying inconvenience. Nicola earlier reminded us that it's always important to remember the presence of the family in court. I strongly endorse that approach.

Let no one think this is just some vague, theoretical point. I came across an example of it during the tour of England and Wales that I conducted in 2022 and early 2023. On one occasion, the physical presence in court of a clinician whose competence had been called into question proved enough by itself to satisfy the bereaved family. That witness made eye contact with the relatives of the deceased as he explained his decisions to them, something he could not have done over a remote live link. The upshot was that the family went away reassured that the doctor concerned had done everything he reasonably could to save the life of their relative.

Through all the practical matters I have mentioned runs a common thread. It is the fundamental duty owed by the living to care for the dead. As long as we never lose sight of the ultimate priority of the deceased in every inquest, we will not stray from the true purpose of the process, nor will we allow families to be marginalised.

Q&A with the Panel

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.

Q&A with the Panel

- However, Coroners receive mandatory yearly training including residential training, as well as training on specific issues e.g. mass fatalities of disaster victim identification.

3. Delays in concluding the inquest

What plan is in place to improve the long wait times for forensic post mortem reports? We have cases that are taking up to 2 years to get to inquest because of this hold up. Further delays are also caused when the police want an independent expert witness to review the forensic PM and to decide if the threshold for CPS has been met. In these cases, surviving siblings are often removed by CYP and put in care with the decision not to review the situation until a decision is made regarding CPS or the inquest is concluded. The cost involved and trauma caused to these surviving siblings who are placed into care is high. Who funds forensic pathologists? It feels like maybe a multiagency approach to funding these posts could be a potential solution and help reduce costs incurred to other agencies (specifically foster care and sibling/parental emotion wellbeing cost).

Answer:

This is a complex situation and a really good question. Forensic pathologists come under the Home Office. In some specialisms they are few and far between. This is a very long standing problem which Professor Hutton correctly diagnosed in his 2015 report Review of forensic pathology in England and Wales - GOV.UK (www.gov.uk). Professor Hutton suggested a sensible way forward but unfortunately we are still in the same position. It is a problem the Chief Coroner has taken very seriously since he took up his post.

The knock on effect in other proceedings such as in the family courts is a real concern. An interdepartmental body is being set up to seek a way forward. One of the problems is the lack of a clear line of responsibility. Whilst the Chief Coroner explained that he cannot say what the timescale is likely to be, he can say that there has been progress made in the last three years. It is a complex problem and may require other issues such as NHS contracts to be addressed. There will always be cases where the old fashioned fully invasive autopsy is necessary but there are a lot of cases where scanning is sufficient by itself, which helps.

4. Inquests following termination of pregnancy

This is an amalgamation of three questions on the same topic, put by a fetal medicine team, an academic in the field and myself

My organisation works with parents going through the painful experience of ending a wanted pregnancy for medical reasons (and their caregivers). Please could you explain how Chief Coroner's Guidance No.45 Stillbirth, and Live Birth Following Termination of Pregnancy - Courts and Tribunals Judiciary is in any way in the public interest? In our experience it has added an extra layer of anxiety and distress to grieving parents (including pressure to consent to feticide, hindered post mortem investigations and delayed funerals) and impeded health care professionals in providing high quality individualised care.

At the very least can there be a recommendation that inquests in the context of legal medical terminations be carried out via email to minimise delays and stress for parents?

Answer: (continued overleaf)

- It's not the Guidance that brings this requirement, it is the law.
- The Guidance has not added anything new. The law was not being correctly applied across the country and the Guidance has clarified the requirements and states what the law is.

Q&A with the Panel (continued)

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Resources

How we can help

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.

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Please note:
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The information and opinions expressed in this document are no substitute for full legal advice, it is for guidance only.

Browne Jacobson