Ms Catherine Rodgers
Departmental Solicitors Office
2nd Floor
Centre House
Chichester Street
BELFAST
BT1 4JE

Your Ref: LIT 477/08/B5/CR

Our Ref: BMcL-0089-13

Date: 10th May 2013

Dear Ms Rodgers,

Re: Raychel Ferguson (Lucy Crawford Aftermath)

Dr Bridget Dolan, at paragraphs 4.32 - 4.34 [Ref: 303-052-730 to 303-052-731 -copy attached] of her report to the Inquiry, discusses the case of **R v H M Coroner for Wiltshire ex parte Clegg** in which an issue arose as to whether a new inquest should be ordered in circumstances where the original inquest was not told of shortcomings in the deceased's hospital care. The citation given by Dr Dolan in her footnote may not be quite correct. We have found the case reported at **(1996) 161 JP 521.**

Giving judgment, Lord Justice Phillips referred to a letter from the then Chief Executive of the NHS Mr Langland in which he said:

"*..I have been unable to trace any specific guidance for NHS staff in relation to giving evidence to the Coroner. Staff are simply expected to do what the law requires; that is to answer the questions which are asked truthfully and to co-operate to the extent they are required to do so.*"

Commenting on this approach Phillips LJ said :

"*Without hearing submissions on the matter it would not be right to express an unqualified conclusion as to whether this case is satisfactory. My provisional view is that it is not and that the National Health Service should give consideration to the appropriate approach of its staff to providing information to a Coroner.*"

Dr Dolan reports [Ref: 303-052-731] para 4.34 that following this case "*the Chief Medical Officer did write to all doctors in 1998 stressing the "need for clinicians to disclose all relevant information to the Coroner to ensure a fully informed decision on the cause of death".*"

Please take instructions from the Department as to whether consideration was given to issuing any such guidance in Northern Ireland following this case and if so what was the outcome of that consideration.

Yours sincerely,

B. Conlon
p.p.

Brian McLoughlin
Assistant Solicitor to the Inquiry

4.28 Firstly, the Coroners Service have produced a detailed booklet entitled "Working with the Coroners Service for Northern Ireland"[24] (Appendix 12) which gives very clear guidance to those who have a statutory duty to report deaths and also encourages those without a statutory duty (such as mortuary technicians) to contact the Coroner where they have any concerns. The service has also appointed a full-time medical examiner who takes the lead when medical deaths are reported and so provides a point of liaison for doctors.

4.29 Secondly, in August 2008 the Department of Health, Social Services and Public Safety, in conjunction with the NI Coroners Service, produced a 52 page "Guidance on death, stillbirth and cremation certification"[25] (Appendix 22). This gives very clear and detailed guidance as to deaths that are statutorily reportable and provides a non-statutory list of diagnoses which should be referred to the Coroner and some sample pro-forma for making reports.

4.30 Thirdly, the Coroners and staff from the Northern Irish Coroners Service deliver training to interest groups such as doctors, police and funeral directors. There are regular meetings of the Coroners Service Users Group where issues of mutual concern are discussed. Finally, the Medical Protection Society also provide their members with a fact-sheet specific to the Northern Irish situation which sets out the statutory duties of doctors in respect of coronial inquiries [26] (Appendix 23).

Quality of information accompanying reports to the Coroner

4.31 Whilst ensuring that all relevant cases are reported to the Coroner has properly been the focus of much attention, the related and perhaps more pressing issue is that of ensuring that, where a death is reported, the information accompanying that report is sufficient to enable the Coroner to form a judgment as to the need for further inquiry and/or an inquest. Of particular concern is assuring that relevant or potentially relevant material is not withheld from the Coroner.

4.32 In *R v HM Coroner for Wilstshire ex parte Clegg* [27] a young woman died in hospital of the effects of a self-administered aspirin overdose in circumstances where it was later found to be "beyond doubt" that a number of people in the hospital service that had treated her before her death were aware that her care had not been appropriate. Her death was reported to the Coroner but he was not informed of the potential shortcomings in assessing, investigating, monitoring and treating her. Hence the inquest,

---

[24] http://www.coronersni.gov.uk/publications/Working%20with%20the%20Coroners%20ServicFinal%20Version%20of%20Best%20Practice%20Guide%2023%20Sept%2009%20_3_.pdf

[25] http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf

[26] http://www.medicalprotection.org/uk/northern-ireland-factsheets/reporting-deaths-to-the-coroner

[27] [1997] JP 521

held within five weeks of the death, found that she had "killed herself" but there was no investigation at the inquest of what a later review under the Health Authority complaints procedure found to be "grossly inadequate" treatment and care.

4.33 In 1996 the Chief Executive of the National Health Service confirmed to the court that there was no "specific written guidance to NHS staff in relation to giving evidence to the Coroner. Staff are simply expected to do what the law requires; that is to answer the questions asked truthfully and co-operate to the extent they are required to do so".[28]

4.34 After that judicial review case the Chief Medical Officer did write to all doctors in 1998 stressing the "need for clinicians to disclose all relevant information to the Coroner to ensure a fully informed decision on the cause of death" emphasising a need to disclose information voluntarily and not only when requested to do so. However the position today is that there is no guidance easily identifiable on the Department of Health website on either reporting deaths or providing information about deaths to the Coroner and in the author's experience whilst some NHS Trusts provide their staff with guidance on what it is a reportable death (see Appendix 10) it remains rare for an individual NHS Trust to have a specific policy for its staff in relation to providing further information for Coroner's Inquests.

4.35 In both Northern Ireland and England and Wales there is no general statutory or common law duty of disclosure to a Coroner. The duty to report a death to a Coroner does not extend to requiring other persons to volunteer information about the wider circumstances of a death once the death has already been reported. Specifically once a death has been reported and an inquest is to be held there is no legal duty upon doctors to draw any concerns they might have about the medical management of the deceased to a Coroner's attention after a report has been made by another person.[29]

4.36 There is no duty to provide opinion evidence from third parties who have at some later stage become appraised of the facts surrounding the death (for example where health care staff learn of facts which lead them to suspect medical mis-management by others, or where an expert opinion on the case has been obtained by an interested party prior to the inquest). This policy is perhaps explained by the purpose of the inquisitorial process being to determine the facts relevant to the death but not to identify matters of clinical negligence. Indeed r.16 of the NI rules and r.42 of the English Rules specifically forbid opinions or determinations of civil liability being made. There are no parties, no indictment, no right to call witnesses, no right to address the coroner or jury as to the facts and hence in this non-adversarial process no legal rules about what must be disclosed by interested persons to the Coroner.

---

[28] The NHS Executive ceased to exist in April 2002 and I have not been able to identify whether any national guidance was produced after this case.

[29] Although the normal practice of Coroners is to request information from the doctors who attended the deceased before their death, and once called as a witness no doctor has a right or privilege to refuse to answer a Coroners appropriate questions (save for the privilege against self-incrimination)