Report to the Inquiry into Hyponatraemia-Related Deaths

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19 April 2011

Report Contents

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1. Instructions

1.1 By a brief received 9 February 2001 I am instructed to assist the inquiry into hyponatraemia-related deaths in Northern Ireland by providing advice in respect of a number of issues related to coronial law.

1.2 I have been appraised of the factual background under investigation in the course of this inquiry into the deaths of children between 1995 and 2003, however I am not asked to give any consideration to the factual matrix under investigation.

1.3 I am instructed that an important element of the investigation will be the extent to which any of the deaths might have been avoided if lessons learned had been effectively communicated to the relevant bodies, both in terms of deaths being promptly reported to and investigated by the Coroner, and in terms of lessons being communicated and learned by the appropriate bodies post-inquest.

1.4 Further, the Chairman is empowered by the Revised Terms of Reference to: *"Make such recommendations to the Department of Health, Social Services and Public Safety as he considers necessary and appropriate."*

1.5 The Inquiry has sought my advice on the following issues:

(i) Between 1995 to date, what was/is the system of procedures and practices in the UK for the reporting of unexpected deaths in hospitals to the Coroner? In addition, your comments and/or observations on the scope for improvement in the current system of procedures and practices would also be of benefit.

(ii) Between 1995 to date what is/was the system of procedures and practices in the UK for the reporting and dissemination of information on the outcomes or lessons to be learned from Coroner's Inquests to the hospital where the patient was treated, other hospitals, the doctors and nurses, Trusts, Boards and the DHSSPS including the Chief Medical Officer? Again, your comments and/or observations on the scope for improvement in the current system of procedures and practices would also be of benefit.

(iii) How, particularly with the advent of the amended Rule 43 and the Coroners and Justice Act 2009, does Coroners Law and Practice in Northern Ireland differ from that in England and Wales in reference to the issues noted above, and what are the advantages and/or disadvantages of these differences?

2. Methodology

2.1 In compiling this report, in addition to the documentary sources referenced below, I have consulted with the following people:

Mr Derek Winter – HM Coroner for Sunderland and Coroners Society of England and Wales (CSEW) Archivist of rule 43 reports;

Mr Brian Sherrard – HM Coroner for Northern Ireland;

Ms Lynette Hill – Coroners and Burials Division, Ministry of Justice.

I am extremely grateful for all the assistance they have given me, however any opinions expressed are my own and I alone am responsible for the content of this report.

3. Source Material

3.1 I have consulted a number of documentary sources which will be referred to throughout this report. The main statutory and documentary reference material is set out below. In addition to providing hyperlinked internet addresses for documents, where available, the key documents consulted are contained in the separate bundles appended to this report.

Relevant Legislation

3.2 The key legislation currently in force relevant to the reporting of deaths to the Coroner, coronial powers and inquest procedures in England and Wales is as follows:

- **The Coroners Act 1988** (*'the 1988 Act'*)
- **The Coroners Rules 1984** (*'the 1984 Rules'*)
- **The Births and Deaths and Registration Act 1953** (*'the 1953 Registration Act'*)
- **The Registration of Births and Deaths Regulations 1987** (*'the 1987 Registration Rules'*)

3.3 In Northern Ireland the relevant legislation currently in force is:

- **The Coroners Act (Northern Ireland) 1959** (*'the NI 1959 Act'*)
- **The Coroners (Practice and Procedure) Rules (Northern Ireland) 1963** (*'the NI 1963 Rules'*)
- **The Births Deaths and Registration (NI) Order 1976** [1] (*'the NI 1976 Registration Order'*)

[1] http://www.legislation.gov.uk/nisi/1976/1041/contents

Relevant reviews

3.4 The UK systems of death certification and investigation were the subject of two detailed and lengthy reports published in 2003:

- **Death Certification and the Investigation of Deaths by Coroners**, the 3rd Report of the Shipman Inquiry under Dame Janet Smith (the "Shipman Inquiry");[2] and
- **Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003** (the "Luce Review")[3]. (Appendix 1)

Relevant reports from governmental and other bodies

3.5 Amongst the many governmental reports, consultations and position papers published since 1995 in respect of the Coroners service the following are of most direct relevance to matters discussed in this paper:

- Reforming the Coroner and death certification service: a position paper (March 2004)[4] (Appendix 2)
- Statutory Duty for Doctors and other Public Service Personnel to Report Deaths to the Coroner. Consultation paper July 2007 (and summary of responses 2008). (Appendix 3)
- Improving the process of death certification in England and Wales (August 2010)[5] (Appendix 4)

From Northern Ireland

- Modernising the Coroners Service in Northern Ireland: the way forward. (2004) (Appendix 5)

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[2] Cm 5854 ; http://www.the-shipman-inquiry.org.uk/tr_page.asp
[3] Cm 5831; http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf
[4] Cmd 6159
[5] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119411.pdf.

Future Legislation

English and Welsh legislative change

3.6 Royal Assent was given on 12 November 2009 to the Coroner's and Justice Act 2009 ('the CJA")

3.7 If brought into force this Act would make significant amendment to the English and Welsh legislation in respect of coronial law. The most significant changes involve: the appointment of a Chief Coroner; the creation of Medical Examiners to scrutinise death certificates; making Coroners post-inquest reports to prevent future deaths mandatory; providing a new route of appeal and revision of the Coroners Rules.

3.8 However shortly before the planned implementation date of the CJA in February 2010 the government announced a stay on bringing its provisions relating to Coroners into force.[6]

3.9 Whilst the government has since indicated that its intention is that those parts of the CJA 2009 relating to the creation of the posts of Medical Examiners (see sections 19 and 21 CJA 2009) will be brought into force[7], the Ministry of Justice have recently, in March 2011, informed members of the Coroners Society of England and Wales that budgetary restraints are such that the relevant sections of the CJA 2009 dealing with Medical Examiners will not be brought into force before April 2013 at the earliest.

3.10 It is further proposed in the Public Bodies Bill 2010 (s.1 and Sch 1) that the power to abolish a body or office will be used to abolish the office of the Chief Coroner and related posts before they have come into existence. That Bill, which has been the subject of lengthy debate in parliament, had reached the report stage of the House of Lords as of 4 April 2011 with a view to a third reading of the Bill on 9 May 2011.

3.11 It is of note that some of the restructuring proposed, but now on hold, in respect of the English and Welsh jurisdiction has to a large extent already taken place within the Coroners Service for Northern Ireland (CSNI). Since April 2006 the CSNI has provided a centralised service within the Northern Ireland Court Service. The revised judicial structure is headed by a High Court Judge, Mr Justice Weir, with one Senior Coroner and two Coroners. Centralisation has improved service standards and consistency, and a recent inspectorate report considered that the CSNI now provides a sensitive,

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[6] Only limited parts of the CJA touching on coronial law came into force on Royal Assent (most relevantly s.47 and s.48 in respect of properly interested person and interpretation)

[7] See: Improving the process of death certification in England and Wales (Department of Health)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119411.pdf

responsive, and open service. The reforms were found to have improved outcomes for bereaved families, both directly and indirectly.[8]

Northern Irish legislative change

3.11 It is understood that proposals to amend Rule 23 of the 1963 NI rules (Coroners reports to prevent future deaths) and bring in a provision similar to the amended r.43 currently in force in England and Wales are being considered. (See para. 6.34 below)

3.12 Additionally consultation is currently underway regarding modification of the death certification process in Northern Ireland and the possible implementation of a Medical Examiners system similar to that in the CJA. (See para. 4.56 below)

[8] HMICA – Report on the inspection of the Coroners Service for Northern Ireland (2007) http://www.courtsni.gov.uk/NR/rdonlyres/665EF6BB-384F-4E61-8699-6BFA44F47C94/0/p_tp_NI_Coroners_report.pdf

4. Issue (i)

Reporting of Hospital deaths to the Coroner

Between 1995 to date, what was/is the system of procedures and practices in the UK for the reporting of unexpected deaths in hospitals to the Coroner?

In addition, your comments and/or observations on the scope for improvement in the current system of procedures and practices would also be of benefit.

Duty to report deaths in England and Wales

The statutory duty to report deaths in England and Wales

4.1. In England and Wales the circumstances in which a Coroner acquires jurisdiction over a body are set out in s.8(1) of the Coroners Act 1988 as being where there is reasonable cause to suspect the deceased:

(a) Died a violent or unnatural death;
(b) Has died a sudden death of which the cause is unknown;
(c) Has died in prison or in such place or circumstances as to require an inquest under any other act.

These broad categories delineating the Coroner's jurisdiction therefore provide the only basis upon which any legal duty to report deaths can be founded.[9]

4.2 The Coroners Act 1988 itself does not impose any statutory duty on any person to report a death to a Coroner. However a specific obligation to report to a Coroner the death of someone in custody is found in a number of statutory instruments in some specified cases (deaths in prisons, detention centres, young offender institutions or where detained in armed forces establishments)[10].

4.3 Additionally there is a reporting duty upon a registrar who, by virtue of regulation 41 of the Births Deaths and Registration Regulations 1987, is required to report a death to the Coroner as follows:

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[9] The latest figures provided by the Ministry of Justice for 2009 estimate that of 500,100 deaths in England and Wales 46% (229,000) were reported to Coroners and of those inquest were held in 13% of cases.

[10] The duty falls on the on a Prison Governor or commanding officer as appropriate (e.g r.29(2) Young Offenders Institute Rules 2000) - although notably no equivalent statutory duty to report a death is placed on those who compulsorily detain a patient under mental health law provisions.

41 Reference to Coroner

(1) Where the relevant registrar is informed of the death of any person he shall, subject to paragraph (2), report the death to the Coroner on an approved form if the death is one—

(a) in respect of which the deceased was not attended during his last illness by a registered medical practitioner; or

(b) in respect of which the registrar—

(i) has been unable to obtain a duly completed certificate of cause of death, or

(ii) has received such a certificate with respect to which it appears to him, from the particulars contained in the certificate or otherwise, that the deceased was not seen by the certifying medical practitioner either after death or within 14 days before death; or

(c) the cause of which appears to be unknown; or

(d) which the registrar has reason to believe to have been unnatural or to have been caused by violence or neglect or by abortion or to have been attended by suspicious circumstances; or

(e) which appears to the registrar to have occurred during an operation or before recovery from the effect of an anaesthetic; or

(f) which appears to the registrar from the contents of any medical certificate of cause of death to have been due to industrial disease or industrial poisoning.

4.4 In summary therefore a statutory reference should be made of every death in custody (save for those detained under the Mental Health Act 1983 or Mental Capacity Act 2005) and (by the registrar) where any of the following apply:

- No doctor attending the last illness;
- There is no (or is an inadequately completed) medical certificate of cause of death (MCCD);
- MCCD shows the certifying doctor did not see the patient either 14 days before death or after the death;
- Cause of death is unknown;
- Death appears to be:
    - Unnatural;
    - Due to violence;
    - Due to neglect;
    - Suspicious;
- Death was during surgery or recovery from surgical anaesthesia;
- Death was due to industrial disease or industrial poisoning.

The Common Law Duty in England and Wales

4.5. Despite the absence of a statutory duty in England and Wales there is a common law duty on everyone to report a violent or unnatural death and those deaths due to unknown cause over which a Coroner might assume jurisdiction.

4.6 The common law duty to report deaths can be traced back to at least the 1700's[11] and falls upon anyone who is about the deceased to give immediate notice to the Coroner "whilst the body is fresh and while it remains in the same situation as when death occurred". As such the common law duty is not limited to professionals dealing with a death. However the majority of members of the public are unlikely to be aware of the duty.

4.7 There is no legal sanction that enforces the common law duty save that associated with criminal offences arising from an act such as disposing of or hiding a body to prevent inquiries being made as to the death.

Practice in England and Wales

4.8 In practice, registrars report deaths to the Coroner comparatively infrequently and the vast majority of deaths are referred to Coroners by doctors and/or police officers. The Shipman Inquiry[12] recorded that in 2001, 95.7% of coroners' referrals were made by doctors and around 4% by registrars, with the remaining deaths (less than 1% of referrals to the Coroner in 2001) being made by the police and other agencies. [13] Similarly the Luce Review estimated that only 3.4% of deaths in England and Wales were reported to Coroners by registrars under their statutory duty.

4.9 The small percentage of registrar referrals reflects the fact that most reportable cases have already been reported to the Coroner by a doctor before they reach the registrar.

4.10 However, where a death has not been previously reported the registrars, who have an essentially administrative role, have only a limited opportunity to learn information that might result in the realisation that the death is reportable and also limited if any medical knowledge to understand which questions might reveal that a death is reportable.

4.11 The Shipman Inquiry found that in general, a registrar would report a death to the Coroner's office where one of the following circumstances had arisen[14]:

a. "The cause of death (or certain words used to describe the cause of death), as certified by the doctor, is one which the registrar has been instructed should be referred to the Coroner. This might arise, for example, if the word

[11] R v Clerk (1702) 1 Stalk 377
[12] Third report at para 6.13
[13] Other estimates suggest around 60% of reports are made by doctors (see Dorries at para 3.04)
[14] Third report at para 6.14

'dehydration' (which might suggest an element of neglect) or 'fracture' (which might mean that the death was due to an accident and, therefore, violent or unnatural) appears within the causes of death stated.

b. The informant or another member of the deceased's family had given the registrar information that suggests that the death might fall into one of the categories referred to in regulation 41 (most commonly in the case of industrial disease).

c. There is disclosed on the face of the MCCD information that suggests that the death should have been reported to the Coroner by reason of the statutory requirements or because of a 'local rule' operated by the Coroner. Regulation 41(1)(b)(ii) requires that a death must be reported to the Coroner, if the certifying doctor did not see the deceased either after death or within 14 days before the death (the 'either/or rule'). However, many Coroners have a 'local rule' whereby all deaths where the certifying doctor did not see the deceased during the 14 days before death must be reported, irrespective of whether the doctor saw the deceased after death. Another common local rule requires deaths occurring within a certain period (usually 24 hours) after admission to hospital to be reported.

Statutory duty to report deaths (Northern Ireland)

4.12 In contrast to the position in England and Wales, under the Coroners Act (Northern Ireland) 1959 there is a statutory duty on a wide category of professionals and the public to provide information to a Coroner as follows:

s. 7.Duty to give information to Coroner.

Every medical practitioner, registrar of deaths or funeral undertaker and every occupier of a house or mobile dwelling and every person in charge of any institution or premises in which a deceased person was residing, who has reason to believe that the deceased person died, either directly or indirectly, as a result of violence or misadventure or by unfair means, or as a result of negligence or misconduct or malpractice on the part of others, or from any cause other than natural illness or disease for which he had been seen and treated by a registered medical practitioner within twenty-eight days prior to his death, or in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic), shall immediately notify the Coroner within whose district the body of such deceased person is of the facts and circumstances relating to the death.

s. 8 Police to inform Coroner.

Whenever a dead body is found, or an unexpected or unexplained death, or a death attended by suspicious circumstances, occurs, the superintendent or chief superintendent within whose district the body is found, or the death occurs, shall give or cause to be given immediate notice in writing thereof to the Coroner within whose district the body is found or the death occurs, together with such information also in writing as he is able to obtain concerning the finding of the body or concerning the death.

4.13 Hence, in Northern Ireland, the statutory duty to report any unexplained or suspicious death falls not only on the registrar of deaths but also on police, doctors, undertakers, those in charge of any type of residential institution and members of the public who occupy dwellings to report all deaths where they have reason to believe that the death involved any cause other than a natural illness or disease which had been treated by a doctor in the last 4 weeks.

4.14 As in England and Wales very few Northern Irish deaths are first reported by the registrar, indeed the CSNI figures for 2010 are that approximately 56% of reports were made by doctors and 44% by the police in Northern Ireland.[15] I am informed that the registrar does refer questionable death certificates to the Northern Irish Coroners (however these referrals often come too late for a post mortem examination as the body has been prepared for burial). Funeral directors very rarely report a death. However in one notable Northern Irish case a funeral director noted strangulation marks on the deceased and therefore reported the matter, leading to a coronial investigation and ultimately a criminal conviction.

4.15 The Northern Irish statute specifically includes deaths appearing to be the result of:

- Violence
- An accident
- Misconduct
- Negligence or malpractice
- Or any circumstances requiring investigation

4.16 Whilst the statutory duty is differently expressed from that in the English and Welsh rules the types of death falling within the statutory reporting requirements in each jurisdiction are much the same. The only substantive difference between reportable categories being in respect of reporting deaths from natural causes. In England and Wales a report need not be made where the deceased was 'attended' by a doctor during his last illness and there is no limit as to how long before the death that attendance may have been (so long as the certifying doctor has seen the deceased after death). In contrast in Northern Ireland there is a more stringent requirement that a doctor must have "seen and treated" the person *within 28 days* of the death otherwise a report to the Coroner will be required.

4.17 In practice this may make little difference as one might anticipate that it will only be in a small proportion of cases that someone with a natural illness serious enough to be

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[15] In 2009, there were 14,413 deaths registered in Northern Ireland. The majority (51%) of deaths were in hospital whilst 19% died in nursing homes or hospices. The remaining 30% of deaths occurred in other places, such as at home, at work etc. Source: NISRA Press Release; Deaths in Northern Ireland (2009) Approximately 26% of deaths are reported to a Coroner.

terminal is already under medical care for their illness yet does not see a doctor within 28 days of their death.

4.18 However one notable difference between the jurisdictions is that the statutory requirement in Northern Ireland under s.7 is not merely to report the fact of death (as in England) but to report "the facts and circumstances relating to the death". Hence more detailed information as to how the death came about might be provided under the Northern Irish legislation.

Guidance for Health Care Staff as to the Reporting of Deaths

4.19 In England and Wales only very limited guidance is provided by the Department of Health to health care staff regarding the common law duty to report a death to a Coroner. Indeed use of the search facility on the current DoH website does not reveal any easily identifiable guidance on health staff's duties to report deaths. The only guidance I have been able to identify is that set out in a two A4 page leaflet produced in March 2010 by the Department of Health for Organ Donor Co-ordinators, which states that: [16]

A death should be reported to the Coroner if:

- The cause of death is unknown
- It cannot readily be certified as being due to natural causes
- The deceased was not attended by a doctor during their last illness or was not seen within the last 14 days or viewed after death
- There are any suspicious circumstances or history of violence
- The death may be linked to an accident (whenever it occurred)
- There is any question of self neglect or neglect by others
- The death has occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station)
- The deceased was detained under the Mental Health Act
- The death is linked with an abortion
- The death might have been contributed to by the actions of the deceased (such as a history of drug or solvent abuse, self injury or overdose)
- The death could be due to industrial disease or related in any way to the deceased's employment
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred
- The death may be related to a medical procedure or treatment whether invasive or not
- The death may be due to a lack of medical care
- There are any other unusual or disturbing features to the case

[16] See Appendix 6
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114801.pdf

- The death occurred within 24 hours of admission to hospital, unless the admission was for the purposes of terminal care
- It may be wise to report any death where there is an allegation of medical mismanagement

This list is not exhaustive. If in any doubt do not hesitate to contact the Coroner's Office for advice

4.20 There is also some specific guidance available in respect of patients detained under the Mental Capacity Act entitled "Reporting the death of a person subject to an authorisation under the Mental Capacity Act Deprivation of Liberty Safeguards".[17] However this is only a single page leaflet. Beyond these two specific situations there appears to be no general guidance provided by the Department of Health to health or social care staff as to how to meet their common law duties.

4.21 Since 1996 the Deputy Chief Medical Statistician at the Office of National Statistics (ONS) has provided written guidance for those doctors who certify a death on medical certificates of cause of death (MCCD). A brief list of reportable deaths is given and the guidance states that the ONS "would like to encourage...voluntary referral to the Coroner" by those certifying a death. However this guidance which is sent out with books of MCCDs will not be available to all healthcare staff.

4.22 For doctors the General Medical Council (GMC) provide guidance on "Good Medical Practice"[18] which merely states that:

> "You must comply with the legal requirements where you work for reporting deaths to a Coroner (England, Wales and Northern Ireland) or procurator fiscal (Scotland)"; and
>
> "You must assist the Coroner or procurator fiscal in an inquest or inquiry into a patient's death by responding to their enquiries and by offering all relevant information. You are entitled to remain silent only when your evidence may lead to criminal proceedings being taken against you".

No guidance on which deaths are reportable or what might be "relevant evidence" is given.

4.23 Although there appears to be a dearth of national guidance, in England and Wales local guidance is available to doctors and hospital personnel as to the reporting of deaths to the Coroner from a number of different sources. Firstly, in several individual coronial jurisdictions in England and Wales the incumbent Coroner has produced his/her own guidance for doctors and Hospital Trusts as to which deaths should be reported. For

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[17] See Appendix 7
http://www.dh.gov.uk/en/SocialCare/Deliveringsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/DH_123578

[18] http://www.gmc-uk.org/guidance/ethical_guidance/6912.nd

example that produced by the Plymouth Coroner in 2003 is made readily accessible on the internet,[19] as is the current guidance at of HM Coroner for Sunderland[20](see Appendix 8). However there is no standard guidance adopted by Coroners nationally.

4.24 Secondly, there are factsheets provided by medical defence societies (see for example that of the Medical Protection Society at Appendix 9)[21] and some individual NHS Trusts produce their own internal guidance for staff.[22] However there is no standard approach and practice varies widely.

4.25 Thirdly, standard coronial texts provide learned guidance. In England and Wales particularly *Dorries*[23] not only gives practical guidance but also goes as far as printing that guidance note as a frontpiece to the book (Appendix 11). Indeed it is Dorries' guidance which has been adopted by the Department of Health in the 2010 leaflet for Donor Co-ordinators referred to above. Dorries' book is in my view the most clear explanation that is available to doctors, giving a detailed analysis of the type of case which might fall into each reportable category. He also provides "a simplified guide" for "teaching purposes" which reduces reportable deaths to six categories:

- Cause is unknown
- Not treated in last 14 days
- Cause may be unnatural (with some examples)
- Deceased was under detention
- Known complaint about medical treatment
- Other unusual or disturbing features

4.26 However despite the great utility of Dorries' book it is not known how widely his guidance is used for teaching doctors, and unfortunately it must be unlikely that many doctors would choose to purchase what is essentially a legal textbook.

Non Statutory Guidance in Northern Ireland

4.27 In Northern Ireland both the quality and quantity of direct guidance to doctors regarding reporting deaths and providing information to the Coroners Service appears superior to that available in England.

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[19] Arguably the most readily accessible in that it appears as the second hit on a Google search for "reporting deaths to Coroner":
http://www.plymouth.gov.uk/a_guide_to_reporting_deaths_to_h.pdf

[20] http://www.sunderland.gov.uk/CHttpHandler.ashx?id=122&p=0

[21] MPS factsheet is at http://www.medicalprotection.org/uk/uk-factsheets/reporting-deaths-to-the-coroner

[22] For example that of The Newcastle upon Tyne Hospitals NHS Foundation Trust which can be found at Appendix 10 and at http://www.newcastle-hospitals.org.uk/downloads/policies/Operational/ReportingDeathstotheCoroner201008.pdf

[23] Dorries C (2004) Coroners' Courts: A Guide to Law and Practice see para 3.16 et seq.

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,

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[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.

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[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)

Future changes in reporting of deaths in England and Wales

4.37 Both the Luce and Shipman reports found the systems for the certification and investigation of deaths in England and Wales to be "unfit for modern society". The Luce review specifically recommended that statute should define clearly and comprehensively the types of death which should be reported and who should report them to Coroners.

4.38 In response the Government published a position paper *Reforming the Coroner and Death Certification Service* in March 2004 (the "Home Office Position Paper") in which it accepted many of the recommendations made by the Luce Review. The Government's 2004 proposals were broadly welcomed by stakeholders in the coronial system and, following a number of consultations,[30] have led to the many changes proposed within the Coroner's and Justice Act 2009.

4.39 With particular reference to the reporting of deaths in England and Wales the government launched a Consultation paper 26 July 2007 entitled '*Statutory Duty for Doctors and other Public Service Personnel to Report Deaths to the Coroner*'. This consultation explored the suggestions of the Luce review that a statutory duty to report deaths might be placed on regulated health care personnel, care inspectorate personnel, fire service personnel and funeral service staff in addition to doctors. Such a step if adopted would have widened the statutory duty beyond the categories of persons set out in s.7 the 1959 NI Act.

4.40 The outcome of that consultation was reported in May 2008 [31] with Ministers accepting the recommendation that the duty to notify a Coroner of a death should be placed only on registered medical practitioners in prescribed cases and not on a wider group of professionals. That duty is now set out in the CJA s.18 (although not yet in force) and is to be further defined through regulations made under s.18(1) CJA 2009.[32]

4.41 The recommendation arising from the consultation procedure was that the categories of deaths notifiable to the Coroner should be the following:

- death resulting from self harm and neglect (excluding deaths from alcohol or nicotine abuse where the death would not be investigated but for those reasons);

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[30] For example in August 2006 The House of Commons Constitutional Affairs Committee reported on "Reform of the Coroners' system and death certification". Appendix 13 http://www.publications.parliament.uk/pa/cm200506/cmselect/cmconst/902/902i.pdf

[31] Statutory Duty for Doctors and other Public Service Personnel to Report Deaths to the Coroner Summary of responses 21 May 2008 http://www.justice.gov.uk/docs/cp1207-response.pdf Appendix 3

[32] **S. 18 Notification by medical practitioner to senior coroner**

(1)The Lord Chancellor may make regulations requiring a registered medical practitioner, in prescribed cases or circumstances, to notify a senior Coroner of a death of which the practitioner is aware.

- death resulting from neglect or abuse where there is an established duty of care by a public authority, other organisations and individuals;
- death occurring during or shortly after a period of detention
- death caused or contributed to by the conduct of the police or any other state authority or public organisation;
- death relating to past or present employment;
- death resulting from lack of care or appropriate treatment, defective treatment and adverse reaction to prescribed medicine;
- death of a child where it is unexpected;
- death where a violent crime is suspected;
- sudden and accidental death, and deaths resulting from traffic incidents;
- where a death has not been certified as the doctor is unable to identify with any confidence the cause of death;
- death where there is reason to believe it may have been caused or contributed by a disease or condition that has been specified as being reportable to the Coroner because of regional social history, for example lung disease caused through working in the coal industry; and
- death associated with pregnancy and childbirth.

4.42 The regulations to be made under s.18(1) are understood to be in preparation and already in draft form. That draft is not publicly available, however a Ministry of Justice memorandum to the House of Lords in March 2009[33] stated that it is intended that the regulations will say that the duty falls on a doctor who attends a deceased person at or shortly after the time of death, or a doctor on whose list of patients the deceased person was; and that, once one medical practitioner has notified a death, there is no duty to notify on any other medical practitioner.

4.43 The cases or circumstances that will be prescribed will include deaths resulting from self harm and neglect, deaths that may have been caused or contributed to by neglect on the part of a public authority which has responsibility for the deceased, deaths which may have been caused or contributed to by the police, and deaths where a violent crime is suspected.

[33] http://www.justice.gov.uk/publications/docs/coroners-justice-bill-delegated-powers-memo-march09.pdf

The Medical Examiner System

4.44 Sections 19 and 21 CJA 2009, when in force, will significantly amend the system of registration of deaths in England and Wales in creating the new post of Medical Examiners. The new system will require that there is a confirmation of all medical certificates of cause of death (MCCDs) by an independent 'Medical Examiner'.

4.45 Medical examiners will have powers to *examine patient records and speak with treating clinicians to ascertain further information about how the death came about.* This new system that is primarily aimed at increasing the quality and accuracy of the MCCDs, is also likely to lead to more accurate reporting of the circumstances of deaths to coroners.

4.46 Doctors who have previously over reported natural deaths, either due to an abundance of caution or because of uncertainty as to either what to write as the cause of death on the MCCD or whether the death is actually reportable, will be able to call the Medical Examiner for guidance. It is anticipated that the will reduce the number of deaths that are unnecessarily reported to the Coroner but also assist in identifying deaths that give cause for concern so as to justify further coronial inquiry.

In addition, your comments and/or observations on the scope for improvement in the current system of procedures and practices would also be of benefit.

4.47 The vast majority of deaths are reported to Coroners by doctors and police and it remains an extremely rare event for a member of the public to report a death to a Coroner in any jurisdiction, this is despite the statutory obligations falling on the public under s.7 of the 1959 NI Act. Given that the overwhelming majority of members of the public will be unaware of any such statutory duty upon them, its creation (in England or Wales) or continuation (in NI) is in my view likely to be of little practical benefit.

4.48 However in respect of professionals, certainly in England and Wales it makes good sense to reinforce the common law duty in respect of doctors and police with a statutory obligation (as already exists in Northern Ireland).

4.49 Doctors and police are likely to be the first professionals to become aware of the vast majority of deaths and there are great advantages in those professionals reporting cases directly, before the registration process hence avoiding the delay which might be incurred were notification to be left to the registrar.

4.50 However, and particularly in respect of doctors, any duty to report deaths to Coroners should be in clearly specified circumstances with clear guidance provided that can be applied nationally.

4.51 A national agreed standard for reporting with clear guidance (such as that provided by Department of Health, Social Services and Public Safety in NI) has many advantages over a system subject to the vagaries of local directions, as persists in England and Wales, and can ensure more consistency in the teaching and training of doctors. Indeed in my view England and Wales would benefit from adopting the approach of the Northern Irish Department of Health, Social Services and Public Safety (perhaps with guidance devised jointly by the Coroners and Burials Division of the Ministry of Justice and the Department of Health).

4.52 After the Shipman Inquiry and in the light of the large number of deaths as a result of Dr Shipman's criminal actions that had not been reported to a Coroner consideration was given in the government consultation paper as to whether there should be sanctions for failure to notify a Coroner of a death. The majority of responses advocated the creation of an offence for deliberately and wilfully failing to report a death however that majority view was not accepted by the government.

4.53 Given that professional misconduct charges and sanctions can already be brought by the GMC against doctors who do not comply with their obligations to assist a Coroner[34] it is not clear that deliberate defaulters would be any more deterred by additional statutory sanctions. Further the creation of a criminal offence for those doctors who fail to report a death is likely to lead to a large degree of unnecessary over-reporting by doctors which would in turn place a greater administrative and financial burden on the Coroners Service.

4.54 Further in England and Wales, once the medical examiner system is put in place all death certificates will be scrutinised by an independent doctor hence the prospect of a death remaining wholly outside the Coronial system will be much reduced. Additionally the medical examiners' ability to obtain and scrutinise medical records makes it far less likely that any potential medical mismanagement will not be drawn to the Coroner's attention.

4.55 The Northern Irish Coroners Service does already have the benefit of a full time medical adviser who provides medical advice to the Coroners, Coroners' Liaison Officers and other Coroners Staff, communicates with registered medical practitioners reporting deaths and meets with bereaved families to provide advice on the cause of death and discuss their concerns. However the medical adviser does not scrutinise those deaths that are not reported to a Coroner, i.e. around three quarters of the annual deaths.

4.56 In December 2010 a consultation document on death certification by the Northern Irish DHSSPS[35] sought views about introducing a Medical Examiner system

[34] Scrutiny of the GMC website on which the outcome of disciplinary proceedings are reported reveals that professional conduct charges were brought (although not proven) in 2010 against a medical practitioner alleged to have failed in the duty to assist a Coroner.

[35] http://www.dhsspsni.gov.uk/consultationexecutivesummary151210.pdf

similar to that proposed in CJA for England and Wales. The consultation closed on 11 March 2011 and the findings will soon be reported. Whilst I support the implementation of that system in England and Wales, given that the consultation outcome will shortly be available the Inquiry may find it more appropriate to consider the views of the Northern Irish stakeholders and consultees on this issue rather than my own opinion. Further information about the consultation can be obtained from the DHSSPS.[36]

[36] http://www.dhsspsni.gov.uk/showconsultations?txtid=46432 Contact: George M Russell at the Department of Health, Social Services and Public Safety Standards and Guidelines Unit

Section 5: Issue (ii)

Dissemination of information from Coronial Inquiries

Between 1995 to date, what was/is the system of procedures and practices in the UK for the reporting and dissemination of information on the outcomes or lessons to be learned from Coroner's Inquests to the hospital where the patient was treated, other hospitals, the doctors and nurses, Trusts, Boards and the DHSSPS including the Chief Medical Officer?

Again, your comments and/or observations on the scope for improvement in the current system of procedures and practices would also be of benefit

5.1 I address the position in England and Wales only up until 17 July 2008 in this section and deal with amendments to the English and Welsh legislation and comments and/or observations on the scope for improvement in the current system in section 6.

Coroners' powers to make reports to prevent similar fatalities

5.2. In England and Wales the power to add a rider to a verdict was abolished in 1980 and replaced (until July 2008) with r.43 of the Coroners Rules 1984 which gave the Coroner the following power to report the circumstances of an inquest case to an appropriate authority.

> **Prevention of similar fatalities**
>
> A Coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly.

5.3 In Northern Ireland an almost identical rule, r.23(2)[37] remains in force at the present time and states:

> A Coroner who believes that action should be taken to prevent the occurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter to the person or authority who may have power to take such action and report the matter accordingly.

5.4 Research commissioned for the Luce review[38] estimated that this power to report matters was being used in just less than 1 in 50 inquests but with marked variations

[37] Which also replaced the previous provision of r.16 that permitted a jury to make 'recommendations' in 1980

between coronial districts such that one Coroner had made 60 such reports in a year whilst one third had made no reports.

5.5 In Northern Ireland the average number of reports issued was said to be 2.2 per Coroner in the year under study. However, as in England and Wales there was a wide variation between the six Northern Irish coroners responding - with three issuing no reports, one issuing one report, and two issuing six reports.

5.6 Despite such reports often being construed as Coroners "recommendations" the relevant rules actually provide no power to make any recommendation or propose remedies for any danger they only give only a power to report facts. Notwithstanding this coroners frequently use the report to suggest necessary action to relevant bodies.

5.7 The recipient of a report under these rules is under no duty to respond to or even acknowledge the report. Although many recipients would choose to do so, and this was particularly so for those organisations such as Health Trusts who might reasonably expect to be involved in further inquests held by the same Coroner on a subsequent occasion. However, as was stated by Phillips LJ in *Clegg*[39], "a Coroner cannot be expected to do more than make general recommendations and it must, at the end of the day, be for the National Health Service to give detailed consideration to how the recommendations should be implemented".

5.8 The Luce review found that, according to those Coroners who had made reports, around half of their reports had led to some remedial action being taken, however in around a quarter of cases the Coroner believed the response was inadequate or that "the recommendation had been rejected".

5.9 The Coroner has no power to enforce action under the rules and the view of many is that the only weight the reports had was the adverse media publicity either when the report was made or when the media later asked question about what had been done in response.

5.10 I am not in a position to comment in any detail upon the application of r.43 as far back as 1995, there is no data I have been able to identify that shows how often and when the provision would be used. However perhaps one indication of the relative importance of r.43 reporting at that time is indicated by the fact that r.43 issues were dealt with in only one sentence in the 366 pages of text in the definitive work on coronial law and practice in England and Wales that was published in 1993 (Jervis on Coroners 11th edition). The current 12th edition (published in 2002) gives slightly more attention to r.43 matters, but this is still only a scant five sentences.

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[38] See page 93 para 42-43
[39] [1997] JP reports 521 at 530F

Dissemination of information from Coroners' reports in England and Wales

5.11 In terms of dissemination of r.43 reports and lessons learned from inquests to hospitals and clinical staff there was to my knowledge no national procedure and policy for dissemination of reports beyond the recipients of a r.43 letter prior to 2008.

5.12 In England and Wales there was no central collation of reports pertaining to healthcare issues by the Department of Health, nor any overview of the rule 43 reports received by NHS bodies.[40] Hence many reports would often only be sent to the Trust or institution under whose care a person had died and the decision of whether to respond to the report fell to the individual organisation. Whether there was wider than local circulation of the facts arising at an inquest would depend wholly upon whether the individual Coroner had, at the inquest, heard evidence that suggested to him or her that the issue identified was of wider than local relevance and hence perceived a need to make a report to a national body.

5.13 Even in cases which might appear on first analysis to have only local relevance there was of course nothing to prevent a Coroner bringing the case to the attention of Department of Health or relevant professional body who may be better placed to determine if there were any wider national implications, however such action would be at discretion of the Coroner. There was no body with responsibility for, or any guidance on, determining whether what might appear on first analysis to be matters of only local relevance might be matters of wider application.

5.14 Whilst the receiving Trust would be free to choose, as part of the action taken in response to receipt of a r.43 report, to forward the report to the relevant section within the Department of Health if they believed changes might require the input of a national policy unit, there was no guidance to this effect.

5.15 It is of note that an exploratory study reported in 2008, used qualitative methodology to investigate organisational learning in the NHS following recommendations of the coroner under Rule 43. The study found that the role of the Coroner was not clear even to the most senior interviewees. There was said to be little evidence of organisational learning generated or shared in the NHS organisations involved in the study from the recommendation of the coroner after a death. There was evidence of a lack of clarity in handling of and learning from coroner's recommendations both within and between the organisations involved in the study. Whilst this was a small study limited to a single English health district it is of concern that prior to 2008 there appeared to be little learning from r.43 reports within and between NHS organisations.[41]

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[40] This is based upon information from 2006 provided to "Forum for preventing deaths in custody" the predecessor of the current "Independent Advisory Panel on deaths in Custody" (created April 2009) http://www.preventingcustodydeaths.org.uk/coroner_rule_43_reportspaper_09.doc - See Appendix 14

[41] Organizational learning and patient safety in the NHS: an exploration of the organizational learning that occurs following a coroner's report under Rule 43. Claridge, Cook and Hale **Clinical Risk 2008;14:8-13** http://cr.rsmjournals.com/cgi/content/abstract/14/1/8

5.16 Since 1996, the Mental Health Act Commission (MHAC) has maintained records of every patient who has died while subject to detention under a section of the Mental Health Act 1983.[42] Where an inquest into a death of a patient detained under the Mental Health Act occurs the majority of Coroners would extend the status of a properly interested person to the MHAC, hence through that route the Commission could have become aware of any rule 43 report arising from the inquest. However as recently as 2006 the "Forum for preventing deaths in custody" found that this arrangement was usually based upon the existence of good working relationships between the MHAC and individual coroners rather than a systematic approach to sharing the learning from the reports.

5.17 The only government body that appears to have had any system for oversight of r.43 reports before 2008 was the Home Office. In respect of deaths in prisons, the "Safer Custody Group" (SCG) (part of the Ministry of Justice National Offender Management Service) was responsible for considering and responding to Coroners' rule 43 reports of which it was made aware.

5.18 The SCG would assist the Governor of the individual prison where the death occurred in responding to a rule 43 report. Consequently, the SCG had oversight of the issues raised nationally by Coroners under rule 43 which could then lead to policy revision at a national level even where the r.43 report had only initially been addressed to the prison locally. However, there was no specific mechanism through which the contents of rule 43 reports, or the responses to them, were collated or disseminated throughout the Prison Service or beyond.

5.19 In specific cases, particularly where high profile deaths occurred, the Ministry of Justice could choose to publish for wider dissemination the Coroner's r.43 recommendations and the government's response to them. This was done in 2008 following the inquests into the deaths of Gareth Myatt and Adam Rickwood in 2004. These inquests raised particular issues about the use of restraint with young persons in secure training centres.[43]

5.20 In the case of deaths in police custody or following police contact it is understood that there was no single body with oversight of all the rule 43 reports sent to police forces. Chief Officers were not compelled to share the reports or responses with

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[42] The Commission's functions have since April 2009 been taken over by the Care Quality Commission (CQC). Whilst the CQC regulations require registered persons to provide them with notification of the death of a service user (save death from natural causes in an NHS establishment) and of any patient detained under MHA, they do not require all Coroner's r.43 letters received by registered persons to be provided to them.

[43] The most recently updated version of the government's action plan in response to the Coroner's recommendations having been place do the internet in October 2010 at: http://www.justice.gov.uk/response-inquest-myatt-rickwood.pdf - See Appendix 15

others and there was no requirement for the Independent Police Complaints Commission (IPCC) to be made aware of rule 43 reports or of forces' responses to them.

Situation in Northern Ireland 1995 to date.

5.21 I have not been able to identify any formal or informal mechanisms in place in Northern Ireland for consideration of r.23 reports. I am informed that the Coroners Service does not currently hold central figures for r.23 referrals, each Coroner being aware only of their own r.23 reports. This is essentially the same as the position in England and Wales before the amendments to the equivalent rule in 2008.

5.22 Some limited information regarding r.23 reports from a study conducted in 2004 is available in a paper published by the Northern Irish Human Rights Commission in 2006.[44] A survey of five of the then Northern Irish Coroners was conducted, largely directed at inquests involving lethal force by public bodies. The results if the survey in respect of r.23 reports were stated as follows.

> "None of the Coroners has made a recommendation in a lethal force case involving the security forces. They have made them in other cases and have received no response beyond an acknowledgment, although one coroner did indicate that there appeared to be an improved attitude from other public authorities in this regard and that they were trying to be slightly more proactive and take such recommendations onboard.
>
> The Coroners suggested that a new coronial regime could include the publication of an annual report to include statistics on deaths, deaths engaging Article 2 and cases in which recommendations had been made. Copies of the letters sent by Coroners making such recommendations and any responses received could be appended to the report."

5.23 I am informed by Mr Sherrard that there is a plan in place for the NI Coroners Service to record r.23 reports in the future.

[44] http://www.patfinucanecentre.org/hrights/NIHRC_Feb06.pdf

Section 6: Issue (iii)

Effect of the amended r.43 and CJA 2009

How, particularly with the advent of the amended Rule 43 and the Coroners and Justice Act 2009, does Coroners Law and Practice in Northern Ireland differ from that in England and Wales in reference to the issues noted above, and what are the advantages and/or disadvantages of these differences

Coroners' current powers to make reports to prevent deaths in England and Wales.

6.1 From 17 July 2008 in England and Wales r.43 Coroners Rules 1984 was amended, the most relevant parts of which now read as follows:[45]

Prevention of future deaths

r.43(1) Where—

(a) a Coroner is holding an inquest into a person's death;

(b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and

(c) in the Coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the Coroner may report the circumstances to a person who the Coroner believes may have power to take such action.

....

(4) The Coroner making the report under paragraph (1)—

(a) must send a copy of the report to—

(i) the Lord Chancellor; and

(ii) any [properly interested persons]; and

(b) may send a copy of the report to any person who the Coroner believes may find it useful or of interest.

(5) On receipt of a report under paragraph (4)(a)(i), the Lord Chancellor may—

(a) publish a copy of the report, or a summary of it, in such manner as the Lord Chancellor thinks fit; and

(b) send a copy of the report to any person who the Lord Chancellor believes may find it useful or of interest (other than a person who has been sent a copy of the report under paragraph (4)(b)).

[45] The full text of amended r.43 and r.43A is set out in at Appendix 16. See also Guidance for Coroners on changes to Rule 43: Coroner reports to prevent future deaths at Appendix 17 http://www.justice.gov.uk/guidance/docs/coroners-reports-future-deaths.pdf

Response to report under rule 43

43A.—(1) A person to whom a Coroner sends a report under rule 43(1) must give the Coroner a written response to the report containing—

(a) details of any action that has been taken or which it is proposed will be taken whether in response to the report or otherwise; or

(b) an explanation as to why no action is proposed

within the period of 56 days beginning with the day on which the report is sent. [46]

(2) On receipt of a response under paragraph (1), the Coroner—

(a) must send a copy of the response to—

(i) the Lord Chancellor; and

(ii) ... any [properly interested persons]; and

(b) ... may send a copy of the response to any person who the Coroner believes may find it useful or of interest.

(3) ... on receipt of a response under paragraph (2)(a)(i), the Lord Chancellor may—

(a) publish a copy of the response, or a summary of it, in such manner as the Lord Chancellor thinks fit; and

(b) send a copy of the response to any person who the Lord Chancellor believes may find it useful or of interest (other than a person who has been sent a copy of the report under paragraph (2)(b)).

(4) A person giving a response under paragraph (1) may make written representations to the Coroner about—

(a) the release, under paragraphs (2)(a)(ii) or (b) or (3)(b), of a copy of the response; or

(b) the publication, under paragraph (3)(a), of the response.

(5) Representations under paragraph (4) must be made to the Coroner no later than the time when the response is given under paragraph (1).

6.2 In summary, the effect of the amended rule is as follows:

- Coroners now have a wider remit to make reports to prevent future deaths. It does not have to be a similar death;
- a person who receives a report must send the Coroner a written response;
- Coroners must provide interested persons to the inquest and the Lord Chancellor with a copy of the report and the response;
- Coroners may send a copy of the report and the response to any other person or organisation with an interest;
- the Lord Chancellor may publish the report and response, or a summary of them;
- the Lord Chancellor may send a copy of the report and the response to any other person or organisation with an interest.

[46] Under rule 43B. A Coroner may extend the period of 56 days even if an application for extension is made after the time for compliance has expired.

6.3 Previously rule 43 limited Coroners to writing reports where they believed that action should be taken to prevent the recurrence of similar fatalities. The amended rule widens the ambit of the public health powers in that Coroners may now make reports to prevent any other deaths even if the anticipated risk creating circumstances may not have actually caused the death under scrutiny in the inquest.

6.4 The only requirement is that any report is based on the evidence heard at an inquest (rule 43(1)(b)). This allows the Coroner to report issues of concern that may not have been causative in the current case but nevertheless may prevent a death in the future.

6.5 Unlike the old rule 43 the amended version (by virtue of 43(4)(a)(ii) and (b) and 43A(2)(a)(ii) and (b)) provides a clear statutory authority for Coroners to share the report and response with any person or organisation who may find the information useful. Similarly the Lord Chancellor may distribute reports and responses more widely.

6.6 In addition to the Lord Chancellor distributing reports those with a special interest may also now request copies of reports from the Lord Chancellor. As an example, the Department for Transport's Road User Safety Division has asked to receive copies of any reports and responses relating to deaths on the road. Similarly INQUEST (a charitable organisation that assists families of those who have died in custody) have asked the Lord Chancellor to disclose to them all reports related to custodial deaths. The Ministry of Justice have indicated that they comply with those requests.[47]

Lord Chancellor's Summary of r.43 Reports

6.7 From the outset of the changed rule the Lord Chancellor indicated that, on his behalf, the Ministry of Justice (MoJ) would produce a regular bulletin on Coroners' reports and the responses.

6.8 To date there have been four bi-annual bulletins produced (the latest having been publish in March 2011, which covers reports made to 30 September 2010).

6.9 In these bulletins the MoJ collates data from all r.43 reports made by Coroners in the previous six months and it is made publicly available on the internet.[48]

6.10 Cumulative data since 2008 has not been provided by the MoJ, however I have extracted the information from the summary reports that are available to obtain the

[47] The Lord Chancellor will redact reports where he deems this necessary.
[48] See Appendices 18 to 21 for the 4 individual bulletins or on the internet as follows:
http://www.justice.gov.uk/publications/docs/rule-43-bulletin-06-07-2009-web.pdf
http://www.justice.gov.uk/publications/docs/summary-coroners-reports-rule43-april-sept09.pdf
http://www.justice.gov.uk/publications/docs/third-summary-coroners-reports-rule43a.pdf
http://www.justice.gov.uk/publications/docs/rule-43-coroners-report-march2011.pdf

following cumulative data on Coroners' use of rule 43 reporting powers under the amended rule in the 26 months between July 2008 and September 2010.

Cumulative data on amended Rule 43 reports from July 2008 to Sept 2010

6.11 Between 17 July 2008 and 30 September 2010 a total of 905 r.43 reports have been issued by Coroners in England and Wales arising from 741 inquests (some inquests leading to more than one report being issued).

Coronial jurisdictions making r.43 reports.

6.12 Rule 43 reports have been issued post-inquest by Coroners sitting in 94 (82.5%) of the 114 different coronial jurisdictions in England and Wales.

6.13 Hence there have been 20 coronial jurisdictions (17.5%) where no r.43 reports have been issued by any Coroner following the amendment to the rule. In a further 19 jurisdictions (16.7%) there has only been one inquest that has resulted in a r.43 report being issued since July 2008.

6.14 Overall the median number of inquests resulting in reports has been 4 per coronial district in the 26 month period.

6.15 However, the figures demonstrate that the use of the amended r.43 powers varies greatly. A very small number of coronial districts have been responsible for a very high proportion of the reports made. Just seven[49] jurisdictions (6%) account for almost a third of the total inquests that lead to reports (240 of 741 ie 32.4%).[50]

6.16 As data is provided by jurisdiction it is not possible to discern within any one jurisdiction whether those reports that have been issued by the Coroner, a Deputy Coroner or an Assistant Deputy Coroner. However it must be assumed from the figures that a large number of those holding coronial posts have still not deemed a r.43 report to be required in any case, despite the legislation change.

6.17 Whether a report is issued must to a large extent be determined by the particular circumstances of the death that is investigated and, where only local issues arise, whether or not remedial action has been taken pre-inquest. However I would suggest that the wide variance of practice demonstrated in the statistics above is unlikely to be wholly explained by those factors and can only represent a wide individual variation between Coroners in their attitude towards the use of r.43 reports, particularly different views as to the perceived threshold for and the purpose of reporting under r.43.

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[49] These are: Cardiff; Devon (Exeter); Manchester City; Manchester South; Greater Norfolk; Staffordshire South and West Yorkshire (Eastern)

[50] The most frequent use of r.43 - accounting for 13.7% (101) of the reported inquests - was from within only two jurisdictions: Greater Manchester South (56 inquests) and Staffordshire South (45 inquests).

Recipients of r.43 reports

6.18 There has been a consistent picture from each of the bi-annual summaries that around a third of reports have been issued to NHS organisations.

Table 1 : Rule 43 reports issued by organisation

Reporting Period	7/08-3/09	3/09-9/09	10/09-3/10	4/10-09/10	Total Reports	%
Type of Organisation						
NHS Hospitals and Trusts	78	65	74	72	289	32
Ministers Central Government	48	31	39	44	162	18
Local Authorities	37	38	34	22	131	14.5
Private Companies	36	10	19	17	82	9
Regulatory bodies/ trade orgs	22	20	26	21	89	9.8
Police and emergency services	11	14	22	22	69	7.6
Prisons	7	4	14	10	35	3.9
Care and nursing homes	6	2	8	6	22	2.4
Other	5	11	7	3	26	2.9
Total Reports Made	250	195	243	217	905	
Inquests Generating Reports	207	164	195	175	741	

6.19 In addition to the statistical summary the MoJ bi-annual reports also provide a summary setting out the contents of each report (in very brief detail), who the recipient is and whether a response has been received within the statutory limits.

Responses to r.43 reports

6.20 The figures show that the overwhelming majority of reports do now receive a response from the recipient as required under the rules. Although there is no information against which one can judge the general quality of responses received.

6.21 Although there is no statutory sanction for non-response the small number of defaulters are named in the bi-annual MoJ document. There have been 23 defaults reported in respect of the 905 reports issued. In the first bulletin it was reported that 10 organisations had failed to either respond be granted an extension of response time (including 3 Health Trusts), in the second all recipients had responded, in the third bulletin three organisations had not responded (including 1 Health Trust) and in the

fourth there were 10 defaulters (including 3 NHS organisations, the Health and Safety Executive, the Home Office, a prison and a District Council).

Rule 43 Reports of wider National significance

6.22 Within the MoJ bi-annual statistical summary a summary is also given of those reports deemed to be of wider than local implication.

6.23 Examples of those cited as having national implication in respect of the Health Service have included issues of:

The absence of a National Allergy Service
The gate keeping function of Community Psychiatric Nurses
Transfer of out-of-hours GP calls and use of non-UK based locum GPS
Labelling on intravenous infusion bags
Sharing of information between GPs and police re firearms licencees
Use of oral chemotherapy in prison

6.24 However beyond citation and publication in the bi-annual report there is no formal provision for the MoJ to take any other steps to bring the reports to the attention of those who may benefit from awareness of these cases.

6.25 It have been informed that a civil servant at the Department of Health is now provided by MoJ with copies of all r.43 reports and responses relating to NHS institutions, General Practitioners or any clinical issue. However this is an informal agreement and there is no formal procedure nor resources allocated within the DoH to undertake a systematic review of the r.43 reports and wider lessons arising for the NHS.

CSEW: Archive of r.43 Reports and Responses

6.26 The CSEW through its rule 43 archivist, Mr Winter (HM Coroner for Sunderland) provides an archive of rule 43 reports and responses. Mr Winter catalogues, scans and posts all reports and responses on the confidential website accessible only by CSEW members. The catalogue includes: the name of the jurisdiction; the Coroner or Deputy issuing the report; the date of report and name of the deceased. Hence each jurisdiction has easy access to their own data.

6.27 The archive is collated by category of organisation receiving the reports but is also searchable by date and key word. This has the great advantage that any Coroner member of the CSEW who is contemplating making a r.43 report will be able to use the CSEW resource to ascertain whether similar facts or issues have arisen in other jurisdictions, and hence may have more than local significance.[51] The reports can also be usefully reviewed by Coroners before an inquest is held to inform them of issues identified by others that might also arise in their case.

[51] As an example a search under "hyponatraemia" in March 2011 produced a single report made in January 2011 to the National Offender Management Service in respect of the ingestion of an excessive amount of water by a detainee in a police custody suite.

6.28 However the quality of the database relies upon individual Coroners themselves providing information to the CSEW and the service is provided gratuitously by Mr Winter without any support or additional resources allocated.

Future amendment of r.43 under CJA 2009

6.29 Under CJA 2009 (schedule 5 paragraph 7) it is proposed that the current discretion to write a 'rule.43' report will become a compulsory requirement.

> **Action to prevent other deaths**
>
> 7(1) Where—
>
> (a) a senior Coroner has been conducting an investigation under this Part into a person's death,
>
> (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
>
> (c) in the Coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
>
> the Coroner **must** report the matter to a person who the Coroner believes may have power to take such action.
>
> (2) A person to whom a senior Coroner makes a report under this paragraph must give the senior Coroner a written response to it.
>
> (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.

6.30 This amendment making a report mandatory once a Coroner comes to the view that action should be taken to reduce the risk of death in the circumstances reflects what is arguably already the case in law, further to the recent judgment in R (Lewis) v HM Coroner for Mid and North Shropshire and the Secretary of State for Justice [2009][52].

6.31 In Lewis Etherton LJ stated that:

> "38. Although r.43 is expressed in permissive language, the circumstances, particularly in the light of the Art 2 obligation, may be such that the failure to report on a systemic failure would be a breach of duty.

[52] [2009] Inquest Law Reports 294; [2009] EWCA 1403 (Civ))

> 39. It is doubtless with a view to the Art 2 obligation that the permissive language of r43 has been changed into one of obligation in para 7 of Sched 5 to the Coroners and Justice Act 2009."

6.32 Although obiter, these comments support the contention that as the State has a duty under Art 2 to ensure that there are systems in place to protect the lives of it subjects, then to satisfy those requirements a report by a Coroner will *always* be required where a Coroner believes that action should be taken to eliminate or reduce the risk of death to others.

6.33 Indeed, even the current discretionary power must be exercised reasonably, and it is difficult to see any circumstances in which a Coroner could come to the view on the evidence that action should be taken to prevent the occurrence or continuation of risky circumstances and then choose not to exercise his/her discretion in favour of making a report about this.

Future amendment of r.23 under NI rules

6.34 I have been informed by Mr Sherrard, Coroner for Northern Ireland, that there are currently proposals to amend r.23 NI rules to adopt a format similar to that currently in force in England and Wales. However further information in respect of these proposed changes is not currently publically available.

6.35 I am informed that Ms Alison Houston at the Lord Chief Justice's department is overseeing this proposal and she may be able to give the Inquiry further details of the progress of the proposals if such is required.

Advantages of the amended r.43 powers

6.36 The amended rules on reporting matters after inquests have been generally positively received in England and Wales and I would endorse the adoption of the revised formula for r.23 in Northern Ireland.

6.37 There remains a criticism by some that the rule has no force behind it, in that there are no sanctions for failure to respond to a Coroner's report nor any requirement on the recipient to accept the suggestion in the report that action should be taken. However, receipt of a report is perceived by many to be an indication of organisational shortcomings and hence the additional publicity now associated with a report does carry some weight with responsible organisations.

6.38 Particularly for health care bodies, the statutory requirement to respond, coupled with the knowledge that they are very likely to have their actions scrutinised by the same Coroner in the future, is an important persuasive factor that leads to matters in a Coroner's r.43 report to generally be given very full consideration.

6.39 However that the reports arise from an inquisitorial process is, in my view, a strong consideration against imposing sanctions for non response or placing any requirement on a recipient to actually take the suggested action.

6.40 The issues raised in the report may have only been superficially considered in the inquest. In many cases the recipient will not have been aware that the Coroner was considering making a report on the matter until the end of the inquest evidence. The recipient may not have had any opportunity to place evidence before the court that would go to show that a report is either misconceived or otiose. Indeed, many recipients will not have been aware that the inquest is taking place. Even those who attend and are designated properly interested persons are likely to have had little or no opportunity to address the Coroner as to whether a report should be made. Indeed the practice of some Coroners is to decline to permit submissions on whether or not a r.43 report is apposite.

6.41 However the most important factor against giving the reporting power any additional weight in my view is that it should not be or become the role of a Coroner to write policy or procedures for other organisations. Such matters are outside a Coroner's expertise and the decision as to whether action needs to be taken may depend on many factors of which the Coroner is wholly unaware.

6.42 Instead employing the power under the amended r.43(4)(b) to copy the report to any person who might find the report useful is an important measure in my view, in that it allows a Coroner to bring the matter the attention of the relevant government department or inspectorate who, it may be hoped, will have the relevant expertise to determine whether policy or guidance should be amended in the light of the case.

6.43 Indeed consideration might be given as to whether there should be a requirement, rather than an option, to send reports to the relevant 'oversight body'.

6.44 What is also important in my view is that Coroners do not use their reports as a means of censure and hence, wherever possible, they avoid writing their reports in tones imputing blame or criticism. The public health value of learning lessons from the circumstances of previous deaths will be lost if a culture develops where reports are not shared because their content reflects badly on an organisation. The key aim of the r.43 provision or its successor must be to foster and disseminate organisational learning and openness.

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Having been a forensic and academic psychologist for 13 years before her call to the Bar in 1997 it is unsurprising that Bridget's practice has a strong focus on matters involving psychological issues and that she specialises in all areas of mental health law. She sits as a part-time Tribunal Judge in the First Tier Mental Health Tribunal and she frequently acts in all types of mental health related cases for both claimants and defendants. She represented the NHS Trust in the first mental health appeal to be heard in the Upper Tier Tribunal (UTT) and has also represented patients seeking to appeal to the UTT.

Bridget also specialises in inquest law. She sits as an Assistant Deputy Coroner in West Sussex and is one of the editors of the Inquest Law Reports. She has acted for countless families, NHS Trusts and other statutory bodies at inquests around the country and recently brought a successful JR against a Coroner overturning his inquest verdict on grounds of insufficient inquiry. She has represented interested persons in a large number of lengthy inquests held under Art 2 ECHR investigating deaths in police or prison custody and deaths of detained patients in psychiatric hospitals.

Bridget has also been instructed by a Coroner to act as counsel to the inquest and represents parties in inquiries. She was counsel to the panel of inquiry into the care and treatment of Michael Stone following his convictions for the murder of Lin and Megan Russell and has acted as counsel to an NHS Trust in another long running and high profile inquiry following a homicide by a psychiatric patient.

A large proportion of Bridget's professional life is also spent in the Court of Protection and the High Court's Family Division in cases involving issues of capacity and best interests. Her practice covers all types of disputes regarding the social welfare of incapacitated adults and children and medical treatment issues. She is regularly instructed by the Official Solicitor, families of patients, NHS bodies, local authorities and private care providers.

Bridget has a particular interest in cases involving deprivation of liberty having appeared in two of the headline Court of Protection cases concerning the interplay between the MCA and the MHA. Her legal analysis of the MCA/DOLS provisions was described as 'a model of succinct lucidity' by Wood J in *W PCT v TB*. In 2010 Bridget was appointed as Advocate to the Court in LS, a Court of Protection case addressing the civil test for capacity to consent to sexual relations.

http://www.3serjeantsinn.com/barristers/bridget_dolan/public_and_administrative

Report to the Inquiry into Hyponatraemia-Related deaths

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