Written evidence from Maggie Brooks and Janet Brooks

We write in response to your call for evidence about the need for improvements in services for the bereaved at inquest and about the need for fairness in the Coronial system

We refer to our experience of an inquest which took place in November 2014. This was into our mother's avoidable death in an NHS Trust hospital,

This inquest was subsequently overturned in 2018 and a new inquest ordered in a new jurisdiction, which has opened but has yet to take place.

To summarise, in this submission we give instances of:

- The adversarial nature of the inquest exacerbated by No Win No Fee clinical negligence claims
- Unfairness towards relatives and perceived institutional bias towards NHS Trust
- Lack of security of inquest recordings and their storage
- Need for financial parity in funding for the bereaved at inquest

Background

1. Our mother, Elsie Ellen Emily Brooks, died in an NHS Trust hospital on 06 January 2010.

   We told the ITU Consultant Intensivist who had overseen completion of the death certificate that it was inaccurate.

   We said we would be making a complaint of neglect. We asked about a post mortem.

   He said there were no grounds for a post mortem.

   He told us the death had been 'waived' by the Coroner.

   There followed an 18 month long investigation by the NHS Trust. This brought no facts to light.

2. The Trust withheld records, withheld the identities of witnesses, obfuscated the facts and dragged everything out for the longest possible time.

3. The Trust's investigation having failed, the Parliamentary and Health Service Ombudsman then agreed to investigate.

   But the Trust supplied a set of my mother's medical records to the Ombudsman with over 100 crucial records taken out.

As a result, the Ombudsman's year-long investigation produced a report that was inaccurate and gave a totally misleading account of our mother's death.

The Ombudsman was in the process of reviewing its investigation report because of the records the Trust had withheld.

4. Meanwhile, we determined to get an Inquest because no-one had established our mother's actual cause of death.

No Win No Fee to fund the inquest

5. In 2012, we found lawyers who were prepared to try to get an inquest into our mother's death.

However, the only way to finance the inquest was if we took out a No Win No Fee claim for clinical negligence.

This was not something we had ever thought of doing but now we had no option.

6. Our lawyers applied to the local Coroner. He opened an Inquest on 7 November 2012 on the suspicion that my mother's death had not been natural.

The first Pre-Inquest Review took place on 17 December 2012.

The Coroner warned the Trust and our lawyers that the inquest was not to be used to fight the clinical negligence claim.

We did not understood what he meant.

We thought the inquest process was supposed to be inquisitorial and all the parties were there to help the Coroner gather the facts.

We did not realise that the clinical negligence claim guaranteed that the inquest would be adversarial.

And that the NHS Litigation body would soon send in its own advocate to represent the Trust, whose job would be to fend off or minimise any future liability.

7. The Coroner made directions that the NHS Trust should provide witness statements urgently within 6 weeks.

The NHS Trust did not provide these statements for **10 months**.

No-one at the Coroner's court chased these up and the Coroner did not express disapproval to the Trust because of this delay.

8. The Coroner left his post in November 2013 and the Assistant Coroner took over the Inquest. At the same time, the advocate appointed by the NHSLA[1] took over representation of the Trust.

Article 2

9. At the second Pre-Inquest Review in April 2014, our lawyers made submissions that the inquest needed to be held under Article 2 of the ECHR.

   We believed that it had been a serious system failure which caused our mother's death.

   To investigate this, we needed to get the wider scope of inquest which looked at 'the circumstances' around the death.

10. The Trust / NHSLA advocate argued against Article 2 saying that there had already been a Trust investigation and a full Ombudsman's investigation.

    It seemed that the Coroner accepted this.

    We tried repeatedly to explain to the Coroner that the Ombudsman's report was currently under review because the Trust had withheld records from the investigation but we never seemed to get this point across to her.[2]

Witnesses

11. A crucial witness to the system failure was the Divisional Nursing Director who had opened the contingency ward where my mother came to serious harm.

    The Trust / NHSLA advocate claimed ignorance of the DND's identity, putting forward 3 wrong names to confuse matters, although the DND had been referred to the NMC by name so everyone knew who she was.

12. The Trust / NHSLA advocate proposed that in place of the Divisional Nursing Director, the Trust would put forward a Deputy Head of Nursing who had only been in post for six months.

    The Trust claimed to have no records or policy or operational documents from the time of the events in 2009. / 2010. This made it hard to see how the recently appointed Deputy Head of Nursing could comment on these events that had happened 5 years before.

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[1] NHS Litigation Authority – now NHS Resolve

[2] The Ombudsman personally quashed our 2012 Ombudsman's report in 2018 following a review which identified that the Trust had provided them with a set or edited and misleading medical records.

13. As to other eye witnesses, the Coroner said she would not call them because they were too junior. She would mostly be calling consultants to answer for their juniors.

    But these consultants had not been present at the events.

14. By August, we were worried about the way things were going. The inquest's scope was limited and the Coroner did not have the relevant witnesses or any independent medical expert.

    The three pre inquest reviews were over and we seemed to be hurtling towards an inquest for which we were completely unprepared. I spoke to the Senior Coroners Officer about this.

15. He said I was worrying unnecessarily since the outcome of the inquest had already been decided. He said the Coroner would find 'pneumonia' or 'aspiration pneumonia' and that the inquest itself was just to 'tie a bow on it'.

    I told him that my mother had not had pneumonia and that the purpose of the inquest was to bring the true facts to light. But he did not reply

Trust makes Part 36 offer

16. 3 months before the inquest hearing which was scheduled for November 2014, the NHS Litigation Authority made a Part 36 offer and accepted liability for my mother's death.

    In a case with a No Win No Fee agreement such as ours, this offer results in the insurers withdrawing funding for representation of the bereaved at inquest.

    We parted from our lawyers in late August.

    From the Trust / NHSLA lawyers' point of view, with our 'representing ourselves' our inquest was now an open goal.

Coroner grants Article 2

17. We set about putting in our own submission for Article 2.

    Being amateurs, these submission took us two months to formulate with the help of an inquest book.

18. When I went into the Court to deliver supporting documents to this application, the Senior Coroners Officer told me that the Coroner had granted Article 2.

    I was pleased and said, "We'll need another Pre Inquest Review."

He said, “The Coroner won’t want any more delays.”

I said we needed independent expert medical opinion.

He said, “The Coroner’s a doctor.”

This was true but she had been a GP and long out of medical practice. We needed an expert with specialist knowledge of Acute Respiratory Distress Syndrome and sepsis.

19. I told him that the Matron (who was a Properly Interested Person) was a crucial witness.

    But the Senior Coroners Officer now said the Trust / NHSLA advocate advised that she had relocated back to Ireland.

    He said he had made extensive inquiries but she could not be traced, not even through her NMC registration.

    We did not believe this.

    It only took us 2 phone calls to establish that she still lived locally and had a new post at a private medical facility on the same Trust hospital site where my mother had died.

Our request to Coroner for adjournment

20. The Coroner’s granting of Article 2 meant we were eligible for Exceptional Funding.

    We wrote asking the Coroner to grant an adjournment for a further Pre Inquest Review so we could:

    - obtain more relevant witnesses for this wider scope Article 2 inquest.
    - get lawyers to represent us who could apply for Exceptional Funding and represent us at an Article 2 inquest.
    - ask the coroner to instruct an independent medical expert
    - seek disclosure of the microbiology from the last 2 days of my mother’s life.
    - obtain medical records which the NHS Trust had been withholding from us

21. The Coroner turned this down, saying the inquest had been open for 2 years and that to delay further would not be fair on the Trust.

Considering that the Trust had caused a 10 month delay, and had since failed to name various crucial witnesses, we thought this was extremely unfair on us.

The Coroner wrote on her email to the Senior Coroner's Office – 'Give them time for Judicial Review.'

We weren't sure if this was a private joke between them or whether relatives were expected to attempt Judicial Review as part of the process.

Our attempt to take Coroner to Judicial Review

22. Accordingly, we wrote a Letter before Claim before Judicial Review, asking for an adjournment.

    We listed the witnesses we felt were essential and why we felt the Coroner would not be able to do a proper inquiry without independent medical opinion.

    We went to the High Courts of Justice to file this. Our application was turned down the night before the inquest.

23. This was a bitter blow.

    We had waited 4 years for an inquest. And now we were going to have to sit through a 2 day inquest that stood little to no chance of bringing any facts to light.

The first day of the inquest hearing

24. The next morning, we arrived at the court to find the 12 NHS Trust witnesses sitting in the foyer apparently being coached by the NHS Trust / NHSLA advocate.

25. We had no lawyers representing us but we consoled ourselves that we still had one thing going for us –

    The file of documents we had submitted to the Coroner to support our submission for Article 2. The Trust claimed to have no policy documents from 2009 and no memory of how systems had worked back then.

    But we had Trust FOI responses from 2009 / 2010 which gave insight into the system at that time.

    And transcripts of the surgeon and anaesthetist's testimony to the NMC about the system failures which had led to my mother's death.

26. But as soon as the Inquest started, the Coroner said that she didn't intend to refer to any documents we'd provided other than the medical records as she preferred 'live' testimony from the witnesses present.

    We knew the Coroner had absolute discretion as to what evidence she allowed –

    But it was hard to see the logic in an Article 2 inquest of ruling out the evidence which had led her to give us Article 2 in the first place.

    It felt like the Coroner was laughing at us.

The Trust witnesses

27. None of the witnesses had been present at the events where my mother came to harm so they had to speculate by piecing together entries from the medical records which were patchy and, in some areas, highly inaccurate.

    It was torture to listen to them when we had actually been present at these events. But our eye witness accounts were given no weight against anyone with 'doctor' or 'nurse' in their title.

    Some of the clinician witnesses seemed to had been asked by the Coroner to double up as 'experts' for economy's sake but this smacked of conflict of interest when it was their own actions they were commenting favourably on.

28. There could be no doubt that the witnesses had had 'coaching'. Each witness would stumble through their evidence until the NHSLA advocate asked what improvements had been made by the Trust since my mother's death.

    At this point, the witness would visibly relax and snap into a different, more vivacious, persona – expounding with practised fluency how the Trust was totally reformed and how what had happened back then could never happen again.

    Since the inquest was falling well short of establishing what actually HAD happened to my mother, it was infuriating to listen to witness after witness trot out these glib assurances aimed at avoiding a Preventing Future Deaths report.

The key witness

29. The key witness in our eyes was the on-call Surgical Registrar called Miss S.

    She had been called to our mother in the early hours of the morning after my mother had been vomiting bowel contents non-stop for 11 hours and had aspirated the vomit into her lungs.

Miss S explained in her testimony how aspiration occurs in this situation and how the aspiration of bowel contents causes serious and immediate irritation to the lungs.

She said that the x-ray she had ordered at the time had not suggested the presence of infection and that the diagnosis she had made was ‘pneumonitis’.

The Coroner corrected her and said “aspiration pneumonia.”

But Miss S corrected the Coroner firmly and said “aspiration **pneumonitis**.”

The distinction was crucial as pneumonia would suggest an infection whereas pneumonitis – damage to the lungs caused by aspiration of bowel contents – would be an injury.

And such injury would be the underlying cause of death – and not a natural one.

We knew this was significant testimony.

(Perhaps that is why this passage of testimony disappeared from the inquest recording.)

The Missing Microbiology records

30. Another witness, the Consultant Microbiologist, Dr M, said he thought there were microbiology reports missing from the last two days of my mother’s life.

    We had been asking for these missing reports for the last 4 years as they were crucial to establishing my mother’s cause of death.

    The Coroner asked the NHSLA advocate to arrange for a witness who had access to the Trust’s electronic Microbiology system to bring these in on the following day.

    But, on the following day, the witness said the NHSLA advocate had not contacted her and she had not been asked to bring these in.

    The Coroner did not call for an adjournment to locate the reports, but just carried on regardless without the evidence that was needed.

Events in ITU: Avoiding the Issues

31. On the second day of the inquest, the ITU Consultant Intensivist, Dr Y, was in the witness box for what seemed like most of the afternoon.

Since he had been the Duty Consultant for the last 3 days of my mother's life, it might be thought that this would have finally brought to light the facts that had been hidden for the previous 4 years such as:.

- Why had my mother's condition suddenly deteriorated on ITU on the morning before she died?
- What was the name of the junior doctor who had sent off the cultures?
- Why had this doctor not given an antibiotic for suspected sepsis for 17 hours?

But Dr Y was not able to answer any of these questions.

He said he could not identify the doctor on his team who had been working under him that day –

even though he had the doctor's signature and initials on the medical chart

even though this doctor had handed over to him

even though this was just an 8 bedded unit.

So much for the Coroner's assertion that Consultants could speak on behalf of the junior members of their teams.

32. We believed the Coroner should have asked Dr Y some serious questions since, after he took the handover from this doctor, Dr Y had not given my mother the potentially life-saving drug for sepsis for a further eight hours, if at all.

    Instead, the Coroner was treating him as an expert, asking him to give an overview of the overall care on ITU, deferring to his greater expertise.

33. The Coroner looked to him for expert advice on sepsis.

    Dr Y replied, making a number of startlingly false statements about sepsis.

    When I questioned these, the Coroner backed him up.

34. Dr Y was the Consultant who had overseen completion of the first death certificate wrongly, but the Coroner now asked him to advise her as to how to complete the second one.

    This was so blatantly wrong that it took my breath away.

35. The Coroner ended the inquest and said we would meet again in 5 days to hear her deliver the narrative conclusion.

After the end of evidence

36. When I got home, I emailed The Sepsis Trust and asked their expert whether the evidence Dr Y had given was accurate.

    Their expert emailed back confirming the errors in it.

    I emailed this to the Coroner along with a booklet on sepsis.

37. At the meeting for the narrative conclusion, the Coroner said she had asked Dr Y to come back to court to go over his evidence but he refused.

    So she told us she had ruled out Dr Y's evidence on sepsis.

    With Dr Y's testimony discredited, there had been no evidence given about the last two days of my mother's life.

The Reading of the Narrative Conclusion

38. Over the break, the Coroner had emailed the Trust / NHSLA advocate, asking him to come into the session ready to make his arguments against a rider of neglect.

    It came as a shock to us when he started to make these arguments, which were full of highly disputable statements.

    We asked the Coroner to allow us to give our opposing arguments as we believed there SHOULD be a rider of neglect.

    The Coroner heard our arguments with the appearance of grave attention then, as soon as we finished, picked up her pre-prepared statement and read out her Conclusion in which she said she had found against adding a rider of neglect.

39. That was it. The Inquest was over. It had been Article 2 but it had not investigated the system failure that had led to my mother's death and so there was nothing to stop this same thing happening again.

    It found that she had died of aspiration pneumonia, for which there was no medical evidence at all.

    Aside from the testimony of the Surgical Registrar, Miss S, it had brought no new facts to light.

    As far as Dr Y was concerned, it had not allayed our suspicions. If anything, these had intensified.

The Recordings of the inquest

40. As soon as the inquest finished, the Senior Coroners Officer came down from the bench to speak to us.

    I asked him for the discs of the inquest.

    I knew that the Chief Coroner's guidance was that these could be obtained by relatives for £5 a disc.

    I had worked as an audio medical secretary and so planned to transcribe the inquest recordings myself.

41. Only days before, the Senior Coroners Officer had assured me we would be given these.

    But now, he said that these could not be de-encrypted except by specialist lawyers.

42. I was astonished to hear him say this.

    He said we could get the discs transcribed by a transcription service which would cost us around £900 plus VAT.

    He emailed me the next day, repeating that the discs couldn't be de-encrypted and quoting a 'guesstimate' of £1,500.

    He copied his answer to the Coroner's AOL email account so I assumed he was telling me this with the Coroner's knowledge and approval.

43. I emailed him again saying my former lawyers could de-encrypt the discs and to release the discs to them.

    However he emailed me back again, apologising that he had been 'inadvertently misled'.

    He had now been advised that it was not technically possible to burn a copy of the master disc.

44. I did not believe him.

    I couldn't imagine what use it would be to a court to have a master disc that could not be copied.

45. He said he was going on leave and I should liaise with the Coroner's PA.

    When I contacted her, she too said that the recordings were 'encrypted' and that the court did not have the facility to copy discs.

    She said if we wanted access to the recordings, we would need to commission a transcript from a firm called Kellie Transcribers.

By now, the quote had gone up to £3,400. She said she was about to go off on leave.

46. My sister and I discussed this. It was clear the court was not going to give us the recordings of the inquest.

    We only had 2 months if we wanted to refer the conclusion to Judicial Review. There was only a week to go before we would be out of time to refer doctors to the GMC.

    My sister reasoned that time was slipping away and, since the only way we could access the evidence of our inquest was to pay for the transcript, we should borrow the money and commission it from Kellie Transcribers.

47. I emailed the 'Coroner's PA' that afternoon asking for confirmation that this company was independent of the court. She assured me that it was.

    She instructed us to send a cheque to Kellie Transcribers at an address in North East London.

    I looked the company up online. It had no entries. It had no website and was not registered with Company House. The postcode appeared to be a house in a residential area.

48. My sister sent the cheque for £3,400 to the address the PA gave us 'for a signature'.

    Track and Trace showed the cheque was delivered to the home of the 'Coroner's PA'.

49. All this seemed very fishy.

    We were planning to challenge the Coroner's conduct of the inquest. We, therefore, did not want her PA typing up the transcript.

    The PA might alter it or leave chunks out and since we couldn't access the discs, we wouldn't be able to check this.

    It seemed to us that some people at the court were operating a scam to rip off bereaved relatives when they were at their lowest ebb.

50. I wrote to the Chief Coroner asking for advice. His lawyer advised me to complain to the Judicial Complaints Investigation Office.

    The JCIO advised us to inform the Senior Coroner.

    It was news to us that there WAS a Senior Coroner. I sent her an urgent message.

51. The Senior Coroner phoned me immediately, expressing concern.

She said she would be instigating 2 investigations – one at the court, and another corporate fraud investigation managed by the Local Authority.

To compensate for distress and inconvenience, she offered to commission a transcript of our mother's inquest recordings from transcriptionists Merrill Legal at no cost to ourselves.

52. We accepted this because of our pressing deadlines but said we still wanted the discs.

The Senior Coroner invited me to the court and gave these to me, saying that they were not encrypted, could be easily copied and could be played on free downloadable software on any PC.

She said she didn't know why the Senior Coroners Officer and the 'PA' had told me differently.

It turned out that the 'Coroner's PA' had been typing the transcript from copies of our inquest discs on a computer in the Coroner's court.

Evidence missing from the discs

53. When we got the discs, we went straight to Miss S's evidence. It was the bitterest of blows to find that the passage of evidence we had heard at the inquest was not there.

I took a while for this to sink in.

This loss left us feeling utterly bereft.

54. We were told that the 'Coroner's PA' had been dismissed and that the case was passed to the Police for prosecution – Operation Falcon failed dismally to live up to the racy promise of its name, moving at the pace of a snail and achieving nil results.

55. The cheque for £3,400 was slipped back anonymously through my sister's door.

56. When the Merrill Legal transcript arrived, the Assistant Coroner had signed it off as accurate.

But when we checked the 700 pages of the transcript against the copy disc, we found a crucial 15 minute passage missing from the Consultant Surgeon's testimony.

There was also a crucial 5 minute passage missing from the Matron's testimony.

57. We informed the Senior Coroner, who commissioned another transcript with the passages reinstated. But the passage of Miss S's evidence could not be found.

58. We asked the court to appoint an independent expert to look at the recording apparatus and the software.

    The system seemed quite informal and insecure. The recordings were not saved to the Cloud but archived manually to disc by anyone who was passing.

59. The Court appointed the representative of the account holder of the recording equipment to investigate.

    He wrote in his report that:

> 'It is technically possible that the system could be modified to alter recorded content although this would be a very complicated process which we believe would leave a footprint.'

    Off the record, he told us 'anything was possible' if someone had the skills.

60. He also reported that no archive discs of our mother's inquest had been found. These had never been made, or had been lost or destroyed since the inquest.

    On 28 July 2015, he wrote to the London Borough lawyer:

> 'The fundamental issue is that the correct process is for recordings to be archived at the end of a session in order to create a master record.
>
> In the absence of the archive media against which we can compare the recordings on the PC and the CD copies, we cannot 100% state the integrity of the recordings.'

61. In the end, the 'fraud' we fell prey to in the Coroner's court was never properly investigated.

    This was because of the inquest triumvirate –

    Coronial office staff answerable only to the Local Authority

    Coroner answerable only to the JCIO

    Coroners' Officers answerable only to the Police Authority

    This meant the issue got tossed between the 3 authorities until it was conveniently lost.

The Local Authority offered us £300 compensation which we refused. We wanted someone to investigate the lost evidence from the court recording but this did not happen.

And that was because none of these 3 authorities were prepared to ask the relevant staff members the obvious questions.

New evidence

62. The GMC Fitness to Practice proceedings and the Ombudsman's Review resulted in new medical evidence and we were able to use this to argue that a new inquest should be held.

63. We made an application under Section 13 of the Coroner's Act to the Attorney General. The Coroner who had conducted the inquest supported this, saying that, had she seen the new evidence at the time of the inquest it was possible she would have found neglect.

64. In 2018, the High Court quashed the first inquest and ordered the new inquest to be held by a new Coroner in a new jurisdiction.

65. The Senior Coroner asked us where we would like the inquest to be sent to.

    This sent us into an anxious frenzy, ringing round, asking lawyers and medical support charities to give us a list of Coroners with a reputation for being fair.

    We were shocked by the cautious response to this and the very small number of names of 'fair' Coroners being put forward to us.

    There were only about 3 or 4 and some of those were outside London.

66. We consider ourselves fortunate that one of these well-respected coroners took on our inquest and that we have been granted Article 2.

    But the second inquest is unlikely to be plain sailing.

    It is now 10 years since our mother's death, and this time lag is wholly due to the Trust's successful tactics of delay, deny and defend.

    We find, at the new inquest, that the Trust is still at its old tricks of delaying, denying and failing to deliver - in the hope that they can stretch this out for another ten years.

    The Coroner has a team of high powered lawyers managing the case for him and the Trust's new high powered lawyer introduced herself to us at the hearing.

    The only party at the inquest with no power is us.

    Because of the paucity of the funding available, we see little prospect of being represented and, that being so, we contemplate the second inquest with dread.

Conclusion

67. I defy anyone to read the account of our inquest and its aftermath and say this is a way to treat bereaved relatives of patients who have died avoidable deaths in NHS institutions.

    It should not be that an inquest further traumatises already traumatised people.

68. We learned from our inquest that clinical negligence makes inquest even more adversarial than they might be otherwise.

    All pretence that inquests are inquisitorial not adversarial should be abandoned.

69. Relatives should, of right, be represented at inquest. As a result of not being funded, they are walked over and treated with contempt.

70. There should be oversight of Coroners.

    Coroners have too much power in too much isolation and there is the risk that such power leads to shortcuts in the name of value for money and institutional bias in favour of NHS Trusts.

71. All relatives should be informed that they are entitled to the recordings of the inquest.

72. There should be a reappraisal of how evidence of inquests is recorded and stored in Coroner's courts with an emphasis on how to avoid fraudulent practice and tampering with the evidence on discs.

    02 September 2020