Written evidence submitted by Association of personal Injury (TCS0020)

Evidence from the Association of Personal Injury Lawyers

About APIL

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation which has campaigned for the rights of victims of negligence for more than 30 years. Our vision is of a society without needless injury but, when people are injured, a society which offers the justice they need to rebuild their lives.

Bereaved families and the Coroner Service

1. Families who attend an inquest to find out why their loved one died will be going through the most difficult time of their lives. Unlike all others involved in the inquest, including the coroner and representatives of the organisations where the death occurred, such as lawyers for an NHS Trust, it is likely that bereaved families are attending their first ever inquest. They will be unfamiliar with the process. They will need support to help them through the inquest, and receive the answers they need about their loved one's death. Bereaved families must, therefore, be at the heart of the Coroner Service. There is, however, still too much inconsistency across England and Wales, and not all bereaved families are made to feel like they are at the heart of the process.

2. Across England and Wales there are many good and hardworking coroners, who appear determined to ensure that inquests are as thorough as possible, and will get the answers bereaved families most desperately need. Unfortunately, there are also coroners whose attitude and actions do not ensure bereaved families feel comfortable, and have confidence in the inquest. This is either through a coroner's failure to prepare for the inquest, such as by not reading the papers for the inquest in advance, or a coroner appearing to want to conclude an inquest as quickly as possible, such as by not taking, or limiting expert evidence.

3. An example of a coroner's poor attitude was experienced in a case shared with us by one of our members. The coroner's combative, sarcastic, and terse tone caused the bereaved family serious distress, and undermined their faith in the coroner's ability. Fortunately, the family had legal representation, and the coroner was replaced under threat of judicial review. Our members have also reported instances where coroners have objected to bereaved families placing a picture of their loved one on the table during an inquest, which can immediately make families feel uncomfortable.

4. It can be difficult for bereaved families to feel that they are at the heart of the Coroner Service if they are alone at an inquest, while the other parties involved have legal representation. Often, these other parties will be hospitals, the police, local authorities, or other public bodies, and they will have legal representation funded by the public purse. Most families apart from those who are well off financially will not be able to afford to pay for legal representation out of their own pockets, especially for representation on equal terms with public bodies, which often includes Kings' Counsel. It is also difficult for families to secure financial help to pay for this representation, despite recent changes by the Government after pressure from the justice committee.

5. In response to the committee's report on the Coroner Service in 2021, the removed the financial means test in applications for exceptional case funding (ECF) which provides legal aid for legal representation at inquests. But this change did not go far enough. It is the experience of our members that even before the financial situation of the families was considered, it was rare for applications for ECF to be successful, especially in healthcare-related inquests. Families are still required to provide evidence that the case in the inquest is in the wider public interest, or relates to a breach of Article 2 of the European Convention of Human Rights – both of which are incredibly difficult to do.

6. Justice secretary Alex Chalk KC has now confirmed the Government will "consult on an expansion of legal aid for families bereaved through public disaster where an Independent Public Advocate is engaged, or in the aftermath of a terrorist attack" [1]. We look forward to responding to that consultation, but there must also be a review of the legal aid hourly rate, which is too low and has not kept up with inflation or the commercial costs of private practice. The low hourly rate has left some solicitors considering whether is it viable to still do legal aid work in this area. We agree with the recommendation made by the committee in 2021, however, that legal aid or other public funding should be available for bereaved people in inquests where public authorities are legally represented.

A guide for bereaved people

[1] https://www.gov.uk/government/speeches/hillsborough-charter-is-legacy-of-victims-families

7. In response to the committee's report on the Coroner Service in 2021, the Government did agree to ensure that the *Guide to the Coroner Service for Bereaved People* is freely available both online and, where requested, in hard copy by post. We have no evidence to conclude how widely known the guide is among bereaved people, but while the guide is freely available on the Ministry of Justice (MoJ) website, there is no option on the website to request a hard copy by post[2].

8. We are also concerned about the accessibility of the guide for blind people, or those people for whom English is not their first language. A Welsh version of the guide is available on the website, but it is unclear if hard copies of the guide are available in braille. It is also unclear if the guide is available in other languages such as Polish, Romanian, Punjabi, or Urdu which, according to the Office for National Statistics (ONS) were the most common main languages other than English or Welsh which were recorded in the 2021 Census[3].

9. The guide is comprehensive and written in a way which is accessible for bereaved families, but we are concerned that the guide does not make it immediately clear that a bereaved family can, and may want to, seek legal advice and representation. Section 5, for example, includes a subsection on whether bereaved people can 'bring someone along for support'. The guide that says that 'if you choose to attend the inquest you can bring someone with you such as a friend, or a family member or someone from your community to give you support in the hearing'[4]. The subsection does not say that a bereaved person can bring a lawyer for support. This should be made clear in this subsection.

10. We do note, however, that the guide does provide advice on how to find a lawyer, but the emphasis appears to be that bereaved families do not need a lawyer. The guide does say, however, that someone 'may want to consider getting legal help for an inquest hearing if other interested

[2] https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide
[3] https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/language/bulletins/languageenglandandwales/census2021
[4] A Guide to the Coroner Service for Bereaved People, page 24

persons are represented'[5]. This advice is welcome, but it might not be clear immediately to bereaved families if the other participants at the inquest have legal representation. By the time they are aware of this and decide they need legal advice, it could be too late for that advice to be sought, and for representation to be secured. The guide should, therefore, advise bereaved families to seek independent legal advice as soon as possible.

Prevention of Future Death reports

11. An inquest is crucial to get answers about why and how someone died, but it is also crucial to identify failings which should be addressed to prevent another needless death from happening again. Prevention of Future Death (PFD) reports are, therefore, a vital part of the inquest process. It is the experience of our members that while coroners are now more willing to produce PFD reports, enough is still not done to ensure that those reports are followed-up, the recommendations are implemented, and they do make a difference.

12. The Government missed an opportunity to improve the use of PFD reports when it did not accept the committee's previous recommendation to 'consider setting up an independent office to report on emerging issues raised by coroners and juries…'[6]. The Government did say it would consider options to ensure that reports 'actively contribute to improvements in public safety' alongside the committee's recommendations on an inspectorate of Coroner Services[7]. We are not aware of any options which have been considered by the Government, nor have there been any proposals made public by ministers to improve the use of PFD reports.

13. An online preventable deaths tracker, which is updated weekly, has been established by an academic, Dr Georgie Richards[8]. This tracker, which was established in 2000, includes more than 4,700 PFD reports. As part of her work, Dr Richards, who is supported by a team of academics, clinicians, and a practicing coroner, conducts 'bespoke analyses and studies of coroner reports to

[5] A Guide to the Coroner Service for Bereaved People, page 16
[6] https://publications.parliament.uk/pa/cm5802/cmselect/cmjust/68/6810.htm#_idTextAnchor088
[7] https://publications.parliament.uk/pa/cm5802/cmselect/cmjust/675/67502.htm
[8] https://preventabledeathstracker.net/

identify trends and lessons for improving public safety and reducing avoidable harm'[9]. To date, Dr Richards and her team have published more than 25 studies, articles, and reports.

14. The website of the online tracker says its mission is 'to make coronial data accessible so that it can be used to learn lessons and improve public safety', and the tracker has highlighted repeated failings identified in PFD reports. But this vital work should not be left to academics and others who volunteer their time to report on emerging issues from these reports. Nor it should be left to journalists, such as those working for BBC News who last year investigated the deaths of dozens of young autistic people [10], to identify where similar failings have occurred and resulted in deaths.

15. The Government must provide leadership in this area. We agree with the committee's previous recommendations to ensure that PFD reports are meaningful, and prevent the same failings from happening time and again. We look forward to an update from the Government to the justice committee on its considerations to ensure that reports 'actively contribute to improvements in public safety'.

Inquest delays

16. In the call for evidence for this inquiry, the committee asked whether there is evidence that inquests are taking long to be completed and, if so, what can be done in response. Statistics published by the Government reveal that the 'estimated average time taken to process an inquest decreased from 31 weeks in 2021 to 30 weeks in 2022'[11]. This is an estimated average time, but it is the experience of our members that it is not unusual for healthcare-related inquests to take at least three years, with these delays caused by changes in coroners leading the inquiries, evidence gathering, and representations made by interested persons.

17. In commentary published alongside the coroner statistics, the Government acknowledges that the time taken to process an inquest varies by coroner area. The Government also highlights the possible differences which contributes to this, such as the 'availability of resource, staff, and judicial resources'[12]. We agree that coroner resources do need to be addressed, as some areas have better

[9] https://preventabledeathstracker.net/research/
[10] https://www.bbc.co.uk/news/uk-66731265
[11] https://www.gov.uk/government/statistics/coroners-statistics-2022/coroners-statistics-2022-england-and-wales
[12] https://www.gov.uk/government/statistics/coroners-statistics-2022/coroners-statistics-2022-england-and-wales#time-taken-to-process-an-inquest

resources than others, but our members have noted a recruitment drive for assistant coroners in some areas, which is helping to bring down the waiting times for inquests.

18. Our members find that once an inquest has started, it is rare for bereaved families to express concern that the inquest is taking too long. All that matters to those bereaved families is getting the answers they deserve. It is the truth which is important, not the speed of an inquest. We would, therefore, caution against proposals to speed up the inquest process which could put at risk a bereaved family's opportunity to get the answers they need, and deserve, about why their loved one died.

January 2024