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Albion Chambers INQUEST TEAM NEWSLETTER

Appeals revisited

As so often seems to be the case these days, an amendment to legislation is proposed just as the value of that legislation is demonstrated. The first annual report of the Chief Coroner to the Lord Chancellor revealed that the Government has agreed in principle to an amendment to Section 13 Coroners Act 1988. This report preceded by two days a High Court decision (*Bloom v HM Senior Coroner for the Western District of London* [2014] EWHC 2698 (Admin)) where Section 13 was put to good use to order a third inquest into the death of a 51 year old woman. To be fair to the Chief Coroner, HHJ Peter Thornton QC, he is the author of the report and presided together with Mr Justice Mitting over the *Bloom* case and so one ought to be confident that his intention is to amend Section 13 in a manner that makes it more, rather than less, useful to bereaved families.

Section 13 of the Coroners Act 1988 allows the High Court to quash an inquest's findings and order a new inquest where it is desirable in the interest of justice to do so. It is an important safety valve, given that the test is significantly lower than judicial review, and that there is no time limit.

The motivation for amending Section 13 is to ease the process of making uncontroversial amendments to the findings of an inquest, a process which at the moment is far from simple as highlighted in the case of *Roberts v Coroner for North and West Cumbria* [2013] EWHC 925 (Admin). The original inquest recorded an open verdict, the cause of death and the identity of a male washed up on a beach being unascertained. Subsequent DNA profiling, with the assistance of Interpol, allowed the identity of the deceased to be known. The obvious next step would be to amend the original inquisition to add the deceased's name but there is no mechanism for doing so. The only remedy available to allow the recording of the identity of the deceased on the inquisition was to order a new inquest under Section 13. In such circumstances this is a waste of resources and has the potential to cause more distress and uncertainty for the family of the deceased.

An amendment to Section 13 to allow administrative changes to an inquest's findings would be welcome. However, at a time when access to judicial review is being significantly curtailed by the Lord Chancellor, let us hope that any amendment to Section 13 is restricted and that the Government does not take this opportunity to further limit the availability of justice to those parties to an inquest.

The case of *Bloom* demonstrates admirably the value of the safeguard provided by Section 13. The deceased was a healthy woman, admitted to hospital following severe pain to her left side. X-ray revealed a blocked ureter and surgery was performed to remove the obstruction. The procedure revealed infection at the site of the obstruction. Antibiotics and large quantities of intravenous fluids were administered both pre- and post-operatively. The condition of the deceased deteriorated and she was moved to the ITU at the nearest NHS hospital. The report to the ambulance service said that the deceased was septicaemic, had pulmonary oedema and was coughing blood.

The ambulance was not equipped with intubation and ventilation equipment. Shortly after arrival at the NHS hospital, the deceased suffered a cardiac arrest and remained critically ill until her death ten days later.

At the first inquest, a verdict of death by natural causes was recorded. The coroner concluded on the basis of evidence from a pathologist that the septicaemia present before the operation led inexorably, or very nearly so, to her death and that the treatment received was appropriate.

The family then obtained reports which concluded that the risk to life, pre-operatively, was minimal and that although septicaemia was life-threatening, if immediately diagnosed and treated it was curable. The problem seemed to be the inadequate resuscitation. This material persuaded the High Court to order the second inquest. Unfortunately neither of the experts who had been instructed by the family were called at the second inquest, despite a submission to do so, and so the family of the deceased had still not received a full answer of how it was that an otherwise healthy patient died in circumstances in which the risk of death was very small.

Further information was then obtained, largely at the behest of the MP for the deceased's constituency. A further expert was instructed and his report was supported by material which emerged during the Fitness to Practice Panel hearing into allegations brought by the GMC against the original treating physicians. The report concluded that the deceased died as a result of an avoidable medical disaster which occurred in a hospital inadequately equipped to deal with it. The principal reason for that conclusion was the administering of an excessive volume of intravenous fluids to the deceased prior to her being moved to the NHS hospital. The new evidence leaves open the possibility of a conclusion of neglect and critically might change the cause of death. In those circumstances, and applying the test from the Hillsborough inquest, it is unsurprising that the High Court considered it in the interests of justice to order a third inquest into the death.

Fiona Elder

Chief Coroner's annual report

2013-2014

The Chief Coroner, HHJ Peter Thornton QC, recently published his first annual report to the Lord Chancellor pursuant to Section 36(6) of the Coroners and Justice Act 2009. The Chief Coroner's first annual report actually covers a period of slightly less than 12 months, 25 July 2013 to 30 June 2014, as Section 36(5) requires the report to be given to the Lord Chancellor by 1 July 2014.

Section 36(2) requires the report to cover matters which the Chief Coroner wishes to bring to the Lord Chancellor's attention. In this report, those matters include the implementation of the statutory reforms which came into force in July 2013; the additional package of reforms which the Chief Coroner has devised and developed; and actions taken by the Chief Coroner under his powers and duties in the 2009 Act.

Implementation of the statutory reforms

The Chief Coroner believes that under the 2009 Act there will be fewer inquests with a natural causes outcome. If early investigation by the coroner, or even preliminary inquiries before that stage is reached, leads to the conclusion that the death was from natural causes, the case can be recorded with a natural causes conclusion without the need for an inquest. Already there is an indication from the Ministry of Justice annual statistics that there may be fewer inquests across England and Wales.

He reports that new provisions provide for earlier release of the body, where appropriate, for burial or cremation and that it is no longer necessary to open an inquest before the body may be released. There is also no longer a requirement for an inquest into a death in custody to be held with a jury, where the death was from natural causes. He believes that this may reduce the number of inquests with juries (presently about 450), although the balance may, in due course, be redressed by the likely requirement to hold an inquest with a jury in cases where a person dies in local authority accommodation under deprivation of liberty safeguarding orders.

The Chief Coroner believes that the 2013 Rules and Regulations give the coroner service a more modern look, with more hearings being held in public now, all hearings being recorded, most inquests being held within six months, more disclosure to families and more involvement with families through notifications and explanations.

The Chief Coroner's package of reforms

There are six strands to the Chief Coroner's package of reforms, each designed to provide a better, more effective and prompt process for bereaved families, and to achieve greater consistency of standards in coroner areas across England and Wales.

1. The role of the Chief Coroner

Although it is too early in the reform process for the Chief Coroner to give a clear assessment, he believes that good progress is being made in achieving consistency of standards between coroner areas. He has devised and implemented training for all coroners, which for the first time is compulsory. His report sets out the detail of the training that has been undertaken to date and future courses that are planned. There is also a working group for training of coroners' officers.

He reports on the written guidance that he has produced and circulated to all coroners in order to achieve national consistency and reports that he also gives advice, when appropriate, in High Court cases when he sits on applications for judicial review and applications for orders for a fresh inquest.

2. Mergers

19 coroner areas were merged in July 2013 to create nine new areas. The Chief Coroner intends, in the long term, to reduce the number of coroner areas from the current 99 to 75, with each coroner area having 3,000-5,000 reported deaths each year, with a full-time senior coroner in post.

3. Appointments

Under the 2009 Act, all coroners are now appointed by local authorities but the consent of the Chief Coroner is required and he monitors the appointment of all coroners. Previously, coroners were appointed with freehold tenure for life. Now, newly appointed coroners must retire by 70 and the Chief Coroner has encouraged older coroners to consider retiring by about 75. New assistant coroners are welcomed and encouraged. The Chief Coroner has told senior coroners that he normally expects assistant coroners to be given at least 15 days' work a year.

4. Senior coroners

The Chief Coroner expects a senior coroner today to be more than a coroner. He acknowledges the additional functions of their role and says that the triangle of responsibility which they have to manage is not an easy one. He is working with coroners and local authorities on a proposal for a new standardised scheme of salaries and fees for coroners.

5. Investigations and inquests

The Chief Coroner has provided guidance and advice to all coroners on a wide range of topics in order to promote good practice. His advice is designed to do no more than give coroners the necessary tools for making their own decisions. He has repeatedly stressed the need for setting dates for inquests and having timely hearings. A delayed inquest may lead to formal disciplinary action and the Chief Coroner will be writing to all senior coroners shortly so that they can report to him all coroner investigations which are more than one year from the death, requiring coroners to explain why each such investigation has not been completed or discontinued. He is working on reducing delays to inquests by inviting coroners to direct at the opening of an inquest that a medical report such as a pathologist's report should be produced to the coroner within four to six weeks, the shorter the better.

6. Reports to prevent future deaths

Coroners now have a duty, not a discretion, to write reports with a view to preventing future deaths where the investigation reveals to the coroner that circumstances creating a risk of death will occur and the Chief Coroner encourages coroners to write reports. All reports must be sent to the Chief Coroner and they are published on the judiciary website. Some are selected to pursue further.

7. Action taken by the Chief Coroner under his statutory powers and duties.

In this section of the report, the Chief Coroner notes, amongst other things, the following.

Where a senior coroner exercises his discretion to report to the Chief Coroner under Section 1(4) of the 2009 Act that he has reason to believe that a death has occurred in or near the coroner's area, that the circumstances of the death are such that there should be an investigation into it, and the duty to conduct an investigation does not arise because of the destruction, loss or absence

of the body, the Chief Coroner may direct a senior coroner to conduct an investigation into the death (Section 1(5)). Since July 2013 there have been 40 applications and the Chief Coroner has granted 33 of them.

The Chief Coroner has received 621 notifications in writing of requests by senior coroners for an investigation to be carried out by another coroner. He has exercised his power to transfer investigation from one coroner area to another twice.

He has not yet made any notifications to the Lord Advocate that it may be appropriate for the circumstances of certain deaths of service personnel abroad to be investigated in Scotland. Nor has he yet used his power to direct a senior coroner to conduct an investigation into such a death despite the body being in Scotland. On 25 July 2014, a register was to be opened of notifications received from senior coroners of investigations lasting more than a year.

The Chief Coroner is at present conducting the investigation into the death of Dr Abbas Khan who died in custody in Syria in December 2013. He has not yet requested the Lord Chief Justice to nominate, under section 41, Schedule 10, a judge, former judge or former coroner to conduct an investigation.

Conclusion

The Chief Coroner concludes by saying that although the new reforms need to bed in, there are already considerable signs of positive change and he is confident that coroners are embracing that change. He will continue to monitor the reforms so that next year he can report to the Lord Chancellor about consistency of standards between coroner areas.

Simon Emslie

Virtues of virtual autopsy

Many bereaved families are further traumatised by the thought of an autopsy being performed on their loved one. They fear that the procedure will delay funeral arrangements, that it is disrespectful and disfiguring and that it adds insult to fatal injury. Autopsy can preclude organ donation, contrary to the wishes of the deceased and family. Others have concerns on religious grounds. Some who practice Islam or Judaism object to invasive procedures, often because of ideas about the sanctity of keeping the body complete, or the delay in the preparation of the body as prescribed by tradition. Almost 100,000 post mortems are carried out each year in England and Wales, a far higher proportion than in countries with comparable coronial jurisdictions. A tiny proportion of these deaths are investigated using 'virtual autopsies', but that number is set to climb as national medical bodies and the Chief Coroner have come together to guide coroners in the use of non-invasive post-mortem techniques.

Virtual autopsy is not new; it was developed in Switzerland over a decade ago to investigate homicides where the victims had suffered such significant trauma that the original cause of death was obscured by extensive tissue and bone damage. The term is used to refer to any non-invasive technique to establish cause of death, most commonly computer tomography (CT) and magnetic resonance imaging (MRI). In CT imaging, the body is put into a scanner which takes up to 3,500 x-ray slices from top to toe, which are then combined into a 3-dimensional image of the body. MRI can add information about soft tissues, and the state of the heart, brain and other abdominal organs. These imaging techniques are sometimes combined with other analysis, including toxicology.

As well as entirely non-invasive autopsy, minimally-invasive autopsies are also becoming more common, including techniques such as needle biopsies, tissue sampling, and removal of a single organ through a small incision for further analysis. Scanning can assist pathologists in directing their scalpel, for example by pin-pointing the location of bullets in a body.

Virtual autopsy is highly accurate in identifying cause of deaths from brain haemorrhage, ruptured blood vessels, and major trauma. It was successfully used to identify the two fatal blows to King Richard III by pathologists at the University of Leicester; the team were able to match marks on his skull with contemporaneous descriptions of the blows he sustained from a sword in 1485. In Switzerland, at the Institute of Forensic Medicine in Zurich, it has been used to identify cause of death in a number of hit and run cases, including use in a criminal prosecution to prove that a cyclist sustained the fatal blow from behind, rather than veering into the path of the defendant's car as the defendant had claimed.

Scanning is particularly accurate in determining cause of death in foetuses and children; a study in the Lancet in 2013 found that MRI identified the same cause of death as traditional post mortem examination in almost 90% of cases involving foetuses and children. The study found a sharp drop-off with increasing age; for children over a year old the match rate was only 53%. This is thought to reflect the fact that the youngest group were likely to have died from structural anomalies, whereas many of the older children died of infective causes which are not detectable through imaging.

Despite its many advantages, virtual autopsy is not appropriate in many cases. It is incapable of ascertaining some of the most common causes of death, including coronary heart disease, pneumonia and pulmonary embolism, although research is ongoing to improve techniques for cardiovascular imaging.

Against the background of these technical advances, moves are afoot to regularise the use of scanning in England and Wales. The Department of Health is currently considering recommendations for a national autopsy imaging service; at present, the service is only available in a small number of centres. The Royal Colleges of Radiologists and Pathologists have reached agreement on standards to be applied in post-mortem imaging. And the law is keeping up; while previous legislation was silent about post-mortem imaging, the Coroners and Justice Act 2009 allows a senior coroner to 'specify the kind of examination to be made of a body' which may include imaging and instruct 'a suitable practitioner' to carry it out (Section 14). The Chief Coroner has issued guidance as to how coroners should exercise this discretion, which includes the following:

- Coroners should bear in mind the wishes of the bereaved family, and the deceased, if known, when deciding whether to conduct a scan;
- A thorough external examination by a pathologist should always be conducted;
- The Radiologist who conducts the scan must have access to a deceased's medical history;
- Following the scan, the coroner will determine whether a traditional autopsy is required.

The Chief Coroner's guidance also includes the instruction that scanning should not be used where the circumstances of death are suspicious or controversial, except where the cause of death is obvious, an approach which is not supported by the advances in Switzerland in just such cases.

The guidance from the Chief Coroner does, and can do, little more than make it clear to coroners that they should consider the use of non-invasive techniques. Although each coroner has discretion as to whether to use scanning, that discretion clearly needs to be exercised with care. The Chief Coroner, in July 2014, overruled a coroner

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Richard Shepherd
Call 2001

Anna Midgley
Call 2005

Simon Emslie
Call 2007

Alexander West
Call 2011

Alexander Small
Call 2012

Team Clerks Nick Jeanes, Michael Harding, Ken Duthie

who refused to order an MRI scan. The family of Mordechai Weiss won a victory in the High Court, overturning the refusal of the Camden coroner to arrange scanning. A non-invasive post mortem was subsequently held, and identified that the cause of death was head injuries, consistent with evidence that the deceased had fallen down stairs.

Despite the Chief Coroner's desire for a regularised system, the option of scanning is likely to remain a postcode lottery. It has become almost commonplace in Manchester, where there is an arrangement to use hospital machinery out-of-hours, and in Sheffield where a specialist centre has been built. In other areas it is not routinely available, and not publicised to bereaved families. Those of us who represent bereaved families would do well to add information about non-invasive techniques to correspondence to ensure that they know of their right to ask for such a procedure. In areas where it is routinely available, the usual cost is between £500 and £1,000, which families are required to pay themselves. Against the background of lack of public funding for inquest advice and representation, the cost will be prohibitive for many bereaved families. Advances in virtual autopsies have been welcomed by groups representing the bereaved, and religious organisations, but it may yet be funding issues which restrict the new technology to long-deceased kings.

Kate Brunner

Inquiries

Better than inquests?

Only a Minister can decide that an Inquiry should be held, and there is no state obligation to hold one. However, as the Litvinenko case demonstrates, pressure can be brought to bear upon the government by way of a Judicial Review of a decision not to hold an inquiry.

Inquiries under the Inquiry Act 2005 are not limited to the investigation of deaths, but are designed to investigate matters of public concern. Under the Coroners and Justice Act 2009 the Lord Chancellor has the power to require an inquest to be suspended, effectively replacing it with an inquiry, on the grounds that the cause of death is likely to be adequately investigated by the inquiry. If the inquiry is instigated as a result of the suspension of an inquest, the terms of reference for the inquiry must have among its purposes those that the Inquest would have had.

The remit of an inquiry is limited in similar terms to that of an inquest, with no determination to be made on any person's civil or criminal liability. However, the inquiries Act 2005 states that the inquiry is not limited by any likelihood of liability being inferred from the facts that it determines, which appears to give inquires greater leeway. In fact the scope of any inquiry will be limited by terms of reference determined by the Minister. In the Litvinenko Inquiry the terms of reference ask the Inquiry to identify where responsibility for the death lies, although the possibility of the UK government being culpable has been excluded from scope as a consequence of rulings made by the Coroner presiding over the original inquest and who now chairs the inquiry.

With Litvinenko, the inquest could not proceed. The inquest procedure was severely constrained by the existence of material subject to Public Interest Immunity. The Coroner and Divisional Court between them upheld the Public Interest Immunity claims. After that the Coroner was unable to take the material into account as part of the inquest, but to leave the material out of account would be to ignore relevant evidence and defeat the whole purpose. There was pressure from Mr. Litvineko's widow but also an invitation from the Coroner to hold an inquiry instead.

In an inquiry there is power to hold "closed" hearings where parts of the evidence are not heard by the public. In this way, the inquiry can take into account the material that is subject to Public Interest Immunity. The inability of inquest procedure to accommodate sensitive material in the same way as an inquiry is deliberate. Before the Coroners and Justice Act 2009 hit the statute book, proposals for "closed" inquests were discussed and met with opposition. Inquiries may look like an escalation of issues that could have been dealt with at an inquest, are by reputation more costly, and are by no means automatic. However in this context, the juxtaposition between inquiries and inquests accommodates both the State's obligation to investigate deaths and the principles of open justice.

Kirsty Real