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Coroners' inquests are just the NHS investigating itself

A lack of independent clinical scrutiny leaves the door open for lawyers to put the reputation of the health service above patient safety

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The health service cannot be trusted to investigate itself. Reputation is supreme, trumping patient safety, to maintain the delusion that the NHS is the envy of the world.

Wes Streeting, the health secretary, called it "cultural rot". The parliamentary ombudsman's report, entitled Broken Trust, detailed a litany of NHS failings, including "failure to be honest" and "poor-quality investigations".

Which leads to the issue of the fitness of inquests to investigate patient deaths.

The coroner's jurisdiction is wide-ranging. The duty to investigate can arise where the coroner has reason to suspect that a patient has died an unnatural death. It is a low threshold — mere suspicion suffices. The meaning of "unnatural" can be difficult to apply to an adverse outcome concerning the effect of a therapeutic act or omission on underlying disease.

The central question for the inquest is: how did the patient die? The inquest is fact-finding. It is not a trial to determine legal liability; there are no parties. The coroner decides the evidence, the witnesses, and the scope of the investigation.

Bereaved relatives have little say. However, it is litigation — whether civil or criminal — that provides an adversarial forum that enables the parties themselves to choose the witnesses and ask appropriate questions to uncover the truth.

The NHS spends huge amounts on legal representation at inquests. Legal rights are neither asserted nor defended, so the purpose must be to protect reputation, a fight over the facts, with the attitude being that it is better that an inquest conclusion is unclear than damaging. The solution is not legal aid for bereaved families to fill the court with yet more expensive lawyers at vast public expense, but to reduce the overall number of lawyers involved in the process. Inquests are fact-finding processes, during which it is difficult to see what lawyers have to contribute apart from intimidating bereaved relatives and billing the public purse.

Independent rigorous clinical scrutiny is vital not only for effective investigation but also for public confidence. Most coroners are not medically qualified — so how do they understand medical issues to identify lines of inquiry?

Too often there are no independent clinical expert witnesses. Instead, the court relies on the testimony of doctors acting both as witnesses of fact and as expert witnesses — a potential conflict of interest. Where is the essential rigorous independent clinical scrutiny? It is the NHS investigating itself, but with the cloak of respectability of a judicial process. Medically qualified coroners, expert witnesses, or medical assessors can provide the essential independent clinical oversight.

Challenging coronial decisions is expensive and cumbersome. Public dissatisfaction seems widespread and largely unaddressed — amply demonstrated by the written evidence submitted to a recent inquiry on coroners by MPs on the justice committee.

The Ministry of Justice has proclaimed that the bereaved should be “at the heart” of the inquest process. Fine words, but too often the opposite is true.

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