ANNEX 1: RELEVANT ASPECTS OF CORONIAL LAW

Coroners and their role

1. The formal role of coroner as an investigator of sudden, violent or unnatural deaths dates back to 1194[1] and is now codified in Coroners and Justice Act ("**CJA 2009**"). Section 1(1)-(2) of the require the investigation of certain deaths (including when the cause of death is suspected to be unknown). The investigation must be by way of inquest (CJA, s.6). The primary purpose of an inquest is to establish who the deceased was, and how, when and where they came by their death, and the particulars needed to register the death (CJA 2009, s.5(1)). At the end of the process, the coroner (or jury) must reach a conclusion on these matters on the balance of probabilities (CJA 2009, s.10). Subject to the duty to make a 'prevention of future deaths' report in some cases (see §§4-8 below), the coroner (or jury) may not express any opinion on other matters (CJA 2009, s.5(3)).

2. Inquests follow an inquisitorial procedure because the role of the coroner (or jury) is to conduct a thorough investigation into the death, rather than to determine guilt or liability (see, e.g. *R (Hambleton) v Coroner for Birmingham Inquests (1974)* [2019] 1 WLR 3417 at §46). Coroners have broad powers to obtain evidence, including expert evidence, and to call witnesses to appear to give oral evidence (CJA 2009, Sch. 5).

3. Prior to 2013, coroners were doctors or lawyers; coroners appointed since 2013 must have at least 5 years' experience as a qualified lawyer (CJA 2009, Sch. 3, §3). Subject to the consent of the Lord Chancellor and Chief Coroner, the relevant authority (see Sch. 2, §3) appoints a senior coroner for each area e.g. those who heard the inquests of Benedict Peters and Emily Chesterton (CJA 2009, Sch. 3, §1). Area coroners and assistant coroners are appointed to support the senior coroner, performing the same functions (CJA 2009, Sch. 3, §§2 and 8).

Prevention of Future Deaths reports

4. Ancillary to the inquest, the coroner must identify systemic deficiencies that pose a risk to life in the future. Paragraph 7 of Schedule 5 to the CJA 2009 imposes a duty on coroners to make a report where they have been conducting an investigation into a death and:

> *"(a) 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*
>
> *(b) 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".*

[1] https://www.coronersociety.org.uk/the-coroners-society/history/

5. Such reports are known as "Prevention of Future Deaths" ("**PFD**") reports. Regulation 28 of the Coroners (Investigations) Regulations 2013 ("**2013 Regs**") make procedural provisions for PFD reports, so they are also referred to as "Regulation 28 reports". Only c.1.5% of inquests (some 569 in number) result in a PFD report being issued.[2] As the Chief Coroner's Revised Guidance No.5 ("**Guidance No.5**") states (see §2):

> *"PFDs are vitally important if society is to learn from deaths… a bereaved family wants to be able to say: 'His death was tragic and terrible, but at least it's less likely to happen to somebody else.' PFDs are not intended as a punishment; they are made for the benefit of the public."*

6. A PFD report should be "*intended to improve public health, welfare and safety*" and "*wherever possible, designed to have practical effect*" (Guidance No.5, §4).

7. The coroner must send a copy of the PFD report to the Chief Coroner and to those who in their opinion should receive it, and may send a copy to others who may find it useful or of interest (2013 Regulations, Reg. 29(4)(a) and (c)). A person to whom such a report is made is must provide a written response to it within 56 days (CJA 2009, Sch. 5, §7(2); 2013 Reg, Reg. 29(4)).

8. If a doctor receives such a report, they are also obliged to respond pursuant to their duty under Good Medical Practice to "*cooperate with formal inquiries*" (see §98 **[SB1/G/18/381]**). Certain public bodies charged with safeguarding public health have published policies concerning receipt of PFD reports. For example, NHS England logs and codes such reports into categories, to assist it to "*identify new or emerging themes that may require further review or escalation*".[3] There is a designated central team within the Medical Directorate that commissions the relevant policy and programme teams and experts within NHS England whose input is required to respond to a PFD. All 7 NHS regions have designated PFD leads who input into responses. A national working group meets to examine themes from PFD reports and identify appropriate action.

9. So far as the Claimants are aware, the GMC has no such policy or system for responding to PFD reports. Melville 2, §21 **[CB/F/32/471]** states that coroners sometimes 'refer' individual doctors to the GMC following an inquest and the GMC may then investigate (cf. it will do so). What constitutes a referral is not explained. No examples are given of investigations prompted by PFD reports not deemed to be referrals. Melville 2, §§18-20 **[CB/F/32/470-471]** states there

[2] See the Government Statitstics for 2023/24 at https://www.gov.uk/government/statistics/coroners-statistics-2023/coroners-statistics-2023-england-and-wales
[3] See https://www.england.nhs.uk/long-read/action-to-prevent-future-deaths-reports-regulation-28/.

were no referrals made in respect of the doctors who are the subject of the coronial evidence in this case.

Coronial evidence in this case

10. The coronial evidence is this case can be found as follows:

    (1) Record of inquest into the death of Emily Chesterton (20 March 2023, Mary Hassell, Senior Coroner for Inner London) **[CB/D/20/330]** (also Chesterton 1, §§42-60 **[CB/C/13/177-180]**).

    (2) Benedict Peters PFD report (16 May 2023, Chris Morris, Area Coroner for Manchester South) **[CB/D/21/331 - 333]**.

    (3) Susan Pollitt PFD report (31 July 2024, Joanne Kearsley, Senior Coroner for Manchester North) [**CB/D/22/334 - 335**] (Report); **[CB/D/24/337-341]** (GMC response); **[CB/D/25/342/354]** (FPA response); **[CB/D/26/346-350]** (RCP response).

    (4) Pamela Marking PFD report (24 February 2025, Dr Karen Henderson, Assistant Coroner for Surrey) **[CB/D/28/355-358]**.

11. This evidence has several common themes, notably:

    (1) PAs missing or misdiagnosing 'red-flag' symptoms and so failing to deal with a case appropriately, including by failing to conduct appropriate examinations and tests, failing to escalating the case (e.g. seeking a doctor's review or referring to A&E), and not asking for the right prescriptions, or asking for harmful ones;

    (2) Patients not being reviewed in person by a doctor, even when seeking medical attention for 'red-flag' symptoms or seeking help multiple times;

    (3) Lack of adequate and effective supervision, including because the supervision is indirect, or requires the PA to escalate the case themselves to the supervisor, meaning that the PA is effectively working independently and unsupervised;

    (4) PAs working outside their capabilities, and general difficulties identifying PA competence, including due to a lack of insight by the PA into their own limitations;

    (5) Using PAs to fulfil doctors' roles, including PAs being treated as equivalent to a doctor at a given stage of training without evidence to support that;

(6) Patients (and their families) being unaware that the person is not a doctor and so not being able to give informed consent or take an informed decision about seeking a second opinion, including because the title itself is misleading; and

(7) Variance between Trusts/lack of national standards on when treatment by a PA is appropriate.