From: "Mckenzie, Gary (RCJ)" <********** >
Subject: RE: Coroner's Section 28 reports on action to prevent future deaths
Date: 6 December 2017 at 14:58:17 GMT
To: Minh Alexander <**********>

Dear Dr Alexander,

Thank you for your recent email and apologise for the delay in replying. Just to clarify the point you have raised, we have not been asked by any organisation to withhold any responses on our website.

Kind regards

Gary

Gary McKenzie | Assistant Private Secretary of the Chief Coroners Office | Judicial Office | 11th Floor Thomas More Building | Royal Courts of Justice | London WC2A 2LL |www.judiciary.gov.uk

From: Minh Alexander <**********>
Subject: Coroner's Section 28 reports on action to prevent future deaths
Date: 1 December 2017 at 07:27:11 GMT
To: chiefcoronersoffice@judiciary.gsi.gov.uk
Cc: Gary McKenzie **********

BY EMAIL

His Honour Judge Mark Lucraft QC

Chief Coroner

1 December 2017

Dear Judge Mark Lucraft,

Coroner's Section 28 reports on action to prevent future deaths

Thank you very much for yesterday's response below, which was kindly conveyed by your office.

It is very reassuring that there is a commitment to full publication in future.

I should just caveat one point – whilst it may be that there have been isolated administrative errors in not publishing some Section 28 reports, the publication of responses seems a more substantial issue. This summer, I found that there were no published responses for 62% of published Section 28 reports on your website, up to 31 July 2017.

If as you previously implied it remains your intention to publish all responses, an audit may be helpful in shedding light on how such a substantial proportion of responses are not published.

Lastly, may I ask one final question. I was unclear of the following sentence in Mr McKenzie's email yesterday:

> *"However, we can confirm that the CQC, nor the related organisations, such as the Department of Health, which you mention in your letter, have requested that the Chief Coroner refrain from publishing a report or a response."*

I was not sure whether this sentence meant that the CQC, DH et al have, or have not, asked your office not to publish their responses to Section 28 reports.

I would be very grateful for clarification.

Many thanks again for your office's time in bearing with my enquiries.

Yours sincerely,

Dr Minh Alexander

From: "Mckenzie, Gary (RCJ)" <**********>
Subject: Section 28 reports
Date: 30 November 2017 at 15:16:32 GMT
To: Minh Alexander <********** >

Dear Dr Alexander,

The Chief Coroner has read your email and note its content, he has asked that I respond on his behalf.

It is the Chief Coroner's intention that all Reports to Prevent Future Deaths received by the Office of the Chief Coroner are published on the Courts and Tribunals Judiciary website on an ongoing basis in a redacted or summary form. We accept that there will be some isolated cases where a Prevention of Future Death report has been issued but not published on the judiciary website. However, this is merely down to administrative error, which we are fully committed to rectifying on an ongoing basis to ensure all issued reports and responses received are published on the judiciary website within a reasonable time frame.
It is the responsibility of the recipient of any Prevention of Future Death report to make their representations known to the coroner who has written the said report at the time of their response, about the release or publication by the Office of the Chief Coroner.
We do not keep a central record of requests made to withhold publication of reports or responses. However, we can confirm that the

CQC, nor the related organisations, such as the Department of Health, which you mention in your letter, have requested that the Chief Coroner refrain from publishing a report or a response.

It is also worth pointing out that some reports are sent to various organisations like the CQC and the Department of Health not for them to formally respond too but merely for their information only.

Kind regards

Gary

Gary McKenzie | Assistant Private Secretary of the Chief Coroners Office | Judicial Office | 11th Floor Thomas More Building | Royal Courts of Justice | London WC2A 2LL |www.judiciary.gov.uk

From: "Mckenzie, Gary (RCJ)" <**********>
Subject: RE: Coroners' Section 28 reports
Date: 23 November 2017 at 15:20:09 GMT
To: Minh Alexander <**********>

Dear Dr Alexander,

I do apologise for the delay in responding to your email, unfortunately the Chief Coroner has been sitting in the Crown Court for the last few weeks. However, we hope to get a response to you shortly.

Kind regards

Gary

Gary McKenzie | Assistant Private Secretary of the Chief Coroners Office | Judicial Office | 11th Floor Thomas More Building | Royal Courts of Justice | London WC2A 2LL | Telephone 0207 073 4777 | www.judiciary.gov.uk

From: Minh Alexander [mailto:**********]
Sent: 23 November 2017 15:13
To: Mckenzie, Gary (RCJ) <**********>
Subject: Coroners' Section 28 reports

Hi Gary,

Thanks for your email.

Would it be possible to have some idea of when the Chief Coroner's office might be able to respond?

BW

Minh

From: "Mckenzie, Gary (RCJ)" <**********>
Subject: RE: Coroners' Section 28 reports
Date: 10 November 2017 at 19:27:04 GMT
To: Minh Alexander <********** >

Dear Dr Alexander,

Thank you for your recent email to our office, we will respond to you shortly with a full response.

Kind regards

Gary

Gary McKenzie | Assistant Private Secretary of the Chief Coroners Office | Judicial Office | 11th Floor Thomas More Building | Royal Courts of Justice | London WC2A 2LL | |www.judiciary.gov.uk

From: "Mckenzie, Gary (RCJ)" <**********>
Subject: Section 28 reports
Date: 30 November 2017 at 15:16:32 GMT
To: Minh Alexander <**********>

Dear Dr Alexander,

The Chief Coroner has read your email and note its content, he has asked that I respond on his behalf.

It is the Chief Coroner's intention that all Reports to Prevent Future Deaths received by the Office of the Chief Coroner are published on the Courts and Tribunals Judiciary website on an ongoing basis in a redacted or summary form. We accept that there will be some isolated cases where a Prevention of Future Death report has been issued but not published on the judiciary website. However, this is merely down to administrative error, which we are fully committed to rectifying on an ongoing basis to ensure all issued reports and responses received are published on the judiciary website within a reasonable time frame.
It is the responsibility of the recipient of any Prevention of Future Death report to make their representations known to the coroner who has written the said report at the time of their response, about the release or publication by the Office of the Chief Coroner.

We do not keep a central record of requests made to withhold publication of reports or responses. However, we can confirm that the CQC, nor the related organisations, such as the Department of Health, which you mention in your letter, have requested that the Chief Coroner refrain from publishing a report or a response.

It is also worth pointing out that some reports are sent to various organisations like the CQC and the Department of Health not for them to formally respond too but merely for their information only.

Kind regards

Gary

Gary McKenzie | Assistant Private Secretary of the Chief Coroners Office | Judicial Office | 11th Floor Thomas More Building | Royal Courts of Justice | London WC2A 2LL |www.judiciary.gov.uk

From: Minh Alexander <********** >
Subject: Coroners' Section 28 reports
Date: 6 November 2017 at 08:41:28 GMT
To: chiefcoronersoffice@judiciary.gsi.gov.uk

BY EMAIL

His Honour Judge Mark Lucraft QC

Chief Coroner

6 November 2017

Dear Judge Mark Lucraft,

Coroners' Section 28 reports

Thank you very much for the swift response by your office to my letter of 24 August 2017, both of which are copied below.

I write to follow up due to some anomalies that have subsequently arisen.

Whilst your office advised me that it has published all Section 28 reports on action to prevent future deaths and related responses that it has received, I have received information that some

organisations' responses to Section 28 reports do not appear to have been published.

For example, the Care Quality Commission informs me that it has on some occasions asked that its responses are not published by your office. CQC indicated that this was in order not to prejudice ongoing enforcement action.

I provide below a sample list of Section 28 reports to which the CQC says it responded, but for which none of the CQC's responses appear on your website. 1

Most of these responses related to Section 28 reports issued in 2013 and 2014. It appears unlikely that the prejudice of enforcement of action remains a valid reason for withholding publication these CQC responses.

Similarly, I have received information that there have been Section 28 reports issued by coroners which, for whatever reason, have not been published by your office. Obviously, one possible reason is that the reports may not have been forwarded to your office

I provide an example below of Section 28 reports that are not accounted for by your published record. 2

Please could you therefore review the accuracy of your office's response to me of 4 September and advise:

1. Is it correct to conclude that not all Section 28 reports and related responses received by your office have been published?

2. Does your office keep a central record of requests by respondents for their responses not to be published and responses that are withheld from publication?

3. Can you advise if the CQC originally asked for its response to the Nottingham coroner's Section 28 report on Ivy Atkin's death not to be published?

4. If the data is reasonably easy to locate and it is within the cost limits, is it possible to advise:

   a) How many responses to Section 28 reports since July 2013 have been held back from publication by your office?

   b) Since July 2013, how many responses by the Department of Health, NHS England, CQC, NHS Improvement (and its predecessor bodies Monitor and NHS TDA) have been held back from publication by your office?

5. If your office has withheld responses from publication, is it possible to now publish any responses by NHS bodies, and indeed any other sources, that have hitherto not been published?

6. Please could you advise what your office's mechanism is for ensuring and or supporting:

   a) Reliable submission of Section 28 reports and related responses by coroners to your office

   b) A good response rate by named respondents to Section 28 reports

   If there are any written protocols and procedures or memorandums of understanding with local coroners' offices governing these matters, please may I have copies.

Many thanks.

Yours sincerely,

Dr Minh Alexander

EXAMPLES OF ANOMALIES:

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1 The CQC has confirmed that it has responded to the following coroners' Section 28 reports, but CQC's responses are still not published on you website as of today (6 November 2017):

i.Death of Ozan Atasoy a detained patient after absconding

https://www.judiciary.gov.uk/publications/ozan-atasoy/

ii.Death of Neil Carter with ‘deliberate falsification’ of the patient record by Priory Group staff

https://www.judiciary.gov.uk/publications/neil-carter/

iii.Death of Mohammed Chaudhury with pressure sores of unusual extent and severity which developed whilst he was in hospital

https://www.judiciary.gov.uk/publications/mohammed-chaudhury/

iv.Death of Barbara Cooke from pressure sores with contributory neglect

https://www.judiciary.gov.uk/publications/barbara-cooke/

v.Death of Robert Entenman after his humidifier was switched off

https://www.judiciary.gov.uk/publications/robert-entenman/

vi.Death of Edwin Thompson with contributory neglect

https://www.judiciary.gov.uk/publications/edwin-thompson/

vii.Death of Derrick Rivers with institutional abuse and criticism of CQC’s failure to review medicines management which was a contributory factor in the death, Section 28 report sent to you personally.

https://www.judiciary.gov.uk/publications/derrick-rivers/

viii.Death of Dennis Teesdale after perforation of bowel from PEG insertion, with breach of clinical protocol, Section 28 report sent to you personally.

https://www.judiciary.gov.uk/publications/dennis-teesdale/

2 An example of apparent under-reporting by coroners and or non-publication by your office:

I found only two published Section 28 reports on Oxford University Health NHS Foundation Trust between July 2013 and July 2017.

However, the Trust informed me that it had received twelve Section 28 reports in that period.

From: "Mckenzie, Gary (RCJ)" <**********>

Subject: RE: Coroners' Section 28 reports

Date: 4 September 2017 at 10:21:20 BST

To: Minh Alexander <**********>

Dear Ms Alexander,

Thank you for your recent email to our office and apologise for the delay in responding.

- All Reports to Prevent Future Deaths received by the Office of the Chief Coroner are published on the Courts and Tribunals Judiciary website on an ongoing basis in a redacted or summary form at https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/

- Since July 25th 2013, (1818) prevention of future deaths reports have been published on our website along with any subsequent responses to those reports that we receive.

- Coroners are independent judicial office holders. Their role in relation to Reports to Prevent Future Deaths is a limited one and is are governed by the provisions in Schedule 5 paragraph 7 of the Coroners and Justice Act 2009 and the Coroners (Investigations) Regulations 2013. The Chief Coroner's Guidance on the topic also provides further detailed information for coroners about their role,

see: https://www.judiciary.gov.uk/wp-content/uploads/2013/09/guidance-no-5-reports-to-prevent-future-deaths.pdf

- Organisations or individuals who are required to provide a response must do so within 56 days. The Coroners (Investigations) Regulations 2013 allow the coroner to provide an extension to the 56 day time limit. The Coroners and Justice Act 2009 nor its subordinate secondary legislation do not provide for a sanction for non-response.

- The office of the Chief Coroner has not undertaken any unpublished analyses of prevention of future deaths reports. We are also not in a position to comment on whether another government department has carried out such analyses on prevention of future deaths reports in the past. You will need to approach these departments directly if you wish to establish whether any analyses of these reports has been undertaken.

- However the Chief Coroner will make some thematic remarks about Prevention of Future Death Reports relating to deaths in prison in his Annual Report 2016-17, which will be published by the Lord Chancellor in the Autumn of 2017.

- In relation to the way the data is held and shown on the Chief Coroner's web pages, unfortunately we simply do not have the infrastructure or technology to provide significantly more functionality than we already provide and are therefore limited to what we can offer. We are committed to providing the best possible service for our stakeholders and continually try to improve the web page and the information contained on it. We have noted the concerns you have raised in your email and value your feedback on our website. We will use this going forward as part of our continuous improvement plan.

Kind regards

Gary

Gary McKenzie | Assistant Private Secretary of the Chief Coroners Office | Judicial Office | 11th Floor Thomas More Building | Royal Courts of Justice | London WC2A 2LL | www.judiciary.gov.uk

From: Minh Alexander [**********]
Sent: 24 August 2017 15:05
To: chiefcoronersoffice <chiefcoronersoffice@judiciary.gsi.gov.uk>
Subject: Coroners' Section 28 reports

BY EMAIL

His Honour Judge Mark Lucraft QC

Chief Coroner

24 August 2017

Dear Judge Mark Lucraft,

Coroners' Section 28 reports

I write to seek your help on a number of issues relating to Section 28 report process and data accessibility.

Section 28 process, analysis and publication:

1) May I ask how decisions by your office are made on whether (a) coroners' Section 28 reports (b) responses to coroners' Section 28 reports are published? If there is written guidance on this, may I have a copy.

2) May I ask since Section 28 arrangements were established in 2013, how many Section 28 reports in total have been issued and how many of these have been published by your office?

Is there a central record of which reports have not been published, the broad reasons for not publishing and the factors distinguishing this group of reports from those that are published?

3) Please can you advise if there is a process which may apply if coroners are dissatisfied with the responses that they receive to their Section 28 reports, and if so what are the relevant guidance documents governing this process.

4) Please can you advise if there is a process which may apply if coroners do not receive any response at all to their Section 28 reports – what action is open to them and what governs such action?

5) To your knowledge, has your office or any government department or arms length body undertaken any central analysis of Section 28 reports and if so, are these published? If not, please can you advise of any unpublished analyses and share any that have been undertaken by your own office.

Access to published Section 28 data

I am interested in the data from Section 28 reports, especially from the point of NHS patient safety, and have found the publication of reports very valuable.

That said, there are some practical problems with access to the Section 28 data on your website because of the way it is presented which I feel I should feedback:

- The data is not searchable and cases have to be laboriously scrolled, making large scale searches very onerous. Losing one's place during a large scale search is very troublesome as it means starting back at square one.

- In the absence of a search function, the cases are organised into categories. However, the categories contain incomplete data due to imperfect indexing. For example, less than half the cases of suicide are actually captured by the section labelled 'suicide'. This is partly as this is a relatively new section, but even some cases of deaths by suicide that were published after the introduction of this category in 2015 are not correctly labelled as suicides and do not appear in this category. I attach a spreadsheet which shows the problem. I can confirm that similar problems apply to all the other categories as I reviewed all Section 28 reports published up to 31 July 2017.

- There is also a problem of some cases being mislabelled. For example, some deaths in custody, suicides, police deaths, service personnel deaths and accidents at work were labelled as ‘other deaths’.

I wonder if it would be possible to make improvements to the website by improving the accuracy of categorisation and by making the website searchable and more accessible to the public.

If cases could be searched under a range of parameters such as by

- Free text
- Name of deceased
- Date of Section 28 report
- Name of coroner
- Coroner area
- Category of case

this would increase user friendliness and transparency.

A number of Tribunals currently offer comparable search facilities, in order to give meaningful access to Tribunal and Tribunal appeal decisions, which is very helpful.

If the Chief Coroner’s office was to introduce such improvements, I think this would help bereaved families who might be interested in trends and patterns that are currently hard to elicit, given the presentation of the data as it currently stands.

Many thanks.

Yours sincerely,

Dr Minh Alexander

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read at any time. You have a responsibility to ensure laws are not broken when composing or forwarding e-mails and their contents