

Failure to act on inquest advice blamed for thousands of deaths

28

Thursday January 16 2025 | THE TIMES

Letters to the Editor

Letters to the Editor should be sent to letters@thetimes.co.uk or by post to 1 London Bridge Street, London SE1 9GF



Prison innovation

Sir, Your leading article "Prisoners Dilemma" (Jan 13) is right: more imaginative policies could change the burgeoning incarceration rate. Your correspondents (Jan 13) point to the need to promote employment for suitable former prisoners. These are tried and tested policies, but they lack the imaginative proposals called for if the numbers in custody are to be brought under control. What needs to be addressed is the imposition of a prison sentence as a binary policy, namely that unless the convict hears the clang of the prison gates, he is insufficiently punished, and others will be insufficiently deterred.

An innovative policy, proposed but not needed for 20-plus years, is the regular review by the sentence (or a nominated judge) routinely to review the progress of those whom they have sentenced. Those reviews can reward effective progress by reducing the time to be served in custody. They can also, in conjunction with prison and probation officers, make effective plans for the prisoner's ultimate release, to the benefit of victims and society as a whole. It is to be hoped that the Cautle sentencing review will adopt this as the kind of innovative proposal your editorial calls for.
John Samuels
Ret'd crown court judge, Richmond

Chancellor's circle

Sir, Your article ("Team Reeves seeking to revise her fortunes", Jan 14) summarising the professional experience of those surrounding the chancellor concretely illustrates the problem: none of them have substantial experience in the private sector, so how on earth do they expect to put the country on a path to growth? We should run from the surgeon who talks with great authority about a procedure that he or she has never performed. As every successful businessman knows, theory is one thing, the practical realities something else. Reeves's economically illiterate budget is devoid of all practicalities. Growth for this government risks remaining a word.
David Crags
Dockenfield, Surrey

Corrections and clarifications

● We said (Sport, Jan 13) Dame Tracey Crouch had "intimidated" that sport regulator who had stopped the Saudi takeover of Newcastle. In fact she said, when asked in 2021, "I certainly can't tell you whether or not this integrity test would have stopped the Newcastle takeover. I don't know the details of it. But I would say that it would certainly have stress-tested it more and it would have been more transparent in that testing." We are happy to make this clear.

IPSO. Regulated We are committed to abiding by the Independent Press Standards Organisation ("IPSO") rules and regulations and the Editors' Code of Practice that IPSO enforces. Requests for corrections should be sent to feedback@thetimes.co.uk

Apprenticeship scams and training the young

Sir, Libby Parves is right to mourn the decline in the number of young people undertaking apprenticeships ("Apprenticeship scams is cheating our young", Jan 13). While much of her analysis is spot on, I disagree with her implication that older workers and those with degrees should not receive government-funded training. A recognised shortage of management skills is a key cause of our low productivity, and many degrees do not create skills that employers value. We need both more management training and large numbers of graduates to be trained beyond their degree.

To achieve a greater number of younger apprentices and enable older workers to get the training they need, we should align the apprenticeship levy, soon to become the growth and skills levy, to be used on shorter, more focused programmes for older workers. This would save money that could be redirected to full apprenticeships for younger workers. It should include stronger financial incentives to support the full costs for employers of giving that "young stranger" the chance they need.

Ben Rowland
Chief executive, Association of Employment and Learning Providers

Sir, Further to Libby Parves's article on "apprenticeship scams", perhaps the time has come to revert to the traditional approach to training. Historically, apprenticeships were associated with crafts, from plumbers to hairdressers, and were conducted in the context of a form of contract between employer and apprentice in which those in training benefited from real learning experiences alongside the skilled and experienced, in both the workplace and at local colleges. This approach succeeded largely in the absence of state interference and was largely regulated with a light touch by employers and trade unions. The emphasis was on skill development and the acquisition of personal confidence and competence. The great majority of apprentices completed their "time" and dropout rates were low, unlike today. Other mechanisms were in place to develop those not engaged in craft-based employment.

We should reintroduce this approach and establish apprenticeships as a desirable route to skilled status. The identifier "apprentice" should be a protected title, thereby enhancing its value and appeal. The role of the state could be

limited to operating a licensing system to define only responsible employers, large and small, to participate. We have a prime minister who is the son of a toolmaker and should be supportive of helping to reinstate what worked in the past. Anyone for a Campaign for Real Apprenticeships (Camrap)?
David Baldry
York

Sir, Libby Parves cites the Social Market Foundation's research on apparent abuse by employers of the apprenticeship funding schemes. But there is one sector where the apprenticeship scheme is absolutely not cheating "our young". Research by the Bridge Group, commissioned by leading City law firms who take school leaver apprentices through to qualification as a solicitor under the City Century scheme, demonstrates that more than 98 per cent of our apprentices come from those aged 18 to 24. In addition, this scheme has had the most positive impact in terms of attracting diversity into the legal profession that I have seen in 40 years of practice.
Colin Passmore
Chair, City of London Law Society

Chagos agreement would boost China

Sir, Britain giving away the Chagos Islands to Mauritius, a country that never owned them, will infuriate Donald Trump as it will enable China to increase its malign influence in the Indian Ocean ("Chagos Islands deal on verge of agreement", Jan 15). Trump will also consider the British government's plan to increase defence spending to only 2.5 per cent of GDP, with no declared timescale, to be woefully inadequate, given the mounting global security threats and his unwillingness to continue subsidising Nato. These deeply flawed defence and foreign policy decisions will risk fracturing the US-UK special relationship, the pinnacle of which is the exchange of highly sensitive nuclear submarine technology and support for the Trident strategic-weapon system. Without this assistance, Britain would no longer be able to sustain its nuclear deterrent.

Rear-Admiral Philip Mathias (ret'd)
Director of nuclear policy, 2005-08, Southsea, Hants

Sir, Your editorial ("No Deal", Jan 14) invites two further comments. First, the only human rights "on the ground" (or not in this case) are those of the Chagosians who were removed from the Chagos Islands in the 1960s. Their return could easily be permitted by the UK, unilaterally and not depend on a deal with Mauritius. Second, leaving back Diego Garcia alone ignores the fact that there are other islands and reefs in the Chagos archipelago. Given the activities of the Chinese in establishing military bases on reefs in the South China Sea the security risk is obvious. It is difficult to see whether Sir Keir Starmer is a fool or a knave in pressing ahead with a deal that is so obviously against the interest of the UK.
Anthony de Winton
London SW10

Inquests ignored

Sir, Concerns about the repeated failure to act on inquest advice ("Failure to act on inquest advice blamed for thousands of deaths", Jan 15) are seemingly mirrored by the performance of NHS Resolution,

which manages defence claims for NHS hospitals. In more than 20 years of providing independent reports for and against this organisation and its predecessors, I have never seen evidence of publication or action on lessons arising from adverse case experiences, many of which are recurring problems.

David Rew
Consultant general and endocrine surgeon, Southampton Hospitals

Military disservice

Sir, I find it mildly amusing that students have taken to "cancelling" the RAF and other perceived enemies of the liberal state on campus ("Protesters clip the wings of RAF recruitment at university job fairs", Jan 15). They fail to grasp that without these entities they wouldn't even have the right to protest. Maybe in future they should stick to irritating motorists instead and leave our brave service people alone. As the proud daughter of an RAF veteran, I would go as far as to suggest that they could even try to show a bit of gratitude.
Voirrey Davies
Wivenhoe, Essex

MOTHERS' LIVES SPARED BY NEW LAW

FROM THE TIMES JANUARY 16, 1925

At the Central Criminal Court yesterday, before Mr Justice Salter, Florence Margaret Marsh, otherwise Reynolds, 22, pleaded "Guilty" to an indictment under the Infanticide Act, charging her with causing the death of her newly-born child by strangling it with a piece of tape.

Sir Henry Curtis Bennett, KC, who appeared with Mr Leveson for the defendant, said he was instructed by people who were interested in her. The woman was employed as a domestic servant and made the acquaintance of a young

man named Marsh, who proposed marriage to her. They were going to be married, but Marsh's step-father objected to the marriage, and as the young man was under age it did not take place. The defendant was absolutely alone when the child was born, and Dr Morton, Governor and Medical Officer of Holloway Prison, said she must have suffered untold agony. The young man Marsh was present in Court and would say that he was most anxious to marry the girl directly he came of age.

Mr Justice Salter said he should like the girl to go to a home for six months, and if she was willing to do that he was prepared to bind her over.

The Court missionary said a home would be found for her. Sir Henry Curtis Bennett stated that the defendant was willing to go to the home; the judge thereupon bound her over in her own recognizances in £10 to come up for judgment if called upon, and she was discharged.

Dorothy Hagon, 18, shop assistant, pleaded "Guilty" to a charge of infanticide, it being alleged that she caused the death of her newly-born child by strangling it with a piece of ribbon. Mr GD Roberts prosecuted; Mr LA Byrne appeared for the defendant.

Mr Byrne, addressing Mr Justice Salter, said she was seduced by a man who promised to look after her but had not made any effort to keep his promise. Her father was anxious to take her back at once.

On the defendant undertaking to stay in a home for six months, which would be found for her by the Court missionary, Mr Justice Salter bound her over in her own recognizances in £10 to come up for judgment if called upon. The defendant was accordingly discharged.

THETIMES.COM/ARCHIVE

Feed supermarket data to AI models

Sir, Further to the letters (Jan 14 & 15) on the AI revolution, the government needs to recognise that AI is only as good as the data on which it is trained. If it is serious about its plans, it should deploy AI against supermarket, debit and credit card data on purchases in off-licences, pubs, fast-food restaurants and grocery stores to understand and measure our obesity crisis. This data already exists, we have the tools and computing capacity to analyse it and it gets to the heart of the core drivers of one of the biggest crises in public health today. At present NHS data is measuring the outcome, not the cause, and is merely a "lag indicator". The public's privacy can be easily protected by summarising this data, as is done with census information, with modest impact on the efficacy of the models.
Clive Hamby
Visiting professor of data science at Sheffield University, London W8

Clearing your plate

Sir, Further to your report "Parents fuelling obesity crisis" by forcing children to clear their plate" (Jan 15), I take the opposite view: that by not finishing their meals of healthy protein and vegetables children will be hungry a few hours later, and the consequent consumption of crisps, biscuits and other fast-food snacks will be the culprits leading to obesity.
Christina Parker
Verham Dean, Hants

Low-traffic support

Sir, Further to the letters (Jan 14 & 15) opposing low-traffic neighbourhoods, in Islington, which some of your correspondents complain about, LTNs were given a resounding democratic endorsement in the 2022 local elections. No anti-LTN councillors were elected. All those returned represented parties supporting LTNs. If people want change, they should vote for it.
Andrew Willett
London N5

Wire in the blood

Sir, In the mid-1950s, when I was about eight, my father introduced me to the wonders and mysteries of electricity (letters, Jan 14 & 15). I assisted him in the rewiring of a ceiling rose for a light fitting, which required me going up the ladder and poking various wires and connections. By the method of me complaining that he was "showing" me, we were able to ascertain which were the live wires. I like to think I'm still a live wire.
Alan Phillips
Epping, Essex

Duvet disaster

Sir, In the late 1970s I went on a two-day business trip to Germany, accompanied by a colleague. We stayed at a small hotel. At breakfast he asked if I had any difficulty getting into bed, as it had taken him ages to work out how to get into "that thing on top of the bed" (letters, Jan 14 & 15).
Nick Butcher
Abinger Common, Surrey

Letters to the Editor must be exclusive to The Times and may be edited. Please include a full address and daytime telephone number.

Inquests ignored

Sir, Concerns about the repeated failure to act on inquest advice (“Failure to act on inquest advice blamed for thousands of deaths”, Jan 15) are seemingly mirrored by the performance of NHS Resolution, which manages defence claims for NHS hospitals. In more than 20 years of providing independent reports for and against this organisation and its predecessors, I have never seen evidence of publication or action on lessons arising from adverse case experiences, many of which are recurring problems.

David Rew

Consultant General and Endocrine Surgeon, Southampton Hospitals

Background

As an interesting and challenging element of my professional clinical practice, I have provided a large number medicolegal reports on claims for clinical negligence for claimants and defendants. Many of these claims have been on similar cases and similar errors.

NHS Resolution, which is the central UK agency for the management of such claims, holds a very large number of such case files, from which major lessons could presumably be learned to inform best clinical practice. Indeed, NHS Resolution states that it invites insightful feedback.

Despite the stated good intentions, I have not been aware of published outputs with clear messages from the organisation in the surgical domain, and the most recent annual corporate report of the Agency provides no clarity beyond generic aspirations as to how such insights might be secured and promulgated. Many case settlements are wrapped in confidentiality clauses, which further impede the ability of front line clinical practitioners to understand outcomes, financial settlements or the factors which make break medico-legal cases. In consequence, defensive practice is often excessive and wrapped around in mythology and uncertainties.

I had not previously focussed on this issue in respect of coroners reports, and I am not aware that my letter has in any way moved the dial of NHS Resolution’s corporate plans.

The matter stands in stark contrast to the Aviation Industry, where rigorous analysis, no-blame reporting and an open approach to information has produced huge improvements in air transport safety over the decades.

The original article by Sean O’Neill which prompted my letter is as follows:

Failure to act on inquest advice blamed for thousands of deaths

Sean O’Neill The Times 15th January 2025 (page 1)

Thousands of deaths could be prevented every year if public bodies acted on concerns highlighted at inquests.

Almost 82,000 deaths in 2022 were recorded by the Office for National Statistics in England and Wales as “preventable”, meaning they could have been avoided “through effective public health and primary prevention interventions”.

Measures that could slash that toll are highlighted by coroners in reports to prevent future deaths, about 500 of which are published every year.

Coroners have a statutory duty to alert public bodies - including ministers and their departments, NHS trusts, prisons or regulators - when they fear there is “a risk that future deaths could occur unless action is taken”. Recipients must respond in writing but are not required to address the concerns that are identified by coroners.

Katy Skerrett, the senior coroner for Gloucestershire, published a report last week following the inquest into the death of Thomas Kingston, 45, the husband of the King’s second cousin, who took his own life while suffering an adverse reaction to antidepressants.

Skerrett asked whether patients were made sufficiently aware of the risk of suicidal thoughts associated with taking the drugs sertraline and citalopram, which belong to a class of medication known as SSRIs (selective serotonin reuptake inhibitors) that are widely prescribed for anxiety.

The Times and the Preventable Deaths Tracker at King’s College London have identified 40 previous coroners’ reports in which the use of the drugs had been a problem — including several in which the coroners said people had not been fully informed of the increased risk of suicidal ideation associated with the medication.

Coroners' reports of lethal dangers 'vanish into ether'

Sean O'Neill, Lottie Hayton The Times Page 16 15th January 2025

Reports highlighting reforms that could save lives are written in fewer than 2 per cent of inquests in England and Wales, analysis has shown.

Coroners have a duty to alert organisations, government ministers and their departments to failures that led to avoidable deaths.

About 37,000 inquests were opened in 2023, but just 547 reports to prevent future deaths (PFDs) were written that year. No official mechanism exists to pass on lessons from those reports or to monitor whether action is taken.

Although public bodies that receive PFDs are legally required to respond, hundreds have been ignored since publication began in 2013. Organisations that do respond are not required to take any further action to address concerns over matters such as drug safety, healthcare provision or professional training.

Inaction causes fatal failings to recur again and again:

- A coroner asked last week whether patients were properly aware of suicide risks associated with certain antidepressants after the death of Thomas Kingston, 45, husband of the King's second cousin. Several other coroners had expressed concern about inadequate labelling of selective serotonin reuptake inhibitors (SSRIs), but their warnings were overlooked.
- An inquest into the death of William Northcott, 39, opened this week in Exeter and is examining whether the antipsychotic drug clozapine was a contributory factor; coroners have written 17 previous reports suggesting reforms in its prescription and monitoring.
- Coroners have expressed concerns about the availability of a poison linked to suicides for four years, but the Home Office has not restricted it.
- At the inquest last year into the death from myalgic encephalomyelitis of Maeve Boothby O'Neill, 27, a Devon coroner complained: "I write a lot of these [PFD] reports and often nothing happens."

A DECADE OF MISSED CHANCES

Since 2013 more than 5,400 PFDs have been published by the chief coroner. Each one marks an area in which changes - such as better recordkeeping, more staff training, clearer food or drug labelling or increased care provision - might have saved a life.

Analysis by the Preventable Deaths Tracker project at King's College London revealed that 1,495 reports had not had any responses and 741 had received only partial responses.

Georgia Richards, founder of the tracker, said: "Very few PFDs have led to meaningful change, and often it's not the PFD that triggered it. Change comes from additional factors like change in leadership of the organisation, huge media scrutiny or dedicated families."

SYSTEM IS ‘A WASTE OF TIME’

Although they are considered serious enough to warrant a coroner’s investigation, the deaths involved often result in no reports. Almost half of the 900 coroners in England and Wales have not written any PFD reports; 37 per cent of the reports have been written by just 30 coroners.

Richards said it was “mind-blowing” that there was no system to disseminate lessons from inquests. “Across 5,000 reports over the last 12 years, it is impossible to know anything about what action might or might not have been taken following a coroner’s report,” she said.

“People think there must be a system that’s protecting us. We assume that if you were in government you would want to know what’s happening in these death investigations.

But the system doesn’t work. It’s a waste of time.”

TWO-YEAR BACKLOG

Merry Varney, an inquest specialist at the law firm Leigh Day, said: “Sadly PFD reports and the responses promising actions are not effectively monitored ... Lives are lost unnecessarily as well as others undoubtedly suffering non-fatal harms from the same risks.”

Deborah Cole, executive director of the campaign group Inquest, said: “There is a serious gap in accountability after a coroner issues a PFD. While there is a duty for those who receive reports to respond, responses are often late, of poor quality or simply never sent. In effect, PFDs just disappear into the ether.”

Sir Peter Thornton KC, chief coroner in 2012-16, said: “First, there are not enough coroners writing these reports. Second, they can’t force a response. Third, they can’t follow up a response.

Fourth, they can’t force action — they can only suggest that an area of action is considered. And last, there’s no national follow-up; there’s no coordination.”

He urged reform through the creation of a national coroner service.

The inquest system is jointly managed by the judiciary, local councils and the police. It is poorly funded and has big backlogs: 1,685 bereaved families have been waiting longer than two years for hearings.

The chief coroner, Alexia Durrant, declined an interview request. Her office said producing PFD reports was “an ancillary part of the coroner’s judicial role” and that issuing them marked the end of a coroner’s part in the process. Questions about what followed were for the government.

Analysis: I've spent years trying to make sense of our lethally flawed system

If you lose a loved one following a failure in care, you might assume that a robust system is ready to investigate and act ([Georgia Richards writes on p 17 The Times 15th Jan 2025](#)).

Thousands of families experience this “system” every year. Nearly 37,000 inquests were opened in 2023 to investigate who, how, when and where the deaths occurred. Inquests vary widely - some last weeks and have juries while others are concluded in writing without a court hearing - but all involve immense resources and are hugely distressing for those who have to relive the trauma of their loss or provide evidence as witnesses. So what happens afterwards? Coroners have a statutory duty to write to organisations, including hospitals or the government, if they believe that action should be taken to prevent future deaths. These prevention of future deaths (PFD) reports have been published online since 2013, but no one knew how many reports were being written, who received them, whether responses were sent and whether action was taken following the reports.

Now, after years of research - dedicating every spare moment and my personal funds to creating the Preventable Deaths Tracker - it's possible to understand what's going on. In 2023 only 1.5 per cent of inquests led to a PFD - that's just 547 reports.

The flow of key information relies on the email etiquette of thousands of recipients. First, the coroner must email the report to the listed addressee - and there are likely to be multiple addresses. Next, the addressees must receive the report, formulate a response and reply within 56 days. If the coroner's office receives a reply, they forward it to the chief coroner, who is responsible for redacting and publishing the reports.

If I do my maths correctly, that's a minimum of three emails for a single report with one addressee. Since 5,443 reports had been published as of December 15, last year, that's at least 16,329 unnecessary emails. It gets worse, however. Reports are then manually published online at [judiciary.uk](#), leading to a wealth of errors and inconsistencies.

In Australia and New Zealand, information from every inquest is collated in the national coronial information system. This has been functioning for 25 years and is actively used to save lives.

The system, which has ten staff, was set up in response to recommendations made following the Royal Commission into Aboriginal Deaths in Custody. Governance, licensing and funding had to be agreed and approved by the leaders of each state and territory — a challenge that the English and Welsh system does not need to overcome.

The system's success is about more than mere data. It is hosted by the state of Victoria's department of justice and community safety, while the Victorian Institute of Forensic Medicine is tied to Monash University; academic research provides evidence to improve the justice system and save lives.

In England and Wales, the same deaths continue to occur. The inaction and inability to learn lessons from deaths is harming the living.

A system without a memory that relies on the goodwill of campaigners for action to be taken should be a national scandal.

To truly learn lessons from preventable deaths, we cannot continue inefficient and outdated practices. To start the transformation, a national database of inquests - and an independent, interdisciplinary research unit that works alongside the coroner service to inform policy and prevention - needs sustainable funding. Until then, the Preventable Deaths Tracker will keep tracking.