Inquests: The Risk of Prosecution

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In May 2019, HM Assistant Coroner for West London, Mr John Taylor, imposed a fine against "Dr" Duncan Lawrence for failing to attend and disclose evidence at the inquest of Sophie Bennett. The Coroner also referred Lawrence to the police/CPS. It is understood that this is an unprecedented case as it may be the first time someone has been prosecuted for withholding information from a Coroner.

Background

This case arises from the inquest of Sophie Bennett who died on 2 May 2016, aged 19. Ms Bennett had been a resident at Lancaster Lodge run by RPFI, since April 2015. She had a diagnosis of bipolar affective disorder, social anxiety disorder and atypical autism. In September 2015, CQC inspected the home and rated it as "Good". In January 2016, a number of changes were made, including cancelling all external therapies, which led to the Registered Manager resigning. It is understood that Lawrence led those changes. When CQC inspected in March 2016, the home was rated "Inadequate".

Due to a number of concerns, a decision had been made to move Ms Bennett out of the home to alternative accommodation. However, she remained at the home until May 2016. On 28 April 2016, Ms Bennett had suicidal thoughts and a high impulse to act on them. Staff called a crisis line and were advised to take Ms Bennett to the hospital, but they did not follow the advice. Ms Bennett was placed on close observations but on 2 May 2016, she was allowed behind a closed bathroom door and was not subject to close observations. Ms Bennett was found hanging, having used a skipping rope as a ligature. Two days later, on 4 May 2016, she sadly died.

A three week inquest was held earlier this year and the jury found that neglect contributed to Ms Bennett's death. Lawrence had been summoned by the Coroner to give evidence at the inquest but he failed to attend. During the inquest, a number of concerns were raised regarding RPFI and Lawrence, including the fact that, although he described himself as a doctor and staff believed he was a medical doctor (he was the clinical lead), Lawrence did not actually have a medical degree. The company was unable to produce evidence of his credentials.

The Coroner held a separate hearing in May 2019, which Lawrence also failed to attend, and determined that a fine of £650 should be imposed. Lawrence was also referred to the police/CPS and at a hearing at Wimbledon Magistrates Court on 16 August 2019, Lawrence stated he was "100% guilty". A sentencing hearing was listed for

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27 August 2019, but at that hearing, it is reported that the Judge commented that this is not a straightforward matter. The sentencing hearing has been adjourned to enable Lawrence to obtain legal advice. It is currently unknown how this matter will proceed.

In respect of the concerns regarding RPFI, CQC has confirmed it will prosecute for exposing Ms Bennett to a significant risk of avoidable harm. Additionally, the Charity Commission has also opened up a statutory enquiry. The Charity Commission's focus is on governance and compliance under charity law and it will assist other agencies (i.e. CQC) who take the lead on safety and quality of care provided.

Important things to note from this case

1. It is important to respond to requests from the CoronerA failure to respond to a request for information or to attend an inquest is a criminal offence. This case reiterates that Coroners have the power to take action where there has been a failure to respond to a summons. The repercussions of such a failure can be catastrophic for registered healthcare professionals. If Lawrence had been a medical doctor and registered with the GMC, it is likely that he would now be facing a professional disciplinary investigation as well as criminal prosecution.

2. You should be fully prepared to attend and give evidence at an inquestReceiving a request from a Coroner to provide information or attending an inquest to give evidence can be a stressful experience. Coroner's inquests are different to civil or criminal proceedings and if you are not familiar with the process, you should obtain legal advice at the earliest opportunity to ensure you are aware of the risks and are properly prepared.

3. CQC will look into potential failingsIf you or your service is criticised during an inquest, there is a risk that CQC may investigate and consider taking enforcement action. This may include criminal prosecution of the Provider and/ or Registered Manager.

4. Adverse publicity can have huge impactInquests are normally held in public and often attract media publicity. If you have been criticised during the inquest, this may lead to adverse publicity, which, in turn, may have a negative impact on you or your business.

As experienced inquest lawyers, we can guide you through the inquest process and advise you on any risks you may be exposed to. It is important to seek legal advice at the earliest opportunity to ensure you provide the Coroner with the best possible evidence from the outset.

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