THE LEAD

Failing the dead: How medical ignorance is killing Britain’s coroner service

Grieving families are being left without answers due to an overstretched, untrained coroner's service that is "not fit for purpose".

ANGELA WALKER AND THE LEAD **JUNE 21, 2025**

In Cornwall, 54-year-old Charles Devos died from a bowel infarction in January 2021 after waiting several hours for an ambulance. The coroner court refused to open an inquest for over a year, despite repeated submissions there was reason to suspect the death was “unnatural.”

Four years later, a Judiciary Prevention of Future Deaths Report eventually stated: “If an emergency ambulance had collected Charles in the early hours of 9 Jan it is probable he would have received lifesaving treatment.”

A coroner is a judge whose job is to investigate unnatural or violent deaths, to find out who died, how, when, and where. They should, in the words of former Chief Coroner Thomas Teague KC, “provide bereaved families with answers.” However, too often, key details are being missed or omitted from coroners’ records – meaning families are left without answers, and the possibility to prevent future deaths is being missed.

Charles Devos’ avoidable death highlighted a systemic failure of the ambulance service due to extreme operational pressure. Records show that the coroner court, which is supposed to be impartial, held private meetings with the ambulance service about Mr Devos’ case. The court also disclosed vital documents less than three days before the inquest – essentially withholding them.

Daniel Menell, director of Ross Aldridge Solicitors who represented the family, said: “The distress of Mr Devos’ partner has been aggravated by the court’s conduct of this inquest.”

Guy Davies, the Assistant Coroner of Cornwall and Isles of Scilly said he was not permitted to comment.

Incidents like this one are happening all over the country. In Huntingdon, Cambridgeshire, Hannah Appleby’s family were left outraged and distressed by the conduct of a coroner. Hannah was found dead in her bedroom by her teenage son in March 2022. In the months prior, she had sought help for depression and insomnia. Her father, retired RAF pilot, James A Cowan MBE, says the circumstances around her death must be fully investigated.

The inquest was held by assistant coroner Anita Davies who determined Hannah had died by suicide, without calling any witnesses. Her family were not consulted about the decision not to hold a full

inquest – contrary to the chief coroner's guidance. Cambridgeshire coroners have since admitted that was an error, but refuse to order a second inquest.

Hannah's family want those involved in Hannah's care to be called as witnesses: "She was prescribed a medication, Zopiclone," says Mr Cowan. "The packaging says quite clearly that Zopiclone can cause suicidal thoughts. As a family we feel badly let down by the coroner's service."

Cambridgeshire County Council, on behalf of the coroner's office, said judges cannot comment on these matters.

Vital details excluded

Gaia Young's case is well known thanks to the tireless campaigning of her mother Lady Dorit Young. Gaia, a healthy, vivacious 25-year-old who loved ballroom dancing, was rushed to hospital in July 2021, confused, vomiting and with a severe headache. Gaia died the next day with swelling to the brain. Her mother wanted answers. She trusted that the coroner service would provide that, yet four years on, she says the coroner has been obstructive and tried to shut her down.

"The feeling really stuck with me, of being very vulnerable – a bereaved mother, pulling all your strength together to stand up in court as a witness – then just being wiped off the table like a fly," she tells *The Lead*. "I think it's horrendous the way she treated me."

Gaia Young's mother – and a number of independent medical experts – believe her death could have been prevented had she received the right medical treatment. They say the coroner excluded vital information from the inquest. Her medical notes show several possible failings by hospital staff. Doctors wrongly assumed she was drunk or on drugs. Basic tests were omitted. What was recorded by the coroner doesn't reflect any of this.

Coroners must be qualified as a barrister or solicitor but – surprisingly – medical experience is not mandatory. There are currently 394 coroners covering 509 appointments, but the Ministry of Justice does not hold information on the number of coroners who are medical practitioners.

It is this lack of medical expertise that some coronial service insiders say is leading to systemic failures. They say cases are being rushed through the system, and many causes of deaths are being inaccurately recorded – meaning medical negligence can go unchecked, and those responsible are free to carry on treating patients and endangering lives.

In January this year – more than three years after Gaia's death – an independent expert stated a scan of Gaia's brain that had been excluded from the inquest showed severe swelling. The hospital radiologist who examined it at the time wrongly said the scan was normal. Two further experts from UCHL quoted in the Trust's Serious Incident investigation into Gaia's death also wrongly stated it was normal.

Experts *The Lead* have spoken to say the scan clearly shows Gaia's brain was extremely swollen, and that this should be obvious to anyone with medical training.

One medically qualified coroner who considered Gaia's case at her mother's request, said: "Had this inquest been heard by a medically literate coroner, they would have found a failure to rule out raised intracranial pressure prior to doing a lumbar puncture contributed to her death."

They said an accurate inquest could have helped to produce a prevention of future deaths report. "In other words," they told us, "had the inquest been heard by someone medically literate, the chance of this happening to someone else could be reduced." They added that hospital trust investigations are

essentially worthless: “Internal investigations are an exercise in damage limitation and serve only to protect senior doctors and the reputation of the institution.”

A UCLH spokesperson said: “We are sorry that Gaia’s care fell below the high standards we strive to provide and that we did not communicate with her mother as well as we should have done at the time of her admission. We acknowledge the distress this has caused Lady Young and sympathise greatly that the cause of her beloved daughter’s death is still unknown.

“In 2022, we agreed to commission a range of independent experts to explore further the circumstances surrounding Gaia’s death. We agreed with Lady Young the scope of the reviews and the experts who will undertake them.”

The coroner’s office was not able to comment.

Because so few coroners are medically trained, many have to turn to the hospitals to get information for each case they are looking into. “If hospitals don't do their own proper investigation, the coroner is basing their investigation on very flawed information,” says Gaia’s mother Lady Dorit. “And that's exactly what happened in Gaia’s case. The coronial system is not fit for purpose.”

A culture of “lies and cover-up”

A third coroner, a solicitor and medical practitioner who is afraid to be named due to the possibility of repercussions, tells *The Lead* they think the whole system is flawed: “The essential question concerns the independence and rigor of hospital death investigations,” he says. “If you invite the hospital to investigate itself, all you’re doing is replicating a lie, a culture of lies and cover-up.”

By law, deaths where an act or omission by medical services contributed are classed as unnatural and should have inquests. But, the first coroner explained, “most of my peers fail to recognise where a medical failure may have contributed because they are lawyers with no medical training.”

They added that some doctors used “barefaced attempts to mislead the court,” and “had learned they could do this without the risk of getting into trouble.”

This long-serving coroner, who has worked in several jurisdictions, believes the system is skewed towards protecting the NHS.

“Coroners who return verdicts or conclusions which are inconvenient and speak truth to power are targeted,” they explain.

They believe the Judicial Code of Conduct gags coroners: “I think the code should emphasise the importance of judiciary and that as part of it, you have an obligation to speak up if you see the system failing, not working or being corrupted.”

“Fatally flawed”

When someone dies in hospital, a doctor calls the coroner’s officer to register the death – that officer will decide what the doctor should write down as the possible cause of death, before the coroner themselves has seen the case.

“It is bizarre for a coroner’s officer to advise a doctor,” says another respected senior coroner, commenting on this practice.

“The system in this country is fatally flawed,” he tells *The Lead*. “It's failing because firstly, coroners do not manage the cases directly. They are using coroner's officers to manage the cases for them. How on earth can a coroner’s officer be giving advice that's independent to a doctor who is seeking to establish what to write on the medical certificate?”

Reforms to the coroners’ service in 2013 included the new role of a Chief Coroner. It followed reviews that identified fundamental problems including, “a lack of consistency between coroner districts and an absence of national supervision or leadership.” This is hardly surprising with 77 coroner areas across England and Wales, all operating separately, and all funded by a different local authority.

Ten years later, Chief Coroner Thomas Teague KC, who retired last year, toured the country to find out if the reforms had been a success. He wrote in his report that judicial independence is impacted by the local funding model, which means it is important for coroners to “maintain a good relationship with their local authorities”, adding there is “an obvious danger that those making appointments on behalf of a local authority will naturally tend to favour candidates whom they perceive to be more compliant.”

He also reported the service “has insufficient personnel.” By 2023, the average length of time taken to complete an inquest had crept up to 31.5 weeks, from 27 weeks in 2019 – that’s despite the number of deaths referred to coroners being at the lowest level since 1995.

A Ministry of Justice spokesperson said: “Stringent criteria is in place for the appointment of coroners, who can hear evidence from witnesses with medical expertise for the purposes of their investigation. In order to ensure that all deaths are subject to independent review, we implemented the statutory Medical Examiner system in September 2024, meaning that every death is now subject to a medical examiner’s scrutiny or a coroner’s investigation.”

That means if a death is referred to the coroner, it may not be subject to independent medical scrutiny at all, if that coroner is not medically trained.

The coroners we spoke to are now calling on the Ministry of Justice to introduce medical training for all coroners. “Too often, inquests concerning patient deaths are unsatisfactory,” Dr Anthony Barton former assistant coroner and medically qualified solicitor with Medical Negligence Team Law tells *The Lead*. “Too often the court allows the health service to investigate itself, allowing cover up – where is there independent clinical scrutiny? Wes Streeting rightly described ‘a cultural rot that places protecting the reputation of the NHS above protecting the public’.”

The role of a coroner is a difficult and crucial one. Crucial for families seeking closure, for identifying failings in the system, and for highlighting patterns and preventing future deaths. With financial pressures, strained resources, medically ignorant coroners and an incentive to keep the peace with local authorities, families are left wondering who the coroners’ service is serving. Until all coroners have medical training, countless more preventable deaths are likely to slip through the net, leaving the bereaved without answers.