CHIEF CORONER

STATEMENT FROM THE CHIEF CORONER

1. The Chief Coroner welcomes the publication by the Equality and Human Rights Commission of their inquiry report *Preventing Deaths in Detention of Adults with Mental Health Conditions*.

2. Coroners play an important role in the investigation of unnatural deaths of adults detained in prisons, hospitals and police custody. Coroners are judicial office holders who have a duty to investigate all such deaths 'fully, fairly and fearlessly' (*Jamieson* case). They also have a special responsibility in order to satisfy the state's duty to investigate deaths where the right to life under Article 2 of the European Convention on Human Rights may have been breached. For all investigations, including inquests, coroners act independently of the state and any institution.

3. It is the function of coroners therefore to investigate and come to conclusions about each death at an inquest. Where appropriate they also report to prevent future deaths (PFD reports).

4. The Chief Coroner therefore acknowledges the following part of Recommendation 3 and responds in paragraph 5 below:

> *The Chief Coroner to continue to produce summary reports (as outlined in the Coroners Act 2009) from Preventing Future Deaths Reports, particularly to ensure there is the opportunity for learning from non-natural deaths in psychiatric hospitals.*

5. The Chief Coroner has constantly encouraged coroners to write PFD reports, because they may lead to changes which save lives. The Chief Coroner has given written guidance to all coroners on the need for reports (Guidance No.5 *Reports to Prevent Future Deaths* and No.5A *Practical Guidance: PFD Reports*) and has designed a template for easy use. The Chief Coroner has replaced bi-annual summaries of PFD reports with publication of full reports and responses (subject to occasional redaction) on the judiciary website under searchable topic headings.

6. Coroners are required to make a report where they have a specific concern. By statute they may recommend that action may be taken but not what that action should be. In some cases the Chief Coroner will subsequently pursue an issue to ensure compliance with a coroner's report and request information by way of follow-up.

7. The deaths in places of detention of adults with mental health conditions continue to be a matter of ongoing concern. The protection of vulnerable adults in detention is a matter of considerable public importance. The Chief Coroner will continue to ensure that coroners continue to play their part fully in investigating these deaths and reporting to protect and save lives in the future.

HH JUDGE PETER THORNTON QC
CHIEF CORONER

25 February 2015