



CHIEF CORONER

GUIDANCE No.5

REPORTS TO PREVENT FUTURE DEATHS¹

Introduction

1. Rule 43 reports were replaced on implementation of the Coroners and Justice Act 2009 with Reports on Action to Prevent Future Deaths ('reports') under paragraph 7, Schedule 5, of the 2009 Act and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. For short they can be referred to as PFDs or PFD reports or Regulation 28 reports.
2. These reports are important. Coroners have a duty not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths. A bereaved family wants to be able to say: 'His death was tragic and terrible, but at least it shouldn't happen to somebody else.'
3. The importance of PFD reports is emphasised by their upgrading by Parliament from a rule (Rule 43 of the Coroners Rules 1984) to part of the 2009 Act (para.7, Schedule 5) and by changing the coroner's discretion to make a report to a duty to make a report where a concern is identified.
4. Responsibility for reports was transferred from the Ministry of Justice to the Chief Coroner's office on 1 April 2013. The Chief Coroner has expressed his commitment to taking value from reports with a view to encouraging persons and organisations to make changes which may prevent future deaths.
5. Broadly speaking reports should be intended to improve public health, welfare and safety. They should not be unduly general in their content; sweeping generalisations should be avoided. They should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect.
6. Reports are important, but they are 'ancillary to the inquest procedure and not its mainspring' (*Re Kelly (deceased)* (1996) 161 JP 417. In an Article 2 inquest the report may complete the state's duty to inquire fully (see *R (Lewis) v HM Coroner for the Mid and North Division of the County of Shropshire* [2009] EWCA Civ 1403).
7. Coroners should look at the precise wording of the Act and the Regulations.

¹ As always I am very grateful for the input of many coroners into this Guidance, especially Derek Winter, HM Coroner for the City of Sunderland.

8. This Guidance is not intended to cover every possible situation in which the duty to make a report may arise. It is for each coroner to decide on a case by case basis whether he or she has a statutory duty to make a report.
9. Please use the template documents for making reports, as attached at Annex A. For ease of use in the Chief Coroner's office the templates should not be amended or altered.

The coroner's duty

10. The coroner's duty arises in the following circumstances:
 - (1) The coroner has been conducting an investigation into a person's death. Normally the investigation will be complete, with the inquest concluded, but not necessarily (see below).
 - (2) Something revealed by the investigation (including evidence at the inquest) gives rise to a concern. The coroner is not restricted to matters revealed in evidence at the inquest (as was the case with Rule 43 reports). The matter giving rise to concern will usually be revealed by evidence at the inquest, but it may be something revealed at any stage of a coroner's investigation. Giving rise to a concern is a relatively low threshold (*Coroners Inquests into the London Bombings of 7 July 2005*, per Lady Justice Heather Hallett, Assistant Deputy Coroner for Inner West London, ruling 6 May 2011, transcript p15).
 - (3) The concern is that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future. It is concern of a risk to life caused by present or future circumstances (*ibid.* p15).
 - (4) In the coroner's opinion, action should be taken to prevent those circumstances happening again or to reduce the risk of death created by them.
 - (5) If (1) – (4) apply, the coroner has a duty to report ('must report') the matter to a person or organisation who the coroner believes may have power to take such action.

Pre-condition to making a report

11. It is a pre-condition to making a report that 'the coroner has considered all the documents, evidence and information that in the opinion of the coroner is relevant to the investigation' (Regulation 28(3)).

The timing of the report

12. Normally the report will be made after the inquest is concluded. That is because of the pre-condition to making a report provided by Regulation 28(3), above.
13. Previously, under the version of Rule 43 which was substituted by the Coroners (Amendment) Rules 2008, the coroner's concern could only arise from evidence given at the inquest. Now, however, the concern may arise from 'anything revealed by the investigation' (including the inquest). The wording of para.7 of Schedule 5 therefore permits a report to be made before an inquest is heard (so

long as the pre-condition is complied with). Where, for example, the coroner concludes that there is an urgent need for action he/she may report with a view to action being taken without delay. The Regulation 28(3) pre-condition may be satisfied during the investigation but before inquest when the coroner takes the view that there is unlikely to be more material to come on the matter of concern.

Procedure at inquest

14. It was not the intention when changes were made to Rule 43 in 2008, nor is it the intention under the 2009 Act, that inquests should be lengthened or their scope widened for the purpose of hearing representations. Although a report may become an important aspect of the outcome of an investigation, it is essentially ancillary to the primary purpose of an inquest which is to determine the statutory determinations, findings and conclusions relating to the death as recorded in the Record of the inquest (section 10 of the Act, Rule 34 and Schedule Form 2 of the Rules).
15. Coroners may hear and give weight to representations by interested persons at the inquest as they see fit. Sometimes it may be necessary to hear some evidence which may be relevant for the purpose of making a report but not strictly relevant to the outcome of the inquest. For example, a medical witness could, where appropriate, enlarge on his or her earlier evidence while the jury is deliberating. Adding to an inquest with lengthy additional evidence or conducting a separate lengthy additional hearing should, however, be avoided. An inquest is an inquest, not a public inquiry.

The nature of the report

16. Where a coroner has a duty to report, the report must state the coroner's concerns and that in the coroner's opinion action should be taken to prevent future deaths. The report must be sent to a person or organisation who the coroner believes has power to take such action (para.7(1)(c), Schedule 5 of the 2009 Act).
17. The report need not be restricted to matters causative (or potentially causative) of the death in question. Paragraph 7 is not so restricted. Paragraph 7(1)(b) refers to 'anything' revealed by the investigation which gives rise to concern that 'circumstances creating a risk of other deaths will occur ...' It does not use any phrase such as 'in similar circumstances'.
18. The original Rule 43 used the phrase 'to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held', but the word 'similar' was deleted from the later version. When the change to Rule 43 was made in 2008 the Ministry of Justice's *Guidance for coroners on changes to Rule 43* referred to the change allowing coroners to report issues that may be peripheral to a particular case but nevertheless will prevent deaths in the future. The word 'similar' remains absent from the 2009 Act. The report does not, therefore, have to relate to a death in similar circumstances.
19. By way of illustration, in a suicide case involving hanging at home, firearms are found at the house. The deceased has a history of serious violence and questions are raised during the course of the investigation about the police checks made for the purposes of firearms certificates. These questions raise sufficient concern with the coroner that action should be taken to prevent future deaths, not deaths in circumstances similar to the deceased's death, but relating

to other possible deaths where police checks about firearms are shown to be inadequate.

20. Each report should be a carefully considered, professional document bearing in mind that it is likely to be published in due course on the judiciary website.
21. Do not include a confidentiality clause. In most cases it will not be necessary to send extraneous documents such as the Record of the Inquest or a recording to the recipient. The report should be complete in itself.

The coroner's concerns (Box 5 of the template)

22. The report, having set out the details of the investigation (and inquest) and the circumstances of the death, must then list the coroner's concerns (in Box 5 of the template, Annex A). These are the concerns which the investigation has revealed, either at the inquest or earlier during the investigation.
23. This part is the essence of a report to prevent future deaths. The coroner should express clearly, simply and 'in neutral and non-contentious terms' the factual basis for each concern (*R v Shrewsbury Coroner's Court, ex parte British Parachute Association* (1988) 152 JP 123). See Box 5 of the template forms at Annex A.
24. In some cases the action to be taken following the coroner's concern will be obvious. But it is not for the coroner to express precisely what action should be taken. **A PFD report is a recommendation that action should be taken, but not what that action should be.** The latter is a matter for the person or organisation to whom the PFD report is directed. Hallett LJ expressed it in this way:

'However, it is neither necessary, nor appropriate, for a coroner making a report under rule 43 to identify the necessary remedial action. As is apparent from the final words of rule 43(1), the coroner's function is to identify points of concern, not to prescribe solutions.' (7/7 *Bombings Inquests, ibid.* p15.)

25. Coroners should be careful, particularly when reporting about something specific, to base their report on clear evidence at the inquest or on clear information during the investigation, to express clearly and simply what that information or evidence is, and to ensure that a bereaved family's expectations are not raised unrealistically.
26. Reports should not apportion blame, be defamatory, prejudice law enforcement action or the administration of justice, affect national security, put anyone's safety at risk, or breach data protection for example by naming children or breaching medical confidentiality.
27. Coroners should not make any other observations of any kind, however well intentioned, outside the scope of the report. Such observations are an expression of opinion wider than is permissible (under section 5(3) of the 2009 Act - the old Rule 36) and are therefore unlawful and to no effect: see *R (Mowlem plc) v Avon Assistant Deputy Coroner* [2005] EWHC 1359 (Admin).
28. In the past some coroners have from time to time expressed themselves in public with forceful language. Phrases such as 'I am appalled' or 'I am disgusted' or 'shame on you' have been used. They should not be used. Coroners should

at all times use moderate, neutral, well-tempered language, befitting the holder of a judicial office. This applies to public hearings as well as correspondence and reports.

Action (Box 6 of the template)

29. Next, the report must state that ‘in the coroner’s opinion action should be taken’ and that the coroner believes the person/organisation has ‘power to take such action’ (paragraph 7(1)). See Box 6 of the template forms at Annex A. The coroner should not recommend what that action should be (see paragraph 24 above), but the coroner can highlight the area of concern and draw attention to it (see Box 5 above).
30. Under this heading the report should usually do no more than state in these terms: ‘In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.’ See template and specimen attached.
31. It is not for a coroner to make recommendations as to what specific action should be taken. The wording of the 2009 Act does not go as far as, for example, the New Zealand law which permits coroners to make recommendations (section 22A, Coroners Act 1980). The coroner in England and Wales may draw attention to an area of concern for the person/organisation to consider, such as: ‘You should consider a review of your procedures on safety and the use of ladders’. But that is not a specific remedial recommendation.
32. In *Re Clegg (deceased)* (1996) 161 JP 521 (DC) Phillips LJ used the word ‘recommendations’ in a general sense only: ‘Again my conclusion is that in a situation such as this a coroner cannot be expected to do more than to make general recommendations and that it must, at the end of the day, be for the National Health Service to give detailed consideration to how their recommendations should be implemented’. In other words the coroner should identify the specific area of concern, raise it, but then allow the person/organisation to provide the remedy.
33. A number of cases are consistent with that approach. In *Re Kelly (deceased)* (1996) 161 JP 417 Pill LJ endorsed the coroner’s recommendation under Rule 43 for a review of methods of communication during live military firing exercises. In *R v Shrewsbury Coroner’s Court, ex parte British Parachute Association*, above, the Rule 43 ‘recommendation’ was expressed by Lloyd LJ to be confined to the coroner announcing, ‘presumably in neutral and non-contentious terms’, that he was going to report the matter to the relevant authority.
34. And in the *7/7/ Bombings Inquests* Hallett LJ set out in her Rule 43 letter of 6 May 2011 her nine ‘recommendations’ and the reasons for them at some length and listed them in a Summary of Recommendations. But her recommendations involved no more than proposing reviews of specific aspects of procedures, protocols or training, for example: ‘I recommend that the London Resilience Team reviews the provision of inter-agency major incident training for frontline staff, particularly with reference to the London Underground system.’ She did not purport to suggest what the outcomes of those reviews should be.

Sending the report

35. The coroner must send the report to 'a person who the coroner believes may have power to take such action': paragraph 7(1). 'Person' includes organisation. Where a report is sent to an organisation the coroner should seek to identify a relevant person in the organisation who is sufficiently senior to have the 'power' to take action.
36. The report should be sent out (a) within 10 working days of the end of the inquest, or (b) within 10 working days of the time, earlier, before inquest, when the matter of concern is revealed and considered during the course of the investigation (see paragraph 13 above).

Letter instead of report

37. Where the duty to make a report does not arise, but the coroner wishes exceptionally to draw attention to a matter of concern which has arisen during the investigation (including the inquest), the coroner may choose to write a letter expressing that concern to the relevant person or organisation. For example, the matter in question may not relate to a risk of future deaths. Such a matter could be discussed with interested persons at the inquest and the correspondence could be copied to them.
38. An example of this arose in the inquest into the death of *Ian Tomlinson* who died during protests at the G20 summit in London in April 2009. There was evidence, which in the end was excluded from the inquest hearing, about police service vetting arrangements. This evidence did not relate to the death or to future deaths but it caused concern to the coroner who discussed it with counsel, corresponded with the Home Secretary about it, and disclosed the correspondence (with the Home Secretary's consent) to all interested persons. In due course the Home Secretary amended the vetting arrangements.

The role of the jury

39. A jury is not permitted to make riders or recommendations: see *R v West London Coroner, ex parte Gray* [1988] 1 QB 467; *R v Shrewsbury Coroner's Court, ex parte British Parachute Association*, above; *R v HM Coroner for West Somerset ex parte Middleton* [2004] 2 AC 182, [38].
40. Coroners should not invite juries to make any kind of observation. Indeed, quite the contrary; juries should be directed not to express an opinion on any matter other than the section 5 matters to be ascertained (who, how, when and where). In the right case, however, the coroner has a discretion (not a duty) to leave to the jury, in addition to the direct or indirect causes or contributions to the death, facts which are relevant to the coroner's reporting power under paragraph 7 of Schedule 5, particularly where those facts are disputed or uncertain: see *Middleton* and *Lewis*, above (both Article 2 cases).

Article 2 cases

41. The coroner's procedural obligation under Article 2 is 'most effectively discharged' if the coroner announces publicly not only his/her intention to make a PFD report, if that is the intention, but also in broad terms the substance of the report which he/she intends to make: *Middleton*, [38].

Requirements relating to reports: format, responses, copies and publication

Format

42. When writing a PFD report the coroner should **always use the template form** which the Chief Coroner's office has previously provided. The form is in Word format. Coroners should not write PFD reports in letter format.
43. The completed template form should then be sent to the responder(s) in electronic form.

Responses

44. A person or organisation must respond within 56 days or longer if the coroner grants an extension (Regulation 29(4) and (5)).
45. A response must detail the action taken or to be taken, whether in response to the report or otherwise, and the timetable for it, or it must explain why no action is proposed (Regulation 29(3)).

Copies

46. The coroner must send a copy of the report to the Chief Coroner and all interested persons who in the coroner's opinion should receive it (Regulation 28(4)(a)). Where the deceased is believed to be under 18, a copy must also be sent to the Local Safeguarding Children Board (Regulation 28(4)(b)).
47. The coroner must send a copy of any response to the Chief Coroner and all interested persons who in the coroner's opinion should receive it (Regulation 29(6)).
48. All copies should be sent to the Chief Coroner's office **electronically**, preferably in PDF format. This is important, since there are likely to be something in the region of 600 reports a year. Electronic submission will aid filing, processing, reviewing and publication. There is no need to send a hard copy. Copies will be retained in the first instance for a period of five years.
49. The coroner may also send a copy of the report and/or the response to 'any other person [other than interested persons] who the coroner believes may find it useful or of interest' (Regulations 28(4)(c) and 29(6)(c)). The coroner should consider requests for copies from other persons on a case by case basis. A blanket policy of only providing reports or responses to interested persons would be unlawful. Coroners should err on the side of openness unless there is a very good reason for restricting access to these documents.

Reports about deaths in custody

50. All reports and responses about deaths in prisons and other detention centres should as a matter of good practice be sent to HM Inspectorate of Prisons in all cases. The present Inspector has indicated that he would welcome this practice. They should also be sent to the National Offender Management Service and the Independent Advisory Panel on Deaths in Custody.

Other reports

51. Coroners should routinely send relevant reports to other organisations, such as the Department of Health, the Care Quality Commission, or the Department of Transport, so that wider lessons can be learnt.

Publication

52. The Chief Coroner may publish a report or a response, or part of one or in a redacted or summarised form (Regulations 28(5)(a) and 29(7)(a)).
53. A person or organisation giving a response to a report may make representations to the coroner about the release or publication of their response (Regulation 29(8)). Representations must be passed by the coroner to the Chief Coroner (Regulation 29(10)).
54. The Chief Coroner may also send a copy of a report or a response to any person the Chief Coroner believes may find it useful or of interest (Regulations 28(5)(b) and 29(7)(b)).

Making use of reports

55. In practice the Chief Coroner publishes on the coroner section of the public judiciary website as many reports as possible, subject to some limited redaction. As a matter of policy there is, subject to representations and exceptions (see paragraph 26 above), a presumption of publication.
56. It is implicit in the statutory framework that the Chief Coroner should have a role in taking some reports (and responses) further. Therefore from time to time the Chief Coroner makes an assessment of areas of concern, whether from single or multiple reports, and may advise action where appropriate. He may consult on areas of concern and where feasible recommend action, whether by way of advice to government or an organisation or individual or where necessary by recommending a change in the law. These recommendations may also be published.

**HH JUDGE PETER THORNTON QC
CHIEF CORONER**

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