CHIEF CORONER

REVISED GUIDANCE No.5

REPORTS TO PREVENT FUTURE DEATHS[1]

Introduction

1. Under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 Act, and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, where an investigation gives rise to concern that future deaths will occur, and the investigating coroner is of the opinion that action should be taken to reduce the risk of death, the coroner *must* make a report to the person the s/he believes may have the power to take such action. These prevention of future deaths reports are known as PFDs.

2. PFDs are vitally important if society is to learn from deaths. Coroners have a duty to decide how somebody came by their death. They also have a statutory duty (rather than simply a power), where appropriate, to report about deaths with a view to preventing future deaths. And a bereaved family wants to be able to say: 'His death was tragic and terrible, but at least it's less likely to happen to somebody else.' PFDs are not intended as a punishment; they are made for the benefit of the public.

3. The Chief Coroner is committed to learning from PFDs with a view to encouraging persons and organisations to make changes to try to prevent future deaths. All PFDs must be copied to the Chief Coroner's office, as well as to persons or organisations who in the coroner's opinion should receive them.

4. Broadly speaking, PFDs 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.

5. PFDs should not contain a detailed rehearsal of the facts of the death that has been the subject of investigation, or the history of the inquest. They are about learning. They should not contain personal information about the deceased, their family or others, that is unnecessary for the understanding of the learning points. An overview contained within a relatively short paragraph or two will usually be sufficient, followed by the specific points of concern.

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[1] As always, I am very grateful for the input of many coroners into this Guidance, especially Mary Hassell, Alison Mutch, Nadia Persaud and Graeme Irvine.

6. PFDs 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 PFD 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), but a PFD is not mandatory simply because an inquest is an Article 2 inquest.

7. In considering whether they are under a duty to make a PFD report, coroners should focus on the current position. This will normally be the position at the end of the inquest unless, unusually, consideration is being given to making a PFD report before the resumed inquest. Coroners should consider evidence and information about relevant changes made since the death or plans to implement such changes. If a potential PFD recipient has already implemented appropriate action to address the risk of future fatalities, the coroner may not need to need to make a report to that body. Whether a coroner needs to do so or not is a judicial decision for the coroner to make on a case by case basis taking into consideration all the circumstances. However, a report to a relevant national organisation to highlight the issues more widely may still be appropriate provided the evidence suggests that the risk of future fatalities may arise nationally and the coroner believes that national action should be taken. In other cases, action may not yet have been fully implemented by the potential PFD recipient, but such action may be ongoing, or the coroner may be told that a decision has been taken to take specific action in the near future. Occasionally, the need to take action may only have arisen from the evidence emerging at the inquest itself. Whether a PFD report is required in these cases will be highly fact sensitive, depending upon the circumstances of each individual case. Relevant factors may include the nature of the commitment to take action, any evidence in support of it, and the coroner’s assessment of the organisation’s understanding of, and commitment to addressing, the area of concern.

8. It is for the coroner to decide whether the duty arises in any particular instance, having considered the matter as a whole and heard representations if there are any. The coroner may be assisted by considering the potential recipient in the context of any other PFDs sent to that individual or organisation. The coroner is a local judge and is able to consider local trends.

9. This Guidance is not intended to cover every possible situation in which the duty to make a PFD may arise. It is for each coroner to decide on a case by case basis whether he or she has a statutory duty to report.

10. The template documents for making a PFD, as attached at annex A, should be used by coroners. For ease of use in the Chief Coroner’s office, the templates should not be amended or altered. If possible the template documents should be uploaded onto coroners’ systems so the basic information is populated automatically.

The coroner’s duty

11. 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. 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 PFD

12. It is a pre-condition to making a PFD 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 PFD

13. Normally, the PFD 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.

14. The concern may arise from 'anything revealed by the investigation', including the inquest. The wording of para.7 of Schedule 5 therefore permits a PFD 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, s/he 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

15. It was not the intention under the 2009 Act that inquests should be lengthened, or their scope widened for the purpose of hearing representations on PFDs. 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 Inquest (section 10 of the Act, Rule 34 and Schedule Form 2 of the Rules).

16. Coroners may hear and give weight to representations by interested persons at the inquest as they see fit. Sometimes the coroner may find it helpful to hear some evidence which may be relevant for the purpose of making a PFD, but not strictly relevant to the outcome of the inquest.

17. A medical witness could, where appropriate, enlarge on his or her earlier evidence while the jury is deliberating and, for example, talk about an action developed post death. When coroners take evidence relevant to PFD matters in the absence of the jury in this way, care must be exercised to ensure that such evidence is strictly limited to post-death improvements and changes, and does not include substantive evidence about the death being investigated. . All relevant evidence regarding the death should be heard in front of the jury, before the coroner sums up and directs on law. And adding to an inquest with lengthy additional evidence or conducting a separate lengthy additional hearing should be avoided. An inquest is an inquest, not a public inquiry.

The nature of the PFD

18. Where a coroner has a duty to report, the PFD must state the coroner's concerns and say that in the coroner's opinion action should be taken to prevent future deaths. The PFD must be sent to the person(s) or organisation(s) who the coroner believes has power to take such action (para.7(1)(c), Schedule 5 of the 2009 Act).

19. The PFD 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'. A report does not have to relate to a death in similar circumstances.

20. By way of illustration, say that in a suicide 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. That is acceptable.

21. A coroner may shed light on a system failure that has regional or even national implications. However, coroners should not be drawn into reporting about matters that have not been explored properly at inquest (or investigation). It is not a sufficient basis for a PFD simply because it occurs to the coroner or an interested person that a certain matter might benefit from consideration, if it has not been at all germane to the death under investigation.

22. Again by way of illustration, say the coroner hears evidence that an operation has resulted in death. The surgeon gives evidence at inquest that, as a result of this, there is now an addition to the sum of medical knowledge that could improve surgical outcomes in the future. Bringing this learning to trust, regional or national attention by way of a PFD may be entirely proper. However, if a witness mentions in passing that other discoveries have been made about different operations that have not been explored at inquest, the coroner should be circumspect about reporting on these.

23. Each PFD should be a carefully considered, professional document, bearing in mind that it is likely to be published in due course on the judiciary website.

24. Coroners should not include a confidentiality clause in a PFD. And it should not generally be necessary to send extraneous documents, such as the Record of Inquest or a recording, to the recipient, save for a narrative determination if one has been made. The report should be complete in itself.

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

25. 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 inquest or earlier during the investigation.

26. 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.

27. In some cases, the action to be taken following the coroner's concern will be obvious. But it is not for the coroner to dictate precisely what action should be taken. **A prevention of future deaths report raises issues and 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 [the predecessor to para 7, Schedule 5 of the 2009 Act] 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.)

28. 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.

29. PFDs 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.

30. 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) and are therefore unlawful and to no effect: see *R (Mowlem plc) v Avon Assistant Deputy Coroner* [2005] EWHC 1359 (Admin).

31. 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' have been used. They should not be used. Coroners should at all times use moderate, neutral, well-tempered language, befitting a judge. This applies to public hearings as well as correspondence and reports.

Action (box 6 of the template)

32. 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 28 above), but the coroner can highlight the area of concern and draw attention to it (see box 5 above), saying 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.

33. 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.

34. 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 the old 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.

35. 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.

36. 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.

Sending the PFD

37. 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, if that is possible.

38. 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 before inquest, when the matter of

concern is revealed and considered during the course of the investigation (see paragraph 15 above).

39. Once a PFD has been sent, the coroner has no power to withdraw it. The appropriate remedy for correcting any mistake of fact in the report is by responding to it, as provided for in paragraph 7(1), Schedule 5 of the Coroners and Justice Act 2009 Act, and as confirmed in *R (Siddiqui & Paeprer-Rohricht) v HM Assistant Coroner for East London* (28 September 2017) Admin Court CO/2892/2017.

Letter instead of report

40. Where an investigation (including inquest) gives rise to a concern that future deaths will occur, the coroner should make a PFD report. In exceptional circumstances, the duty to make a report does not arise, but the coroner nevertheless wishes to draw attention to a matter of concern. The usual reason that no duty to make a PFD arises is because the matter does not relate to a risk of future deaths. In these circumstances, the coroner may write a letter expressing the concern to the relevant person or organisation. This could be discussed with interested persons at inquest and the correspondence could be copied to them.

41. 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.

42. As with a PFD report, any letter must identify clearly the specific element of concern. Writing a letter instead of a report is an exceptional course of action. If the subject matter relates to the prevention of future deaths, writing a PFD report is the default position. The matter raised in the PFD does not have to have been causative of the death under investigation. If there has been a serious failure in, say, a trust's investigative process, this could have an impact upon the ability to learn from one death and so avoid other deaths, and may therefore be included within a PFD report.

The role of the jury

43. 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]. 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).

44. In the right case, the coroner has a discretion to leave to the jury, in addition to the direct or indirect causes or contributions to the death, facts that 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). However, this is a discretion not a duty, and in general it is better for the coroner alone to deal with PFD matters, unless he or she specifically

needs assistance from the jury on what occurred factually. Even if facts are disputed, that does not prevent the making of a report. A matter raised in the PFD does not have to be demonstrated to have been causative of the death under investigation.

Article 2 cases

45. 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 s/he intends to make: *Middleton*, [38].

46. In an Article 2 inquest the PFD 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), but a PFD is not mandatory simply because an inquest is an Article 2 inquest.

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

Format

47. When writing a PFD, 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 PFDs in letter format. Some examples of PFDs are included with this Guidance at Annex B to assist coroners with drafting.

48. The completed template form should then be sent to the responder(s) in electronic form.

Responses

49. A person or organisation must respond within 56 days, or longer if the coroner grants an extension (Regulation 29(4) and (5)).

50. 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)).

51. The responder should also use the template form, which the Chief Coroner's office has previously provided.

Copies

52. The coroner must send a copy of the report to the Chief Coroner and to 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)).

53. The coroner must send a copy of any response to the Chief Coroner and to all interested persons who in the coroner's opinion should receive it (Regulation 29(6)).

54. 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.

55. 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.

PFDs about deaths in custody

56. 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. They should also be sent to the HM Prison and Probation Service and to the Independent Advisory Panel on Deaths in Custody.

Other PFDs

57. Coroners should routinely send relevant PFDs to other organisations, such as the Department of Health and Social Care, the Health & Safety Investigation Branch, the Care Quality Commission, or the Department of Transport, so that wider lessons can be learnt.

Publication

58. 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)).

59. A person or organisation giving a response to a PFD 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)).

60. 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 PFDs

61. In practice the Chief Coroner publishes on the coroner section of the public judiciary website as many PFDs 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.

62. 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 MARK LUCRAFT QC
CHIEF CORONER

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