Section 16

REPORTS TO PREVENT FUTURE DEATHS

KEY MATERIALS

Legislation:

Coroners & Justice Act 2009: Paragraph 7 of Schedule 5

Coroners (Investigations) Regulations 2013: Regs 28 and 29

Chief Coroner's Guidance:

No. 5: Reports to Prevent Future Deaths

Other Materials:

Reports to Prevent Future Deaths Publication Policy, Chief Coroner, 9 November 2021

Reports to Prevent Future Deaths: Office of the Chief Coroner, Published Reports

Preventable Deaths Tracker

The Law

1. Coroners have a statutory duty, should the relevant pre-conditions be met, to make a report to those who can take action to prevent future deaths.

2. The duty to make a report to prevent future deaths (known variously as PFDs or PFD reports or Regulation 28 reports) was introduced in the 2009 Act[1] which elevated what was previously a discretionary power to become a statutory obligation.

3. The duty arises under paragraph 7 of Schedule 5 of the Act, which also places an obligation upon the recipient to reply within a specified time.

[1] In June 2013

4. Regulations 28 and 29 of the Coroners (Investigations) Regulations 2009 (the Investigation Regulations) provide detail as to the required process.

The extent of the obligation

5. PFD reports are, however, 'ancillary to the inquest procedure and not its mainspring'.[2] They arise where a coroner is investigating a death and a matter giving rise to a concern is revealed by that investigation. There is no statutory duty to seek out or gather evidence regarding wider matters that might potentially generate a PFD report. Nor was it the intention of the Act that inquests should be lengthened, or their scope widened, for the purpose of hearing evidence or representations regarding PFD reports.[3]

6. A coroner may choose to hear and give weight to representations by interested persons (IPs) about whether a PFD report should be issued. Such submissions may be helpful, but there is no obligation in law upon a Coroner to invite submissions before deciding whether their duty to issue a PFD report has arisen.[4]

7. The PFD reporting power serves an important public health function, however it is no part of the purpose of a PFD report to advance the interests of any person nor to express opprobrium for the shortcomings of others.

8. All PFD reports must be copied to the Chief Coroner's office and the Chief Coroner has set out a publication policy in relation to PFD reports. The reports can be found on the Courts and Tribunals Judiciary website here and are also searchable through the Preventable Deaths Tracker.[5]

The circumstances in which the duty arises

9. Where a coroner investigates a person's death and 'anything revealed by that investigation gives rise to a concern that circumstances creating a risk of other deaths will occur or continue to exist' then if, 'in the coroner's opinion, action should be taken to prevent the occurrence or

[2] *Re Kelly* (1996) 161 JP 417 and *Takoushis v HMC Inner North London* [2006] 1 WLR 461 at 469E
[3] Chief Coroner's Guidance 5 at para 15.
[4] *R(Gorani) v HM Assistant Coroner for Inner West London* [2022] EWHC 1680 (Admin) at §93-§97.
[5] A searchable resource provided by a team from the Universities of Oxford, Birmingham, and London.

continuation of those circumstances' or to reduce the risk of death created by them, a coroner must report the matter to a person or organisation who may have power to take such action.

10. That *anything* revealed by the investigation may trigger the duty means that a coroner is not confined to considering evidence given during an inquest hearing. The matter may have come to light during the earlier investigation. Further, whatever the concerning matter revealed may be, there is no requirement for it to have been a causative factor in the death of the subject of the inquest, or even give rise to a risk of death in similar circumstances to the index death.[6]

11. A coroner is under a duty to issue a PFD report ("must report") if both the statutory criteria are met. First, there must be a concern (arising from the investigation) that circumstances creating a risk of other deaths will occur or continue in the future; the phrase 'gives rise to a concern' suggests a relatively low threshold here. Second, the coroner must have formed the opinion that 'action should be taken' to prevent the occurrence or continuation of the circumstances creating a risk of death, or to reduce the risk of future deaths created by those circumstances.

12. There is a significant subjective element in relation to this second criterion. The Divisional Court have held that a coroner must act rationally in coming to the opinion held, but different coroners could reasonably come to opposite opinions on the same facts without either being wrong to do so. In other words, there is no single, objectively correct answer to the question raised by the second criterion in any particular case.[7]

13. The coroner is also entitled to consider what can practically be achieved before issuing a report and not to engage with 'ideal world' scenarios. It is open to a coroner to take into consideration whether there is any realistic prospect, including on resource grounds, that a PFD report will be acted upon by its recipient.[8]

Hearing evidence relevant to the duty under paragraph 7(1) of Schedule 5

[6] See as an example the PFD report issued after the Grenfell Tower fire, here, that among other matters raised concerns about the emotional trauma to survivors, the psychological wellbeing of those involved in the tragedy and their need for mental health support.
[7] *R(Dillon) v HM Assistant Coroner for Rutland and North Leicestershire* [2022] EWHC 3186 (KB) (Admin)
[8] See *Dillon* at §71-72

14. Once a concern has arisen on the part of the coroner that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future *and* in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, then issuing a PFD report is mandatory and so by that stage there should be no need to call additional evidence about the matter at the inquest. An inquest should not be extended unreasonably by calling lengthy additional evidence that only addresses potential PFD matters, and does not relate directly to the statutory questions to be answered under s.5 of the Act.

15. At a jury inquest all evidence that might touch on the circumstances of the death in any way should be heard in the presence of the jury. If any evidence is, unusually, heard in the jury's absence the coroner must ensure that it is strictly limited to post-death improvements and changes.

16. That the duty under paragraph 7(1) of Schedule 5 is triggered by "anything revealed by the investigation" means that it would be inappropriate to convene a separate hearing to consider evidence about PFD matters after the inquest (and hence the investigation) has ended and a conclusion has been returned.

Consideration before making a PFD report

17. Regulation 28(3) provides that a PFD report may not be made until a coroner has considered all the documents, evidence and information that, in the opinion of the coroner, are relevant to the investigation.

18. It is suggested that this does not mean a coroner must wait until the end of any inquest before making a report. A coroner may issue a report during an investigation and before the inquest concludes *if* sufficiently urgent to do so. However the coroner must consider all of the relevant documents, evidence and information that is available at the time of making the report and be of the view that there is unlikely to be further relevant material to come on the matter of concern.[9]

19. Ordinarily therefore, a PFD report will only be considered once all the inquest evidence has been heard. A coroner should only consider sending a PFD report at an earlier stage if the issue the PFD addresses is sufficiently urgent to justify early action. In such cases:

[9] See for example the PFD report issued after the Grenfell Tower fire as discussed here.

a. the particular matter is likely to be a narrow point or one capable of being readily discernible and considered in isolation from the wider issues that will properly be the central issues at a final inquest hearing; and
b. the coroner must comply with reg 28(3) and so have considered all available documents, evidence and information relevant to the particular matter of concern.

20. Where the identified risk to life has already been ameliorated by local changes the coroner may wish to consider whether the matter is an issue that only affects the relevant local organisation or is a wider or national issue. In the latter case then directing a report to a national, professional or regulatory body might enable them to also consider relevant changes that might protect lives.

21. It would be inappropriate to direct a PFD report to another coroner, a tribunal or members of the judiciary regarding any judicial decision, or for a coroner as part of the PFD report to pass comment upon any judicial decision that has been made.

Structure and content of PFD reports

22. The Chief Coroner has provided a template to be used when drafting either a pre-inquest, or more usually, a post-inquest PFD report.[10]

23. It is good practice to announce the intention to make a post-inquest PFD report in open court at the end of the inquest, although it is not a statutory requirement to do so.

24. Points that should be considered when writing a PFD report include: [11]
a. reports should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect;
b. the language used should be moderate and neutral;
c. they should not be unduly general in their content – sweeping generalisations are to be avoided;
d. they need not contain a detailed rehearsal of the facts about the death. An overview contained within a paragraph or two will usually be sufficient, followed by the specific points of concern. PFD reports are about learning, and often, but not always, the recipient will have attended, or been represented at, the inquest;

[10] See Appendix A of Guidance No.5
[11] Guidance no.5 also appends an completed template as an example here. Examples of PFD reports that have been issued (and the responses to them) can be found on the Courts and Tribunals Judiciary Website, here.

e. the report should be based on clear evidence at the inquest or on clear information during the investigation, and refer to that information or evidence clearly and simply;

f. in most cases there will be no need to send extraneous documents such as the Record of the Inquest or an inquest recording to the recipient. The report should be complete in itself;

g. the concern must be of a risk to *life* caused by present or future circumstances, and not any other type of risk;

h. the report should identify concerns and suggest action that needs to be taken, but it is not for the coroner to express a view about what that action should be. The report should not set out recommendations: the coroner's function is to identify points of concern, not to prescribe solutions;[12]

i. whilst it is permissible to propose reviews of specific aspects of procedures, protocols or training, coroners should not suggest what the outcomes of those reviews should be;

j. coroners should not make any other observations of any kind, however well intentioned, outside the scope of the report. Such expression of opinion is impermissible under section 5(3) of the 2009 Act;

k. the coroner must be of the view that action *should* be taken, hence where appropriate action has *already* been taken a PFD report will be otiose, serving no practical purpose. [13]

25. It is for this latter reason that it may be appropriate to give the likely recipient of a report the opportunity to provide the court with information about any relevant changes in systems or practice since the death before determining whether a PFD report is required. However, there is no requirement in law to give a likely recipient of a PFD report an opportunity to make representations before one is issued.[14]

Sending the PFD report

[12] See *In Re Clegg (deceased)* (1996) 161 JP 521 "the coroner should identify the specific area of concern, raise it, but then allow the person/organisation to provide the remedy."
[13] See *R(Dillon) v HM Assistant Coroner for Rutland and North Leicestershire* [2022] EWHC 3186 (KB) (Admin) at §62
[14] See *R(Dillon) v HM Assistant Coroner for Rutland and North Leicestershire* [2022] EWHC 3186 (KB) (Admin) at §43 and *R (Gorani) v HM Assistant Coroner for Inner West London* [2022] EWHC 1593 at §94 to §96.

26. There is no statutory period for sending out a PFD report, however, the Chief Coroner's guidance is that a PFD report should be sent out within 10 working days of the end of the inquest.[15]

27. 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.

28. There is no obligation to send a copy of the PFD report to all the IPs in an inquest. All that Reg 28(4)(a) mandates is that a copy of the report is sent to the Chief Coroner and every interested person who in the coroner's opinion should receive it. The coroner also has a general discretion to send a copy of the PFD report to 'any other person who the coroner believes may find it useful or of interest'.[16] The usual practice however is to copy the report to all those IPs who attended the inquest or who have indicated an interest in the inquest's outcome.

29. Reports and responses to them should be sent electronically to the Chief Coroner's Office in PDF format to chiefcoronersoffice@judiciary.uk

30. Under Reg 28(4)(b) where the coroner believes the deceased was aged under 18, a copy of the report must be sent to the appropriate Local Safeguarding Children Board.

31. The coroner should consider requests from other persons and the media for copies of PFD reports they have issued and any responses to them on a case by case basis. To have a blanket policy of only providing copies of reports and/or any responses to IPs alone would be unlawful. Coroners should generally share copies of their PFD reports with the media if requested in the interests of open justice. However, there must be a balance between openness, and the need to respect individuals' privacy and protect the public from harm. It may therefore be appropriate to redact some PFD reports and responses prior to sharing copies with others.

32. Most reports are now published by the Chief Coroner (pursuant to Reg 28(5)(a)) on the coroner section of the Courts and Tribunals Judiciary website (here), but the fact a report will ultimately be published there is unlikely to be good reason for refusing a media request for

[15] If there is not sufficient time to draft the report immediately after the inquest coroners may find it helpful to make brief notes for themselves of the key points for any report as soon as possible after the inquest hearing concludes.
[16] Reg 28(4)(c)

more prompt access to a copy of a PFD report directly from the coroner's office, particularly where the intention to make such a report has been announced in open court.

33. The Chief Coroner's publication policy (here) includes that the information set out below will usually be redacted from PFD reports and responses prior to publication, to remove information on how death can be caused, and to protect the privacy of individuals. Therefore Coroners should always consider whether it is necessary to include any of the information below in their initial PFD report. If the recipient could understand why the PFD report is being issued and the coroner's concerns without the following information then it should not be included in the initial report.

- Any names, initials and signatures of individuals, except for those of the deceased;
- Email addresses of individuals;
- Personal address details;
- Direct telephone numbers of individuals;
- Case reference numbers;
- Information that could help someone to cause a death, including:
  - the name of any products or substances that were used to cause a death,
  - information on how such products or substances were obtained;
  - the amount of any substance that caused a death;
  - websites that were used to plan a death;
  - the locations of suicide spots;
  - details of how any secure areas used for suicide were accessed.

34. So that wider lessons can be learnt, the Chief Coroner's guidance advises that:
    a. 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, HM Prison and Probation Service and to the Independent Advisory Panel on Deaths in Custody;
    b. Coroners should routinely send relevant PFDs to other organisations, such as the Department of Health and Social Care, the Health & Safety Investigation Branch, the CQC, or the Department of Transport.

c. Reports directed to NHS England should be sent to: England.Coronersr28@NHS.net

Response to a PFD report

35. The recipient of a PFD report must respond within 56 days[17] unless the coroner agrees to extend the response period.[18] There is no template for the response to a PFD report, however Reg. 29(3) specifies that the response must contain either (a) the details of any action that has been taken or which it is proposed will be taken and set out a timetable of the action taken or proposed to be taken or (b) an explanation as to why no action is proposed.

36. The coroner must in turn send a copy of any response to the Chief Coroner and to all interested persons who in the coroner's opinion should receive it.[19] Responses will normally be published on the Courts and Tribunals Judiciary website, however a person giving a response to a report may make written representations to the coroner about the release of the response or its publication.[20] From late 2024 a list with the details of all those departments and organisations who have not responded to PFD reports within the provided time limit will be published on Courts and Tribunals Judiciary website.

Requests to withdraw a PFD report

37. On occasions, the recipient of a PFD report will take exception to it and may request that it is withdrawn. This may be, for example, because of an error of fact that has led to the PFD report being issued in the first place. In other cases a challenge to a PFD report may be predicated upon a fundamental misconception of the proper purpose of a PFD report, which is to reduce ongoing risks to life.

38. Importantly, a PFD report is simply the vehicle by which a coroner brings a public safety concern to the attention of the recipient. It is not intended to be, nor should it be, framed in a way that appears disapproving or punitive in nature. It engages no civil or criminal right or obligation on the part of the recipient other than the obligation to reply in writing within 56 days.

39. There is no power to withdraw a PFD report once it has been served, even if a coroner recognises that a PFD report has been based on a misunderstanding. Rather, the appropriate

[17] Reg. 29(4)
[18] Reg. 29(5)
[19] Reg. 29(6)
[20] Reg. 29(8)

response is for a recipient who believes that a PFD report is not justified is simply to reply in accordance with Reg. 29(3)(b) stating why they will be taking no action in response to the stated concern.[21]

Where action has already been taken to reduce the risks to other lives.

40. It is common for the factual circumstances that existed at the time of a particular death to be much altered (and remedied) by the time a final inquest hearing takes place. Where the 'old' facts would have given rise to a concern that would have required a PFD report to be made but, given the action taken, the 'new' facts do not, the question may arise as to whether there is still a duty to make a PFD report.

41. Where the potential PFD recipient has already implemented appropriate action to address the risk of future fatalities it is difficult to see how a coroner could reasonably continue to have the concern that 'a risk of other deaths will occur, or will continue to exist, in the future' or how a coroner could be of the opinion that 'action should be taken to prevent occurrence or continuation of such circumstances'. In such cases the preconditions for making a report under sched 5 part 7(1)(b) and 7(1)(c) will not be met.

42. However, where some steps have been taken but these remain inadequate or incomplete, a PFD report may still be required. Alternatively, it may be that adequate steps have been taken at a local level but there is still a perceived need for wider learning. In this case a PFD report directed at a national body or even a government department may be appropriate.

Absent or inadequate reply to a PFD report

43. Schedule 5 part 7(2) and Reg 29(3) set out the mandatory requirements for a formal reply to a PFD report. The recipient must respond within 56 days setting out a timetable of the action taken or proposed to be taken, or give an explanation as to why no action is proposed.

44. Just as there is no power in the Regulations to withdraw a PFD report, there is no power authorising a coroner to take any steps if they receive an inadequate or vague reply. Once the PFD report has been sent out the coroner will have competed their functions in respect of that

[21] See *R (Dr Saddiqui and Dr Paeprer-Rohricht -v- Asst Coroner for East London* [2017] here as explained and discussed here

report and no longer has a mandate to take any further steps. Where no reply is received or an inadequate response is made a coroner would exceed their powers if they chased a missing reply or requested additional detail in respect of an inadequate response.

45. Where no reply is received, it will be consistent with keeping the bereaved at the heart of an investigation, to write and inform the bereaved (and all other recipients of the original PFD report) of the absence of a response and explain to them that the non-responder is now in breach of Reg 29(3) and Schedule 5 part 7(2), but as the inquest has concluded the coroner has no authority in law to take any further steps. In explaining the situation, the coroner should use neutral terms and not express irritation or frustration at the failure of a PFD recipient to comply with their legal obligation.

46. There is no reason why such a letter could not also be copied to the non-responder, which then might generate a delayed response from them.

47. Similarly, where an inadequate response is received, all that either a coroner, or the Chief Coroner, has the power to do is to send the inadequate reply to another person who may find it useful or of interest pursuant to regs 29(6) and (7). Where the reply has come from a local company or organisation, this could be to a national body or regulatory authority.

Letter instead of a PFD report

48. In exceptional circumstances, the duty to make a PFD report does not arise, but the coroner nevertheless wishes to draw someone's attention to a matter of concern. This will be the situation where the matter of concern does not impact on the risk of future deaths and so the duty to make a PFD report has not arisen. The Chief Coroner's guidance suggests that in these circumstances, the coroner might then write a letter bringing the matter to the attention of the relevant person or organisation.

49. As with a PFD report, any letter should identify the specific concern, but a coroner has no jurisdiction to make any suggestion about what could or should be done to address the concern. Writing such a letter instead is an exceptional course of action. Coroners adopting such a course should be very careful to respect the statutory prohibition on a coroner expressing an opinion about any matter other than those specified in s.5(1) of the Act.

50. If the subject matter relates to a risk of future deaths then writing a letter will not be appropriate and a PFD report should be made.