Powers, Purposes and Patterns of Coroners Prevention of Future Death Reports, a review of the past 12 months

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Whether your clients are NHS Trusts, Social Care Providers, Education Providers, Housing Associations, Police Services or individuals, the powers, purposes, and patterns of Coroners Prevention of Future Death Reports (PFDs) are likely to be of interest. In the past 12 months there have been a number of relevant cases and publications.

Powers to prepare PFDs

A Coroner's power to prepare a PFD report is set out in Paragraph 7(1) of Schedule 5 of the Coroners Act 2009, which states:

> *"(1) Where—"*
>
> *(a) a senior coroner has been conducting an investigation under this Part into a person's death,*
>
> *(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and*
>
> *(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,*
>
> *the coroner must report the matter to a person who the coroner believes may have power to take such action."*

The Chief Coroner's Revised Guidance No. 5 'Reports to Prevent Future Deaths'[1] at paragraph 2 states:

> *"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".*

Where the duty to make a PFD is engaged a coroner must state his or her concerns and say that in the coroner's opinion actions should be taken to prevent future deaths. The PFD must be sent to person(s) or organisation(s) who the coroner believes has power to take such action. The Coroner should not make recommendations or prescribe what action should be taken. PFDs are not restricted to matters causative of the death in question.

In June 2022, the High Court in ***R (on the application of Fatmire Gorani) v HM Coroner for Inner West London and others [2022] EWHC 1593 (QB)*** concluded that nothing in the wording of Schedule 5 imposes a requirement on a coroner to hear submissions from interested person before deciding whether or not the duty to report arises. Further the Court could see no grounds to imply such an obligation, or for rejecting Chief Coroner Guidance on the topic which in relation to PFDs states: "Coroners may hear and give weight to representations by interested persons at the inquest as they see fit".

In December 2022, ***Dillon v HM Assistant Coroner for Rutland and North Leicestershire*** **[2022] EWHC 3186 (KB) (Admin)** the High Court dismissed an application for judicial review of a coroner's decision refusing to make a PFD. The judgment considered that there is a significant subjective element to the criteria that the coroner should have formed the opinion that "action should be taken" and considered that the coroner was entitled to conclude that the threshold for a PFD report was not meet.

Dillion was referred to by the Chief Coroner, in March 2023 at the **Death in Custody Symposium**, where His Honour Judge Teague KC stated:

> *"It is important to remember that although the provision is now a mandatory one, so that we can correctly speak of a duty, rather than a mere power, to issue such a report, the statutory criteria giving rise to the duty are not quite as sharply defined as we might be tempted to assume. In particular, the duty only arises where "**in the coroner's opinion**" action should be taken. That necessarily imports a subjective element the coroner's*

[1] https://www.judiciary.uk/wp-content/uploads/2020/11/GUIDANCE-No.-5-REPORTS-TO-PREVENT-FUTURE-DEATHS-1.pdf

opinion – into the process. In the recent case of Dillon v HM Assistant Coroner for Rutland and North Leicestershire, the High Court stated that:

"The 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."***[2]

The Chief Coroner continued:

"It follows that the statutory duty to make a prevention of future deaths report may arise in one case and yet not do so in another, even where the underlying facts are completely indistinguishable.

The speech, while not undermining the importance of PFDs stressed the need to recognise their limitation, which include:

"…although there is an obligation to respond to a report within 56 days, coroners have no role in supervising what action may have been taken. If you think about it this is sensible on two fronts: first the report is a recommendation action should be taken but not what that action should be – therefore it would be inconsistent with that limitation if coroners were then required to follow-up. Secondly the coroner has only seen the evidence in the inquest' he or she is not a subject matter expert. In short coroners are not regulators- they are judges- and should not be confused with them".

Purpose of PFDs

The Chief Coroner's at paragraph 2 states:

"PFDs are vitally important if society is to learn from deaths…..a bereaved family wants to be able to say 'His death was tragic and terrible, but at least it is less likely to happen to somebody else' PFDs are not intended as a punishment; they are made for the benefit of the public".

At paragraph 4 the Chief Coroner's Guidance continues:

"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".

[2] https://www.judiciary.uk/wp-content/uploads/2023/03/Death-In-Custody-speech.pdf

In *Dillion* the High Court endorsed the Chief Coroner's Guidance that PFDs should be meaningful and designed to have practical effect.

In short, the purpose of PFDs is where necessary to promote and encourage, practical and meaningful, local and national change, with the aim of preventing future deaths.

Patterns

PFDs are published, however, without more patterns, locally or nationally, or in relation to the cause of death, or in respect of recipients, or in respect of the nature of concerns, are not easily identifiable.

In May 2022, for the first time, the **Coroners statistics**, included the number of PFDs issued by Coroners[3]. The annual statistics set out that in 2021 440 PFDs were issued. These statistics demonstrated that in 2021 all coroners regions issued PFDs, with the North West region at 86 issuing the most (it also had the highest number of inquest conclusions) and Wales at 16 issuing the fewest. In 2021, 29 coroner areas issued no PFDs.

Another first for the Office for National Statistics (ONS) and PFD reports was the publication on 29th March 2023 of '**Prevention of Future Death Reports for Suicide submitted to Coroners in England and Wales'**[4]. The aim of the publication was to identify themes from concerns raised in PFD reports that may inform future research or policies for suicide prevention and it is hoped that the analysis will provide valuable insight for those concerned with suicide prevention.

- 164 reports were available to the ONS from the period considered, in which 485 concerns were recorded, an average of 3 concerns per report. Common themes included: Processes followed (54% of reports) with sub themes including: inadequate monitoring and documenting.
- Assessment and clinical judgment (34% of reports).
- Communication (34% of reports).
- Policy (27% of reports) with sub themes including: no policy in place, inadequate policy, with these including both organisational and national policy.

[3] https://www.gov.uk/government/statistics/coroners-statistics-2021/coroners-statistics-2021-england-and-wales
[4]https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/preventionoffuturedeathreportsforsuicidesubmittedtocoronersinenglandandwales/january2021tooctober2022#:~:text=A%20total%20of%20164%20PFD,England%20and%20Wales%20each%20year

- Access to services (32% of reports), with sub themes including: delays in accessing services, inadequate staffing, services not being appropriate.
- Improvements not being implemented (20% of reports).
- Training (18% of reports).
- Products (15% of reports) with sub themes including: access to medical products, access to harmful internet and social media content.
- Culture (15% of reports) with inadequate staffing and/or way of working being the most common sub theme.
- Care plans (15% of reports).
- The NHS (health boards, trust, clinical commissioning groups, primary care services, health and care partnerships and ambulance services) were the most frequent recipient of these PFD reports (42% of all reports), followed by government departments.

At the Death in Custody Symposium, HHJ Teague KC recognised more needs to be done to exploit the valuable information contained in PFDs as efficiently as possible. This includes more work to make them as accessible as possible, including making targeted online searching easier. HHJ Teague KC also stated that in 2023 he intends to begin issuing the first in a series of bulletins highlighting thematic learning points.

It is hoped that this time next year we will be able to report on issues identified within the Chief Coroner's proposed PFDs bulletins.

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