

June 2019

briefing

Preventing future deaths - matter of common sense and good governance for organisations

Introduction

When a death occurs it is more important than ever to identify risks that might cause deaths in the future and make sure you take action immediately. This briefing looks at the duty on Coroners for reports on matters relating to the prevention of future deaths (PFD).

There is no doubt that the inquest hearing is becoming the common public forum where the deficiencies of organisations (and actions taken and changes made as a result) are subject to public scrutiny.

It is more important than ever to prepare for the inquest hearing and get your action plan and evidence spot on.

PFD reports

One job of the Coroner is to identify future risks and write reports where he or she feels action might need to be taken to prevent future deaths.

The Coroner must report the circumstances of a death to a person they believe may have the power to take action to prevent future deaths.

In short, it is a system prompting rapid action to put things right after a death and at the same time promoting openness and public confidence in safety as a key issue.

The main provision is in Part 7 of Schedule 5 of the Coroners and Justice Act 2009. They are known as "Reports on Action to Prevent Future Deaths" or "PFD" reports for short. Further provision about PFD reports is set out in The Coroners (Investigations) Regulations 2013 at Regulations 28 and 29.

The Coroner does not have to wait until hearing the evidence in court to issue a report. He or she can make a report at any stage during the investigation, which could be before the inquest takes place, provided he or she has considered all the documents, evidence and information relevant to the investigation.

The person in receipt of a PFD report must respond within 56 days. They must detail any action that has been taken, or which they propose to take, although it is possible that no action may be required if, for example, changes have already taken place. Now you also have to set out a timetable for the proposed action or an explanation as to why no action is proposed.

The report and the response will be sent to:

- 1 Any interested persons who in the Coroner's opinion should receive it.
- 2 Anyone else who the Coroner considers may find it useful or of interest.
- 3 The Chief Coroner (who publishes all PFD reports).

The Coroner is also obliged to send a copy of the report to the appropriate Local Safeguarding Children Board if the deceased was under 18. Following the recommendations of the Robert Francis QC report, these reports are sent to the CQC if they involve health and care providers.

It's a serious business: the Chief Coroner has issued guidance

As part of the Chief Coroner's brief to bring greater consistency to coronial practice across England and Wales, he has now issued guidance to Coroners and one of the first papers is on PFD reports – [guidance No. 5](#).

Anyone involved in managing inquests should take a look.

The Chief Coroner is committed to best use and value from PFD reports with a view to encouraging changes that may prevent future deaths. He will publicise as many as possible on the Coroner section of the public judiciary website. There will be a presumption in favour of publication, subject to representations and exceptions. He will make an assessment of areas of concern and advise on action, where appropriate. He will consult on areas of concern and, where feasible, recommend action whether by way of advice to the Government or an organisation or individual or, where necessary, by recommending a change in the law (which may also be published). Themes and issues are likely to be drawn out to promote safety and necessary change. The stated intention is to use the reports to improve public health and safety and they will now be much more public.

The guidance states reports should not be unduly general in their content but they should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect. The report should identify the concern or problem, it is not for the Coroner to identify particular actions required.

Ancillary business?

Interestingly, the Chief Coroner suggests in the guidance that PFD reports are "ancillary" to the main inquest procedure and, on careful thought, that must be the right approach to adopt. 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 that is to determine the statutory questions, findings and conclusions relating to the death.

The Chief Coroner says that adding to an inquest with lengthy additional evidence should be avoided. A PFD report does not need to be restricted to matters causative (or potentially causative) of the death in question.

PFD reports should be a recommendation that action should be taken, not a recommendation of what that action should be. Coroners should not make any other observations of any kind outside the scope of the report and only moderate, neutral, well-tempered language, befitting the holder of a judicial office, should be used. It should not become a method of expressing censure or disapproval.

This is, of course, only guidance, but the number of PFD reports is increasing.

What will be the impact for you?

Risks need to be identified following an unexpected death; action put in place and evidence prepared to satisfy the Coroner and offer public assurance. PFD reports are harder to avoid, despite action taken. That may assist in terms of the collection of national statistics and identification of themes nationally. While some Coroners appear to be adopting this approach, and feel inclined to write a report irrespective of actions already taken, we take the view that if action has already been identified and taken then the duty to report is not triggered. It is still the case that PFD reports should not be seen as a method to censure an organisation. While such reports are more common, if they are overused there is surely an argument to say that their value will become diminished.

If the Coroner identifies an issue that causes concern and, at the time of the inquest (or at any point during the investigation), action has not yet been taken by the organisation concerned to properly deal with it, a Coroner will consider that the duty to make a report is triggered. You could face these reports with little chance of negotiation or discussion.

Historically, many Coroners were satisfied and assured by representations made at the inquest that action will be taken, or is being taken, to address any outstanding concerns. That is no longer likely to be sufficient. In future, we need robust action and timetables to ensure investigations are completed promptly and properly in a timely manner. Your evidence on actions taken to prevent a future death (or risk) needs to be clear and unambiguous and supported by those staff working on the ground. Time frames to complete actions recommended must be strictly adhered to but without compromising on the thoroughness and quality of the action taken (which must, of course, be the priority).

In some cases, it may not be possible to ensure all the actions are completed prior to the inquest and, of course, if implementation has been rushed, the Coroner may not be convinced that an issue has been adequately addressed in any event.

Conclusion

Finally, to emphasise one point (and perhaps on a more positive note): PFD reports are seen as ancillary and not the main purpose of the inquest. Though it is an important part of the coronial function, it is not, nor has it become, an end in itself. A Coroner should not be permitted to make wide ranging and extensive inquiries simply “looking” for issues and concerns. That, in our view, would not be consistent with the power granted by the legislation and guidance set down by the Chief Coroner.

A balance has to be achieved between public safety and assurance and identifying only those important issues that warrant action. It should not become a method to criticise or judge organisations. That is in nobody's interests.

Training and advice

If you would like further advice on the management of the risk of receiving a PFD report, or any other assistance with the inquest process, please do not hesitate to get in touch.

The training and experience of staff has never been more important both in managing inquests and handling investigations and putting action plans into practice. We can run sessions for your team, bespoke to your organisation's needs. Get in touch with us and we can talk about what would work best for you.

Legislation

[Coroners and Justice Act 2009](#)

[Coroners \(Inquests\) Rules 2013](#)

Guidance

[Chief Coroner's guidance - No.5: reports to prevent future deaths](#)

Useful links

[Courts and Tribunal Judiciary website: Chief Coroner](#)

Mills & Reeve on-line inquest support

You will find this guidance and a lot more information and guidance documents on our free on-line support page.

There is also a set of videos with top tips on what to do and others tell their stories of who they got through the process. All designed to make it a little bit easier for you.

Follow the link or type in:

<https://www.mills-reeve.com/foresight/inquests/information-on-inquests>

Recent Feedback

“ I’m most grateful for your support during the Inquest. It was outstanding. ”

Executive Director Forensic Services, NHS Client

“I feel genuinely privileged to know that you are on our team and offer my heartfelt thanks”

Dr Stephen Merron, Consultant Anaesthetist, University Hospital North Midlands NHS Trust

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