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Briefing: Preventing future deaths

Matters 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.

At inquests, the deficiencies of organisations (and actions taken and changes made as a result) can be subject to public scrutiny. It is crucial to prepare for the inquest hearing and ensure your action plan and evidence is robust.

PFD reports

One role of the Coroner is to identify future risks and write reports where they feel action should be taken to prevent or reduce the risk of future deaths. These are known as 'Reports to Prevent Future Deaths', 'PFD Reports' or 'Regulation 28 Reports'.

The Coroner must report the circumstances to a person they believe may have the power to take such action.

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 for PFD Reports is in Part 7 of Schedule 5 of the Coroners and Justice Act 2009, with further provision set out in The Coroners (Investigations) Regulations 2013 at Regulations 28 and 29.

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

There is no statutory period for sending a PFD Report, but the Chief Coroner considers this should usually be done within 10 working days of the end of an inquest.

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. The response should include a timetable for the proposed action or an explanation as to why no action is proposed. A template published by the Chief Coroner can be accessed here.

The PFD Report and the response will be sent to:

- Any interested persons who in the Coroner's opinion should receive it.

- Anyone else who the Coroner considers may find it useful or of interest.
- The Chief Coroner (who publishes PFD Reports; please see below).

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 Francis Report, PFD Reports should be sent to the CQC if they involve health and care providers.

Publication

A policy setting out the Chief Coroner's approach to the publication of PFD Reports and responses was issued in 2026, and can be accessed here.

The guidance confirms that *'to comply with the principle of open justice, the public must be able to access PFD reports and responses, unless there is a compelling reason to restrict access. The scrutiny of PFD reports and responses is also vitally important to society, to enable themes to be recognised, any necessary systemic changes to be put in place, and any promises of change to be enforced'*.

There is a presumption that PFD Reports and responses will be published by the Chief Coroner.

Ancillary business?

In the Chief Coroner's Guidance for Coroners on the Bench, it is noted that the duty relating to PFD Reports 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 confirms that Coroners should be cautious of requests to widen the scope of an inquest to obtain evidence unrelated to the death in question, just because it may provide a foundation for a PFD Report.

PFD Reports should be a recommendation that action shou6ld 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 and neutral language should be used. It should not become a method of expressing censure or disapproval.

What will be the impact for you?

Risks need to be identified following an unexpected death. Action should be put in place and evidence prepared to satisfy the Coroner and offer public assurance. The Coroner must be of the view that action should be taken in order to issue a PFD Report, and so where appropriate action has already been taken, a PFD Report will serve no practical purpose.

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 issue a PFD Report is triggered. To reduce the risk of facing this with little chance of negotiation or discussion, it is crucial that organisations ensure they have implemented robust action and timetables to ensure investigations are completed promptly and properly.

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. Timeframes 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.

An organisational learning statement may be helpful in setting out the action taken, or planned, by your organisation.

Conclusion

It should be emphasised that PFD Reports are seen as ancillary and not the main purpose of the inquest. Although they are an important part of the Coronial function, a PFD Report is not 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 in managing inquests, handling investigations and putting action plans into practice. We can run sessions for your team, bespoke to your organisation's needs. Please get in touch, and we can talk about what would work best for you

Legislation

Coroners and Justice Act 2009
The Coroners (Inquests) Rules 2013
The Coroners (Investigations) Regulations 2013

Guidance

Chief Coroner's Guidance on Reports to Prevent Future Deaths

Useful links

Courts and Tribunal Judiciary website: Chief Coroner
Template Response to a Report to Prevent Future Deaths
Chief Coroner's Publication Policy

Mills & Reeve inquest support

Visit our inquest support webpage for guidance and short videos to help you prepare for and navigate the coronial process.
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