9 September 2024

Shared Insights

Insights from the Chief Coroner of England and Wales

Panel of speakers

Nicola Evans, Partner, Browne Jacobson LLP
Her Honour Judge Alexia Durran, Chief Coroner of England and Wales

Browne Jacobson

Introduction

We were delighted to be joined for this Shared Insights session by HHJ Alexia Durran, the Chief Coroner. HHJ Durran provided a comprehensive overview of the current state and future direction of coronial work in the UK. With a distinguished background as a criminal barrister and Senior Circuit Judge, HHJ Durran shared her journey into the role of Chief Coroner, an overview of the inquest process (from the point of death to conclusion of the inquest) and her insights on the significant reforms and modernisation efforts underway in the coronial system.

Contents

Key topics covered in the session included:

- The New Death Certification System
- Modernisation of the Referral System
- Post-Mortem Examination Innovations
- Inquest Process
- Prevention of Future Deaths Reports (PFDs)

HHJ Durran has very kindly allowed us to publish her speech within this note.

How we can help

Inquest Team

Our specialist Inquest team provides expert legal advice and representation to organisations across the public and private sector including health, care and many other organisations. Please do not hesitate to contact us if we can assist with any inquest matters or support you with training.

Mock Inquest

Our market leading Mock Inquest training course provides essential knowledge and tools delivered by a range of legal experts. It includes lectures and mock inquest scenarios involving an experienced Medical Examiner and five experienced Coroners from different jurisdictions who share their insights throughout the course.

The course covers the inquest process from start to finish and provides practical advice and guidance on reporting deaths and certification, writing reports for the Coroner and giving oral evidence in court or remotely. It includes several mock in-person inquests and a mock remote inquest hearing to provide a realistic experience from opening to conclusion and aims to introduce delegates to best practice when dealing with inquest hearings.

It also considers the wider impact of an inquest for the organisations and staff involved, looking at media coverage, compensation claims, disciplinary and professional implications. See Mock Inquest Course details and register your place here Mock inquest training | Browne Jacobson.

Inquest Guides

We have also produced the following inquest guides which are free to access and share with colleagues:

Guide to coroners' inquest process for witnesses.

Guide to writing coroner's inquest statements.

Guide to preparing evidence of organisational learning to the Coroner

There are other free resources available on Browne Jacobson's Inquest page which you can access here.

Nicola Evans
Partner

+44 (0)330 045 2962
nicola.evans@brownejacobson.com

The Chief Coroner's Note

HHJ Alexia Durran
Chief Coroner of England and Wales

Can I begin by thanking you for inviting me to join you today to talk about my insights into the inquest process. I have seen the list of delegates and there is a very wide ranging audience today. Some of you are lawyers and will have a considerable understanding of the inquest process. Others of you are medical and healthcare professionals, some of you are social workers and others work for bereavement organisations. I hope there will be something for everyone in this talk. I am sorry in advance if there is not.

I would like to begin if I may with something of an introduction to those who don't know me.

I was a criminal barrister for 19 years. I prosecuted and defended. For the majority of my career, I handled cases of serious sexual abuse, child cruelty and homicide.

I was made a Recorder (part time judge) in 2009 and became a full time judge in 2014. I have sat at a number of crown courts – Kingston, Reading and Guildford before being appointed to the Central Criminal Court, better known as the Old Bailey in 2021. As a judge at the CCC I am a senior circuit judge.

As well as being a criminal judge I have sat as a first tier tribunal Judge in the mental health jurisdiction. I applied to sit in that jurisdiction in order to better understand mental illness and also so that when I impose a hospital order, with or without restriction, I would have a better understanding of what that really meant in comparison to a prison sentence. Sitting as a tribunal judge involved the tribunal visiting psychiatric hospitals in order to determine if the criteria to detain an individual had been satisfied. The tribunal would be provided with reports from the responsible clinician, nursing staff and from a social worker. I was often surprised by how anxious responsible clinicians were about having their evidence tested by another psychiatrist.

In 2019 I was appointed as one of the first two Deputy Chief Coroners. At the time of my appointment I knew nothing of coronial work.

I was reassured by the then Chief Coroner Mark Lucraft KC that this was no impediment. He too had had no experience of coronial work before he took up office. It is fair to say he had a baptism of fire when he had London Bridge, Westminster Bridge, Fishmongers Hall, Grenfell and Manchester Arena all occur during his tenure. He did not of course undertake all of those inquests or inquiries but he learnt very rapidly on the job. I undertook my first inquest during covid times which proved practically challenging. I supported both Judge Mark Lucraft KC and Judge Thomas Teague KC during their terms as Chief Coroner. Including attending the Justice Select Committee investigation into the Coroner service and their subsequent review.

I have also helped draft guidance for coroners and have been leading the writing and editorial team of the Bench book – again more about that later.

In my role as a Deputy Chief Coroner I undertook training with the College of Policing in relation to Disaster Victim Identification. This has enabled me to lead decision making in a number of events where there were international fatalities such as the Easter 2019 Sri Lanka bombings and the British deaths in Israel and Ukraine in the last year. Only last week with my Deputy Chief Coroner we attended a conference with the NATO Joint Health Group on "Preparedness and management of the Dead in Catastrophic Emergencies." This conference was attended by 20 countries with military and health care officials in attendance.

My other main responsibilities as a Deputy have been making decisions on requests to start investigations where the concerns about a death have arisen post cremation (more about this in a moment) and resolving disputes between coroners as to who should investigate a death where for example a death occurs in one coroner area but it is said that the causal reasons for the death occurred in a different jurisdiction.

I have also been involved in all recruitment exercises for assistant, area and senior coroners since 2019.

I should say that the future of the coroner service is in safe hands if the calibre of the candidates seeking appointment is anything to go by.

I became Chief Coroner on the 25th May of this year. Having been a Deputy Chief Coroner for five years I thought I had a pretty good idea of all the work the office undertook. I have discovered in the last few months that there is a lot more than I knew going on. I am doing my second inquest in the new year.

So insights into inquests.

Firstly before an inquest can ever happen there needs to be a referral to a coroner about a death.

As many of you will be aware I am sure today is a very exciting and important day. It is not that I am talking to you. It is the fact that a new system of death certification and registration commences today. I know from the list of delegates I have a number of medical examiners who have registered for this talk.

Death Certification reform

This has been a long time in its implementation, as it was anticipated back in the Coroners and Justice Act 2009.

The implementation of the scheme, and the related rationalisation of the death certification system, affects coroners' responsibilities and ways of working.

The principle underlying the scheme is that where a death is natural and did not occur in custody or state detention, scrutiny should be provided by the medical examiner, and where s1 Coroners and Justice Act 2009 (CJA 2009)* is engaged, scrutiny should be provided by the Coroner. There is therefore a clear delineation between medical and judicial certification of death.

S1 Coroners and Justice Act 2009 provides that

Duty to investigate certain deaths

(1) A senior coroner who is made aware that the body of a deceased person is within that coroner's area must as soon as practicable conduct an investigation into the person's death if subsection (2) applies.

(2) This subsection applies if the coroner has reason to suspect that—

(a) the deceased died a violent or unnatural death,

(b) the cause of death is unknown, or

(c) the deceased died while in custody or otherwise in state detention.

It is obviously far too soon to say if the scheme will meet the intended principles. A very large amount of work has been undertaken by different bodies. There has been close collaboration between the National Medical Examiner, The Chief Coroner, Government Registry office, Ministry of Justice, Ministry of Health and Social Care to name but a few. Guidance notes will be published by all relevant bodies. My guidance note number 47 is published today – although it has of course been circulated for a little time with coroners so that they have been able to prepare. One of your number invited me in a question to provide my thoughts on the pitfalls of this new scheme. I am not I am afraid going to on the launch day provide the Chief Coroner's views of where there may be gaps or problems in this scheme. That would be wrong. We should be positive that the new scheme will work. There may be issues in relation to some aspects that will surprise us as we have not foreseen them but I am confident that the scheme will work.

There have been concerns expressed by some that the change in certification by an attending practitioner in life (which means simply any doctor who has seen the deceased at some point in their life – so could be age 13 for a broken toe for a person who dies age 65) rather than someone who has seen the deceased in 14 or even 28 days before death. We will have to see whether it leads to any increase in cases that are referred to a coroner because it is not possible to ascertain the cause of death.

It is believed that the new system should lead to fewer cases being referred to a coroner as in effect there will be a larger number of cases being handled by the attending practitioner and medical examiner. That should result in fewer inquests.

The new scheme is likely to mean that aside from violent deaths only cases where there are more complex issues will be referred to a coroner. In other words cases where the deaths may be unnatural due to other interventions or omissions.

This is already happening to a degree. I referred earlier to my handling of requests to open an inquest where there is no body remaining in the jurisdiction of the coroner.

These are typically cases where a natural cause of death has been ascribed but only after cremation have issues arisen as to concerns as to care or medication. Very often these cases have come to light following a hospital review or where the family have raised concerns with a hospital medical examiner.

So the medical examiner scheme is likely to mean that although there are fewer inquests they are likely to be more complex.

So before a case is ever referred to a coroner a decision must be taken whether the case needs to be referred to a coroner at all. There is now a clear, my words, "filtering system" of scrutiny by a medical examiner of a death before it is referred to a coroner.

Most cases will come to the coroner by referral by the local medical examiner. If it is clearly a violent death then the police will be the referral mechanism.

How does the referral happen? It could a be telephone call, fax, email or via a digital portal system. Unlike the criminal jurisdiction which has a single portal for the sending of cases known as the common platform, coroner mostly use one of two digital systems known as Civica or WPC. There are a few areas which use older systems or even paper referrals. One of my jobs is to continue the efforts to modernise the coroner system and I have my sights on universal portal referral. This makes good sense.

Coroners work within police areas and some have coroner officers supplied by the police. In the London area there are 7 coroner areas who are all served by one police force, the Metropolitan police service. They currently operate different referral systems. I am working on trying to develop a consistent approach so a police officer called to a suspicious death does not need to remember which coroner area the death is in and how therefore it should be reported. In other words trying to reduce postcode differences on referrals.

One of you asked a question about who is authorised to make a referral via a portal for a neonatal death.

The Notification of Deaths Regulations 2019 refer to a registered medical practitioner and the Guidance says "A registered medical practitioner means a person on the General Medical Council's list of Registered Medical Practitioners, who has a licence to practise. It is anticipated that in practice, where available, it will be the practitioner who is qualified to complete the medical certificate cause of death (MCCD) who will be making the notification to the Senior Coroner" The Coroner covering the questioner's area may have said it has to be a doctor referring not the midwife. However anyone may refer a death to the Coroner but not all will have access to the portal (for security).

There may however be cases where deaths are expected that will be referred to the coroner prior to death. How does this happen? Are coroners and medical practitioners clairvoyant?

No. Obviously there are some cases where life is being sustained only by medical intervention. In these cases there may be discussion about organ donation. Here the coroner may play an important role in deciding the nature of any investigation into a death. Is the cause of death clear? If it is and there is no need for a post-mortem examination then the coroner can indicate that that organ donation can take place. Sometimes however a coroner will not be content about a cause of death and therefore require a post-mortem examination in those cases the coroner may be able to allow limited organ donation or none at all.

My position is that coroners should support where they can organ donation both by making timely decisions and carefully considering a cause of death and the need for any invasive post mortem examination. Please see CCG No 26.

While I am on the topic of post mortem examination can I mention two important developments.

Firstly there is guidance about post mortem examination (CCG No 32)). I encourage you to read it if you want to know about (i) the importance of non-invasive post-mortem examinations – undertaken by scanning and (ii) the need or circumstances in which there should be a second post mortem examination.

The development of scanning technology is being increasingly deployed in identifying a cause of death. My predecessors and I have all encouraged the use of scanning technology in avoiding invasive post-mortem examination.

There are a variety of cogent reasons to do this (i) it assists with timely management of faith deaths, (ii) cost in a number of respects and (iii) timeliness.

The average time for post-mortem examination is over 4 weeks. If a cause of death can be identified by scanning this can rapidly reduce the time in which a body might be released to a family.

If you want to see some examples of where scanning can provide quick identification of a cause of death then please view Cause of Death on Channel 5. The series is based in the Lancashire and Darwin jurisdiction and most episodes involve the use of scanning. Sometimes a scan will not produce a definitive cause but it may help focus the areas of an invasive post mortem examination and that in itself may help prevent unnecessary distress to a bereaved family.

There are now a number of areas where coroners have the facility to use scanning equipment either in or out of hours hospital settings such as Newcastle/Tyneside and Sunderland who through a procurement exercise with their local authority secured an agreement to use scanning equipment at the Royal Victoria Hospital in Newcastle. Or on-site scanning at Sheffield through their medico legal centre or North London Coroner's court in Walthamstow who have a new forensic centre next to their coroner's offices.

I attended the opening of the Walthamstow forensic unit and heard persuasive speeches from the Chief Rabbi and from Mohammed Omer from the Muslim Burial Council about the importance of scanning to faith communities.

The second important and perhaps more recent development in relation to post-mortem examination is a soon to be issued protocol that has been produced in co-operation between the Chief Coroner's office and the President of the Family Division of the High Court.

This protocol sets out each jurisdiction's roles and responsibilities in relation to the sharing of information from post mortem examinations. I am conscious that some of the social workers who have joined this presentation will understand the importance of timely decision making in the family jurisdiction in child deaths where there are surviving siblings. We hope this protocol will promote better understanding between our two jurisdictions.

It also I hope properly highlights the important role that post mortem examinations can play and how important our colleagues in the world of pathology are. I will return towards the end of my presentation with some further brief observations about pathology provision.

So far we have looked at death management in as far as how cases may come to the coroner. Do they come from the Medical Examiner or the Police? The technology that may be deployed and some early decision making.

So what happens when a case comes to the coroner?

The fact a case is referred to the coroner does not of course mean that there will be an inquest. Many cases are sent to the coroner that subsequently do not require an inquest to be heard. Often a case is sent because the cause of death is not known at the time of the referral – you will recall this is one of the s1 categories of referral.

Often a post mortem examination will provide a natural cause of death which means there is no need for any further coronial involvement. A cause of death can be given, a death certificate produced and a death can be registered. In effect the case is discontinued as there is no need for any further investigation.

Another example of a referral to a coroner that may not result in an inquest is a homicide where there is a criminal case. In such a case an inquest will be opened and adjourned pending the outcome of the criminal case. If the criminal case addresses everything that an inquest would, then the inquest is not resumed by the calling of evidence, the conclusion of unlawful killing determined in the criminal court would form part of the record of inquest without further evidence. That is the usual position.

To give you an example where that did not happen were the Steven Port killings in East London. There were inquests at the time when suicide was believed by the police to be the correct conclusion. Subsequently through the determination of the families of the bereaved a detailed police investigation commenced resulting in a murder trial against Mr Port but the police failures did not form part of that criminal trial as part of any determination as to why the later victims of Mr Port died.

There were following the criminal trial new inquests held for all the victims at the same time that explored police failures, something that was important in understanding and preventing future deaths.

So some cases sent to a coroner do not result in an inquest. What about those that do go to an inquest?

What is an inquest?

Apologies at this time to those experienced in coronial law. With such a wide audience I have to deal with some basic principles.

An inquest is to answer four questions. Who died? When did they die? Where did they die? And how did they die? Very often the first three questions do not present any difficulties and the focus of the inquest is how did someone die.

There are still some inquests where the focus will be who died. There are a number of cases every year, often involving street sleepers where the identity of someone is not clearly ascertainable. In those cases the issue at an inquest might well be who it is that died on a street at a certain time from hypothermia or a stroke.

How did they die?

This is often the question that requires the most evidence. If the death engages issues relating to Article 2 of the Human Rights Act then the question will be "in what circumstances" a person died. I do not have time today to speak on the topic of Article 2 inquests. I hope for today's purposes it is sufficient to know that where the deceased was in state detention or the state may have played some role in a person's death there is a wider duty of investigation.

The issue often in an inquest where the focus is how did someone die is the scope of the inquest.

The Courts have been concerned to stress that inquests should be of manageable scale and that may include being careful as to the scope of an inquest.

In R (Morahan) v HM Assistant Coroner for West London [2023] KB 81 at para. 7, Lord Burnett CJ said:

"An inquest remains an inquisitorial and relatively summary process. It is not a surrogate public inquiry. The range of coroners' cases that have come before the High Court and Court of Appeal in recent years indicate that those features are being lost in some instances and that the expectation of the House of Lords in Middleton of short conclusions in article 2 cases is sometimes overlooked. This has led to lengthy delays in the hearing of inquests, a substantial increase in their length with associated escalation in the cost of involvement in coronial proceedings. These features are undesirable unless necessary to comply with the statutory scheme."

The case of Gorani v Assistant Coroner for West London (2022) EWHC 1593 makes clear that even where Article 2 is engaged that does not mean that every aspect of the inquest needs to be given that enhanced scrutiny. Only that aspect where it is said that Article 2 is engaged requires that closer focus. In my view that is a valuable decision in knowing how far the duty to examine extends

Scope

In defining scope a coroner will want to be generous to ensure that a bereaved family can properly test their areas of concern. This does not however mean that all lines of questioning from a bereaved family will be appropriate. The Coroner will want to ensure that all questions are relevant and focused on what is being investigated. That said sometimes questions that don't appear to always be focused on the issues that the court think are of concern can turn out to be of critical importance.

I repeat that paragraph: In defining scope a coroner will want to be generous to ensure that a bereaved family can properly test their areas of concern. This does not however mean that all lines of questioning from a bereaved family will be appropriate. The Coroner will want to ensure that all questions are relevant and focused on what is being investigated. That said sometimes questions that don't appear to always be focused on the issues that the court think are of concern can turn out to be of critical importance.

This paragraph highlights the difficult job a coroner has. They have to keep the inquest focused on the relevant issues.

An inquest should not be a free for all. On the other hand sometimes the pulling of a small thread that does not seem of consequence can turn out to unravel an important issue.

What can be done to manage scope?

The simple answer is case management and Pre-Inquest hearings. Having early hearings to identify scope will be important. A coroner having close regard to the relevance of questioning will be vital.

In the criminal courts for young or vulnerable witnesses a judge can require counsel to prepare questions in advance for the court's approval. I can see no reason why a coroner could not require counsel in an inquest to submit in advance questions of a witness, including of a medical practitioner, to ensure that questions are appropriate.

I hope everyone listening today who practises in inquest law is familiar with the Coroner's toolkits. These were produced by the legal regulators in consultation with practitioners, including Deputy Chief Coroner Derek Winter. Anyone undertaking work in the coroner's court should be familiar with these publications. I have encouraged coroners to confirm with counsel in an inquest whether they have read them. If they haven't giving them time to do so.

There was recently a survey of legal professionals of their knowledge of the existence and content of the toolkits. The survey was clear that practitioners knew of the fact of them but not necessarily the content of them. It is not enough to know there is a toolkit or even where to find it. You must if you practice in coronial work know what is required of you.

So what should you expect from coroners?

I would like to see better case management. Coroners should be drawing up agendas for pre-inquest review hearings to enable focused submissions on the timing and issues for the inquest.

There should be provisional indications from the coroner as to scope to enable focused submissions on where the boundaries of what evidence should be called.

Careful consideration should be given to the necessity versus the desirability of a witness being called and how they should be called.

Perhaps my immediate predecessor and I differ in this regard. HHJ Teague KC was keen to ensure that important witnesses, (and in an inquest focusing on medical care) that might mean senior clinicians, should attend in person at an inquest to better able the family to understand the detail of a witness's evidence.

I take a different approach. What is important is that a witness's evidence can be properly tested and understood. Providing that can be done by live-link/remote attendance I do not have a concern with evidence being received in that way. Clearly the presentation of medical evidence will need to be appropriately reviewed.

Can scans, x rays or photos of relevant sites of injury be properly scrutinised on screen with a witness at a different location?

Can the witness's evidence be understood if they are trying to explain where on a picture the court's attention should be focused?

We have come a long way in a short period of time in being able to present medical evidence using technology and sharing screens so that complex evidence can be understood even if the coroner, interested persons and witness are not all in the same location.

During my tenure as Chief Coroner I will be encouraging coroners to make better use of technology to ensure inquests can be conducted in both a fair but also a timely way.

I do not see that delaying an inquest for months to secure the physical attendance of witnesses in court as opposed to timing a witness's attendance on screen avoiding the need for a witness to travel is a desirable course of action. It is well understood that delay in giving evidence can affect the reliability of evidence.

There will always be cases where some witnesses need to attend in person. Sometimes to really understand a witness's evidence they need to be present so I cannot make any blanket or universal direction.

I will however ask coroners to look critically at the proposed evidence of a witness and see whether or not proper accommodations can be made in the presentation of that witnesses evidence that means that they do not attend.

I cannot interfere with judicial decision making. An inquest will not be unfair because one coroner decided to call a witness in one way and another coroner would have made a different decision. The coroner will always consider submissions from the family and from the other interested persons but I do not see that physical attendance of a witness, even an important one whose evidence is contested requires them always to be physically in court.

One of your number asked a question about late requests for statements. I am sorry if this is occurring. However, it is important to understand the process of preparation for an inquest. This will include taking statements from a number of people and organisations. The statement from one person may lead to subsequent requests for further statements or records and those may be late in the day. Sometimes disclosure may lead to the need for further statements. I cannot give you a definitive response to what you can do about late requests. Clearly there will need to be communication with the relevant coroner. They may insist on the provision of a statement at short notice if a statement is clearly necessary – if it cannot be provided in time that could lead to an adjournment of an inquest for months. That is plainly undesirable for all.

Another of your number asked about disclosure – again time does not permit with such a broad audience to address specific questions about disclosure. However my predecessor HHJ Teague KC issued Guidance 44 on the 13th September 2022 on this topic.

This is a publicly available document published on the CC website. This I would hope will provide you with some assistance.

Pathology

Can I touch briefly on the topic of the lack of pathologists which has been an ongoing problem for a number of years. In particular there is a shortage of paediatric pathologists.

I have already referred to the recent protocol devised to ensure better understanding between the jurisdictions.

I sadly do not have a magic wand to produce a new cohort of pathologists. This problem has been raised repeatedly including as part of the evidence presented to the Justice Select Committee investigation into the coroner service. I have met with the President of the Royal College of Pathologists to discuss this.

A post-mortem examination may provide crucial evidence in an inquest where a cause of death is unknown or where there are concerns about appropriate treatment. The late provision of an pathology report will cause delays as to the listing of an inquest. There is little I can do to address this.

The Inquest

So what should you expect from the inquest?

Most inquests are heard by a coroner sitting alone.

A coroner will hear an inquest with a jury if either s7(2) or s7(3) of the Coroners and Justice Act 2009 apply.

S7(2) provides that a coroner must sit with a jury if the death was in custody or state detention and the coroner believes the death was violent or unnatural or the cause of death is not known, the death arose of the act or omission of a police officer or member of the police service in the purported execution of their duty, or notifiable accident, poisoning or disease.

S7(3) provides that a coroner may sit with a jury if there is sufficient reason to do so.

The disadvantages of a jury is that they will not be able to give reasoned decisions for their conclusions. They may be given a questionnaire to answer in reaching their conclusions that may provide a line of reasoning but they will not get a formal reasoned decision that you would expect from a coroner.

If you are interested in seeing a jury questionnaire from an inquest you can google Hillsborough inquest jury questionnaire to see how it might work.

All participants at an inquest should know what the scope of the inquest is and therefore where the coroner will be focusing their questions.

The coroner will ask questions first and then other interested persons will have the opportunity to ask questions.

Interested persons will have been identified at the earlier hearings. Put simply again for today's purposes it will be the family of the deceased and those individuals or organisations closely concerned with the events that lead to the deceased's death. Each will have a chance to ask questions within the coroner's determination of relevance.

At the conclusion of the evidence the coroner may invite submissions on the conclusions that they could reach. There are no closing speeches – not even in a jury inquest.

The level of certainty for a coroner to have before they can reach a conclusion as to how someone died is on the balance of probabilities.

A coroner may record a short form conclusion or a narrative conclusion or a mixture of the two. The conclusion should answer the "how" question but it need not be a lengthy recitation.

A word about support

Again from my list of attendees I know I have a number of representatives from bereavement organisations. I am delighted that many of you have chosen to attend today. You do hugely valuable work in supporting those who have been bereaved. In many coroner's courts there is additional support for the bereaved attending inquests. The Coroners' Courts Support Service is available in many coroners' courts and is run by volunteers. They will be able to explain how the inquest works.

The value of this organisation was highlighted by the Justice Select Committee letter when they were unable to complete their review of the coroners' courts. They wrote of the valuable support that this organisation gives. Unfortunately there have been funding issues. We are hoping that they will be able to find additional funding so we do not lose this valuable and valued resource.

Prevention of future death reports

A coroner must issue a prevention of future death if they have a concern that circumstances creating a risk of death will occur or will continue to exist in the future.

The coroner may have a concern at the time of their investigation (prior to inquest) or having heard an inquest. A prevention of future death report can therefore be issued at any time. It is usually issued at the conclusion of an inquest.

The prevention of future death report is widely misunderstood. It is very limited in its capacity. A coroner can only say that they have a concern from circumstances that there is a risk of death and invite the recipient of a report to take action. A coroner cannot make recommendations.

As Lady Justice Hallett said in her inquest into the London July bombings:

*'However, it is neither necessary, nor appropriate, for a coroner making a report under (*what was then) *rule 43 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.)

My predecessors (HHJ Thornton and HHJ Lucraft) issued and reviewed guidance into prevention of future death reports. It is Chief Coroner's guidance number 5. I am not going to take you through it. It is available online but I again encourage you to read it to understand what reports can and cannot do.

One of your number asked about the inconsistent nature of application of PFDs in inquests and whether there would be further training. The inconsistent nature of application of PFD may come about in a number of ways.

Firstly as I have said a coroner has to have a concern that circumstances exist that create a risk of future death.

The Coroner may well have heard evidence that since an event systems or staffing for example have changed. This may mean that they no longer have a concern. Then they will not write a report. If another coroner in another similar case had not heard evidence of any change they will write a report.

That may seem like an inconsistency but they will have heard different evidence as to the ongoing situation.

I have already referred to judicial independence. One coroner may have a concern that another may not have. That is the nature of judicial independence that one had a concern and another did not does not mean that it would be wrong to have or not have a concern.

The other inconsistency may be in what is contained in a PFD report. Here perhaps the answer may disappoint. I have already said a PFD is to raise a concern and ask the recipient to respond to the concern. The coroner's job is not to make recommendations. A quick read of coroners' PFDs on the Chief Coroner's website may give you the impression that some coroners think that they can make recommendations – they can't. Recent training has addressed this. If you are wanting recommendations then they will not be forthcoming.

A PFD report is addressed toward those who could take action. The content of the circumstances of a death leading to the writing of a PFD should be sufficient to set in context what the concern was and why a report is being written. That should always be written in an accessible way but it is important to understand who the audience for that report is, it is those that need to take action.

One of your number asked about making them accessible for non-experts including the bereaved. A PFD report should be accessible but sometimes the detail of the concern may involve using technical language. Here I think there is a difference between what may be a conclusion or a narrative conclusion that should explain in simple terms why someone died and a report designed by the person to whom it is directed to review the concerns. The conclusions should be accessible to non-experts and families. Absolutely. The PFD may need to be technical.

There is a common misconception that having a prevention of future deaths directed to you is a badge of dishonour. I have heard of lengthy submissions at inquest being directed to persuading a coroner not to issue a report.

A prevention of future death report means what it says in the title it is a report to prevent deaths. If there have been failings then they should be addressed.

If a hospital trust has failed but has since put in place systems to prevent deaths then shouldn't a report be sent to the Department of Health and Social Care to ensure that other hospitals put in place similar new measures. They should be viewed as documents to encourage learning rather than failures.

A recipient of a PFD has 56 days to respond. A coroner has no power to sanction a recipient of a prevention of future death report. A coroner cannot compel a response. The Justice Select Committee in their inquiry into the coroner service has considered a National Oversight mechanism to monitor or oversee compliance. We support such a framework.

In the absence of any oversight mechanism and without any powers to compel a response I have decided to publish a list of those organisations who do not respond. That WILL be a badge of dishonour. It seems to me that if the Chief Coroner has to publish a prevention of future death report and any response, then if a response is not forthcoming this should be clear. So no longer will there be any suggestion that responses have not been uploaded. Going forward it will be clear that no response has been provided rather than simply an absence of a response.

We are also going to draw up a list of the main recipients of prevention of future death reports so that we have comprehensive and up to date list of addresses to direct prevention of future death reports. This will be available on the Chief Coroner's website and will be annexed to the CC newsletters.

We have been working for a number of years with and highlighting the work of Georgia Richards at Oxford for her prevention of future deaths tracker. Georgia coordinates and teaches Evidence-Based Medicine (EBM) and Systematic Review modules for the undergraduate Medical School and MSc in EBHC Knowledge Into Action at Oxford Nuffield Primary Health Care sciences.

She has a Doctor of Philosophy (DPhil/PhD) from the University of Oxford (2021) and a Bachelor of Science with First Class Honours in Pharmacology from the University of Queensland, Australia (2015). Georgia has expertise in quantitative observational research, open data, open science, and evidence synthesis.

Georgia founded and leads the Preventable Deaths Tracker. She is a Founding Fellow of the Pandemic EVIDENCE Collaboration amongst other organisations. Her interest in prevention of future death reports came out of desire to see if trends could be identified in patient deaths and to see if further deaths could be prevented. Her website includes some analysis of preventable deaths for example in Opioid deaths and sepsis.

We have improved where we can the way that PFD reports are categorised and how searchable they are on the Chief Coroner's website. This may go a little way in helping with Georgia's work.

Training

All coroners must attend mandatory training every year. I have been working on drafting the next year's training. The focus of this coming year continuation training will be on deaths arising from controlling and coercive behaviour and/or domestic homicides and how this might impact the scope of such an inquest.

My annual Senior Coroner conference in March of next year will have as its theme Mental Health. One of your number asked about training Coroners in what good practice is and what good care might look like. That will be one of the areas we seek to address in training in relation to mental health this coming year.

Backlogs

Finally, like many jurisdictions coroners' court continue to suffer from the consequences of the Covid 19 pandemic. There are backlogs in some areas. I am working with a number of coroners to try to assist in reducing the backlogs. We keep a record of the number of cases that have taken over 12 months to come to a conclusion. Sometimes the problem is staff or accommodation. Sometimes it can be the availability of witnesses. Often it is because the Coroner is waiting for a report from another organisation or the outcome of a criminal case.

Very often it is a mixture of a number of factors. I will continue to work to reduce cases that are taking too long to reach conclusions.

Bench Book

We are I hope nearing the end of producing the bench book. We hope to have it published on the Chief Coroner's website shortly. This should, I hope, provide many answers to how practically things work at court in an inquest.

I appreciate I have covered a wide range of topics. Most I have covered with only light detail. I hope I have been able to answer some of your questions. I apologise that I cannot answer all.

Links and Resources

Chief Coroner's website

NHS England » The national medical examiner system

Coroners and Justice Act 2009 (legislation.gov.uk)

Chief Coroner's Guidance, Advice and Law Sheets - Courts and Tribunals Judiciary

Chief Coroner's Guidance No 47 The death certification reforms

Chief Coroner's Guidance No. 32 Post-Mortem Examinations Including Second Post-Mortem Examinations [1] - Courts and Tribunals Judiciary

Cause of Death returns to Channel 5 tonight - first look at new episode (lep.co.uk)

Resources for those practising in the Coroners' Courts (barstandardsboard.org.uk)

SRA | Practising in the Coroner's Court | Solicitors Regulation Authority

Reports to Prevent Future Deaths - Courts and Tribunals Judiciary

Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths[i] - Courts and Tribunals Judiciary

A platform to learn lessons from coroners' inquests - Preventable Deaths Tracker

Coroners' inquests | Inquest lawyers | Inquest law | Browne Jacobson

Checklist for clinical witnesses taking part in a remote inquest hearing (brownejacobson.com)

Mock inquest training | Browne Jacobson

Contact us

Lorna Hardman
Partner

+44 (0)115 976 6228
lorna.hardman
@brownejacobson.com

Simon Tait
Partner

+44 (0)115 976 6559
simon.tait
@brownejacobson.com

Nicola Evans
Partner

+44 (0)330 045 2962
nicola.evans
@brownejacobson.com

Rebecca Fitzpatrick
Partner

+44 (0)330 045 2131
rebecca.fitzpatrick
@brownejacobson.com

Ed Pollard
Partner

+44 (0)330 045 2107
ed.pollard
@brownejacobson.com

Mark Barnett
Partner

+44 (0)330 045 2515
mark.barnett
@brownejacobson.com

Heather Caddy
Partner

+44 (0)330 045 2516
heather.caddy
@brownejacobson.com

Victoria Colcough
Partner

+44 (0)330 045 2133
victoria.Colclough
@brownejacobson.com

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