Browne Jacobson

Update to the Chief Coroner's guidance on Prevention of Future Death reports and summary of the Chief Coroner's annual report

On 4 November 2020, the Chief Coroner issued updated guidance in relation to reports to Prevent Future Deaths, also known as PFD's or Regulation 28 reports. Although the procedural aspects of PFD reports remain largely unchanged in the updated guidance, there is an additional emphasis on this being a statutory duty for the Coroner.

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On 4 November 2020, the Chief Coroner issued updated guidance in relation to reports to Prevent Future Deaths, also known as PFD's or Regulation 28 reports. Although the procedural aspects of PFD reports remain largely unchanged in the updated guidance, there is an additional emphasis on this being a statutory duty for the Coroner. Where a risk of future deaths has been identified, the updated guidance is clear that a Coroner must make a PFD report. In recent years we have seen an increase in PFD reports and it is likely that this trend will continue under the updated guidance. It is therefore more important than ever for healthcare organisations to take proactive steps in advance of an inquest to reduce the risk of a PFD report being issued.

There is an emphasis throughout the updated guidance on the use of PFDs as a learning tool. Identifying areas for improvement and making changes in advance of an inquest is an important factor in lowering an organisation's risk of a PFD report. The updated guidance is clear that a report may not be required if steps have been already been taken to address the concern. Even if there is only enough time before the inquest to make a commitment to that action, the commitment itself may reduce the risk of a PFD report. The Coroner will consider the nature of the commitment to take action, any evidence in support of it, and their assessment of the organisation's understanding of and commitment to addressing the area of concern before making a PFD report.

An exception applies in relation to national organisations where despite remedial action having been taken locally, the Coroner remains concerned that there is a risk of future fatalities nationally and believes that national action should be taken. In such circumstances, the intention of the PFD would be to highlight the issues more widely. National healthcare organisations should therefore consider, in addition to any local remedial action which should be taken, how learning points can be effectively shared with the whole organisation. If it can be demonstrated that local remedial action has been taken and that this best practice has been communicated (and possibly implemented) across the organisation as a whole, submissions could be made that a PFD report is not in fact required to highlight the concerns in question.

In addition to identifying where action is required, it is of the utmost importance that such action is implemented. Unless there are exceptional circumstances, it would be difficult to successfully argue against a PFD report being made if the subject of that report had been raised with an organisation previously but steps had not been taken to address the concern. Taking meaningful action to address any concerns highlighted during the inquest process, whether subject to a PFD report or not, will always be a worthwhile exercise in increasing public safety and reducing risk for organisations in the long term.

Finally, the updated guidance emphasises that both the PFD report itself and the organisation's response should be made using the templates provided by the coroner and available on the website of the Chief Coroner, so as to ensure consistency of approach.

Chief Coroner's combined annual report 2018-19 and 2019-20

On 5 November 2020 the Chief Coroner published a combined version of his Annual Report to the Lord Chancellor covering the years 2018-19 and 2019-20.

In both 2018 and 2019, despite a year on year increase in the number of registered deaths, there was a reduction in the number of deaths reported to the coroner and a reduction in the number of inquests being opened. The Chief Coroner's view is that this was directly related to the removal of the requirement to automatically report deaths of a person under a Deprivation of Liberty Safeguards (DoLS) order. In both years the number of jury inquests remained relatively steady at around 1-2% of all inquests.

The Covid-19 pandemic has had an enormous impact, although the full extent of this will not be apparent until the official figures for 2020 become available. Anecdotally it is clear that whilst some Covid-19 deaths have been reported to the coroner, there has also been a significant rise in the number of deaths reported to the coroner where Covid-19 does not appear to be involved. It is anticipated that the figures for 2020 will also show a large increase in the number of inquests not concluded within 12 months and a reduction in the number of PFD reports due to the pandemic's impact on the number of inquests able to be held during 2020.

The Report also proposes a number of legal reforms to the coronial process including an amendment to broaden the circumstances in which an investigation can be discontinued beyond the receipt of a post-mortem report. There is also a proposal for a mechanism of inquests "on the papers" in circumstances where the facts are not contentious, no witnesses are required to attend, the outcome is clear (at least on the balance of probabilities), the family do not want an inquest and there is no other public interest for conducting an inquest in a public hearing. In such cases, it is proposed that there would be a written ruling.

Finally, the Chief Coroner expresses concern at the dwindling number of pathologists prepared to undertake post-mortem examinations requested by a coroner and the fact that the service is severely underfunded. The Chief Coroner suggests a number of ways this could be addressed including that NHS Trusts could make autopsy work by pathologists part of the working contract for separate fees.

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