Learning from inquests

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Outline

- Prevention of future death reports (PFD report).
- Ensuring that the action plan is followed through.
- Coroner's ability to refer to the Crown Prosecution Service.
- Coroner's ability to refer to the Nursing and Midwifery Council or General Medical Council.
- Care Quality Commission as an interested party.

Prevention of future death report (PFD report) - overview

- Often referred to as Regulation 28 report.
- Coroners have a duty not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths.
- Under the old rules (Rule 43 of the Coroners Rules 1984), the coroner had a discretion to make a report. Under the Coroners and Justice Act 2009 the coroner has a duty to make a report where a concern is identified.
- Responsibility for reports was transferred from the Ministry of Justice to the Chief Coroner's office on 1 April 2013.

PFD reports – the intended aim

- Chief Coroner's Guidance Note No. 5 – reports to prevent future deaths, paragraphs 5 and 6:

  '*Broadly speaking reports 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.*

  Reports are important, but they are 'ancillary to the inquest procedure and not its mainspring' (Re Kelly (deceased) (1996) 161 JP 417. In an Article 2 inquest the report may complete the state's duty to inquire fully (see R (Lewis) v HM Coroner for the Mid and North Division of the County of Shropshire [2009] EWCA Civ 1403).'

Coroner's and Justice Act 2009 Schedule 5 paragraph 7

- The duty arises where:
  a) a 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.
- 'Concern' for this purpose has a relatively low threshold – Hallett LJ as Westminster Assistant Deputy Coroner in the 7/7 Bombing Inquest 2011.
- The report need not be restricted to matters causative of death. Reference in paragraph 7(1)(b) to **anything**. It does not stipulate 'in similar circumstances'.

Coroner's Investigations Regulations 2013

- Regulation 28(4), The Coroner:
  a) must send a copy of the report to the Chief Coroner and every interested person who in the coroner's opinion should receive it;
  b) must send a copy of the report to the appropriate Local Safeguarding Children Board (which has the same meaning as in regulation 24(3)) where the coroner believes the deceased was under the age of 18; and
  c) may send a copy of the report to any other person who the coroner believes may find it useful or of interest.
- Regulation 28(5) On receipt of a report the Chief Coroner may—
  a) publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit; and
  b) send a copy of the report to any person who the Chief Coroner believes may find it useful or of interest.

Responding to a PFD report

- Must respond in writing (Coroners and Justice Act 2009 Sch.5 para 7(2)) within 56 days of the date on which it is sent (Coroners (Investigations Regulations 2013) reg.29(4)).
- Period can be extended by the coroner – reg.29(5).
- Response must (a) contain details of action that has been or is proposed to be taken and set out a timetable for this or (b) explain why no action is proposed – reg.29(3).
- A responder may make written representations to the coroner about the release or publication of the response by no later than the response itself (re.29(8) and (9)).
- Coroner must pass any representations to the Chief Coroner for their consideration.
- Any response must be sent to the Chief Coroner and any interested party.
- Coroner may also send a copy to any other person they believe may find it of interest.

Timing of a PFD report

- Ordinarily made after the inquest has concluded. Regulation 28(3) stipulates '*a report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the corner are relevant to the investigation*'.
- However, Chief Coroner's Guidance Note No.5 provides the following:

> '*Previously,undertheversionofRule43whichwassubstitutedbytheCoroners (Amendment) Rules 2008, the coroner's concern could only arise from evidence given at the inquest. Now, however, the concern may arise from 'anything revealed by the investigation' (including the inquest). The wording of para.7 of Schedule 5 therefore permits a report to be made before an inquest is heard (so long as the pre-condition is complied with). Where, for example, the coroner concludes that there is an urgent need for action he/she may report with a view to action being taken without delay. The Regulation 28(3) pre-condition may be satisfied during the investigation but before inquest when the coroner takes the view that there is unlikely to be more material to come on the matter of concern*.'

PFD reports ancillary to the main inquest

- Under the previous system it was held that the coroner's power to report fact is ancillary to the inquest procedure - *Re Kelly* (1996) 161 J.P. 417, DC; see also *Re Clegg* (1996) 161 J.P. 521.
- Change from 'power' to 'duty' has strengthened the importance of the PFD reports, however no reason to consider that PFD reports were intended to be a basis for holding a fresh inquest.
- Strasbourg case law requires the state's own article 2 complaint inquiry must ascertain '*any shortcomings in the operation of the regulatory system*' even if they were not causative of death - *R. (Lewis) v Mid and North Shropshire Coroner* [2009] EWCA Civ. 1403.

A letter instead of a report

- The coroner may choose to write a letter expressing concern(s) to the relevant person or organisation.
- Trusts may look to avoid a report by writing to the coroner informing him or her what steps they have done. Must assess whether this is sufficient in light of the evidence heard.

Jury inquests

- A jury is not permitted to make riders or recommendations- *R v West London Coroner, ex parte Gray* [1988] 1 QB 467.
- Coroners should not invite juries to make any kind of observation. Juries should be directed not to express an opinion on any matter other than the section 5 matters to be ascertained (who, how, when and where).

Referral to the CPS and other regulatory bodies

- The coroner's court is inquisitorial and not accusatorial in nature. '*Nothing that is done will be conclusive upon the person to be affected by it. All is traversable*.' (per Lord Tenterden CJ *Garnett v Ferrand* (1827) 6 B&C 611, at page 627)
- Conclusions imputing criminal responsibility to a named person have disappeared from the coroner's court - *R. v Crown Prosecution Service Ex p. Hitchens* Unreported June 13, 1997, DC.
- The inquest conclusion may not be framed in a way that appears to determine criminal responsibility.
- Most obvious example that could lead to a referral to the CPS is unlawful killing. It is worth noting that an individual cannot rely upon article 8 of the ECHR to avoid a conclusion of unlawful killing - *R. (Evans) v Cardiff and Vale of Glamorgan Coroner* [2011] EWCA Civ. 719.

Continued…

- In most cases any referral will already have taken place. Duty of self referral.
- More likely that the matter would be referred back to the CPS rather than referred for the firs time.
- If coroner had serious concerns about the evidence of a witness could make a PFD report during the inquest. More likely that will occur after the conclusion of the inquest.
- A coroner is unlikely to hear a case if there is a pending CPS investigation or planned criminal trial.
- CPS is under no obligation to prosecute if matter referred to them. But the DPP will generally be required to give reasons for not prosecuting in respect of the death.

CQC as an interested party

- More likely than not that they will already be an interested party.
- Usually take a passive role at inquests.

Questions?