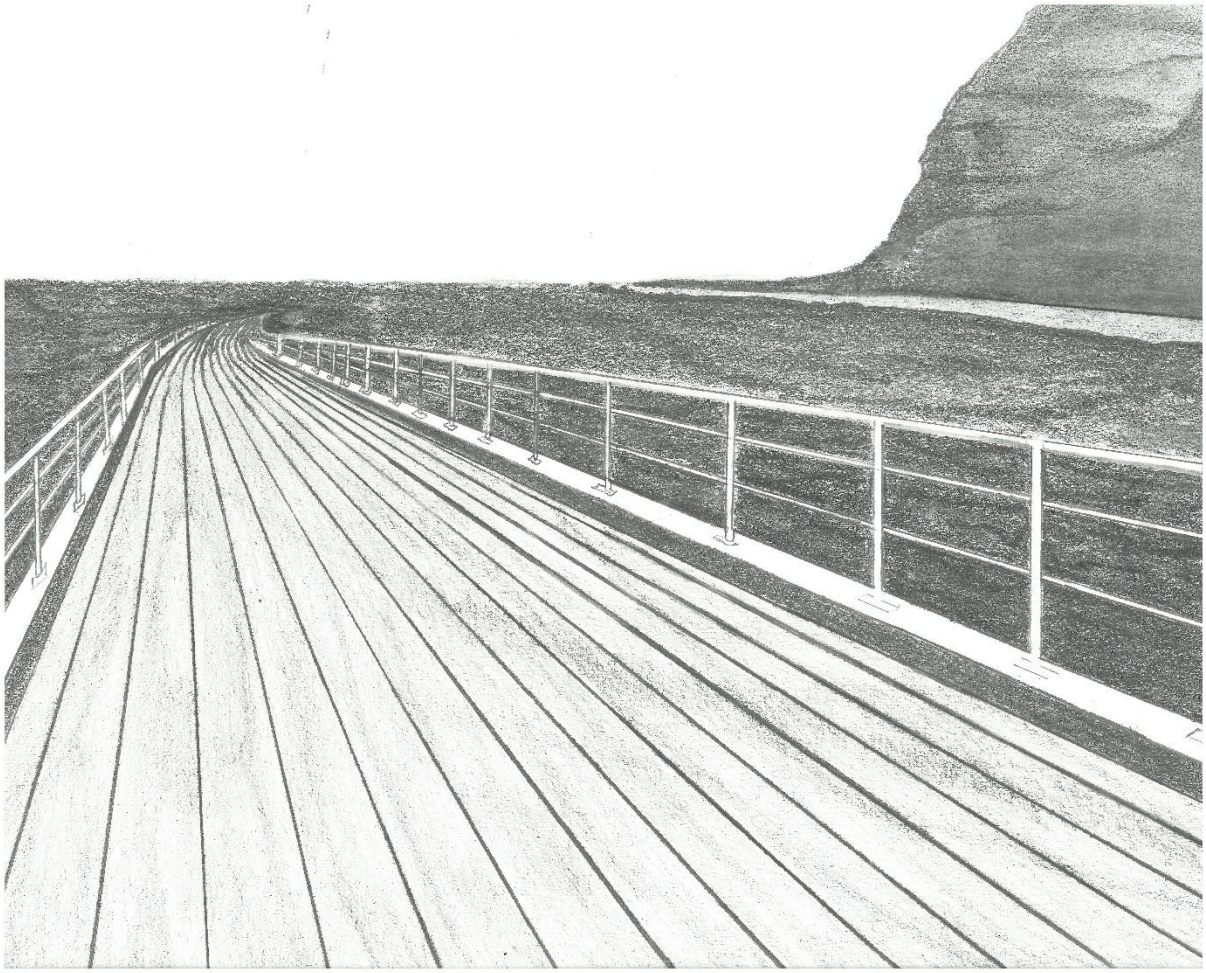
IAPDC

"More than a paper exercise" – Enhancing the impact of Prevention of Future Death Reports



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Independent Advisory Panel on Deaths in Custody
September 2023

Contents

Executive summary

1. **Issuing Prevention of Future Deaths (PFD) reports is an important part of a coroner's role. As the Chief Coroner's guidance on PFD reports explains, *"PFDs are vitally important if society is to learn from deaths…a bereaved family wants to be able to say: 'His death was tragic and terrible, but at least it's less likely to happen to somebody else.'"*[1] Bereaved families and the wider public are entitled to expect that all concerned parties work together to ensure that the PFD process is fully effective, and that PFD reports identifying weaknesses and gaps in how life is safeguarded are taken seriously and acted on wherever possible.**

2. **Evidence suggests that the preventative potential of PFD reports is not currently being fully realised, with families criticising the current system as *"nothing more than a paper exercise"*.[2] This project, led by the Independent Advisory Panel on Deaths in Custody (IAPDC) with support from the Chief Coroner's Office, is intended to identify good-practice recommendations to improve the effectiveness of this vital coronial function, as well as set out proposals for wider reform.**

3. **Our report finds that several factors are limiting the effectiveness of PFD reports to prevent deaths in custody. As reported by coroners themselves, the matters of concern they identify are often only cursorily addressed by respondents, or simply not addressed at all. Both coroners and families express deep frustration that further deaths take place under the very circumstances they have previously warned about or experienced.**

4. **PFD reports can vary significantly in quality, limiting their potential impact. Reports are often published long after the issue in question has been identified and could have been reported on, and then may not be sent to the organisations best placed to ensure that changes are made. There remains much more that could be done by a range of different bodies with the significant learning PFD reports contain. There continues to be a lack of any central research or analytical function on which agencies, services and others can rely to draw trends and themes from PFD reports over time to ensure key learning is not missed.**

5. **Our report makes several recommendations to unlock the preventative potential of PFD reports. Firstly, these reports should be viewed as an opportunity for organisations to improve, share good practice, and ultimately prevent custodial deaths – not as criticism to be avoided at all costs. PFD reports have an integral function in ensuring compliance with the state's duties under Article 2 of the European Convention of Human Rights (ECHR), the right to life, both locally and nationally. This, as well as their immense importance to bereaved families, must be borne firmly in mind.**

6. **Reports should be shared and deployed as widely as possible as part of training and learning. Scrutiny bodies should make better use of reports in their reviews of places of detention. Government should also provide the Chief Coroner's Office with sufficient funding for a research function to regularly monitor and draw learning from reports, especially those relating to deaths in custody.**

7. **We also propose changes to processes and practices. Coroners should proactively ensure that previous PFD reports are brought to their attention where relevant and ensure timely provision of necessary evidence from services and agencies at all stages of the process. Bespoke training on the purpose and production of PFD reports could help ensure they are consistently drafted and distributed to maximise their impact.**

Recommendations

For Government departments, agencies, and private providers:

1. **All** should ensure that their approach to the PFD process is open, non-defensive and that the public interest in preventing future deaths is prioritised over reputational considerations at every stage. For example, lawyers should be specifically instructed not to take an adversarial approach to the making of a PFD report, and instead to neutrally present the evidence in order to assist the coroner.
2. **All** should ensure that they approach the PFD process with full candour and proactively provide all relevant information at the earliest appropriate stage.
3. The **Ministry of Justice (MoJ)** should adequately resource the **Chief Coroner's Office** to produce a yearly review of PFD reports for custody deaths. This should aim to identify themes and trends, and report on the timeliness and quality of responses, as part of the Chief Coroner's role under existing guidance.[3]
4. The **MoJ** should provide dedicated funding to the **Chief Coroner's Office** to enable it to centrally record the conclusions of inquest juries, even where no PFD report is issued, and publish them online for easy referral in the same way that PFD reports are currently published.
5. The **Department of Health and Social Care (DHSC)** should give serious consideration to the creation of an independent body for investigating deaths of those formally or informally detained in mental health settings. This would remove the anomaly between the investigation of such deaths and those of persons in other detention settings and ensure that coroners consistently have the benefit of high quality evidence regarding the circumstances of such deaths for the purposes of the inquest.
6. **Recipients of PFD reports** relating to deaths in custody should hold a "post-inquest learning review" meeting following the conclusion of an inquest, attended by the key persons who participated in the inquest. This will help to ensure both an efficient and fully informed response to PFD reports and the formulation of an appropriate action plan to take forward necessary learning.
7. **Recipients of PFD reports** should ensure that their responses are timely, high quality, case-specific, and fully informed by the inquest evidence and findings. Where the response relays that action will be taken, actions should be identified in precise terms and with precise timelines. Where no action is to be taken, a clear, detailed and respectfully worded explanation should be provided to enable the coroner, family, and wider public to understand the basis for the decision. Recipients should ensure that their responses recognise and reflect the significance of PFD reports to bereaved families, with consideration given to how families can be kept informed and where appropriate consulted on the action plan.
8. **All** should ensure PFD reports are shared 'horizontally' with relevant equivalents across the country – for example, other police forces, prisons, and mental health trusts – particularly where there may be scope for national learning, to ensure opportunities to make change across different custody areas are not missed.
9. **Leaders of local custody bodies**, such as prison governors, should consider adopting the approach of Milton Keynes Together Safeguarding Partnership and hold periodic meetings of representatives from all custodial settings to review relevant PFD reports, with participation, where appropriate, of local coroners.

10. **Government** should consider what enhanced role independent bodies might play in auditing, following up on, and reporting on PFD reports, and this could include establishing a new body for this purpose. More effective oversight of the sharing, use, and implementation of matters of concern in PFD reports is needed.

For the Chief Coroner and his Office:

11. The **Chief Coroner** should consider supplementing his guidance on PFD reports to further address when it may be appropriate, in compliance with the statutory requirements, to make interim PFD reports and the importance of doing so, in particular where a coroner is of the opinion that there is an urgent need for action to prevent future deaths.

12. The **Chief Coroner** should consider supplementing his guidance to advise coroners on the importance of ensuring relevant evidence is provided at a sufficiently early stage, in particular where coroners consider there may be a need for urgent action. The guidance should remind coroners that previous PFD reports and evidence of 'near-miss' incidents may be relevant and important.

13. The **Chief Coroner's Office** should review and consider expanding the list of organisations which should receive PFD reports on deaths in state custody (found at paragraphs 56 and 57 of the guidance on PFD reports) to ensure more comprehensive coverage of relevant bodies, organisations, and departments. This should be circulated to all coroners and used in training on PFD reports. The **IAPDC** could assist with ensuring this list is up to date and comprehensive.

14. The **Chief Coroner's Office** should ensure that its online database of PFD reports is fully searchable by thematic areas and location, and that deaths in detention (particularly under the Mental Health Act 1983 (MHA) are readily identifiable. Consideration should be given to tagging reports according to the deceased's protected characteristics to help better identify and understand issues of disproportionality.

For other bodies with a key role to play in preventing custody deaths:

15. The **Ministerial Board on Deaths in Custody secretariat** should send PFD reports on deaths in custody to **the House of Commons Justice, Health, and Home Affairs Select Committees**, which should consider taking evidence and reporting on significant themes.

16. **All organisations which scrutinise places of detention** should make explicit use of PFD reports to inform their investigations, inspections, and thematic reports and bulletins, including monitoring and reporting on progress made against responses to PFD reports by services and agencies. They should work with the **Chief Coroner** to agree protocols to work together and share learning.

17. The **Ministerial Board on Deaths in Custody (MBDC) secretariat** should continue to review and distribute PFD reports relating to death in custody to MBDC members for the purpose of sharing learning, and consider involving all relevant agencies and partners who would benefit from additional learning across all places of state detention. Issues of significant wider concern arising from recent PFD reports should be discussed at MBDC meetings.

18. The **Judicial College** should work with the **Chief Coroner** to deliver mandatory training to coroners on the purpose, process, publication, and distribution of PFD reports, as well as the role of independent scrutiny bodies, incorporating the perspective of bereaved families.

Chapter one: Background and methodology

8. As part of the inquest process, coroners are required by law to issue a PFD report where their investigation gives rise to a concern that future deaths will occur and they are of the opinion that action should be taken to reduce the risk of death.[4] In reporting these risks as formal 'matters of concern' in PFD reports, coroners have an important role to play in ensuring that avoidable circumstances giving rise to deaths are not repeated.

9. PFD reports are integral to compliance with the UK's human rights obligations. The right to life in Article 2 of the ECHR, which is incorporated into UK law by the Human Rights Act 1998, gives rise to a number of positive duties to safeguard the lives of persons detained by the state and to investigate the circumstances of deaths in state detention. Where an individual has died in state detention, the issuing of a PFD report may be essential to ensuring that the state discharges the mandatory duty of investigation arising from Article 2 (which requires among other things that inadequate or dangerous practices and procedures are identified) and to avoiding breaches of the UK's positive Article 2 duties in the future.[5]

10. It is well-established that PFD reports are "*ancillary*" to the coronial investigation, the primary purpose of which is to consider the death of a particular person and to answer defined statutory questions regarding the death,[6] albeit in an Article 2 inquest this includes investigation of the broader circumstances of the death.[7] In this way, as the Chief Coroner makes clear in his guidance on PFD reports, "*An inquest is an inquest, not a public inquiry.*"[8]

11. There may be a broad range of circumstances giving rise to a matter of concern. As the guidance on PFD reports issued by the Chief Coroner states, "*The matter giving rise to concern will usually be revealed by evidence at the inquest, but it may be something revealed at any stage of a coroner's investigation. Giving rise to a concern is a relatively low threshold*".[9] Different coroners may come to different conclusions about the need for a PFD report on the same set of facts, with *"no single, objectively correct answer"* to the question of whether a PFD report is needed in each case.[10]

12. By law, PFD reports and their responses must be shared with the Chief Coroner and "*every interested person who in the coroner's opinion should receive it*".[11] In addition, the coroner "*may send a copy of the report to any other person who the coroner believes may find it useful or of interest*."[12] But as the Chief Coroner's guidance on PFD reports states, "*A blanket policy of only providing reports or responses to interested persons would be unlawful. Coroners should err on the side of openness unless there is a very good reason for restricting access to these documents*".

13. The Chief Coroner's guidance specifies that all reports relating to deaths in custody should be sent to His Majesty's Inspectorate of Prisons (HMIP), His Majesty's Prison and Probation Service (HMPPS), and the IAPDC. Relevant PFDs should also be sent to other bodies, such as the Department of Health and Social Care (DHSC) (where not a direct recipient), the Health & Safety Investigation Branch, and the Care Quality Commission (CQC).[13]

14. Those who have been sent (rather than copied into) a PFD report must respond within 56 days.[14] Responses must contain "*details of any action that has been taken or which it is proposed will be taken by the person giving the response or any other person whether in response to the report or otherwise and set out a timetable of the action taken or proposed to be taken*", or "*an explanation as to why no action is proposed*."[15]

15. All PFD reports and their responses must be sent to the Chief Coroner's Office which "*may publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit*".[16] Since 2013, his Office has published them online.[17] In September 2022, the Chief Coroner's Office updated its website for publishing PFD reports, adding further facility to search PFD reports by way of subject matter and a range of keywords (including region). All PFD reports uploaded to the online database are now also text-searchable. This took place during the course of our project, and the Panel welcomes these changes to ensure the database is more accessible and user-friendly.

Methodology

16. The stages of this project were as follows:

    (i) **Selecting a small but representative sample of 20 PFD reports** that cover the main detention settings: prisons, immigration removal centres, before and during police custody and following arrest, and detention under the Mental Health Act 1983 (MHA). More detail on the methods used to conduct the sampling exercise is provided in Annex A. We reviewed this sample to understand the impact and quality of selected PFD reports and highlight what changes have been made since the reports were published.
    (ii) **Consulting with coroners** to gather and share best practice, gain an understanding of the key benefits of PFD reports, and understand what more could be done to make effective use of them, by holding two online roundtable events with coroners under the Chatham House rule in the summer of 2022.[18]
    (iii) **Consulting with bereaved families** to understand their experiences with PFD reports and their views on how they could be made more effective, by holding a private roundtable event in early 2023, facilitated by the charity INQUEST.
    (iv) **Consulting with agencies and services** which respond to PFD reports, to identify best practice in responding to PFD reports, gain an understanding of how PFD reports are used, and how they and their responses might be improved, through a questionnaire circulated and answered in early 2023.

17. Care has been taken to ensure that no individuals are identifiable in the way the evidence is used in the Panel's report. The IAPDC would like to thank all those who participated in the three consultation exercises.

Structure of this report

18. This report will cover:

    (i) **The purpose of PFD reports**, including the concerns that PFD reports are being issued in repeat circumstances, and how they are approached by coroners and interested persons at an inquest;
    (ii) **The drafting, publication, and distribution of PFD reports**, including how they are drafted, how timely they are, and how they are distributed among organisations best-placed to help enact change; and
    (iii) **Follow up and learning from PFD reports**, including how agencies and services respond to PFD reports and what that may show about the impact reports can have.

The IAPDC

19. The IAPDC is an advisory non-departmental public body that provides independent advice and expertise on deaths in custody to Ministers, senior officials and the Ministerial Board on Deaths in Custody (MBDC). Along with a wide range of senior stakeholders, including Government departments, charities, and the Chief Coroner, it is a member of the MBDC but is entirely independent of Government.

Chapter two: The purpose of PFD reports

This chapter examines the purpose behind PFD reports and how coroners, families, and agencies and services approach them. It also explores the ways evidence is gathered to inform whether PFD reports are made and what they include.

It makes practical recommendations to ensure that PFD reports are informed by the right evidence and that all parties approach them with the right attitude, so they address the right issues.

20. As Deborah Coles, Executive Director of INQUEST and IAPDC member, has noted:

> *"Whilst shocking and contentious cases or critical reports may generate an immediate response and commitment to change and learning, it is not sustained and doesn't become embedded in culture, approach and practice. We worry that impetus and momentum is lost with the risk that the same cycles are repeated."*[19]

21. The 2020 Coroner Attitude Survey, commissioned by the Chief Coroner and published in March 2023, showed that, while in law PFD reports are "*ancillary*" to the inquest process,[20] coroners view the objective of preventing future deaths as one of the three most important functions of coroners, alongside that of publicly investigating deaths and providing answers to bereaved families.[21]

22. However, only 55% of coroners and senior coroners surveyed agreed that "*PFD reports are effective in preventing future deaths*", 31% were "*not sure*", while 14% disagreed.[22] In other words, while the majority of coroners believe PFD reports are effective in preventing future deaths, a sizeable minority are less clear.

23. At the Panel's roundtables, coroners were concerned that the purpose of PFD reports is being undermined. They expressed frustration at issuing repeated reports covering matters of concern which have yet to be dealt with by the time of subsequent inquests.

24. Coroners also expressed frustration at seeing similar recommendations of independent investigatory bodies, such as the Prisons and Probation Ombudsman, not having been dealt with by the relevant organisation by the time of the inquest.

25. These concerns are borne out in the limited literature exploring the issue of 'repeat' PFD report recommendations. One analysis conducted in 2016, which looked at healthcare-specific reports, highlighted that across the 710 reports analysed, 36 displayed coroners' frustrations about having to issue repeat PFD reports to the same organisation for the same or similar concerns. In these reports, coroners were frustrated that learning from PFD reports was not being utilised.[23]

26. Bereaved family members expressed similar concerns. They described their distress and frustration that the circumstances in which their loved ones died are too often repeated. For example, in one case, a similar death had taken place shortly after their inquest had concluded. The later inquest found that the service had not implemented the interventions promised in the response to the original PFD report. Another reported an absconsion from a mental health setting that took place during the inquest in the same circumstances as the one that had contributed to their loved one's death.

Positive examples of impact

27. The Panel received evidence which showed that PFD reports can make a real difference, and Government departments, services, and agencies agreed that PFD reports were an important means of improving practice to protect lives. In its response to the Panel, the Home Office gave examples of where reports on deaths in immigration detention had led to positive changes being implemented to protect life.

28. Following the unlawful killing of Jimmy Mubenga in October 2010 on board an aircraft whilst being restrained by Detainee Custody Officers on a scheduled removal operation, the coroner issued a PFD report which raised a matter of concern regarding approved methods of restraints. This led to a substantive review of use of force and the introduction of the Home Office Manual for Escorting Safely. The Panel was also told that the Home Office now reviews all reports resulting from a use of force to identify trends and to ensure that techniques are used proportionately and justifiably.

29. Similarly, following the unlawful killing of Tarek Chowdhury in 2016 at Heathrow IRC by another individual who had arrived in immigration detention from prison, the coroner, in his PFD report, raised as a matter of concern the sharing of information relating to moving from prison to IRCs.[24] This prompted the signing of a Data Sharing Agreement between the Home Office and MoJ in 2021, and a new Detention Services Order detailing the risk assessment process is due to be published in the coming months which will reflect these considerations.

Examples of repeat matters of concern going unheeded

30. The sampling exercise identified several PFD reports which highlighted repeat matters of concern. For example, coroners repeatedly expressed concern at the lack of joint national guidance on the management of Acute Behavioural Disturbance (ABD) by police and ambulance services, leading to local authorities having differing understandings of ABD and how to manage it. In all five police custody reports analysed in the sampling exercise, restraint and the use of force were identified as significant risk factors. Coroners found that police demonstrated a consistently limited understanding of how restraint and the use of force could greatly increase the risk of death, coupled with other risk factors (such as ABD), and the importance of an emergency medical response to protect life.

31. Similar patterns are reflected in many high-profile police custody deaths, particularly of Black men, such as Leon Briggs, whose death in 2017 was attributed to the use of force, and Nuno Cardoso, who was the fifth Black man in 2017 to die in police custody following the use of restraint.[25] After many comparable deaths producing similar recommendations,[26] the coroner in the 2021 PFD report following Leon Briggs' death identified that more people could die due to the still-insufficient national guidance for police and ambulance services in responding to medical emergencies.[27]

32. Deaths relating to ABD and restraint continue to occur, with coroners expressing concern about continuing risks to life as a result of a lack of change. For example, the PFD report published in January 2022 into the death of Adam Stone found that the lack of a system for ensuring an emergency medical response for cases of ABD and restraint was continuing to put lives at risk.[28] Following these repeated deaths and PFD reports, guidance has been introduced by professional bodies such as the Royal College of Psychiatrists and the Royal College of Emergency Medicine.[29]

33. PFD reports can play a key role in highlighting areas for improvement and opportunities for shared learning across organisations and geographical regions. This sampling exercise makes clear the importance of these reports in tracking recurring themes, both within and across services, and the continuing risks to life in failing to address them.

How are PFD reports approached by the parties involved?

34. In guidance to coroners in making PFD reports, the Chief Coroner states that they are "*not intended as a punishment; they are made for the benefit of the public*."[30] However, during the roundtables, coroners considered that it was important that agencies and services should see PFD reports as opportunities to learn and improve, and should avoid taking an adversarial approach to the question of whether they should be issued. Meanwhile, family members perceived the approach of agencies and services as "*highly adversarial*", "*fight[ing] tooth and nail*" to avoid receiving a report – something which in their view amounted to "*defending the indefensible*".

35. HMPPS described it as unhelpful for the process of hearing PFD-related evidence to become adversarial. They recognised that agencies and services, through their legal representatives, can approach the issue defensively and may wrongly consider that the issuing of a PFD report in itself constitutes a defeat. Nonetheless, they stated that they make clear when instructing lawyers at inquests that they welcome PFD reports where the coroner believes there are matters of concern needing addressing. They also suggested that bereaved families sometimes argue strongly for a PFD report on the impression that, were one not issued, no lessons will be learned from the death – something they wanted to stress was not the case.

Recommendation:

Government departments, agencies, and private providers should ensure that their approach to the PFD process is open, non-defensive and that the public interest in preventing future deaths is prioritised over reputational considerations at every stage. For example, lawyers should be specifically instructed not to take an adversarial approach to the making of a PFD report, and instead to neutrally present the evidence in order to assist the coroner.

36. Relatedly, families expressed confusion and frustration over the fact that jury findings are not published at the conclusion of an inquest, except as part of a PFD report, despite containing potentially important information that may also contribute to institutional learning. Other than groups, such as INQUEST, independently recording jury findings into some deaths on their website,[31] PFD reports present the only publicly available online record of the jury's findings in any particular case. Jury narrative findings will often have key learning for services even in cases where a PFD report is not made. One family member commented that families and others may become *"locked into the word 'PFD'"* where other parts of the investigation process may be equally or more important. They suggested that both inquest findings and PFD reports should be available online and in searchable format through a properly managed database, as part of the public record of the death.

Recommendation:

The **MoJ** should provide dedicated funding to the **Chief Coroner's Office** to enable it to centrally record the conclusions of inquest juries, even where no PFD report is issued, and publish them online for easy referral in the same way that PFD reports are currently published.

How should coroners approach the evidence available at an inquest relevant to a PFD report?

37. To ensure their reports have greatest impact, it is vital that coroners rely on the best evidence available for the issues that are leading to continued risks to life. Coroners are

subject to a statutory duty to ensure that they have considered all the documents, evidence and information that in their opinion is relevant to the investigation before making a PFD report (regulation 28(3)).

38. Coroners of course may decide that the evidence presented at the inquest does not give rise to any matters of concern. As noted above, different coroners may come to different conclusions about the need for a PFD report on the same set of facts, with *"no single, objectively correct answer"* in each case.[32] Nonetheless, coroners stated to the Panel that where organisations resist the issuing of a PFD report, submitting that they have already made relevant changes, they find that there is little means of testing such claims at the time. This makes it all the more important for coroners to ensure, for their work in this area to have significant impact, that they make such decisions on the best evidence available at the time and consider the need to prevent future deaths at both local and national level.

39. Some family members expressed frustration in understanding the basis on which coroners had determined whether a PFD report was required. One family member described being "*flabbergasted*" at the decision not to issue a PFD report after the death of their loved one, despite what they believed to be the evidence of significant ongoing failings presenting a risk to life in other cases.

40. To ensure the best evidence relevant to whether to issue a PFD report is obtained, coroners suggested that they should set clear expectations of public bodies participating in inquests regarding the PFD report process. One coroner suggested that the duty of candour placed on hospital health trusts has had a positive impact,[33] finding that in their experience some trusts have become better at admitting mistakes. Were all hospital trusts, agencies, and services to adopt such an approach, coroners might acquire valuable early evidence, and families and others would better see agencies and services candidly and transparently engaging with this process.

Recommendation:

Government departments, agencies, and private providers should ensure that they approach the PFD process with full candour and proactively provide all relevant information at the earliest appropriate stage.

41. Coroners also described the importance of being stringent in obtaining high quality evidence and setting requirements on the production of evidence relating to potential PFD issues arising. For example, it was suggested that they might request interested persons to make a statement relating to matters of concern no later than 28 days before the full inquest hearing, which addresses whether any audit had been conducted of changes having been put into practice in the past to address them. This would also provide an opportunity for agencies and services to provide other relevant evidence, for instance, about previous relevant PFD reports or 'near miss' incidents.

42. Family members described their experience of good practice where coroners at an early stage identified issues relevant to the prospect of issuing a PFD report. They described how those coroners made sure that they received relevant evidence, including by recalling previous witnesses to ensure particular issues or conflicts in evidence were resolved.

43. However, they also expressed frustration at coroners not drawing on previous PFD reports issued to the same body in what seemed to them similar, relevant cases often in the same institution or within the same mental health trust. The Home Office agreed that

it would be useful to ensure that all interested persons are made aware of previous PFD reports in advance of the inquest.

44. HMPPS described it as helpful for coroners to identify in advance the issues on which they wish to hear evidence so that HMPPS are able to submit a detailed witness statement, supplemented by oral evidence from a senior operational manager. They described preferring such an approach to one in which additional, later stages are added to the process after the inquest hearing.

45. However, HMPPS also described feeling frustrated to receive reports about matters they felt had been resolved in the evidence provided at individual inquests. They described feeling that PFD reports are sometimes issued because of a failure to address all relevant issues at the hearing or where the coroner has been insufficiently clear about what should be covered in witness statements. They felt this could be improved by using a pre-inquest review to set out the scope of the PFD evidence required.

Recommendation:

The Chief Coroner should consider supplementing his guidance to advise coroners on the importance of ensuring relevant evidence is provided at a sufficiently early stage, in particular where coroners consider there may be a need for urgent action. The guidance should remind coroners that previous PFD reports and evidence of 'near-miss' incidents may be relevant and important.

46. A strong theme among bereaved families with whom the Panel spoke was concern about the evidence that inquests have available to them to inform both substantive findings and PFD reports. Where independent investigations did not take place prior to an inquest, family members expressed concern about the risk that services and agencies were able to "*mark their own homework*" through internal investigations.

47. Unlike deaths in other areas of detention, deaths under the MHA do not automatically attract an independent investigation and never by a dedicated, independent body. Family members felt this contrasted poorly with the process following deaths in prison and police custody, where independent investigations are carried out prior to inquests by the Independent Office of Police Conduct (IOPC) or Prisons and Probation Ombudsman (PPO). They worried that this significantly undermined the evidence available to and therefore the decision-making at inquests into such deaths, including regarding PFD reports.

48. The quality of investigations by health providers after a death of a person detained under the MHA has been raised within PFD reports themselves. For example, the PFD report issued following the inquest into the death of Sharon Langley, published in February 2023, noted as specific matters of concern "*the reliability of the Trust investigation and how the Trust learned lessons*", and how the Trust investigation's author even changed the conclusion of their post-death investigation report during the inquest.[34] The lack of consistent, automatic, and independent post-death investigation for deaths under the MHA suggests that it is particularly important that PFD reports regarding such deaths are comprehensive and effective in driving necessary change.

Recommendation:

DHSC should give serious consideration to the creation of an independent body for investigating deaths of those formally or informally detained in mental health settings. This would remove the anomaly between the investigation of such deaths and those of persons in other detention settings and would ensure that coroners consistently have the benefit of high quality evidence regarding the circumstances of such deaths for the purposes of the inquest..

How wide a view should coroners take in considering PFD reports?

49. Coroners stressed the importance of ensuring that PFD reports help contribute to national learning on particular issues, noting that the families of those who have died would wish to see PFD reports ensure lessons learned from their loved one's death have the widest impact possible.

50. For example, while an investigation may draw upon the evidence from local persons who may contribute to and learn from the experience, a PFD report which covers matters of concern arising across the country can contribute to wider learning if shared more widely. Thus, even where a concern has been addressed locally, a PFD report may well still be appropriately made to a relevant national organisation to highlight the issues more widely if the evidence suggests that the risk of future deaths may arise nationally and the coroner believes national action should be taken.[35] One coroner described in an appropriate case bringing together themes from previous PFD reports as part of the report they were drafting, covering extant local issues but also applying a national perspective.

51. However, there was concern that doing this may move an inquest towards more of a public inquiry, beyond the proper remit of a coroner's investigation. Coroners suggested that further training, provided by the Chief Coroner's Office, might be valuable on this issue, and that there is a need for collaborative learning and training on the purpose of PFD reports more generally.

Recommendation:

The **Judicial College** should work with the **Chief Coroner** to deliver mandatory training to coroners on the purpose, process, publication, and distribution of PFD reports, as well as the role of independent scrutiny bodies, incorporating the perspective of bereaved families.

Chapter three: Drafting, publication, and distribution of PFD reports

This chapter explores how PFD reports are drafted, and identifies ways of improving the resources available to coroners in writing them. It explores their distribution, finding that they are not always distributed as widely as they should, and identifies ways of ensuring they are sent to the right bodies – particularly those scrutinising places of detention as well as relevant Parliamentary Committees – and that those bodies make the best of use of them.

It also looks at how PFD reports are published, particularly the very long period between the date of death and the issuing of a PFD report, and identifies ways of bringing attention to urgent matters of concern as early as possible in the process.

52. The Chief Coroner's guidance on PFD reports states that *"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.*" Similarly, it states, "*The coroner should express clearly, simply and 'in neutral and non-contentious terms' the factual basis for each concern*".[36]

53. When this latest version of the guidance was published in 2020, a number of specimen examples were published to assist coroners with the structures of their reports.[37] The key part of any PFD report is the section entitled 'Coroner's concerns', where coroners' matters of concern are identified. The Chief Coroner describes these as "*the concerns which the investigation has revealed, either at inquest or earlier during the investigation*", which identify continuing risk to life, and are "*the essence of a report to prevent future deaths*". As the guidance continues, "*it is not for the coroner to dictate precisely what action should be taken. A prevention of future death report raises issues and is a recommendation that action should be taken, but not what that action should be*".

Are PFD reports being drafted as effectively as they could?

54. Our sampling exercise examined whether PFD reports are being drafted in ways likely to maximise their impact. Many of the reports sampled follow the structure noted above, and family members with whom the Panel spoke noted that they had found the PFD reports issued in their deceased loved ones' cases clearly written.

55. Our sampling exercise, however, identified some gaps and cases of best practice not being followed. The table below identifies the number of PFD reports in the sampling exercise that we reviewed against the requirements set out by the Chief Coroner, including where the requirements of the guidance could be said not to have been satisfied.

Requirements	Yes	No
Details of inquest and jury verdict outlined	19	1
Circumstances of death detailed	14	6
Specific, practical and clear matters of concern	15	5

56. We reviewed the sample group of PFD reports for their clarity and impact bearing in mind the recipients who need to understand and take on board their content. We identified that some reports included matters of concern spanning a significant number of points and sub-points. We recognise that the complexity of the issues in these cases may well have required this level of detail in order to adequately convey the matters of

concern. However, our review also highlighted the importance of ensuring that key issues of concern are clearly identified, with the intended target audience in mind.

57. We also identified reports which amalgamate the circumstances of death with the matters of concern or use the two sections interchangeably. In the case of some of these reports, the result was that the report did not clearly convey either, with the attendant risk that key points may not be clearly communicated to recipients. Other PFD reports we reviewed adopted practices which we consider could be usefully adopted more widely, and ensured that the recipient could clearly understand the circumstances of death and the matters of concern. Further, one report reviewed clearly and succinctly identified a previous PFD report relating to the same institution that was relevant to the matter of concern identified. This exemplified the value, where relevant, of a report being drafted with reference to previous PFD reports.

Do coroners have the right resources available when drafting PFD reports?

58. Unless they are provided by Interested Persons, coroners are able to take account of relevant previous PFD reports only where they have capacity to undertake their own research or happen to be aware of the report, such as from having happened to hear previous cases. During the roundtables, coroners expressed concern about the accessibility of published PFD reports to inform the discharge of their PFD duty where relevant. While coroners can sign-up to receive copies of other PFD reports when published, they reflected that it is difficult to find time to stay abreast of potentially relevant reports and to integrate them into their investigations.

59. As explored earlier, some services and agencies, coroners and families all noted that it is helpful to proactively seek the assistance of interested persons and in particular the representatives of custodial services and agencies in identifying potential PFD issues and relevant evidence, including where relevant previous PFD reports and evidence of near misses. In addition, some coroners pointed to the work of the London Inner South Coroner's Court in producing an annual report, which includes a section on findings and themes from PFD reports, and importantly whether action has been taken in response.[38] As a result, over a three-year period the most prominent cause of deaths in custody had been identified to be communication failures between organisations, a useful finding to inform relevant matters of concern in future inquests. This was described as invaluable to local coroners.

60. There is currently no centralised mechanism to assist coroners to readily draw on the content of previous PFD reports where relevant. While PFD reports are published on the Chief Coroner's website, it has in the past been difficult to search through them for relevant information.

61. Coroners described often being reliant on colleagues to identify relevant reports and described their frustration, after producing a PFD report, at being told by public bodies that previous reports had already been made about the same issue which they were not aware of. Many coroners do seek to identify previous PFD reports relevant to a matter of concern they are considering, including from other coronial areas, to see whether concerns have previously been raised. However, they recognised that with hundreds of inquests a year, there were limits on their ability to stay informed of relevant developments and also correctly identified that providing wider national oversight of ongoing issues (beyond the statutory PFD duty) was beyond their remit. Further, even in the same local area, a problem may have arisen before but only come to light if the same coroner comes across it, given the challenges of keeping track, on their own, of patterns across institutions even within their own area.

62. One solution suggested at the roundtables was for specific local coroners to cover all deaths for a particular custody area: for instance, a specific local coroner might cover all

deaths occurring in prisons in that area, ensuring that individual coroners is better appraised of relevant issues of concern relevant to individual deaths in a particular custody area over time.

63. The Chief Coroner's Office has recently made improvements to its online database of PFD reports, enabling users to search for PFD reports by thematic and subject area on the Judiciary website.[39] New reports are fully text-searchable, allowing users to search for thematic keywords. However, the website still lacks fully comprehensive tagging functions: for example, no distinction is made between deaths of those detained under the Mental Health Act and those receiving voluntary and community-based mental health services. Without more specific tagging functions, coroners and the public remain reliant on having time to trawl through a large number of reports to identify those relevant to particular areas. Currently, these also do not tag the protected characteristics of the deceased.

Recommendation:

The Chief Coroner's Office should ensure that its online database of PFD reports is fully searchable by thematic areas and location, and that deaths in detention (particularly under the Mental Health Act 1983 (MHA)) are readily identifiable. Consideration should be given to tagging reports according to the deceased's protected characteristics to help better identify and understand issues of disproportionality.

64. Coroners reflected that prior to the establishment of the post of Chief Coroner, annual bulletins were circulated documenting all PFD reports (known then as 'Rule 43 reports') that had been made. The Chief Coroner's Office continues to publish an annual report, which has in the past included detail regarding themes and learning identified from PFD reports in the course of each year.[40] For example, its 2017-18 annual report identified themes relating to deaths in custody such as "*Failure to pass on information between agencies and within institutions*", "*Issues around buildings and estate (such as exposed ligature points in cells)*", and "*the need for extra or reinforced training for staff*".[41]

65. However, no themes or learning were identified in its combined annual reports for 2018-19 or 2019-2020.[42] While these note the impact of the COVID-19 pandemic on the number of PFD reports made during that period, no explanation is provided for why themes or learning could not be identified. It was originally intended for the Coroner Service to have a research function, and coroners expressed that properly providing this, and using it to identify ways of analysing PFD reports for deaths in custody and distributing themes and learning from them across all coroners and among services and agencies, would significantly improve the likelihood of creating effective PFD reports and ensuring responses to bring real change.

66. Over the course of this project, the Chief Coroner has committed to ensuring his annual report identifies key themes from PFD reports across each year. This is a welcome development which will help coroners, and others, identify key trends and learning from PFD reports. However, more could be done to ensure this annual report has maximum impact, such as providing the Chief Coroner's Office with sufficient resource as well as developing closer links with wider stakeholders who may be able to take the learning forward, particularly Parliamentary Committees with responsibility for scrutinising areas of custody.

Recommendation:

The **Ministry of Justice (MoJ)** should adequately resource the **Chief Coroner's Office** to produce a yearly review of PFD reports for custody deaths. This should aim to identify themes and trends, and report on the timeliness and quality of responses, as part of the Chief Coroner's role under existing guidance.

Recommendation:

The Ministerial Board on Deaths in Custody secretariat should send PFD reports on deaths in custody to **the House of Commons Justice, Health, and Home Affairs Select Committees**, which should consider taking evidence and reporting on significant themes.

How timely are PFD reports?

67. Coroners raised concerns that inquests are sometimes not heard quickly enough to ensure that PFD reports have the greatest impact, particularly in the case of deaths in detention. Investigations by other bodies are often carried out first. This ensures that the coroner has all relevant information relating to the incident, but this delays the publication of PFD reports. One academic study found that coroners often use PPO reports as a starting point, having waited for the PPO reports before beginning their inquest and this reflects Panel members' experience of Coronial practice.[43] By the time a PFD report is published, it may be that the authorities have addressed (or argue that they have addressed) the issues raised, although as stated earlier it is important to note that even where a concern has been addressed locally, a PFD report may well still be appropriately directed to a relevant national organisation to highlight the issues more widely if the evidence suggests that the risk of future deaths may arise nationally and the coroner believes national action should be taken.[44] .

68. In the sampling exercise, the average time from the date of death to the publication of the PFD report was 29 months. The overall time ranged from seven months (a death in MHA detention) to 93 months (Prince Fosu died in an IRC in October 2012, the inquest concluded in March 2020, and the report was published in July 2020). A range of factors may impact the period of time it takes to publish a PFD report, such as the length and complexity of the inquest and particularly the need for post-death investigation processes by bodies such as the PPO to be completed before the inquest can begin. A breakdown of average publication times by detention area can be found below.[45]

Detention setting	Average time for publication of report following death (months)
Immigration Removal Centres	64
Police custody	35
Prisons	22
MHA detention	16

69. By contrast, the average time taken to complete all inquests from the reported date of death, according to the 2022 Coroners statistics for England & Wales, is 30 weeks.[46] While it may take some time for a coroner to issue a PFD report following the conclusion of an inquest hearing, this still indicates that inquests on deaths in detention and the subsequent publication of PFD reports can take a significant amount of time.

70. As identified already above, coroners and services suggested that to ensure PFD reports have greater opportunity to make an impact, they should seek wherever possible to identify areas of potential concern at an early stage of an inquest and ensure necessary evidence is produced. This is likely to be particularly important where a coroner forms the view that there is an urgent need for action. In such a case it remains a statutory requirement that the report is not made "*until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation*."[47] While the possibility of such interim reports is recognised in the Chief Coroner's PFD guidance, currently limited practical guidance is provided to assist Coroner's and such interim reports are in practice relatively rare. However, there is evidence of good practice with some coroners having issued significant early interim PFD reports, such as the interim PFD report issued by the Senior Coroner for Inner West London at a pre-inquest review into the deaths of the 72 individuals who died in the disaster at Grenfell Tower.[48]

Recommendation:

The Chief Coroner should consider supplementing his guidance on PFD reports to further address when it may be appropriate, in compliance with the statutory requirements, to make interim PFD reports and the importance of doing so, in particular where a coroner is of the opinion that there is an urgent need for action to prevent future deaths.

How effectively are PFD reports distributed?

71. The coroner who issues a report is responsible for its distribution to the appropriate recipients. PFD reports are sent to organisations who are required to provide a response (which are listed at the top of the report) and those who are copied into the distribution for the purpose of sharing information (listed in section 8 of each report).

72. There are concerns that PFD reports are not always shared with the organisations that would benefit from them and assist with making change.[49] With sometimes a large number of bodies and agencies with responsibilities relevant to preventing deaths in custody, a failure to effectively distribute PFD reports risks leaving those organisations without the benefit of their findings. For example, the National Police Chiefs Council (NPCC) stated that from reviewing historic reports, several were not distributed to them when they should have been.

73. The Home Office also gave examples where they had not been provided with a PFD report but should have been, such as a case in 2020 where a report was distributed to NHS England in relation to healthcare services operating in an IRC but not shared with the Home Office as well. The report came to Home Office's attention shortly before the 56-day deadline and this was said to have impacted on the opportunity for consideration of estate-wide learning before a response was required.

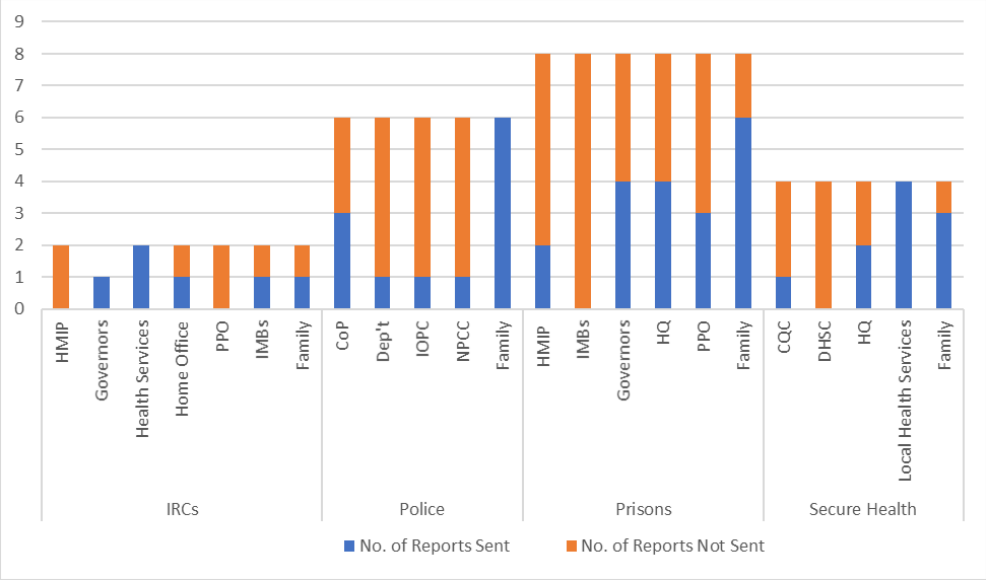
74. Further, we identified some cases of reports being sent to the incorrect bodies. For example, the PFD report relating to the death of Natasha Chin was sent not only to the bodies involved in her custody at HMP Bronzefield, but also to His Majesty's Chief Inspector of Prisons (HMCIP), despite the latter not being able to effect change in relation to the matters of concern identified.[50] Rather, such bodies should be *copied into* reports, as explored further below.

75. Coroners highlighted the importance of ensuring PFD reports are distributed to the agencies and services which need to see them, and suggested that there could be focused training on this topic. Some suggested that an approved list of addresses for each custody area, that expands on the short list already provided in the Chief Coroner's

guidance, could be issued to ensure that PFD reports reach all the organisations they should, and that this would be used in induction training for new coroners. The Home Office told the Panel that it would be beneficial for a wider range of bodies to receive PFD reports, such as their key partners among contracted custodial service and healthcare providers.

76. However, some PFD reports we reviewed included recipient lists which did not appear to encompass all of the agencies with an interest in the issues raised in the report. For example, a PFD report in the sample relating to a death involving police restraint and the swallowing of Class A drugs was only sent to the relevant police force, but others may also have benefited from receiving the report, such as the Ambulance Service.[51]

Figure 4: Number of reports sent (both copied and for response) to recipients by area of detention (right). In relation to the Prison data, HQ encompasses the MoJ, HMPPS, and private prison providers. In relation to the data for Secure Health services, HQ refers to NHS England and private healthcare providers. Regarding the reports recorded as "not sent" to families, the list of recipients who were copied in was either redacted or families were not mentioned explicitly.



Recommendation:

The Chief Coroner's Office should review and consider expanding the list of organisations which should receive PFD reports on deaths in state custody (found at paragraphs 56 and 57 of the guidance on PFD reports) to ensure more comprehensive coverage of relevant bodies, organisations, and departments. This should be circulated to all coroners and used in training on PFD reports. The **IAPDC** could assist with ensuring this list is up to date and comprehensive.

77. Scrutiny bodies – including the PPO, HMIP, Independent Monitoring Boards (IMBs), and the CQC – as well as relevant advisory bodies such as the Panel should also receive reports. Independent bodies such as the IOPC and HMIP have asked to be included in the distribution of any relevant PFD reports and the CQC have a Memorandum of Understanding with the Coroner's Society of England and Wales which makes the same request.[52] Other relevant organisations, such as those falling within the UK's National Preventative Mechanism, should be included through sharing agreements as appropriate.

78. PFD reports represent a potentially invaluable source of learning for scrutiny bodies to use as part of their evidence base ahead of inspections. They may be able to play a role

in monitoring implementation of action plans. Our sampling review appears to indicate that the matters of concern identified by PFD reports and the recommendations in the reports of scrutiny bodies such as the PPO appear to cover different areas, with only eight recommendations on a death made in both reports. To some extent, this is to be expected, since coroners sometimes find a PFD report to be unnecessary where the PPO has already, in effect, identified the matter of concern which HMPPS has then gone on to address. Nonetheless, this suggests that joint working and shared learning may be particularly fruitful.

PFD 'Areas of concern'	PPO recommendations	**Crossover**
33	27	**8**

79. Our sampling analysis indicated that in all four areas of detention scrutiny bodies were sent PFD reports in less than 50% of cases.[53] IMBs for example, were only sent one report out of a possible ten, and none relating to deaths in prisons. Reports on deaths in police custody very rarely went to organisations responsible for standards and good practice, such as the College of Policing. Despite being named in the Chief Coroners' guidance on PFD reports as a body to which PFD reports relating to deaths in custody should be sent, the IAPDC rarely receives them from coroners.

Recommendation:

All organisations which scrutinise places of detention should make explicit use of PFD reports to inform their investigations, inspections, and thematic reports and bulletins, including monitoring and reporting on progress made against responses to PFD reports by services and agencies. They should work with the **Chief Coroner** to agree protocols to work together and share learning.

80. Two of the reports in the sample did not appear to have been sent to the family of the deceased (nor through their legal representatives). In one of the two cases, which related to a foreign national who died in an IRC, it is possible that there were difficulties locating family members but this is not clear from the relevant section of the report.

81. A death may concern multiple agencies but the PFD report may only be sent to a single organisation whose responsibility it is to distribute it further. Indeed, HMPPS stated that they prefer all reports to be sent to their central Director General of Operations. This may suit particular areas of custody where there is a central, coordinating headquarters which may serve this role, such as HMPPS. This is not the case, for example, for those detained under the MHA, who may be detained in an NHS hospital or a private facility hosted by a wide variety of private providers. It is of concern that there is currently no systematic, centralised process to disseminate PFD reports and ensure consistent distribution to all who would benefit from sight of them.

82. Referring specifically to police custody deaths, the Angiolini Review of 2017 called for a "*coordinated, methodical and routine process around the dissemination of Coroners' PFD reports and jury findings to all stakeholders, including (but not limited to) police forces, the College of Policing, the IPCC [now the IOPC], and healthcare professionals*".[54] The Ministerial Council on Deaths in Custody at present plays aspects of this role, reviewing all PFD reports relating to deaths in custody, summarising them, and distributing them to key agencies and services each week.

Recommendation:

The **Ministerial Board on Deaths in Custody secretariat** should continue to review and distribute PFD reports relating to death in custody to MBDC members for the purpose of sharing learning, and consider involving all relevant agencies and partners who would benefit from additional learning across all places of state detention. Issues of significant wider concern arising from recent PFD reports should be discussed at MBDC meetings.

Chapter four: Follow-up and learning from PFD reports

This chapter explores how agencies and services respond to PFD reports, and how this process often fails to have the impact it should. It looks at ways of ensuring there is a greater role for families in this process, examines evidence of how agencies and services respond to PFD reports, and looks at a number of different ways of ensuring there is greater coordination and follow-up of PFD reports after they are issued.

83. The impact of a PFD report lies in the responses it can elicit from agencies and services to demonstrate that changes have been made or commit to making them. PFD report recipients are asked to respond to the report and identify updates or progress made against the matters of concern within 56 days.

84. But coroners have no legal powers or duties to follow up on whether the matters of concern have effectively been addressed, and there is no wider system for doing so. There is widespread concern that this may limit the impact PFD reports can have to prevent deaths.

85. Whether changes have been made following a PFD report is often only highlighted if a similar death later occurs in the same establishment or agency.[55] Particularly, if the issue involves a private company, the only external monitoring which can occur – other than periodic inspections by regulatory bodies – is when contracts are due for renewal. In discussion with the Panel, families expressed dismay at their experiences with the range of different agencies who might be involved in the care or custody of their loved ones, with the profusion of third-party providers in MHA detention making achieving accountability particularly difficult. As one family member described, if it appears so difficult to ensure one government department makes real changes after a PFD report, how much more difficult is it to ensure several different private providers do so?

86. Coroners want to see that actions have been taken by the relevant bodies in response to a PFD report, but when a report is revisited they too often find that the concerns have not been properly addressed. Similarly, family members with whom the Panel spoke felt that after PFD reports were issued in their loved ones' cases, and responses given, they were left unclear about what changes were being proposed, whether there was clear evidence to show the changes were being made, or whether the changes made would be successful in addressing the problem.

87. Families were also concerned that there is no obligation on the coroner, or any other body, to do anything further with responses received, such as assess them for their quality or follow them up. They described this as a *"cliff edge"* after which there are no mechanisms by which to ensure action is taken. Legally, coroners have no power or duty to follow up on the matters of concern identified in their reports. Family members expressed a desire to be given a right of reply to PFD reports, allowing family members to have a voice about the matters of concern identified. While this is not something coroners can facilitate, there is scope for services and agencies to engage with family members to sensitively explain their response and action taken following a PFD report, and where appropriate seek a bereaved family's further views and input.

How do agencies and services respond to PFD reports?

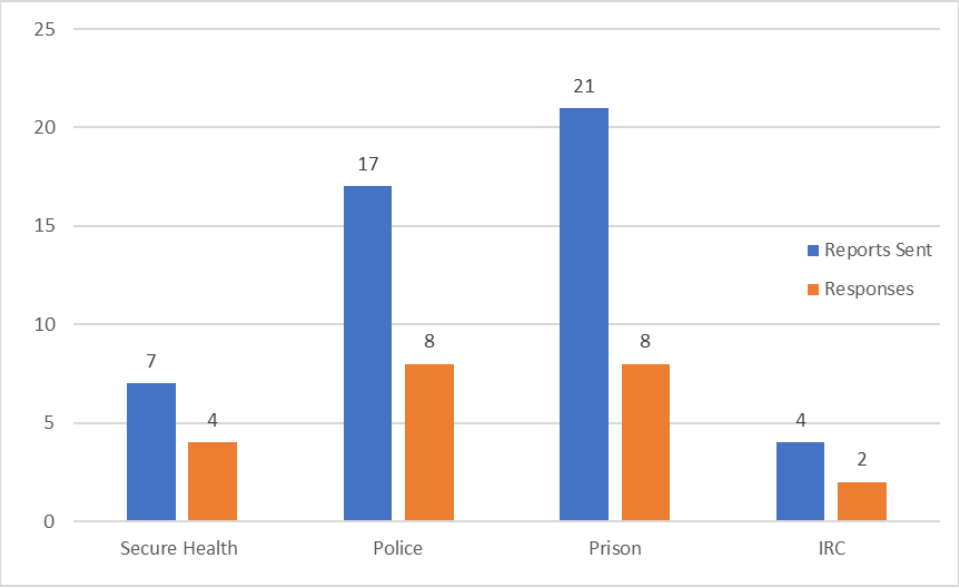
88. Coroners described a high level of variation in responses from different agencies to PFD reports, with some appearing to be "*cut and paste*" and in other cases there being no

response at all. Family members made a similar criticism of responses which appeared to repeat significant passages from previous responses. They felt this suggested both that the matters of concern were going unaddressed and that the agency in question was not taking enough care to address the specific issues arising from each individual death.

89. Our sampling review bore out these concerns. Upon reviewing responses recorded on the Chief Coroner's website, an alarming number of recipients of PFD reports who are required to provide a response were identified as having failed to do so. As detailed below in figure 6, fewer than 50% of recipients of PFD reports had provided a response, with only 38% of recipients of reports concerning prisons providing responses.

90. It is worth noting that arrangements within organisations responding to PFD reports may impact these statistics. For example, regarding prison deaths, the Director General of Prisons in HMPPS responds to all reports, rather than the prison where the death occurred.[56] The way in which responses are recorded may also have an impact. For example, on investigation, HMPPS stated that it had responded to some of these outstanding reports, but these responses had not been published on the Chief Coroner's website. We were concerned to hear this, and we urge that this be remedied at the earliest opportunity. Similarly, it is important to note that organisations who are only copied into PFD reports are not required to provide a response, although they sometimes provide responses. For example, the Home Office stated it provided a response to the PFD report it was copied into, although this response is not recorded on the Chief Coroner's website. Similarly, the fact that some responses, even those not from direct recipients of PFD reports, are not available on the PFD report database is of real concern.

Figure 6: Number recipients of PFD reports who were requested to make a response, against the number of responses recorded on the Chief Coroner's database.



91. The sampling review also explored how PFD reports were responded to. As detailed in the table below, all the responses received detailed action to be taken (or explained why no action was being taken), and almost all explained how the changes will or have been communicated to those involved in the death. However, far fewer provided specific timescales for the action proposed, and almost no responses included direct reference to the wider national evidence and implications.

Requirements	Yes	No	No response
Details the action taken/to be taken, whether in response to the report or otherwise, or explain why no action is proposed	12	0	8
Timescales provided for actions taken	7	5	8
References national evidence/implications (not specific to the local police force, prison, hospital etc)	1	11	8
Explanation of how changes will/have been communicated with those involved in death	10	2	8

92. Proportionally more responses were made to PFD reports in relation to secure health services than any other area of detention covered in this review. In relation to PFD reports concerning police custody, of the individual forces who were sent PFD reports, 47% responded, while the College of Policing responded on both occasions they were contacted. These reports suggest that more could be done to ensure findings are shared and considered among a wider range of bodies, including equivalent agencies and services in different regions who may benefit from the learning they contain. There should be a specific function to ensure that a report targeted at a particular trust, prison, or police force, for example, is shared with their equivalents across the country, even if they were not directly involved in the death that is the subject of the PFD report.

Recommendation:

Government departments, agencies, and private providers should ensure PFD reports are shared 'horizontally' with relevant equivalents across the country – for example other police forces, prisons, and mental health trusts – particularly where there may be scope for national learning, to ensure opportunities to make change across different custody areas are not missed.

93. Where they are provided, the responses to the PFD reports in our sampling review directly addressed the matters of concern raised. However, some lacked clear timescales for when actions would be taken. Some responses appeared to follow best practice, including clear evidence of implementation and commitments to further learning and improvement.

Recommendation:

Recipients of PFD reports should ensure that their responses are timely, high quality, case-specific, and fully informed by the inquest evidence and findings. Where the response relays that action will be taken, actions should be identified in precise terms and with precise timelines. Where no action is to be taken, a clear, detailed and respectfully worded explanation should be provided to enable the coroner, family, and wider public to understand the basis for the decision. Recipients should ensure that their responses recognise and reflect the significance of PFD reports to bereaved families, with consideration given to how families can be kept informed and where appropriate consulted on the action plan.

What processes are in place to respond to PFD reports and make change?

94. Agencies and services provided details on the processes by which they respond to PFD reports. HMPPS stated that they are handled by a central casework team which works with senior staff in prison and policy teams within HMPPS and/or MoJ to draft a response

for clearance by the Governor of the relevant prison. The Director General of Operations responds to the coroner in each case. The team maintains a database of previous responses. Individual caseworkers support particular prisons and are aware of the issues at each prison. Responding to a PFD report involves staff in the casework team, the prison, and policy leads in HMPPS and/or MoJ putting aside time to consider the issues, identify relevant actions, and prepare draft replies.

95. The Home Office stated that following a PFD report relating to a death in an IRC, an action plan is devised to track the implementation of changes and the Minister is informed about the matters of concern, action plan, and work underway with a proposed response to the coroner. An audit and assurance team maintains an actions table, including details of matters of concern from various PFD reports and the resulting changes or work undertaken to improve processes, policies, or operations.

96. The Home Office stated that they are committed to continuous improvement and endeavour to transparently respond to PFD reports, and they seek to accept matters of concern wherever feasible. Where particularly changes are not viable, the Home Office seek to identify alternative changes or improvements in the spirit of the matters of concern and work to prevent future deaths. For example, they suggested that matters of concern can often be appropriately addressed with ongoing continuous improvement work, or through updating published guidance and policies.

97. Regarding deaths of those detained under the MHA, DHSC has a dedicated team to coordinate PFD report responses and work with analysts on ongoing PFD oversight reporting. They also share PFD reports and the department's response with other relevant departments and public bodies. HMPPS has processes for learning from a case before the production of the PFD report: an early learning review (ELR) is conducted to identify any immediate learning, followed by an independent investigation report by the PPO. The inquest then occurs often well over a year after the death. Therefore, HMPPS felt that issues arising from the death have often been identified and addressed some time before the inquest. The Panel was told there is also an ongoing process of system-wide learning so that lessons from other cases are informing action.

98. As a result, HMPPS felt that it is rare for a PFD report to identify a concern of which they are not aware, and responses usually describe action that has already been taken and/or further measures being introduced to provide assurance that such action is effective and that consistent compliance with policy is achieved. These typically include issuing reminders, providing refresher training to staff, and introducing additional management checks with follow-up actions to address identified non-compliance. Overall, HMPPS described using ELRs, PPO reports, and PFD reports to identify themes to inform improved guidance, regular learning bulletins, and the development of the prison safety programme. They described how themes are also discussed at monthly meetings of group safety leads who share the learning with the prisons in their groups.

Why might PFD reports not have the impact expected?

99. Services and agencies sought to situate concerns over repeat recommendations within the context of systemic issues affecting their custody areas. For example, HMPPS described how one of the most frequent matters of concern raised in PFD reports is the operation of the Assessment, Care in Custody and Teamwork (ACCT) case management system for prisoners identified as being at risk of self-harm or suicide. There are a large number of prisoners being managed on ACCT – a complex system involving multi-disciplinary teams of staff operating in a busy operational environment and which sets out numerous mandatory actions that must be undertaken in each case. As a result, they described it as almost inevitable that there will be occasions on which independent investigators identify that one or more of these actions was not taken, or recorded, in a particular case.

100. HMPPS suggested that this does not necessarily mean that the individual at risk was not being effectively supported, or that action being taken to improve the operation of the ACCT system in response to previous reports had not had an impact. Rather, it illustrates the scale of the ongoing challenges presented by the prison population and the environment in which staff operate. As a result, HMPPS suggested that the fact that matters of concern may be repeated does not indicate that effective action is not being taken in response to PFD reports.

101. HMPPS pointed out that, where deaths in detention take place within the context of system-wide problems, or where large, complex policies and mechanisms are used to manage an individuals' care, it may well be that change is slow, or that systems and structures may be open to continual improvement. This may be so without it being also the case that the agencies and services involved had failed to respond to PFD reports appropriately or take action to address them. In some cases, agencies and services appear to be taking action to improve the safety of those in their care, and still receive repeated PFD reports drawing attention to those failings that, given the time needing to be taken, are in fact being addressed.

102. In the Panel's view, it will in practice be difficult for any service or agency to distinguish whether or not a death has been contributed to by an unidentified or insufficiently addressed weakness in its systems without close attention to the evidence in individual cases. Such evidence will often only emerge during the full inquest hearing, which will tend to consider the issues in considerably greater forensic detail than an ELR or PPO investigation. The inquest also tests the evidence gathered as part of those reviews and investigations. It is therefore important that services and agencies have robust internal processes to consider, disseminate, and act on the evidence and findings that emerge from inquest processes. This is important not just in responding to a PFD report in order to reach an informed decision on the need for further action, but to maximise the benefit of the significant expenditure of resources associated with agencies and services participating in full inquest hearings.

Recommendation:

Recipients of PFD reports relating to deaths in custody should hold a "post-inquest learning review" meeting following the conclusion of an inquest, attended by the key persons who participated in the inquest. This will help to ensure both an efficient and fully informed response to PFD reports and the formulation of an appropriate action plan to take forward necessary learning.

103. Coroners and families suggested alternative explanations for why repeat matters of concern may be identified with little change appearing to take place between them. There was a concern that sometimes limited evidence of relevant and sufficient changes was offered by agencies and services in their responses to PFD reports. Since it is outside of the coroner's remit to assess the adequacy of such responses or any action taken, the adequacy of remedial action may remain unscrutinised and untested until there is a further death in related circumstances. This pointed to the need for independent mechanisms to verify that necessary changes have been made and effectively implemented.

104. The lack of a central mechanism makes it difficult to follow up repeat matters of concern. This may also hinder agencies in drawing attention to areas of improvement. This has been identified as a problem for several years. In evidence given to Lord Harris's Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds in 2015, the then-Chief Coroner confirmed that there was no mechanism to ensure that PFD reports are properly examined and agreed such a mechanism was required.[57] This

was echoed by Lady Elish Angiolini KC in her report of the Independent Review of Deaths and Serious Incidents in Police Custody in 2017.[58]

105. These gaps led the JSC, as part of its inquiry into the Coroner Service, to describe the PFD report system as "*under-developed*" and the absence of follow up to PFDs as a "*missed opportunity*".[59] It recommended that the Ministry of Justice "*should consider setting up an independent office to report on emerging issues raised by coroners and juries; and liaise with regulators…to follow up on actions promised to coroners and to report publicly where insufficient action has been promised or implemented"*. As an alternative, it suggested that a new Coroner Service Inspectorate could be given this role.

106. The charity INQUEST have also called for the establishment of a new independent body in the form of a 'national oversight mechanism' to ensure collation, analysis, follow up of, as well as reporting on, recommendations from investigations, inquests, inquiries, and reviews regarding deaths that engage Article 2 of the ECHR, including matters of concern identified in PFD reports.[60] INQUEST state that the preventative potential of PFD reports, as well as that of recommendations from other investigations, is being "undermined by the lack of a framework to monitor compliance with, and/or actions taken in response to, the findings and recommendations that emerge from post-death investigations".[61]

107. It is clear that there remains a considerable gap in the follow-up of PFD reports and matters of concern raised in them. While this report has identified several practical ways for coroners, families, and agencies and services to help improve the impact of PFD reports, Government should give serious consideration to the role an independent oversight mechanism, or additional independent bodies, might play in following up PFD reports, and whether further legislative change is necessary.

Recommendation:

Government should consider what enhanced role independent bodies might play in auditing, following up on, and reporting on PFD reports, and this could include establishing a new body for this purpose. More effective oversight of the sharing, use, and implementation of matters of concern in PFD reports is needed.

108. Coroners identified further ways of ensuring better responses from agencies and services, including proactively engaging local services to ensure that they continue to be engaged on matters of concern raised by reports. As an example of good practice, Milton Keynes has a Safeguarding Partnership comprising senior staff from police, fire services, healthcare organisations, and prisons in the local area, with the partnership sent copies of all relevant PFD reports. These are considered at a local level and follow-up actions are agreed at each meeting. While further consideration would need to be given as to how suitable this may be for different coronial areas, regional leadership may want to consider developing similar schemes.

109. Some coroners told us that they take steps to get to know and visit places of detention, including local hospitals and prisons. Services and agencies felt that visits to detention settings can be beneficial in terms of enabling coroners have a greater understanding of the environment and challenges of processes, setting and population. However, other coroners felt that such contact and visits were not appropriate in light of their independent judicial role.

Recommendation:

Leaders within local custody bodies, such as prison governors, should consider adopting the approach of Milton Keynes Together Safeguarding Partnership and hold periodic meetings of representatives from all custodial settings to review relevant PFD reports, with participation, where appropriate, of local coroners.

Next steps

110. The report makes 18 recommendations (pages 4 to 5) to Government departments, custodial services and agencies, the Chief Coroner, and others to make practical changes that we believe will help unlock the preventative potential of PFD reports. Following the publication of this report, the Panel will seek to work closely with the Chief Coroner, and others to whom these recommendations are directed, to ensure they are implemented and make an impact.

111. While this report focuses on deaths in custody, the principles, findings, and recommendations explored should be borne in mind when considering all PFD reports, not just deaths in custody. This can assist the prevention of all deaths.

Annex A – the sampling exercise

Twenty PFD reports were selected from the database on the Judiciary website to cover the four main places of detention within the remit of the IAPDC. All selected PFD reports were published no later than November 2020 to ensure those addressed had sufficient time to respond to the report prior to the project commencing, accounting for the impact of COVID-19. Reports date from 2 March 2018 to 9 March 2020. Those selected can be found below.

The sample does not rely on an equal weighting of reports relating to all places of detention. Rather, the sampling exercise sought to be broadly representative of the total number of deaths occurring in each place of detention. However, not all inquests result in a PFD report, which explains why the number of PFD reports published are not always representative of deaths that may have occurred in a particular place of detention. The reports were approved by IAPDC member Deborah Coles and then-IAPDC member John Wadham, with the research methodology approved by IAPDC member Professor Jenny Shaw.

Area of detention	Number of PFD reports
Prisons	8
Police custody	6
Secure health	4
Immigration Removal Centres	2
Area of detention	**Average age (years)**
Police	32
Immigration Removal Centres	35
Prisons	38
Secure health	59
Cause of death	**Number of PFD reports**
Non-natural	10
Natural	5
Self-inflicted	5

In total, 18 of the 20 PFD reports related to deaths of males. The ages of the subjects of the reports ranged from 20 to 82, with the average being 30 years old. The PFD reports selected related to a range of deaths as recorded by the jury's verdict. For this report these have been grouped into 1) self-inflicted deaths; 2) natural deaths; and 3) non-natural deaths.

All self-inflicted deaths occurred through hanging. The main causes of the five natural deaths included hypothermia, stroke, heart failure, pulmonary embolism, and bronchiolitis obliterans syndrome. Deaths which occurred during or after the use of restraint have been classified as non-natural. Overall, five of the ten non-natural deaths sampled involved the use of restraint on the individual. Of the remaining five deaths, three involved drug overdoses and the remaining were associated with an accidental drowning and an incorrect use of prescribed medication by a medical professional.

We acknowledge that the size of the weighted sample used in our exercise was small, although conducted according to a methodology that sought to cover a representative sample of areas of custody. Importantly, our weighted sample identified much the same issues identified through the roundtable meetings with coroners, suggesting that the evidence gathered is indicative of the problems that prevail in this area.

Below is a list of the PFD reports reviewed as part of the sampling exercise:

Name	Age at death	Date of death	Date of report	Location of death
Ewan Brown	27	30/04/2019	10/11/2020	Police custody (Northumbria Police)
Roy Campbell	82	21/07/2018	09/03/2020	Worcestershire Health and Care NHS Trust
Natasha Chin	39	19/07/2016	10/01/2019	HMP Bronzefield
Edir Da Costa	25	21/06/2017	27/06/2019	Police custody (Met Police)
Gordon Fenton	70	29/06/2019	23/04/2020	Pennine Care NHS Trust
Prince Fosu	31	30/10/2012	06/07/2020	Harmondsworth IRC
Lewis Francis	20	24/04/2017	23/03/2020	HMP Exeter
Andrew Goldstraw	43	14/11/2018	21/02/2020	HMP Winchester
Emily Hartley	21	23/04/2016	02/03/2018	HMP New Hall
Rebecca Hursey	39	05/04/2018	09/03/2020	St George's Hospital (London)
Jon James	28	27/06/2017	20/02/2020	Police custody (South Wales police)
Meirion James	53	31/01/2015	04/03/2021	Police custody (Dyfed-Powys Police)
David Kirsch	52	19/03/2018	30/10/2019	HMP Long Lartin
Neville McNair	51	16/06/2018	05/11/2019	HMP Lewes
Wayne Millett	46	13/02/2019	18/02/2020	The Priory Hospital (Cheadle)
Carl Newman	23	06/10/2017	06/03/2020	HMP Liverpool
Douglas Oak	25	12/04/2017	24/10/2019	Police custody (Dorset Police)
Carlington Spencer	38	29/09/2017	28/08/2020	Morton Hall IRC
Duncan Tomlin	32	29/07/2014	12/04/2019	Sussex Police
Gareth Warburton	58	01/04/2018	04/12/2019	HMP Hewell

Annex B – About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody (MCDC) formally commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care and the Home Office. The Council consists of three tiers:

• Ministerial Board on Deaths in Custody

• Independent Advisory Panel (IAPDC)

• Practitioner and Stakeholder Group

The remit of the IAPDC (and overall of the Council) covers deaths, natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAPDC, an advisory non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials and the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAPDC's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Lynn Emslie chairs the IAPDC. The other members are:

- Jenny Talbot OBE, Prison Reform Trust
- Professor Jenny Shaw, professor of Forensic Psychiatry, University of Manchester
- Professor Seena Fazel, professor of Forensic Psychiatry, University of Oxford
- Deborah Coles, Director, INQUEST
- Raj Desai, barrister, Matrix Chambers
- Pauline McCabe OBE, international criminal justice advisor
- Dr Jake Hard, Clinical Director in HMP Cardiff

Further information on the IAPDC can be found on its website: https://www.iapondeathsincustody.org.

For more information on this paper – or on the IAPDC more generally - please contact MinisterialCouncilonDeathsinCustody@justice.gov.uk.

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[1] Chief Coroner, 'Revised Guidance No. 5 Reports to Prevent Future Deaths', November 2020, para. 2, available here.
[2] INQUEST, written evidence to Parliament's Justice Select Committee inquiry into the Coroner Service, September 2020, available here.
[3] Chief Coroner, 'Revised Guidance No. 5 Reports to Prevent Future Deaths', November 2020, para. 62, available here.
[4] As set out in paragraph 7, Schedule 5 to the Coroners and Justice Act 2009.
[5] See *(Lewis) v HM Coroner for the Mid and North Division of the County of Shropshire* [2009] EWCA Civ 1403 and *R (Amin) v Secretary of State for the Home Department [*2003] UKHL 51 at [31] per Lord Bingham.
[6] *Re Kelly (deceased)* (1996) 161 JP 417; *Dillon, R (On the Application Of) v HM Assistant Coroner for Rutland and North Leicestershire* [2022] EWHC 3186 (KB) (Admin)
[7] Section 5(2) Coroners and Justice Act 2009
[8] Chief Coroner, 'Revised Guidance No. 5 Reports to Prevent Future Deaths', November 2020, para. 17, available here.
[9] Chief Coroner, 'Revised Guidance No. 5 Reports to Prevent Future Deaths', November 2020, para. 11(2), available here.
[10] *Dillon v HM Assistant Coroner for Rutland and North Leicestershire* [2022] EWHC 3186 (KB) (Admin).
[11] Regulation 28(4)(a) of the Coroners (Investigations) Regulations 2013, available here.
[12] Regulation 28(4)(c) of the Coroners (Investigations) Regulations 2013, available here. Where the PFD report relates to the death of a child, paragraph 4(b) requires the coroner to send it to the Local Safeguarding Children Board.
[13] Chief Coroner, 'Revised Guidance No. 5 Reports to Prevent Future Deaths', November 2020, paras. 56 and 57, available here.
[14] See section (4) of Regulation 28 of the Coroners (Investigations) Regulations 2013.
[15] Regulation 29(3) of the Coroners (Investigations) Regulations 2013, available here.
[16] Regulation 28(5) of the Coroners (Investigations) Regulations 2013, available here.
[17] PFD reports dating back to 2013 can be found on the Judiciary website here.
[18] For explanation, see Chatham House website available here.
[19] Deborah Coles, 'Deaths in detention: Why aren't we learning lessons from UK deaths in police custody', *Lacuna*, March 2021, available here.
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[21] 'Chief Coroner shares the report from the first ever Coroner Attitude Survey and explains how it has shaped his work', 1 March 2023, available here.
[22] 'Chief Coroner shares the report from the first ever Coroner Attitude Survey and explains how it has shaped his work', 1 March 2023, available here.
[23] Alison Leary, David Bushe, Crystal Oldman, Jessica Lawler & Geoffrey Punshon, *A thematic analysis of the prevention of future death reports in healthcare from HM coroners in England and Wales 2016-2019*, March 2021, available here.
[24] ABD is a term which a 2022 position statement of the Royal College of Psychiatrists describes as "used to describe a situation in which a person is extremely agitated and distressed, usually in a public place, and in such a state of agitation that they may be at risk of a potentially fatal physical health emergency" – available here.
[25] IOPC, 'Deaths during or following police contact: Statistics for England and Wales 2017/18', July 2018, available here.
[26] Such as the PFD reports regarding the deaths of Kingsley Burrell, published in 2015 (available here), Darren Cumberbatch, published in 2019 (available here), and Kevin Clarke, published in 2021 (available here).
[27] Prevention of Future Death report for Mr Leon Briggs (2021), available here.
[28] Prevention of Future Death report for Mr Adam Stone (2022), available here.
[29] Royal College of Emergency Medicine, 'Best Practice Guideline – Acute Behavioural Disturbance in Emergency Departments', February 2022, available here, and Royal College of Psychiatrists, 'Position statement – 'Acute behavioural disturbance' and 'excited delirium'', September 2022, available here.
[30] Chief Coroner, 'Revised Guidance No. 5 Reports to Prevent Future Deaths', November 2020, para. 2, available here.
[31] For example: 'Ben Maslin: Jury find multiple failings from healthcare and prison staff at HMP Chelmsford contributed to death of vulnerable 36-year-old', 9 May 2023, available here.
[32] *Dillon v HM Assistant Coroner for Rutland and North Leicestershire* [2022] EWHC 3186 (KB) (Admin).
[33] Under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
[34] Prevention of Future Death report for Ms Sharon Langley (2023), available here.
[35] Chief Coroner, 'Revised Guidance No. 5 Reports to Prevent Future Deaths', November 2020, para. 7, available here.
[36] Chief Coroner, 'Revised Guidance No. 5 Reports to Prevent Future Deaths', November 2020, paras. 4 and 26, available here.
[37] A sample of example PFDs can be found as Annex A to the Chief Coroner guidance available here.

[38] Available here.
[39] Available here.
[40] Available here.
[41] Chief Coroner, 'Report of the Chief Coroner to the Lord Chancellor – Fifth Annual Report: 2017-2018', 2018, available here.
[42] Chief Coroner, 'Report of the Chief Coroner to the Lord Chancellor – Sixth Annual Report: 2018-2019 Seventh Annual Report 2019-2020', 2020, available here.
[43] Dr Philippa Tomczak and Dr Rebecca Banwell-Moore, *Prisoner death investigations: improving safety in prisons and societies? Summary of findings,* (University of Nottingham: SAFESOC:2021), available here.
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[45] It is important to note that statistical outliers may have impacted the averages in light of the low sample size.
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[47] Regulation 28(3) of the Coroners (Investigations) Regulations 2013, available here.
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[54] Rt. Hon. Lady Elish Angiolini DBE QC, 'Report of the Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, p.246, available here.
[55] Occasionally this is raised if a Coroner has dealt with a similar death at the same institution before, such as in the case of Geoffrey Hutton in June 2021, available here.
[56] Where a death occurs in a private prison, however, the private provider is expected to respond, with HMPPS often not represented at the inquest. In this sampling exercise, one PFD report corresponded to a death occurring in a private prison (Natasha Chin).
[57] Lord Toby Harris, 'Changing Prisons, Saving Lives: Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds', July 2015, p.188, available here.
[58] Rt. Hon. Lady Elish Angiolini DBE QC, 'Report of the Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, p.233, available here.
[59] House of Commons Justice Committee. The Coroner Service: Government Response to the Committee's First Report (2021), available here.
[60] INQUEST, 'No More Deaths – Learning, action, and accountability: the case for a National Oversight Mechanism', June 2023, available here.
[61] INQUEST, 'No More Deaths', p. 4.