CTI Paper prepared for Baroness Lampard, Inquiry Chair, in relation to

INQUESTS

Introduction to the Paper

1. This paper is a high-level introduction to and overview of the inquest procedure. It is not intended to provide a detailed analysis of the coronial process in England and Wales.

2. Where possible this paper engages, again at a high level, with areas that are likely to have been relevant to inquests arising out of inpatient deaths that come within the scope of this Inquiry.

3. The Inquiry is grateful to those Core Participants who have engaged with and responded to this paper, providing helpful clarifications and assistance with what is a somewhat complex area of law. The Inquiry notes the expertise, particularly of some of those who represent Core Participants and the real life experience of many Core Participants.

4. This paper does not seek to provide a detailed analysis of the particular issues relating to specific inquests or the actual, real-life experiences of family members and loved ones who have attended and participated in inquests. That evidence is important to the Inquiry, but it is not explored here in this paper. Nor does this paper seek to delve into complex legal arguments – that might defeat its purpose of providing, hopefully, a helpful overview.

5. Later in these public hearings the Inquiry will hear from the Chief Executive of the charity INQUEST, Deborah Coles, she has provided a statement and exhibited several reports, including submissions made to parliament and summary reports of the listening days facilitated by INQUEST – all of which are of interest to the Inquiry. Ms Coles is well-placed to give a broad picture from her experience of providing support to families and the bereaved loved ones who have attended inquests.

6. It is worth noting, at this juncture, the Inquiry's terms of reference, and how inquests will be relevant to the Inquiry's work, particularly 2(j), 2(k) and 8 which state that the Inquiry will consider:

> *2. (j) the quality, timeliness, openness and adequacy of any response by or on behalf of the Trust(s) in relation to concerns, complaints, whistleblowing, **investigations**, inspections, and reports (both internal and external); and*
>
> *(k) the interaction between the Trust(s) and other public bodies, (including, but not limited, to commissioners, **coroners**, professional regulators, and the Care Quality Commission).*
>
> *8. In undertaking its investigations, the Inquiry may consider information which is available from the various published and unpublished reviews, **court cases, and investigations** which have so far concluded.*
>
> [emphasis added]

Inquests introduction

1. The majority of deaths in England and Wales are not referred to His Majesty's Coroner[1] ('the Coroner'). Of those that are referred even fewer will result in an inquest.

2. To put this into context, the latest 'accredited official statistics' published on the Ministry of Justice website were published in 2024. They record that in 2023 581,367 deaths were registered, of those 34% (194,999) were referred to a coroner and of those, less than 20% required an inquest. This means that in 2023 there were 36,855 inquests[2]. Those figures can be further broken down to reveal that in 2023, across England and Wales 492 deaths in state detention were reported to coroners. This was down from 534 in 2022 and is reported[3] to be 'driven by' a 24% fall in deaths of those in Mental Health Act detention. The Inquiry will approach these statistics with caution, noting that for example the Care Quality Commission also publish annual coronial data but adopt a different methodology and use the financial year.

3. The Coroners and Justice Act 2009 sets out in what circumstances the Coroner has a duty to investigate a death. In England and Wales an inquest is required where the Coroner has reason to suspect that:
    a. The death was violent or unnatural;
    b. Where the cause of death is unknown, or;
    c. Where the deceased died while in custody or otherwise in state detention.

4. These types of deaths are called 'reportable deaths', they are referred to the Coroner by the police, a doctor or the registrar for births and deaths.

[1] Coronerssociety.org.uk FAQ's
[2] Coroners statistics 2023 - GOV.UK
[3] Coroners statistics 2023: England and Wales - GOV.UK

5. To break that down a little more, 'state detention' includes those who died while detained under the Mental Health Act 1983. The Inquiry's definition[4] of 'inpatient death' is broader than that and includes deaths that occurred when the deceased was not physically detained at a unit, or when the deceased had absconded or was on leave (supervised or otherwise). Deaths that occurred in these circumstances should still be referred to the Coroner either by virtue of the Ministry of Justice guidance or by reference to the relevant case law:

    a. the Ministry of Justice (MoJ) Guidance for registered medical practitioners on the Notification of Deaths Regulations[5] states that a person's death should always be notified to the Coroner where there is reasonable cause to suspect that the death was due to ('due to' meaning 'more than minimally, negligibly, or trivially caused by or contributed to by') any of the following:
        i. Poisoning including by an otherwise benign substance;
        ii. Exposure to, or contact with a toxic substance;
        iii. Use of a medicinal product, the use of a controlled drug or psychoactive substance;
        iv. Violence, trauma or injury;
        v. Self harm – which is further defined as 'trauma or injuries inflicted by themselves or their actions' [page 8 para 25 of the guidance]
        vi. Neglect, including self-neglect
        vii. The person undergoing any treatment or procedure of a medical or similar nature;
        viii. An injury or disease attributable to any employment held by the person during the person's lifetime.

[4] Terms of Reference: Explanatory Note - The Lampard Inquiry - investigating mental health deaths in Essex
[5] Guidance for registered medical practitioners on the Notification of Deaths Regulations

Each of the above are further defined in the guidance, but not repeated here. Many will not feature in the types of inquest the Inquiry will hear about, but the full list is provided for completeness.

b. The MoJ guidance explains that 'State detention', relates to individuals being compulsorily detained by a public authority, including hospitals where the deceased person was detained under mental health legislation. The guidance expressly includes instances when the deceased person was on a period of formal leave. As to the relevant case law, the Court of Appeal case of *Savage* v *South Essex Partnership NHS Foundation Trust* [2009] AC 681, made it clear that a death that occurs when an inpatient has absconded from the inpatient facility, (whether on leave or not) will be treated as a reportable death within the 'state detention' definition.

6. That is not to say that all deaths that occur in custody or state detention are treated equally. In September 2023, the Independent Advisory Panel on Deaths in Custody (IAPDC) published a report[6] called, '"More than a paper exercise" – Enhancing the impact of Prevention of Future Death Reports'. The IAPDC drew attention to the fact that unlike deaths in other areas of detention, those under Mental Health legislation do not automatically attract an independent investigation, and never by a dedicated, independent body. The IAPDC describe this as an "anomaly" and made recommendations to the Department for Health and Social Care (DHSC) that serious consideration was given to the creation of an independent body for investigating the deaths of those both formally and informally detained in mental health settings. This is an area the Inquiry intends to explore in more detail.

7. Save for those inpatients who died of natural causes, for example older patients who may have suffered from other physical health conditions not

[6] "More than a paper exercise" – Enhancing the impact of Prevention of Future Death Reports – Independent Advisory Panel on Deaths in Custody (IAPDC)

directly related to their mental health, all of the deaths that fall within the scope of this Inquiry should (certainly under the current legislation, guidance and case law) have been referred to the Coroner and ought to have resulted in an inquest. Owing to the significant difficulties in determining the number of deaths in scope, it may never be possible to verify which deaths resulted in an inquest and which did not.

8. Not every inquest that was conducted would have required the Coroner to provide narrative findings in terms of how the deceased died. It is also not possible to assess whether the Coroner would have been obliged to provide a prevention of future deaths report. I will return to 'narrative findings or conclusions' and 'prevention of future deaths reports' shortly to provide a little more detail on what they are.

9. It is of note that, despite the significant number of deaths that tragically come within the scope of this Inquiry, and the likelihood that those deaths would have resulted in inquests, so far the Inquiry has only been provided with copies of 32 prevention of future deaths reports and eight findings of neglect (seven from EPUT and one from St Andrew's Healthcare). The Inquiry will continue to seek more information on the inquests that did occur and for which there must be data available.

10. The next sections will consider the practice and procedure for inquests in England and Wales, funding for representation at inquests, when a jury is required, when Article 2 of the European Convention on Human Rights is engaged, conclusions and the procedure for PFD reports. A summary of the evidence the Inquiry has received so far is then set out.

Inquests practice and procedure

11. While all inquests in England and Wales are conducted within a singular statutory framework; the Coroners and Justice Act 2009 (and a framework

of Regulations[7]), the practice and procedure for inquests varies in different areas of the country and between different coroners. In Essex there is some information available on the Essex County Council Coroner's website but it is often an area of mystery for the bereaved who suddenly find themselves involved in the coronial process.

12. There are currently, approximately 453 coroners in England and Wales[8]. They are appointed by, but independent of, the local authority and their jurisdiction is determined by geographical area. There are currently 81 coroner areas across England and Wales. Where the deceased's body is found will determine which coroner area is responsible for conducting the investigation.

13. A coroner is an independent, judicial office holder. They must be a legally qualified barrister or solicitor[9]. Some coroners are also medically qualified, but this is not a requirement for the role. Coroners work with assistant coroners and coroner's officers who assist a coroner in managing administrative tasks related to the inquest. Many Core Participants will have liaised most directly with the coroner's officer who is responsible for corresponding with relatives and witnesses, collating evidence and overseeing the running of the proceedings. In a complex inquest the Coroner may also appoint counsel to the inquest and solicitor to the inquest.

14. When a death is reported to the Coroner, an inquest *should* be completed within six months of the Coroner being made aware of the death or 'as soon as reasonably practicable' (Rule 8 of the Coroners (Inquest) Rules 2013). In reality, most inquests take much longer than six months to complete. A final hearing can sometimes be over a year after the initial report of the death

[7] The Coroners (Inquest) Rules 2013 and The Coroners (investigations) Rules 2013
[8] Frequently Asked Questions about the Chief Coroner and the Coroner Service - Courts and Tribunals Judiciary
[9] It is also possible to become a coroner if you are a Fellow of the Institute of Legal Executives and satisfy the judicial-appointment eligibility condition which means having 5 years of experience *whilst* holding that qualification. Coroners should be under the age of 75 and are subject to the appointment and eligibility conditions within the Coroners and Justice Act 2009 (s.23 and Schedule 3).

and in some cases significantly longer than a year. The latest government statistics available for 2023, record the average time taken to complete an inquest is 31.5 weeks, this represented an increase of 1.3 weeks from the 2022 average[10]. Those averages must, however, be treated with real caution, especially in respect of the types of inquest that follow an inpatient death. Core Participants' legal representatives would wish to bring to your attention Chair, inquests that have not been concluded five, seven and eight years after the inquest was formally opened. As mentioned earlier, some of the legal representatives for Core Participants have significant experience as inquest practitioners, they and the families they represent know all too well about the intolerable wait endured by those who are grieving which, as you can imagine, compounds the distress and anxiety experienced.

15. Returning to the procedure for an inquest: When a death is reported, the Coroner must first consider the information available at the time and determine whether an inquest is required. Where there is insufficient information to make a decision the Coroner may open a preliminary investigation before opening an inquest. Where there is sufficient information and the Coroner determines that an inquest is required they may open the inquest and then adjourn for further investigations.

16. When an inquest has been opened and it is deemed necessary to establish the 'medical cause of death' a post-mortem examination (or autopsy) will normally be carried out in order to establish the probable medical cause of death. After the post-mortem, the Coroner may determine that an inquest is not necessary.

17. If, after receiving the post-mortem report, an inquest is still required, the Coroner will consider whether or not they are required to suspend the inquest. Schedule 1, paragraphs 1 and 2 of the Coroners & Justice Act 2009 require the Coroner to suspend an investigation on the request of a prosecuting authority i.e. the Crown Prosecution Service, the Health and

[10] Coroners statistics 2023: England and Wales - GOV.UK

Safety Executive or the Care Quality Commission. The inquest will normally be suspended until the outcome of any other proceedings. A police investigation or prosecution does not always require the inquest process to be put on hold however. It may be possible, in certain circumstances, for the inquest process (especially the preliminary stages) to proceed alongside an investigation, including a criminal investigation.

18. If a criminal investigation results in a criminal conviction for murder or manslaughter then the inquest may be concluded without a formal hearing unless 'the senior coroner thinks that there is sufficient reason for resuming [their investigation]' (as per the Coroners & Justice Act 2009, Schedule 1 paragraph 8(1)). When a death has occurred in custody, the Chief Coroner's Guidance (No. 33)[11] notes that the state has a "*particular duty to conduct a public investigation before an independent judicial tribunal in which the deceased's relatives can participate*" meaning that an inquest is more likely to be resumed. The outcome of an inquest resumed in these circumstances must be consistent with the outcome of the criminal proceedings. For example where there has been a conviction for murder or manslaughter the death will be recorded as 'unlawful killing'. The Coroner (or jury) may also provide a narrative conclusion which supplements the short form conclusion of 'unlawful killing', and / or they may determine that a conclusion of 'unlawful killing' was contributed to by neglect. Where there is no conviction, the Coroner will resume the inquest process. It is recognised by the Inquiry that whenever a referral is made to a prosecuting authority, no matter the outcome of an investigation and / or prosecution, the impact on the families and loved ones of the deceased will inevitably involve a further intolerable wait. The Inquiry has heard from families about how incredibly distressing this can be.

[11] Chief Coroner's Guidance No. 33 Suspension, Adjournment and Resumption of Investigations and Inquests[1] - Courts and Tribunals Judiciary

The scope of the inquest

19. The sole purpose of an inquest, (as per the Coroners & Justice Act 2009, section five) is for the Coroner to determine:
    a. Who the deceased was;
    b. Where they came by their death;
    c. When they came by their death, and;
    d. How they came by their death.

20. It is often this last question, 'how' that requires detailed investigation and consideration by the Coroner, in order to understand and draw conclusions about how the death came about. In Article 2 inquests, which are considered in more detail shortly, the question of 'how' is expanded to 'how and in what circumstances the deceased came by their death'.

21. In respect of each of these questions – who, where, when and how - the Coroner will determine the scope of the inquest.

22. The scope will determine what evidence will be required, who will provide that evidence and how that evidence will be presented i.e. in person, in an expert report or by way of a written statement. The Coroner can appoint 'interested persons' and expert witnesses.

23. An interested person is broadly comparable to a core participant at a statutory inquiry. An interested person is someone the Coroner considers to have a "sufficient interest" in the investigation. That may be anyone the Coroner considers may have relevant information about the deceased and how they died. Section 47(2)(f) of the Coroners and Justice Act 2009 expressly includes "*a person who may by an act or omission have caused or contributed to the death of the deceased, or whose employee or agent may have done so*." An interested person would normally be legally represented at the inquest, for family members, however, this is often not possible due to the lack of state funding.

24. The Coroner will often invite the family members of the deceased person to provide a witness statement. Coroners may also invite the family to provide a 'pen portrait' to tell the Coroner (or jury) more about the life of the person at the heart of the inquest. This Inquiry has adopted a similar approach to receiving commemorative and impact evidence.

Legal representation and funding

25. State funding, called 'Legal Aid' is rarely available for families in inquest proceedings, leaving the bereaved to fund legal representation themselves or find a legal representative who is able to provide legal representation for free. Some families may be able to rely on insurance policies, but the charity INQUEST tells the Inquiry that this is incredibly rare and that the majority of bereaved families engaging in inquests are left without any representation.

26. The charity INQUEST has campaigned on the issue of Legal Aid funding for bereaved families in inquests where the state is represented. In January 2022 the availability of non-means tested Legal Aid in inquests was extended, but the circumstances where Legal Aid funding is available to bereaved families remains limited.

27. The House of Commons Justice Committee's Report on the Coroner Service, May 2021[12] commented on the limited provision of legal aid for the bereaved. The Committee drew attention to what they described as an unfair distinction between the bereaved and public bodies in terms of representation and suggested that the Ministry of Justice ensure 'equality of arms'. The Government response to the Committee in September 2021, indicated that this issue would be further considered in response to Bishop James Jones' report 'The patronising disposition of unaccountable power'. A report to ensure the pain and suffering of the Hillsborough families is not

[12] The Coroner Service - Committees - UK Parliament

repeated[13]. The previous Government responded in December 2023[14] and committed to providing Legal Aid for the bereaved following public disasters. A Government policy paper committed to "*seeking to further understand the experiences of bereaved families at other inquests where the state is represented*". At this time, we understand, there have been no changes to the availability of funding for families and the bereaved.

The inquest timeline and procedure

28. The Coroner may arrange a pre-inquest review with interested persons including family members[15]. At the pre-inquest review the Coroner will determine what the relevant issues are, what evidence is required and when that evidence should be provided by. A date for the inquest is then fixed and witnesses are notified. In more complex inquests, including 'Article 2 inquests' there are likely to be several lengthy pre-inquest review and preliminary hearings required.

29. Where a pre-inquest review is not required the Coroner / coroner's office will communicate the scope of the inquest to interested persons, witnesses and family members either directly or via their legal representatives.

Jury inquests

30. Section 7 of the Coroners and Justice Act 2009 sets out when a jury[16] will be mandatory[17], including when the senior coroner has reason to suspect:

[13] 6_3860_HO_Hillsborough_Report_2017_FINAL_WEB_updated.pdf
[14] A Hillsborough legacy: the government's response to Bishop James Jones' report (accessible) - GOV.UK
[15] It is noted that family members may be interested persons (as per s.47(2)(a) of the CJA 2009
[16] The jury for an inquest will consist of between 7 and 11 jurors.
[17] Where an inquest that would have required a mandatory jury has been adjourned, pending a criminal investigation, on resumption of the inquest a jury will no longer be mandatory.

a. That the deceased died while in custody or otherwise in state detention, and the death was either violent or unnatural, or the cause of death is unknown;
b. That the death resulted from an act or omission of a police officer[18] in the 'purported execution of the officer's duty', or;
c. That the death was caused by a 'notifiable accident, poisoning or disease'

31. A coroner may also call a jury where they think there is sufficient reason for doing so.

32. Where a jury has been empanelled on an inquest they will be responsible for determining the conclusions of the inquest. The jury do this by hearing all of the evidence and with guidance from the Coroner. The Coroner will set out the conclusions that are open to the jury, and set out the legal tests which must be met before they document their conclusions on the Record of Inquest (ROI) form.

Article 2 inquest

33. Article 2 of the European Convention on Human Rights (ECHR), enshrined in UK law by the Human Rights Act 1998, imposes substantive obligations on the State "not to take life without justification and also to establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life[19]."

34. An Article 2 inquest, also called a 'Middleton inquest'[20], is held when the State (or its agents) may have failed in its negative obligation to refrain from

[18] Or 'member of a service police force', as per the CJA 2009 s.7 (2)(b)(ii).

[19] R (*Middleton*) v *HM Coroner for West Somerset* [2004] 2 AC 182

[20] Named after the case of R (*Middleton*) v *HM Coroner for West Somerset* [2004] 2 AC 182

taking life, or in its positive obligation to take appropriate measures to safeguard life.

35. Whether an inquest should be an Article 2 inquest or not is a decision normally taken at the pre-inquest review stage. The Coroner may hear submissions on the issue before deciding whether or not to make the inquest an Article 2 inquest. Throughout the inquest it remains open to the Coroner to make the inquest an Article 2 inquest if there are reasons to do so.[i]

36. The case of R (*Middleton*) v *West Somerset Coroner* [2004] 2 AC 182 held that in order to comply with the State's obligations under Article 2, the statutory question 'how' is extended to 'by what means and in what circumstances' the deceased came by their death[21]. As with a non-Article 2 inquest (sometimes referred to as a Jamieson inquest), the findings, determinations and conclusion of the Coroner or jury are recorded on a Record of Inquest (ROI) form, and may include a narrative conclusion.

37. Article 2 may be engaged where, on the evidence "there are grounds for suspecting that a death may involve a breach by the state of one of the substantive obligations imposed by Article 2[22]" – often referred to as an 'arguable' breach of a substantive Article 2 ECHR obligation. This may be in circumstances where the State (or its agents) knew or ought to have known at the time of a real and immediate risk to the life of the individual and failed to take reasonable steps to preserve life. Those reasonable steps must have been within its powers and considered reasonable in order to prevent that risk.

[21] The Coroners Bench book notes that 'Because of the wide discretion afforded to coroners, even an inquest where Article 2 procedural obligations are not engaged may investigate the broader circumstances of the death if the touchstone of possible causation is met.

[22] R (*Smith*) v *Oxfordshire Assistant Deputy Coroner* [2010] UKSC 29; R (*Middleton*) v *HM Coroner for West Somerset* [2004] 2 AC 182.

38. 'Risk' is defined as a significant and substantial risk, rather than a remote or fanciful one. The risk will be immediate if it is present and continuing, it is not necessary for the risk to be apparent just before death. It must be a risk to life rather than a risk of harm or serious harm[23].

39. 'Real' is defined by what was known or ought to have been known at the time[24].

40. Where an individual was detained by the State (i.e. in custody or under the Mental Health Act 1983), and their death was an 'unnatural death' Article 2 will automatically be engaged and it is not necessary to consider whether there has been an 'arguable breach' of the Article 2 substantive duties[25].

41. As you can see Chair, whether an inquest is an Article 2 inquest or not, is not always straightforward and may involve complex legal submissions. You may think this is relevant then to the issue of whether or not families are legally represented at inquests. While some of these issues fall beyond the scope of your Terms of Reference it is necessary to outline them here to assist with the Inquiry's understanding of the different types of inquest and the types of findings that are open to the Coroner (or the jury) to consider and record on the Record of Inquest form.

The inquest hearing(s)

42. Once the Coroner has determined whether a jury is required, whether the inquest engages Article 2, the scope of the inquest, who the interested persons are, what evidence is required, and set a timetable for receiving evidence - the next step is to conduct the inquest hearings.

43. Inquest hearings are normally held in public, that is to say that members of the public are free to attend the hearing and listen to the proceedings. Since

[23] *Rabone* v *Pennine Care NHS Foundation Trust* [2012] UKSC 2
[24] *Rabone* v *Pennine Care NHS Foundation Trust* [2012] UKSC 2
[25] R (*Middleton*) v *HM Coroner for West Somerset* [2004] 2 AC 182

the Covid pandemic many inquests can be attended remotely via a video link. There are rare occasions when it may be in the interests of justice or national security for an inquest to be held in private.

44. The Coroner's court is one of investigation and inquiry, the process for hearing evidence is inquisitorial. In an inquest there are no formal allegations or accusations. While the hearings should not be adversarial, we understand from listening to family members and the bereaved who have attended inquests, that unfortunately this has not always been their experience. Again, that may be a matter that is beyond the scope of this Inquiry but it is important nevertheless to acknowledge these experiences which add to the trauma of the bereaved.

45. During the inquest statements and reports are provided to the Coroner and shared with interested persons. Under Rule 23 of the Inquest Rules, the Coroner can admit some documentary evidence without calling a witness to give the evidence in person. Other evidence will be given 'live' by witnesses.

46. The order in which witnesses give evidence is not prescribed but the Coroner will often hear evidence first from the pathologist before then going through the evidence and the witnesses in the most logical way – i.e. in chronological order of the events leading up to the death.

47. Where the Coroner asks questions of witnesses, the witness will swear an oath or affirmation to tell the truth. After the Coroner has asked their questions, an interested person may also ask questions of a witness, normally this is done by the legal representative of the interested person. Where there is a jury, jurors are also permitted the opportunity to ask questions of a witness. All questions must be directed towards assisting the Coroner. The purpose of the questions is not to apportion blame or raise accusations. Finally, the witness may be asked questions by their own legal

representative, unless a different order of questioning has been agreed by the Coroner.

48. After hearing all of the evidence, the Coroner will hear submissions from the interested persons' legal representatives on the law, including representations as to which conclusions should be considered by the Coroner (or left to the jury). Submissions on the facts of 'who the deceased was and how, when and where the deceased came by his or her death' are not permitted[26].

49. It is a common misconception that a coroner or an inquest jury arrive at a verdict and / or that the Coroner has the power to apportion blame for the death. At the end of the inquest there will, instead, be 'conclusions'.

Conclusions

50. After hearing all of the evidence and legal submissions, the Coroner (or jury) will then make their findings on each of the four questions: who, where, when and how. All conclusions will require a form of words, some conclusions will simply require more words 'a narrative conclusion' and some will require fewer words and may be dealt with by way of a 'short form conclusion'. A short form conclusion may record one of the following[27]:
    a. Accident or misadventure;
    b. Alcohol / drug related;
    c. Industrial disease;
    d. Lawful / unlawful killing
    e. Natural causes;
    f. Open, meaning that there is insufficient evidence to record another conclusion. This does not mean that the case is left open in case further evidence appears. An open conclusion is a 'final

[26] Rule 27 of The Coroners (Inquests) Rules 2013
[27] The Coroners (Inquests) Rules 2013 Form 2 Record of an Inquest notes

conclusion'. It should be noted that an 'open conclusion' is to be discouraged save where strictly necessary.

g. Road traffic collision;
h. Stillbirth
i. Suicide;

51. Some conclusions may include more than one of the above and may also reference neglect, for example 'natural causes contributed to by neglect'. Neglect is not, however, considered a primary cause of death, and is not in itself a conclusion.

52. In a non-Article 2 (or Jamieson) inquest the Coroner may provide a 'narrative conclusion', to enable the Coroner to briefly describe the circumstances by which the death came about. This must be brief, neutral and factual avoiding expressing any judgement or opinion.[28]

53. Whereas in an Article 2 (or Middleton) inquest it would be unlawful for the Coroner to direct a jury so as to prevent them from entering a 'judgemental conclusion of a factual nature'. Permitted judgemental words, in an Article 2 inquest, include 'inadequate', 'inappropriate', 'insufficient', 'lacking', 'unsuitable', 'failure', 'because' and 'contributed to'. An Article 2 narrative conclusion will not necessarily be lengthy, its purpose is to briefly summarise the jury's factual conclusions (as stated in the case of Middleton).

54. After completing the Record of Inquest and any other necessary paperwork, the death can be registered. The findings and conclusions of a coroner's inquest can be challenged by way of Judicial Review or via Section 13 of the Coroners Act 1988.

[28] R v *HM Coroner for Humberside and Scunthorpe*, ex parte *Jamieson* [1995] QB 1.

55. We are told by our Core Participants that the absence of a satisfactory appeals process is a matter which causes real distress and frustration amongst families and the bereaved.

Prevention of future death report (regulation 28)

56. The Coroner has a duty to make a 'prevention of future death report' (or PFD report) where anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future, and, in the Coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the Coroner must (as per paragraph 7 of schedule 5 of the Coroners and Justice Act 2009) report the matter to a person who the Coroner believes may have power to take such action. A prevention of future deaths report is then made to a person, organisation, local authority, government department or agency. All reports and responses must also be sent to the Chief Coroner.

57. Prior to the Coroners and Justice Act 2009, PFD reports were called 'Rule 43 reports' in reference to Rule 43 of the Coroners Rules 1984. The decision by Parliament to enshrine prevention of future death reports in legislation placed a duty on coroners not only to decide how somebody came by their death, but also, where appropriate, to report about that death with a view to preventing future deaths.

58. The Inquiry's Rule 9 requests to providers for PFD reports included a request for any rule 43 reports.

59. It is worth noting The Chief Coroner's Guidance No.5[29] which has recognised the importance of PFDs to bereaved families and the public at large. The Guidance states,

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

"*PFDs are vitally important if society is to learn from deaths. Coroners have a duty to decide how somebody came by their death. They also have a statutory duty (rather than simply a power), where appropriate, to report about deaths with a view to preventing future deaths. And 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.' PFDs are not intended as punishment; they are made for the benefit of the public*."

60. A PFD report is sent to the person or authority which is deemed to have the power to take appropriate steps to reduce the risk of further deaths. That person or authority then has a mandatory duty to respond to the report within 56 days, unless the Coroner agrees to an extension. The Coroner's (Investigations) Regulations 2013 (regulation 29(3)) requires that the written response contains:
    a. 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
    b. An explanation as to why no action is proposed.

61. The Coroner can also refer an individual to their regulator i.e. a doctor can be referred to the General Medical Council and nurses can be referred to the Nurses and Midwifery Council. If there is a criticism then the professional person has a duty to refer themselves to their regulatory body.

62. The Office for National Statistics provides annual reports on data provided by coroners in England and Wales. In 2023, of the 195,000 deaths reported to coroners, 1% of those inquests (569) resulted in PFD reports being issued, this represented an increase of 41% compared to 2022[30]. These figures

[30] Coroners statistics 2023: England and Wales - GOV.UK

provide a current picture, further work will be done by the Inquiry to analyse the coroners statistics which go back to 1995.

63. It is also worth noting the 'Preventable Deaths Tracker', which since 2013, has collated a database of all PFD reports in England and Wales. The Inquiry is aware of this valuable resource and will consider how best to use this and other sources of information on PFD reports.

64. PFD reports are now published on the judiciary website (www.judiciary.gov.uk) and, where provided, responses are also published. It is noted that in 2025, for the first time, the Coroner published a table of 'non responses to PFD reports' for the previous year. The Inquiry is seeking responses and other relevant inquest material.

Evidence received by the Lampard Inquiry

65. Rule 9 letters on the subject of 'Inquests – PFD reports and neglect findings' were sent to EPUT, NELFT, The Priory Group, St Andrew's Healthcare and Cygnet to ascertain, in the first instance, what material they had.

EPUT R9(7)

66. The EPUT response is 37 pages long, it includes a 25-page statement and three appendices. The statement is provided by Ann Sheridan Executive Nurse at EPUT, she has been in post since 09/02/2024.

67. There are 269 exhibits to the statement.

PFD reports

68. EPUT states that "The Trust does not hold a central record of all PFDs and ROIs [Records of Inquest] issued for the entire relevant period." Ms Sheridan's statement then sets out the history of data management systems used by the Trust and its predecessors. She accepts [page 129 of the

Core Bundle para 23] that "It is possible that the Trust would have received other PFD / Rule 43 reports, however we been unable to locate the PFD or find indications that further reports were received within our records." The searches that have been run on the Trust's electronic devices have "relied upon the documents being saved with the patient's correct spelling of name".

69. EPUT has located 32 PFD reports. They have provided the PFDs and responses for the 32 identified. Supporting material for 30 out of the 32; and Records of Inquest for 22 of the 32. Some material is missing and Ms Sheridan states that the Trust is continuing to search for this information.

70. The number of PFD reports found by EPUT and provided to the Inquiry is far smaller than the Inquiry had anticipated. The Inquiry has adopted a trauma informed approach to disclosure of this material and will, disclose the PFD reports, the responses (and supporting materials where available) to the families before disclosing this material to all Core Participants. This will allow the families to discuss these materials with their legal representatives. What is set out in this paper, Chair is necessarily limited to a summary.

71. The first PFD provided by EPUT dates back to May 2001. The next PFD report is from March 2010, then September 2011, there is a PFD report from February 2013, and another in June 2014. The numbers of reports then increase. There are three PFD reports in 2015; three PFD reports are from 2016; five are from 2017; one in 2018; two from 2020; one in 2021, then seven in 2023 and five in 2024. The Inquiry is of course mindful that the numbers may be more reflective of EPUT's record keeping and archiving of PFD reports than they are of the true number of PFD reports received by EPUT since 2001.

72. The Inquiry is aware of a recent PFD report issued in March 2025 (after the response received from EPUT to the Inquiry's Rule 9 request). This recent

PFD report notes that a significant number of the 'serious causative failings' identified in it, have featured in previous PFD reports issued to EPUT, namely: Communication; Training and Supervision; Record Keeping; Discharge Planning; Care Planning; Risk Assessment. The Coroner noted that these issues arose as recently as October 2024 and February 2025.

73. A similar list was identified by EPUT in their review of the 32 PFD reports. In a table, EPUT identified the following recurring themes:

Record keeping - arose in 14 reports;

Communication – arose in 9 reports;

Clinical risk management – arose in 8 reports;

Referrals – arose in 6 reports;

Involvement of family[31] – arose in 6 reports;

Risk assessment – arose in 4 reports;

Medication – arose in 4 reports;

Risky item – arose in 4 reports;

Policies – arose in 4 reports;

Care planning – arose in 4 reports;

Environment – arose in 3 reports;

MHA assessment – arose in 2 reports;

Electronic patient records – arose in 2 reports;

Security – arose in 2 reports;

[31] For the avoidance of doubt the phrase 'involvement of family' is used by EPUT, the Inquiry understands this to mean 'failure to engage with family members and loved ones of the deceased'.

Training - arose in 2 reports;

Staffing - arose in 2 reports;

Disengagement - arose in 2 reports;

Observations - arose in 2 reports;

74. EPUT have also provided information in respect of a deceased patient whose death resulted in correspondence with the Coroner but not a PFD report.

Findings of neglect and other adverse findings

75. 70 narrative conclusions have been reviewed by EPUT to identify adverse findings. 39 included adverse findings against EPUT and / or its staff. Appendix B [pp 150-155 of the Core Bundle] to Ms Sheridan's statement details the 21 ROIs where an adverse finding was made but there was no PFD report. Seven returned a rider of neglect.

76. Themes across the seven conclusions were identified by EPUT:

    Failures in monitoring and observation protocols – arose in 3;

    Inadequate risk assessments both at admission and / or throughout care – identified in all 7;

    Lapses in care planning were also identified in all 7.

Process for responding to PFDs and Inquest outcomes

77. EPUT set out the history, so far as it is recorded, of their approach to responding to and learning from PFD reports and to findings of neglect and other adverse findings by the Coroner.

78. EPUT also set out their current approach to learning lessons.

[NELFT R9(2)]

Content to follow.

The Priory Group R9(3)

79. The Priory response is five pages long. It is provided by Mark Rice-Thomson, Senior Investigations and Inquest Manager. There are no exhibits.

80. In summary, after a review of all digitally held records and paper-based archives the Priory can confirm they have not received any PFD reports (or Rule 43 reports), and there have been no findings of neglect and / or adverse findings made at Inquests in respect of Priory Group or its staff.

81. The Priory Group statement outlines their general approach and the processes they follow when they receive a PFD report and / or a finding of neglect.

St Andrew's Healthcare R9(3)

82. The St Andrew's response is five pages long. It is provided by Stuart Wallace, Data Protection Officer/Senior Lawyer. There is one exhibit.

83. In summary, St Andrew's state that they have not received any relevant PFD reports. There has been one case where findings of neglect were recorded. The Record of Inquest and statement provided to the Coroner in response is provided. The Inquiry has taken the same approach in respect of this material which will be provided to the family before it is disclosed more widely.

84. St Andrew's have outlined their current approach in respect of PFD reports in relation to other hospitals (not in Essex).

Cygnet

85. The Cygnet response is four pages long. It is provided by Christian Joseph Young, General Counsel (UK) of Cygnet Health Care Ltd. There are two exhibits.

86. In summary, there were no PFD reports identified during the relevant period within the scope of the Inquiry.

87. When a PFD report is received by Cygnet they follow the 'PFD process map' exhibited to the statement. The current approach taken by Cygnet is also set out in the statement.

Final remarks

88. Some themes arise in respect of inquests, the coronial process, data retention and the need for oversight and monitoring of inquest findings, and PFD reports.

89. I opened by setting out the most recent data from 2023 concerning the number of inquests in England and Wales, and noted that of those inquests 1% resulted in prevention of future death reports being made.

90. The Inquiry will consider the available data over the relevant period and explore the approach to making PFD reports and then how those reports are responded to, not only by the relevant trusts, bodies and individuals but also by the regulators. Whether there is a gap in the regulatory framework in terms of ongoing monitoring and accountability is an issue the Inquiry is particularly interested in.

01 May 2025

Charlotte Godber

Counsel to the Inquiry

[i] **End note:** In respect of Article 2 inquests and the automatic enhanced procedural obligation in certain cases, Counsel to the Inquiry is asked to reference the case of Maguire, and we are happy to do so. It is not been possible, within the scope of this paper, to consider this and various other relatively complex legal points raised by Core Participant's in detail:

> The United Kingdom's Supreme Court, in the case of R (*Maguire*) v *His Majesty's Senior Coroner for Blackpool & Fylde and anor* [2023] UKSC 20, noted that "There are certain cases where the application of the [Article 2] enhanced procedural obligation is automatic, because of the importance attached to the need for the State in [certain] contexts to provide full accountability in relation to the death." The judgment cites Popplewell LJ in the Court of Appeal case of Maguire,[i] where it was held that "[t]he procedural duty arises in the case of suspicious deaths in custody, not deaths from natural causes, and it does so automatically because all such deaths raise a sufficient possibility of state responsibility to require the enhanced investigation: suspicious deaths in custody are simply a category of case in which it is sufficiently arguable, in every case and without more that there has been a breach by the state of one of its substantive article 2 obligations."