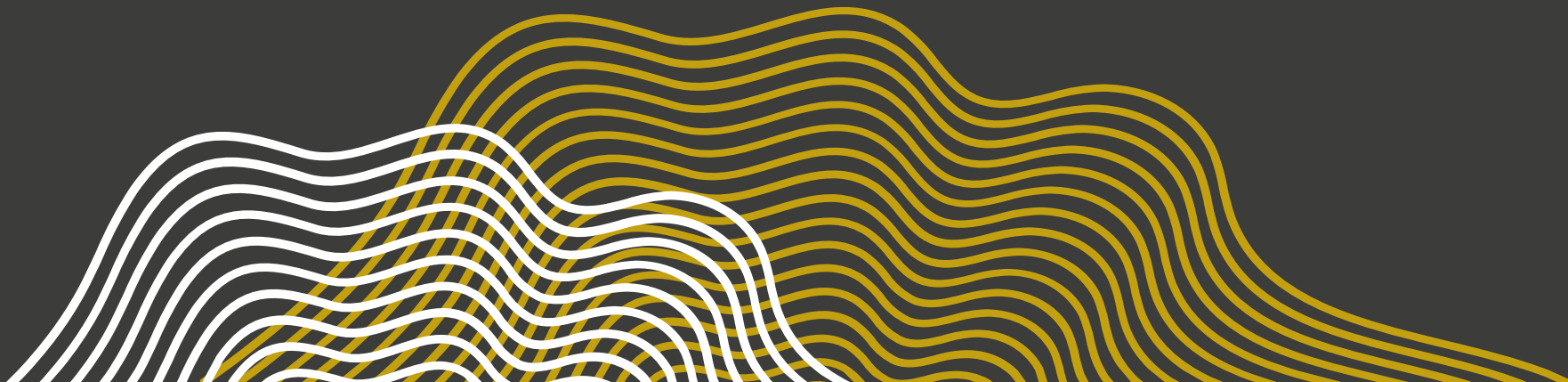


# **WHAT CAN BE LEARNT FROM CORONERS' INQUESTS AND 'PREVENTION OF FUTURE DEATHS' REPORTS**

- The duty of coroners to investigate and the scope of their role
- Inquest conclusions and Prevention of Future Death Reports
- What we can learn from Prevention of Future Death Reports concerning suicide



## SCOPE OF CORONERS' ROLE

1. Answer four questions:

- who the deceased was; how, when and where the deceased came by his or her death

2. Make a 'Prevention of Future Death' Report where:

- Anything revealed gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future
- 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.

## **INQUEST CONCLUSIONS**

A suicide conclusion may be returned where, on the balance of probabilities:

- the deceased died from a deliberate **act** initiated by themselves ('the act') and;
- the deceased intended that their actions would cause their death ('the intention').

Alternatives conclusions include: accident / misadventure, alcohol / drugs, 'open' conclusion.

## **PREVENTION OF FUTURE DEATH REPORTS**

- Factual summary and coroner's concerns
- Mandatory response
- Published on MOJ website (redacted)
- Monitoring of specific responses?
- Monitoring of themes and trends?





## **CHALLENGES IN CONSISTENCY, CATEGORISATION AND CLARITY**

- Narrow legal definition of 'suicide' conclusion
- Inconsistent approach of coroners to PFD reports
- Inconsistent tagging on MOJ website

“In our study on suicides that used the Preventable Deaths Tracker database, we found that **only 1 in 5 suicides were correctly catalogued** in the *'Suicide (from 2015)'* category. This means that studies which use the Chief Coroner's Office death categories to conduct research have hugely underestimated the number of PFDs, creating a selection bias.”

Dr Georgia Richards

“Categorising preventable deaths: The need for a national system” (2023)



“Until now, PFDs were assigned broad categories when published. Following improvements to this website, users can now **search the full text of PFDs** using specific words or phrases. This enhanced search function provides a clearer, more accurate way for the public and organisations to find the information they need.

Because of these improvements, the Chief Coroner will **no longer categorise PFD reports**. Instead, all reports will be fully searchable.

This change reflects the fact that coroners are judicial office holders. Their role is to issue PFDs where required by law, not to classify them or to carry out thematic or policy analysis. Once published, the use of learning from PFDs is a matter for government departments and other relevant bodies.”

Chief Coroner, April 2026



## **WHAT CAN WE LEARN?**

- How – ie. availability of information and means
- Who – eg. neurodiversity, LGBT+
- Where – eg. prisons, mental health care
- Why? – eg. online harm, domestic abuse





## LEARNING FROM ONLINE HARM

s101 Online Safety Act 2023:

- From April 2024, Coroners may notify Ofcom of an investigation ('Coroners Information Notices') and Ofcom must issue a notice to regulated platform requiring the provision of information
- From September 2025, Ofcom must also issue a preservation of relevant information ('Data Preservation Notice') upon receipt of Coroners Information Notice

Includes content encountered, how content came to be encountered, how the child interacted with the content and content generated, uploaded or shared by the child.

# FINAL THOUGHTS ... AND QUESTIONS

