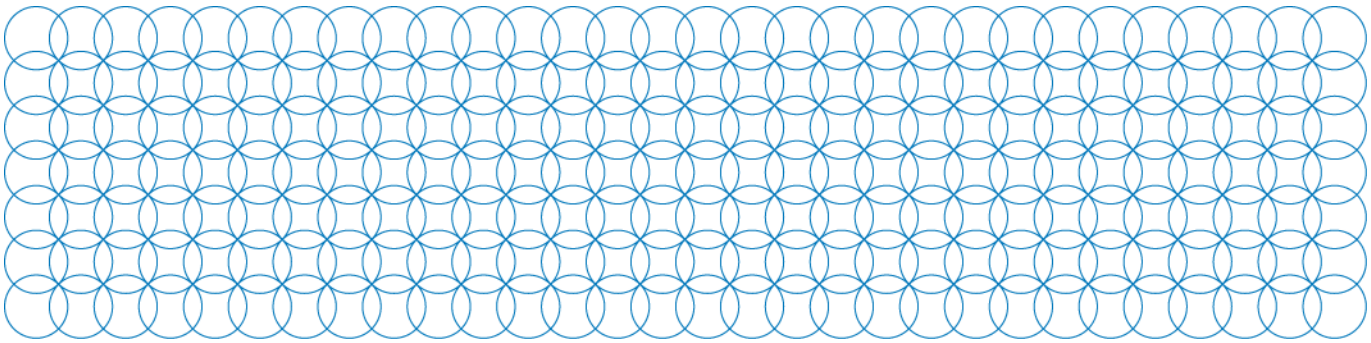
Ministry of JUSTICE

Implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009

Consultation on rules, regulations, coroner areas and statutory guidance

Consultation Paper CP2/2013
This consultation begins on 1 March 2013
This consultation ends on 12 April 2013



Ministry of JUSTICE

Implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009

Consultation on rules, regulations, coroner areas and statutory guidance

A consultation produced by the Ministry of Justice. It is also available on the Ministry of Justice website at www.justice.gov.uk

About this consultation

To:	Coroners and those who work within and who fund the system, bereavement support organisations and the general public
Duration:	From 1 March 2013 to 12 April 2013
Enquiries (including requests for the paper in an alternative format) to:	Reshma Bhudia Coroner Reform Team Area 4.38 Ministry of Justice 102 Petty France London SW1H 9AJ Tel: 020 3334 5259 Fax: 020 3334 2233 Email: coroners@justice.gsi.gov.uk
How to respond:	Please send your response by 12 April 2013 to: Reshma Bhudia Coroner Reform Team Area 4.38 Ministry of Justice 102 Petty France London SW1H 9AJ Tel: 020 3334 5259 Fax: 020 3334 2233 Email:coroners@justice.gsi.gov.uk
Response paper:	A response to this consultation exercise is due to be published within 3 months of the close of this consultation at: http://www.justice.gov.uk

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Foreword

Finding the answers to questions concerning the death of a loved one plays an important part in enabling those who have been bereaved to move on with their lives.

Coroners have a vital role to play in giving certainty and reassurance to bereaved people, meeting the public interest by determining the facts of deaths that are reported to them and protecting public health by making recommendations to prevent future deaths.

Successive reviews and inquiries have identified much that is good in the current coroner system. But these also identified some fundamental problems including a lack of consistency across England and Wales, an absence of national supervision or leadership and most importantly a lack of clear rights for bereaved families to participate in the process, and of standards for the treatment and support of all those who come into contact with coroners.

These reviews and inquiries led to Part 1 of the Coroners and Justice Act 2009. The Act introduces a number of structural changes to the coroner system, taking the best of what works now – local services, locally delivered – but adding national leadership and a new national framework of standards designed to deliver greater consistency and improved services for bereaved people.

I am delighted to be able to present the Government's plans for implementing these important reforms and the essential elements of this new national framework.

The process of change began in May 2012 with the appointment of the first Chief Coroner of England and Wales, His Honour Judge Peter Thornton QC. The Chief Coroner, who started work in September 2012, is already making his mark on the coroner system and we are working very closely with him to deliver these further reforms.

I firmly believe that the proposals outlined in this consultation will help to make the coroner system more responsive to the needs of all those who come into contact with coroners. They are also an important part of the Government's commitment to transform justice – building a system that is fair and transparent, that makes taxpayers' money work harder, with modern services; whilst giving support to those who need it most.

I look forward to receiving your responses to our proposals.

Helen Grant
Parliamentary Under-Secretary of State for Justice

Executive summary

1. This document sets out our approach to implementing the reforms to the coroner system contained in the Coroners and Justice Act 2009 ('the 2009 Act').

2. The primary aims of these reforms are to put the needs of bereaved people at the heart of the coroner system, for coroner services to continue to be delivered locally but within a new national framework of standards and with national leadership, and for a more efficient system of investigations and inquests.

3. The implementation process began with the appointment of the first Chief Coroner of England and Wales, His Honour Judge Peter Thornton QC, in May 2012, who for the first time is providing national leadership to coroners. We have been working with Judge Thornton on our plans for implementation of the 2009 Act and in developing the new national framework within which coroners will operate.

4. This consultation seeks views on key elements of this new framework including the following:

    a. New coroners regulations governing the investigation process, to be made under section 43 of the 2009 Act (see **Annex A**)

    b. New coroners rules to be made under section 45 of the 2009 Act governing the practice and procedure at inquests (see **Annex B**)

    c. New regulations about allowances, fees and expenses in connection with investigations and inquests, to be made under Schedule 7 of the 2009 Act (see **Annex C**)

    d. *'Guide to coroner services'*, our new statutory guidance on the way in which the coroner system should operate for bereaved relatives, to be made under section 42 of the 2009 Act (see **Annex D**)

    e. New coroner areas for England and Wales (to be made in an order under Schedule 2 of the 2009 Act) (see **Annex E**).

5. This document also sets out how we will implement the other coroner provisions in the 2009 Act, and in particular those that will help to ensure a more efficient and more transparent system of coroner investigations and inquests that better meets the needs of bereaved people. It also sets out our intention to bring these changes into force in summer 2013.

6. The Department of Health is planning to issue a consultation on a new system of death certification, which forms part of the reforms in Part 1 of the 2009 Act. The proposals will require the certified cause(s) of all deaths that are not investigated by a coroner to be independently scrutinised and confirmed by a locally appointed medical examiner. Where the attending doctor is not available to certify, the medical examiner will do so instead

and where the scrutiny indicates that the deceased died a violent or unnatural death or where the cause of death is unknown, medical examiners will refer the deaths to coroners. The consultation will be issued shortly and should be read alongside this consultation. The new system for death certification is planned to come into force in April 2014, in order to give time for local authorities to appoint medical examiners and implement other changes at a local level.

7. At the time of publication the Government is considering its response to the report of the Mid Staffordshire NHS Foundation Trust Inquiry, chaired by Robert Francis QC.[a] The report made some recommendations in relation to coroners and inquests. Action is already in hand to address some of these recommendations, particularly on the appointment of assistant coroners, and this is set out in the '**National framework and local delivery**' chapter.

[a] http://www.midstaffspublicinquiry.com/report

1. Introduction

1. This document presents for consultation the Ministry of Justice's proposals for implementation of Part 1 ('Coroners') of the Coroners and Justice Act 2009 ('the 2009 Act') and in particular for secondary legislation (rules, regulations and orders) to be made under the Act. It also sets out our proposals for new statutory guidance on the coroner system for bereaved people.

2. The consultation is aimed at coroners, those who provide local coroner services, bereavement support organisations and others who come into regular contact with the coroner system in England and Wales. We would also welcome comments from members of the public and particularly those who have experience of the coroner system.

3. The 21 individual consultation questions are posed in the relevant chapters of this document and then repeated together in the 'Questionnaire' chapter towards the end of this document.

4. This consultation paper is being sent to the organisations listed at **Annex F**. However, this list is not exhaustive or exclusive, and we welcome responses from anyone with an interest in or views on the subject covered by this paper.

5. After this consultation closes we will consider the responses we have received. We plan to publish a consultation response document in spring 2013 and anticipate that the 2009 Act's coroner provisions will be implemented in summer 2013.

2. Overview of coroner reform

Current legislation

1. The current legislation governing the role of the coroner and the conduct of inquests is primarily the Coroners Act 1988 ('the 1988 Act') and the Coroners Rules 1984 ('the 1984 Rules').

2. Successive reviews of the coroner system – most recently those conducted by Tom Luce and Dame Janet Smith in 2003 – identified much that is good in the current system, but also some fundamental problems. These included a lack of consistency between coroner districts and an absence of national supervision or leadership. Most importantly the reviews highlighted a lack of clear participation rights for bereaved people, and a lack of standards for the treatment and support of all those who come into contact with coroners.

Coroners and Justice Act 2009

3. These reviews – and the issues they identified – led to Part 1 of the Coroners and Justice Act 2009 ('the 2009 Act'). The objectives of the 2009 Act are:

    - to put the needs of bereaved people at the heart of the coroner system
    - for coroner services to continue to be locally delivered but within a new national framework, with national leadership, and
    - to enable a more efficient system of investigations and inquests.

4. The 2009 Act provides for a number of structural changes to the coroner system. It creates the new national head of the coroner system, the office of Chief Coroner. It introduces the new concept of 'investigations' into deaths as well as inquests, as well as making new provisions relating to coroner areas, creating new titles for coroners, and removing barriers to where investigations can be held. The majority of the provisions in Part 1 of the Act have not yet been implemented. They will be commenced when the new rules, regulations and orders on coroner areas come into force.

5. The Ministry of Justice intends to implement the majority of the provisions in Part 1 of the 2009 Act for which it is responsible. The main exceptions to this are the three sections of the Act that have either been repealed or will shortly be repealed – the Chief Coroner's appeal function (section 40), inspection of the coroner system (section 39), and public funding for advocacy (section 51).

2010 policy consultation on implementing the 2009 Act

6. In spring 2010 the Ministry of Justice consulted on aspects of policy to inform the drafting of secondary legislation to underpin the Coroners and Justice Act 2009.[a] The consultation sought views on issues such as:

    - transferring cases from one coroner to another
    - post-mortem examinations
    - disclosure of relevant information by coroners
    - conduct of inquests
    - the training of coroners, their officers and other support staff.

7. Where appropriate the responses to the 2010 consultation have fed into the draft rules and regulations on which we are consulting now.

Public Bodies Act 2011

8. Following a review of public bodies in 2010, the Ministry of Justice set out alternative proposals for delivering coroner reform, including transferring the Chief Coroner's statutory functions to other office holders. However, following debates during the parliamentary passage of the Public Bodies Act 2011, Parliament agreed that the post of Chief Coroner should be preserved, but with a more focused remit than originally intended. The 2011 Act therefore repealed the system of appeals to the Chief Coroner set out in section 40 of the 2009 Act. The Ministry of Justice intends to give the Chief Coroner all of the remaining statutory powers in the 2009 Act.

Approach to implementation

9. In order to allow us to address the current problems within the coroner system and to implement the provisions in the 2009 Act without further delay, our approach is to update the 1984 Coroners Rules, reflecting the new terminology introduced in the 2009 Act and making limited changes, including issues identified during the 2010 consultation. The Chief Coroner will then oversee a longer-term review of rules and regulations.

10. Our approach to implementation is also governed by the current economic situation. The reforms we are implementing will be cost-neutral in nature, in that they will generate some savings for local authorities and keep any additional costs to a minimum.

Assessing the impact of our proposals

11. The 2010 consultation was accompanied by an impact assessment (IA) and equality impact screening. The IA identified some limited costs,

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[a] http://webarchive.nationalarchives.gov.uk/+/http://www.justice.gov.uk/consultations/reform-coroner-system.htm

primarily in relation to training and disclosure of information. The most significant cost related to the new appeals process under the 2009 Act with the costs estimated to be up to £1.8m (which would have been funded by the Ministry of Justice) plus an additional burden on local authorities of up to £0.4m. The IA highlighted a number of non-monetarised benefits, primarily to bereaved people, but also to coroner's offices and local authorities through clearer and more standardised processes.

12. The impact of the proposals set out in this consultation will be the same as that assessed in 2010, aside from the savings generated from the decision not to create the new appeals process. Where the proposals might potentially generate additional costs, we have taken steps to minimise these by, for example, permitting electronic disclosure of information to interested persons to reduce the impact on local coroner services.

13. The equality impact screening carried out under the 2010 consultation noted that individuals and groups representing certain faiths, notably the Muslim and Jewish faiths, have voiced concerns about possible delays in releasing bodies for funerals, and expressed a belief that there should be an increase in the availability of less invasive post-mortem examination methods. The screening noted that both these issues have been addressed in our reforms; the new regulations outlined in this consultation have been drafted to permit expeditious release of bodies where appropriate, as well as permitting less invasive post-mortem examinations.

14. We have discussed the potential impact of our approach to implementation with representatives of the Coroners' Society of England and Wales and the Local Government Association and believe that the proposals outlined in this consultation will not have a significant cost impact on the identified key affected groups, nor have an impact on small or medium sized businesses. Given that equalities issues are also being addressed as part of the implementation package, we consider that a full impact assessment and equalities impact assessment are not required to accompany this consultation. However, the Ministry of Justice will carry out a review of the impact of these reforms 18 months from the date on which the provisions in the 2009 Act come into force in order to assess the impact of the new arrangements.

Question 1: Do you agree that the proposals set out in this consultation paper will impose no significant new burdens on local coroner's services or others? If you disagree, what new costs would arise? And how could these be mitigated?

3. National framework and local delivery

1. Part 1 of the 2009 Act is drafted on the basis of local coroner services delivered within a new national framework of rules, regulations, practice directions and guidance, under the direction of the Chief Coroner. This mix of national framework and local delivery will ensure that we capture the best of what works well now, including local innovation and accessible services, but within a national framework of standards that will lead to greater consistency in practice and procedure across England and Wales.

Chief Coroner

2. In May 2012 the Lord Chief Justice announced the appointment of His Honour Judge Peter Thornton QC as the first Chief Coroner of England and Wales. Judge Thornton, a Senior Circuit Judge at the Central Criminal Court (the 'Old Bailey'), took up post on 17 September 2012.

3. In his first official speech, delivered to the Coroners Society Annual Conference,[a] the Chief Coroner set out a ten point plan for reform of the coroner system. The Ministry of Justice is working closely with the Chief Coroner to implement this plan.

4. The Chief Coroner will oversee the work to establish the new national framework for coroners and will, for the first time, provide oversight and national leadership of the system. His main responsibilities are to:

   - provide support, leadership and guidance for coroners
   - set national standards for all coroners
   - develop training for coroners and their staff
   - approve all future coroner appointments
   - keep a register of coroner investigations lasting more than 12 months and take steps to reduce unnecessary delays
   - monitor investigations into deaths of service personnel overseas
   - oversee transfers of cases between coroners
   - direct coroners to conduct investigations
   - provide an annual report on the coroner system to the Lord Chancellor, to be laid before Parliament, and
   - collate, monitor and publish coroners' reports to authorities to prevent other deaths.

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[a] www.judiciary.gov.uk/Resources/JCO/Documents/Speeches/chief-coroner-speech-coroners-society-conference.pdf

National framework

5. This new framework will comprise the elements set out below.

Regulations on investigations

6. Section 43 of the 2009 Act enables the Lord Chancellor, with the agreement of the Lord Chief Justice, to make regulations about the investigation process (excluding inquests, which are dealt with by coroner rules), including post-mortem examinations, exhumations, and disclosure of information. See **'Summary of proposed regulations on investigations'** chapter and **Annex A** for more details.

Rules on inquests

7. Section 45 of the 2009 Act enables the Lord Chief Justice (or a nominated judicial office holder) to make rules governing the inquest part of the investigation process. See '**Summary of proposed rules on inquests'** chapter and **Annex B** for more details.

Regulations on fees, allowances and expenses

8. Schedule 7 enables the Lord Chancellor to make regulations governing the fees, expenses and allowances relating to coroner investigations.

9. We have worked with the Chief Coroner to develop the draft new coroners regulations attached at **Annex C**. See '**Summary of proposed regulations on fees. allowances and expenses**' chapter for more details.

Statutory guidance for bereaved people

10. The Lord Chancellor, following consultation with the Chief Coroner, will issue new statutory guidance setting out how the coroner system is expected to operate in relation to bereaved people. See '**Improved services for bereaved people'** chapter and **Annex D** for more details.

Practice directions and guidance to coroners

11. Section 45 also allows the Lord Chief Justice to issue practice directions on any matter that could otherwise be covered in coroners rules. Again, this power could be delegated to another judicial office-holder, such as the Chief Coroner[a]. Practice directions have the weight of rules, but allow a more flexible approach where practice may change over time.

12. The Chief Coroner has also indicated that he intends to issue guidance to coroners. He is considering whether an amended and updated Bench Book for coroners, setting out the relevant law and practice, should be

[a] See Part 1 of Schedule 2 of the Constitutional Reform Act 2005.

produced, which will serve as a point of reference to coroners on procedural matters. The Chief Coroner also intends to produce Law Sheets, each of which will cover the law on a particular topic, and practical guidance notes on issues such as case management and disclosure.

Training

13. To help drive up standards and improve consistency between coroner areas, the 2009 Act gives the Chief Coroner specific powers in relation to training coroners and their staff. Training was highlighted as one of the Chief Coroner's key responsibilities and means to improve coroner practice when the future of the post was debated in Parliament.

14. Until now, training for coroners (which coroners' officers have also recently attended) has been organised by a Coroners Training Group, with administrative support from the Ministry of Justice. In future, training will be provided and organised by the Judicial College, which is already responsible for training judicial office-holders in other courts and in most tribunals. This will allow coroners and their officers to benefit from the expertise that the Judicial College (and its predecessor, the Judicial Studies Board) has built up over the years in training judges.

15. Section 37 of the 2009 Act allows the Chief Coroner to make regulations about the amount, type and frequency of training. Judge Thornton has indicated that he wishes to see mandatory training for coroners. To help with this, the Ministry of Justice is more than doubling the training budget available for coroner (and coroners' officer) training.

Coroner areas

16. Coroners will continue to sit, as a matter of course, in the local areas to which they are appointed. At present there are 110 coroner districts served by 97 coroners. This is because a number of coroners hold more than one jurisdiction, primarily where the local authority area is a 'unitary authority'[a]. which has until now prevented amalgamation with a neighbouring district.

17. Under the 2009 Act, coroner districts become 'coroner areas'. Schedule 2 of the Act allows the Lord Chancellor to make an order setting and altering the boundaries of coroner areas for England and Wales. For the first time, the Schedule 2 power will enable us to amalgamate areas that contain a unitary authority.

18. Under the Act each coroner area will correspond to one or more local authority areas. The intention behind Schedule 2 is to move towards fewer but larger coroner areas, each of which supports a full-time coroner caseload. Larger coroner areas will mean economies of scale for local

[a] A unitary authority is a type of local authority that usually covers a town or city which is large enough to function independently of a county. It contrasts with the usual two-tier administrative structure of counties and non-metropolitan districts.

authorities through, for example, sharing of staff and other resources, while full-time coroners will be able to focus entirely on their coronial duties, and thus develop their skills and experiences more fully. This will also help bring about greater consistency of practice between areas.

19. The creation of larger coroner jurisdictions should not mean reduced access to local services and we would not expect bereaved people to have to travel long distances to attend inquest hearings.

20. The way that Schedule 2 is drafted means that we will make two orders. The first will simply specify that each coroner district at the time of the order will become a coroner area. A second order will then bring the relevant amalgamations into effect.

21. We have canvassed views from local authorities on the changes they would like to be included within the second order, primarily where the presence of a unitary authority has in the past prevented a merger, as well as where local authorities have upcoming amalgamations planned.

22. **Annex E** sets out all existing coroner districts, and the new proposed coroner areas that the current districts will become, including the following proposed amalgamations:

    - Bournemouth, Poole and Eastern Dorset with Western Dorset
    - Bridgend and Glamorgan Valleys with Powys
    - Carmarthenshire with Pembrokeshire
    - Coventry with Warwickshire
    - Darlington and South Durham with North Durham
    - Derby and South Derbyshire with North Derbyshire
    - Essex and Thurrock with Southend and South East Essex
    - Mid and North West Shropshire with South Shropshire and with The Wrekin
    - Neath and Port Talbot with Swansea
    - Plymouth, Torbay and South Devon.

23. We seek views on these changes.

24. Under these proposals, and with changes planned between now and June 2013, the number of coroner areas would be reduced to 97, with 96 senior coroners, with the abolition of the office of the coroner of the Queen's Household (see below). Over time, we intend to reduce the number of coroner areas – and senior coroners – to around 60.

Question 2: Do you have any views on the proposed changes to coroner areas under the 2009 Act, as set out in the table at Annex E? If so, please give details.

Coroner of the Queen's Household

25. As part of the changes to coroner areas and jurisdictions, the Ministry of Justice will implement section 46 of the 2009 Act, which abolishes the office of coroner of the Queen's Household. Deaths that would formerly have been investigated by the Coroner of the Queen's Household will instead be investigated by the coroner for the area where the body of the deceased is lying, unless the Chief Coroner decides to nominate a different coroner to conduct the investigation. The Chief Coroner will become the first point of contact for all such deaths.

Provision of local services

26. Local authorities will retain responsibility for funding local coroner services under the 2009 Act. Where a coroner area spans more than one local authority, one of those authorities will be known as the 'relevant authority' (formerly 'lead' authority) for the area. Section 24 of the 2009 Act requires the relevant authority for a coroner area to ensure there is sufficient accommodation and administrative staff and coroners' officers to support the coroner.

27. Section 24 says that the duty on local authorities to provide coroners' officers and other staff applies only where the police authority does not provide such officers and staff. As the Explanatory Notes to the 2009 Act make clear, where police authorities currently provide coroners' officers they are expected to continue to do so in future, unless the local authority and police authority agree alternative arrangements.

Coroner appointments

28. The 2009 Act changes the titles of the office of coroner and amends the eligibility requirements and the appointment process.

29. The hierarchy of coroners under the 1988 Act consisted (in descending order) of coroners, deputy coroners and assistant deputy coroners. Under the 2009 Act, there will be senior coroners, area coroners and assistant coroners. Senior coroners and area coroners are salaried posts, while assistant coroners are fee-paid. Area coroners are an entirely new post and under the transitional provisions in the 2009 Act, deputy coroners will **not** automatically become area coroners.

30. Schedule 3 to the 2009 Act allows the Lord Chancellor, by order, to require the appointment of an area coroner or specified number of area coroners (and a minimum number of assistant coroners) for each coroner area. There are no plans to use this power at this stage and so the decision whether to appoint an area coroner will be for the relevant authority. Area coroners could, for example, be appointed within a particularly large coroner area to assist the senior coroner with his or her duties.

31. The rules and regulations in **annexes A–C** simply refer to 'coroner' rather than using the three different titles.

32. Under the current system, the lead local authority appoints a coroner and the coroner appoints deputy and assistant coroners with the local authority's approval. The Secretary of State for Justice approves only certain coroner appointments.

33. The Ministry of Justice will implement the changes in Schedule 3 of the 2009 Act so that local authorities will become responsible for **all** coroner appointments (i.e. including area and assistant coroners). There is also a new requirement for local authorities to seek the consent of the Lord Chancellor and Chief Coroner to the appointment of new coroners. This will introduce much greater transparency to the process and greater consistency of standards.

34. Schedule 3 also changes the qualifications of senior, area and assistant coroners. At present coroners must either have a five year legal qualification or be a medical practitioner of at least five years' standing. Under the 2009 Act, all coroners must be legally qualified (although transitional arrangements will apply to medical practitioners already in post when the changes come into effect).

35. For any new appointments under the 2009 Act, a person must be under the age of 70 and satisfy the judicial-appointment eligibility condition for five years when they are appointed. Sections 50 to 52 of the Tribunals, Courts and Enforcement Act 2007 ('the 2007 Act') state that a person satisfies the eligibility condition if he or she holds a relevant qualification and, whilst holding that qualification, gains experience in law. A person holds a relevant qualification if he or she is a solicitor or barrister, or holds a qualification specified in an order under section 51(1) of the 2007 Act. The Judicial Appointments Order 2008 extends eligibility for a range of judicial posts (including Deputy District Judges and Judges of the First-tier Tribunal) to Fellows of the Chartered Institute of Legal Executives (CILEX), although this provision will not apply automatically to coroners.

36. The intention behind the 2007 Act and the 2008 Order is to remove barriers to judicial appointments and to encourage greater diversity. We therefore intend to amend the 2008 Order by adding the offices of senior coroner, area coroner and assistant coroner to Schedule 1 of that Order, thereby allowing CILEX Fellows to be eligible for coronial appointment.

Question 3: Do you support the proposal to amend the Judicial Appointments Order 2008 so that Fellows of CILEX are eligible for coronial appointments? Please give reasons for your response.

37. The 2009 Act also introduces a new retirement age of 70 for coroners appointed under the new provisions, although again there are transitional arrangements that apply to those in post when the 2009 Act comes into force.

Guidance to local authorities

38. Recommendation 284 of the final report of the Mid Staffordshire NHS Foundation Trust Inquiry proposed that the Lord Chancellor should issue guidance on the criteria to be used in the appointment of assistant deputy coroners (who will be 'assistant' coroners under the 2009 Act). In future, all such appointments will have to be approved by both the Lord Chancellor and the Chief Coroner. We are working with the Chief Coroner on guidance to local authorities on coronial appointments, including the qualifications and criteria for appointment. This will help to ensure that the process is as robust, consistent and transparent as possible.

Coroner terms and conditions

39. The 2009 Act says that it is for the coroner and the local authority to agree the coroner's remuneration. The practice has been for a Joint Negotiating Committee of the Local Government Association to set out a salary scale for coroner appointments.

40. However, practice has varied and there are some wide discrepancies between coroner salaries, fees and other allowances. In his speech to the Coroners' Society Annual Conference, the Chief Coroner announced his desire to move towards a standardised set of terms and conditions. The Ministry of Justice fully supports this aim and will assist the Chief Coroner in this work.

Coroner disciplinary arrangements

41. The 2009 Act changes the disciplinary arrangements in relation to coroners. At present, only coroners are subject to the disciplinary arrangements under the Constitutional Reform Act 2005 and come within the scope of the Office for Judicial Complaints (OJC) (which advises the Lord Chancellor or Lord Chief Justice in the event of a complaint about the personal conduct of a judicial office-holder). Coroners are currently responsible for appointing their deputies and assistant deputies as well as for disciplining them.

42. The Ministry of Justice will change the position by implementing the provisions in Schedule 3 of the 2009 Act that extend the current judicial disciplinary arrangements to **all** coroners. In future, the Lord Chancellor, with the agreement of the Lord Chief Justice, will have the power to remove a senior coroner, area coroner or assistant coroner from office if that coroner is incapable of performing his or her functions or is guilty of misconduct. The 2009 Act also makes senior coroners, area coroners and assistant coroners subject to the disciplinary provisions of the 2005 Act (which includes the power for the Lord Chief Justice to issue formal warnings or reprimands).

43. In practice, this means that in future the OJC will take on responsibility for investigating complaints against **any** coroner in England and Wales.

4. Improved services for bereaved people

Statutory guidance for bereaved people – *Guide to coroner services*

1. For many bereaved people, the coroner system and the inquest process have been a mystery. The death of a loved one can be a particularly traumatic time and bereaved people need to understand the processes of a coroner investigation if they are to play an active role in an investigation and inquest. It is for this reason that in March 2012 we published our *Charter for Coroner Services*[a] alongside a revised version of the *Guide to Coroners and Inquests*.

2. The Charter has also been an important means of ensuring greater consistency of practice within the coroner system. It sets out for the first time the standards that those coming into contact with the coroner system can expect to receive across all coroners districts in England and Wales. It also tells them how to seek redress when those standards are not met, and sets out their own responsibilities during the coroner's inquiry.

3. The Charter is drafted on the basis of the current system (the 1988 Act), so the Charter and Guide need to change to reflect the changes we are bringing forward under the 2009 Act. We have also taken this opportunity to merge the Charter and Guide into a single and shorter document to make it more user-friendly.

4. Attached at **Annex D** is the draft of the new document, *Guide to coroner services*. This will have the new status, and added weight, of statutory guidance issued by the Lord Chancellor, under section 42 of the 2009 Act. As required by section 42, we have worked closely with the Chief Coroner in drafting the new guidance.

Question 4: In your experience what difference has the current *Guide to coroners and inquests and Charter for coroner services* made since it was published?

Question 5: The new *Guide to coroner services* (at Annex D) revises the *Guide to coroners and inquests and Charter for coroner services,* so that it is consistent with the 2009 Act. Do you think the new document is a helpful summary of what to expect during a coroner investigation? If not, please explain your answer.

Question 6: Is there anything else we should cover in the *Guide to coroner services,* or cover differently? If so, please explain your answer.

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[a] www.justice.gov.uk/coroners-burial-cremation/coroners

Greater transparency

5. Another means of driving up standards of performance across the coroner system will be the Chief Coroner's annual report to the Lord Chancellor, to be made under section 36 of the 2009 Act. The report will be an annual statement on the coroner system with a particular focus on service levels.

6. In particular, the Chief Coroner will be required to make an assessment of the consistency of standards between coroner areas as well as reporting on the number of investigations lasting more than a year (see Chapter 5, paragraph 10 below), including the reasons for the length of these investigations and the actions he is taking to keep such delays from becoming unnecessarily lengthy.

7. The Lord Chancellor will be required to lay the Chief Coroner's report before Parliament. This in turn will lead to much more scrutiny of key issues facing the coroner system, encouraging parliamentary debates on coronial matters.

8. This will be in addition to the information and statistics the Ministry of Justice currently publishes on the coroner system including deaths reported to coroners and post mortem examinations and inquests held. In particular, the Ministry collects detailed statistics from coroners on a calendar-year basis. We expect this detailed information will be annexed to the Chief Coroner's annual report (which has to be published by 1 July each year).

9. The Ministry of Justice will also continue to publish quarterly statistics relating to service personnel deaths. Publication of these statistics has helped to drive down waiting times for such inquests.

Release of bodies for burial or cremation

10. At present there is no time limit within which a coroner must release a body to a family for burial or cremation and delays in release of bodies can be a source of considerable distress for bereaved people. The consultation in March 2010 sought views on whether to impose a requirement on coroners to release a body within 30 days. There was general support for a 30-day release period, although it was recognised that this may not be possible in all circumstances, particularly in cases where criminal proceedings may have been instigated.

11. We have therefore included a new regulation (regulation 21 of the Coroners (Investigations) Regulations 2013) which provides that coroners must release the body to a family within 30 days or notify the next of kin or personal representative of the deceased where this is not possible.

Holding inquests closer to the family home

12. The 2009 Act introduces greater flexibility in where investigations can be conducted in England and Wales and where inquest hearings may be

held, although the wishes of the family should always be paramount in reaching a decision on where the investigation or inquest should take place.

13. As soon as the Chief Coroner took up post in September 2012, we brought into force the provisions under section 12 and 50 of the 2009 Act which allow investigations into deaths of service personnel on operations and exercises overseas to be transferred to Scotland, when the bereaved service family is based there. This means that, in most cases, bereaved service families in Scotland will no longer need to travel to England for an inquest, but will instead be able to have a Fatal Accident Inquiry in Scotland[a] into their loved one's death.

14. We are also bringing into force the other changes in the 2009 Act that allow greater flexibility. In February 2013 we removed the provision in the 1988 Act that said an inquest had to be held in the relevant coroner's district. This provision proved unnecessarily restrictive where, for example, the coroner was unable to find suitable accommodation to hold a jury inquest but an appropriate venue could have been available in a neighbouring district, which could have prevented delays in inquests being held.

Legal assistance

15. Inquests are perhaps unique within our legal system. Finding the answer to the questions concerning the death of a family member, a colleague or someone close, can be an important element in enabling those who have been bereaved to move on with their lives. But given the nature of the proceedings, and the fact that participants are not required to present legal argument, there is generally no need for representation in inquests. Legal representation is therefore not generally available for inquests.

16. Section 51 of the 2009 Act would have brought advocacy at certain inquests into scope of the legal aid scheme (for example, deaths in custody and deaths in active military service). As part of the Ministry of Justice's wider reforms to the provision of Legal Aid, the Government decided not to implement section 51 of the 2009 Act, and the Legal Aid, Sentencing and Punishment of Offenders Act 2012 repeals section 51.

17. We do, however, consider that, as now, legal aid should remain available for representation for individual inquests where there are exceptional circumstances, and will retain the current criteria for funding these inquests.

18. Generally, for Legal Aid to be granted, applicants must qualify financially and applications must meet strict criteria for representation to be funded. These criteria are that:

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[a] There is no inquest system in Scotland. The nearest equivalent is the Fatal Accident Inquiry.

- there is a significant wider public interest (as defined in the Legal Services Commission's Funding Code) in the applicant being represented at the inquest, or
- the applicant is a member of the deceased's immediate family and the circumstances of the death appear to be such that funded representation is likely to be necessary to enable the coroner to investigate the case effectively and establish the facts (as required by Article 2 of the European Convention on Human Rights).

19. In practice, the availability of Legal Aid for inquests will not therefore change significantly as a result of the repeal of section 51.

20. The Ministry of Justice has also taken steps to ensure that Legal Help will also remain available in inquest proceedings, where applicants qualify financially. Legal Help can be used, for example, to assist bereaved people in the preparation of a list of written questions that they wish the coroner to explore with other witnesses.

Disclosure of information

21. If bereaved people are to play an active part in the investigation and inquest process we believe they must have the opportunity to access as much of the material as possible which the coroner will be considering during the inquest.

22. Current coroner practice on disclosure varies. Rule 57 of the 1984 Rules requires coroners to disclose evidence after the inquest to interested persons, on application and on payment of a prescribed fee. (Alternatively, coroners may make information available for viewing, free of charge.) There is, however, no express provision governing disclosure of information before an inquest, although coroners tend to disclose this as a matter of good practice. It is also mandatory in some circumstances (regarding deaths where the state is implicated).

23. The March 2010 consultation sought views on formalising the process of advance disclosure, with the general principle that coroners should disclose to interested persons, on request, all relevant documents for an inquest, although this would be subject to certain restrictions. The majority of respondents supported this.

24. We have therefore drafted new rules (Part 2 of the Coroners (Inquests) Rules 2013) which encourage early disclosure, requiring coroners to disclose information at any stage of an investigation, on application by an interested person, including information that comes to light during the inquest itself. The coroner will have some say over what information is relevant, and may redact a document before disclosing it.

    Disclosure will also be subject to the following exemptions:

    - the document is subject to legal privilege or other legal prohibition on disclosure

- the consent of the copyright owner of the document cannot be obtained
- the coroner consider the request to be unreasonable
- the document relates to commenced criminal proceedings, or
- the coroner considers the document to be irrelevant to the inquest proceedings.

25. As now, there will be no charge for disclosure before or during the inquest. Respondents to the March 2010 consultation pointed out that costs of disclosure could be minimised by sending electronically-held information by email. Electronic disclosure is commonplace in other jurisdictions, particularly in civil proceedings. Our new rules therefore expressly permit electronic disclosure of information, both before and after the inquest proceedings. The rules will also say that a coroner should let an interested person inspect a relevant document, in the coroner's office, free of charge.

26. For post-inquest disclosure, we will permit coroners to continue to charge a fee for disclosure of hard copy documents (reflecting current practice) but only where this has been requested or where electronic disclosure (by email) would not otherwise be possible.

Recording proceedings

27. The disclosure provisions set out above will apply to notes of evidence taken by a coroner at an inquest and any recording or transcript of the inquest proceedings. This reflects the Chief Coroner's wish to standardise practice and for coroners to record digitally all proceedings (in addition to taking notes of evidence). This issue is explored in more detail in the '**Summary of proposed rules on inquests'** chapter below.

Challenging a coroner's decision

28. The 2009 Act originally set out a number of new rights of appeal to the Chief Coroner against decisions of coroners. During the debates on the Public Bodies Bill in 2011, Parliament agreed to repeal these provisions.

29. The Ministry of Justice's view is that it is better to concentrate on getting decisions right first time, rather than adding an additional layer of appeal rights and encouraging interested persons to pursue lengthy legal challenges.

30. We will instead retain the existing means for redress, so that decisions can still be contested by way of judicial review or by application by, or under the authority of, the Attorney General to the High Court under section 13 of the 1988 Act. (The High Court can order an inquest, where the coroner has declined to hold one, or to order a fresh inquest if it is 'necessary or desirable in the interests of justice'.) We will therefore keep section 13 of the 1988 Act, rather than repealing it, although this provision will be amended to reflect the terminology of the 2009 Act.

Bereavement Organisations Committee

31. The Ministry of Justice announced in June 2011[a] its intention to establish a Bereavement Organisations Committee to sit alongside a proposed Ministerial Board to oversee the coroner system and to capture feedback from bereaved people on their experiences of the inquest process.

32. These arrangements were originally intended to form part of the governance arrangements for the coroner system in the absence of a Chief Coroner. Now that we have a Chief Coroner in post, it would be inappropriate to establish a Ministerial Board to oversee the coroner system. It will also be the Chief Coroner's responsibility to determine how to capture the views of bereaved people who are affected by a coroner's investigation. The Chief Coroner is currently considering what arrangements to put in place to enable this.

[a] http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110614/wmstext/110614m0001.htm

5. A more efficient system of investigations and inquests

1. One of the key concerns for bereaved relatives is the length of time the investigation and inquest process can take.

2. There are often good reasons for the length of investigations at an individual case or a local level. This is particularly so where an investigation is complex or dependent on other bodies, such as the Prisons and Probation Ombudsman or the Health and Safety Executive, completing their own enquiries into a death. But taking these factors into account, the statistics still show a wide variety in waiting times for inquests across the country. While the average waiting time in 2011 was 27 weeks (from the date the death was reported to the conclusion of the inquest), in one coroner district this was as low as nine weeks. At the same time there were almost 200 investigations across England and Wales that were over 12 months old.

3. This chapter sets out our plans to tackle delays within the system and allow the coroner system to operate more effectively.

Target date for completing inquests

4. Currently section 8(1) of the 1988 Act requires a coroner to hold an inquest as soon as reasonably practicable. Similarly section 1(1) of the 2009 Act requires a coroner to conduct an investigation into a death as soon as practicable if the coroner has reason to suspect that the deceased died a violent or unnatural death, the cause of death is unknown or the deceased died in custody or state detention. There is, however, no specific requirement on timing in relation to the holding of an inquest.

5. As noted above, one of the Chief Coroner's key responsibilities is to tackle delays within the coroner system. To help him fulfil this duty, the Chief Coroner is keen to see a target date within which coroners should complete most inquests.

6. The draft Coroners (Inquests) Rules at **Annex B** contain a number of provisions on timeliness. In particular, Rule 5(1) would require an inquest to be opened as soon as reasonably practicable after a death has been reported to a coroner, while Rule 8 would impose a target date for completing inquests, wherever possible. Rule 8 does not set the target date at this stage as we are keen to capture views on this.

7. There is a strong argument in favour of a short period of time (for example three months) as an aspirational target date for the more straightforward inquests, and the coroner statistics highlighted in paragraph above suggest that this should be achievable. Allowance would, however, have to be made for the more complex inquests, which may for example be reliant

on other investigations being completed before the inquest can proceed but the majority should be able to be achieved within the target date.

8. Some would argue that holding the inquest too soon after the death may not allow bereaved relatives sufficient time to grieve and to participate fully in the inquest process. This would suggest that a target of less than three months might be too soon.

9. The target would not be binding on coroners (hence the words 'or as soon as is reasonably practicable thereafter' are included in the draft rule) and there would be no sanction for not meeting the target. Performance against this could, however, be measured in the annual coroner statistics and reported on in the Chief Coroner's annual report to the Lord Chancellor (see below). Experience in other areas (such as with the quarterly publication of statistics on service personnel deaths) has shown that this can have a positive impact on reducing delays within the coroner system.

Question 7: Should the new coroners rules include a target date for completing inquests? If so, what should this target be? Would three months be appropriate? Please give your reasons.

Investigations lasting more than a year

10. When the 2009 Act was before Parliament, it was felt very strongly that no family should have to wait more than a year for an inquest hearing unless there were very good reasons for this. Section 16 of the 2009 Act therefore requires coroners to notify the Chief Coroner of any investigation that lasts more than a year, and to give the reasons for any delay.

11. The coroner will also be required to notify the Chief Coroner of the reasons for the delay and the date on which the investigation was concluded. The Chief Coroner will maintain a register of these investigations and we are considering with him how this will work in practice.

12. As noted at Chapter 4, paragraph 6 above, the Chief Coroner will report back to the Lord Chancellor each year on the number and length of investigations reported to him (including those reported in the previous year that are still outstanding), the reasons for the length of these investigations, and the measures he is taking to keep investigations from becoming unnecessarily lengthy.

13. This will put a much greater focus on delays within the system and encourage coroners to better manage their caseload and review investigations where there are delays.

More efficient use of resources

14. As noted in the '**Improved services for bereaved people'** chapter above, the 2009 Act relaxes provisions governing the location of investigations.

These new powers could also help prevent delays and backlogs from building up.

15. In particular, section 3 of the 2009 Act gives the Chief Coroner the power to direct a particular coroner to conduct an investigation. Some investigations may involve complex issues, such as deaths of service personnel killed abroad on active duty or particular types of deaths in custody. The Chief Coroner has announced that he is considering having a number of coroners specially trained to conduct such investigations. This could free up other coroners to clear other, more routine investigations. The specially trained coroners would wherever possible hear cases close to the location of the bereaved family.

16. The 2009 Act (Schedule 10) also provides for judges (and former judges and former coroners) to be appointed to conduct particularly complex or high-profile investigations. Judges are already sometimes appointed to hear particularly complex or high-profile inquests, such as those into the deaths of Diana, Princess of Wales and Dodi Al Fayed, Jean Charles de Menezes, or the victims of the 7/7 bombings. However, at present, the process for appointing 'judge coroners' is cumbersome, as the judge has to be appointed as an assistant deputy coroner in the district where the inquest will be held.

17. In future, the Chief Coroner will simply ask the Lord Chief Justice to nominate a judge or former judge to conduct an investigation and will have the power to direct that judge to conduct it. In addition, the Chief Coroner may himself investigate a death, or ask a retired coroner to do so. These provisions, however, are not expected to be used as a matter of routine.

Post-mortem examinations

18. Coroners often request pathologists to carry out post-mortem examinations to help them ascertain how the deceased came by their death. The 2009 Act introduces more flexibility into where post-mortem investigations can be conducted, by allowing bodies to be moved beyond the coroner's area or adjoining area. This could help coroners where specialist facilities are required, or speed up the process where it is difficult to find an available pathologist locally.

19. There is, however, a strong case for looking again at how and when a post-mortem investigation is commissioned. A number of studies have criticised the high rate of post-mortem investigations in England and Wales. A report by the University of Dundee in 2011, for example, suggested that the number of post-mortem examinations could be cut by 60 per cent.

20. The 2011 coroner statistics show that post-mortem examinations were ordered in 42 per cent of deaths reported to coroners, although this varied widely between coroner jurisdictions (ranging from 13 per cent to 74 per cent).

21. Post-mortem examinations (together with the transportation and storage of bodies they require) are the single biggest expense for local coroner services. While resources should not be the defining factor in whether to commission a post-mortem examination, the rate in England and Wales is considered to be double that in countries such as Ireland, Scotland, Canada and Australia. There is therefore a concern that some post-mortem examinations are being carried out where they are not necessary.

22. Some pathologists themselves are unhappy with the rate of post-mortem examinations, and the fee they receive for carrying them out. Many argue that there should be fewer, but higher quality, post-mortem examinations. The aim is therefore to ensure a more targeted approach to the commissioning of post-mortem examinations so that they are only carried out where necessary.

23. The new Medical Examiner scheme may help to standardise practice when coroners request post-mortem examinations, as it will introduce independent medical scrutiny of deaths – including an examination of the body – which should see fewer deaths referred to coroners. However, this may not necessarily see a fall in the post-mortem examination rate as the pilots of the Medical Examiner scheme have shown mixed results.

24. Many bereaved people object to invasive post-mortem examinations on religious and cultural grounds, wishing to avoid their relative undergoing such an invasive procedure. Some campaigners support the use of less invasive magnetic resonance imaging (MRI) or computerised tomography (CT) scans to examine the body. The Chief Coroner is reviewing post-mortem examination practice with a view to introducing greater consistency between coroners and reducing the rate of post-mortem examinations. He has also issued guidance to coroners on the use of less invasive post-mortem examinations.

Coroner powers

25. The 2009 Act gives coroners new powers to enable them to perform their roles more effectively. We will commence the power in paragraphs 1 and 2 of Schedule 5 to the Act which allow coroners to summon witnesses and to compel evidence to be given or produced. There are corresponding offences in Schedule 6 for those who fail to comply. Implementing these provisions will strengthen coroners' existing powers and speed up both the investigation and inquest process by ensuring that evidence is provided in a timely manner.

26. The 2009 Act also includes new powers allowing coroners to enter and search land and to seize items which are relevant to their investigations. The Ministry of Justice has no plans to commence these powers at this stage, as coroners consider that their existing powers are sufficient.

Evidence at inquest

27. The current rule 37 on documentary or written evidence has been criticised by some as being unduly complicated and restrictive. Under this rule the coroner may admit documentary evidence if it is not, and is unlikely to be, disputed. The coroner may also accept documentary evidence, even if it is objected to, if the maker of the document cannot give oral evidence within a reasonable timescale or has died. Such evidence must normally be read aloud at the inquest. As part of the March 2010 consultation, we sought views as to whether the provision should be extended or clarified, and if so, what would be the best way to achieve this.

28. The majority of respondents, and in particular coroners, said that they would like the admissibility of documentary evidence to be extended and clarified, especially in relation to cases where the death occurred abroad and documentary evidence is often the only evidence available.

29. As a result our proposed new rule expands current rule 37 by saying that written evidence should be admissible where the coroner is satisfied that:

    - the maker of the written evidence cannot attend the inquest to give evidence at all, or within a reasonable time (perhaps due to a severe disability)
    - there is sufficient reason why the maker of the written evidence should not attend (for instance where the person is abroad or ill)
    - there is sufficient reason to believe that the maker of the written evidence will not attend (even though there may not be a justified reason for non-attendance), or
    - the coroner considers the evidence is unlikely to be disputed.

30. The proposed rule also provides for the coroner to have such evidence read aloud.

31. We also propose new rules expressly permitting the coroner to accept evidence by video link, or from behind a screen, where the coroner thinks this will improve the quality of the evidence given. These provisions were originally clauses in an earlier draft Coroners Bill in 2006. They were removed only as it was felt that, because they addressed a process within an inquest, they would be more appropriate located in rules rather than in the Act itself. Screening will be particularly useful in relation to vulnerable witnesses. The coroner's decision on whether to accept screened evidence will be final. These measures should help inquests to run more smoothly.

Treasure

32. The 2009 Act includes measures to reform the treasure investigation system by removing the jurisdiction from local coroners and passing cases to a national Coroner for Treasure. However, funding for this new post is not currently available, although the Department for Culture, Media and Sport still intends to create this post in the future.

33. Given that we are not, for now, having a national Coroner for Treasure we propose to retain section 30 of the 1988 Act, suitably amended. This will preserve a coroner's current duty to investigate any reported treasure finds in his or her area.

Actions to prevent other deaths

34. Coroners already play a vital role in protecting the public through their reporting to the relevant organisation actions that those authorities should take to prevent future deaths (under rule 43 of the 1984 Rules). The 2009 Act strengthens the current provisions, elevating them to the Act itself (rather than just being in the supporting rules as at present) and placing a duty on coroners to report such actions, rather than leaving this to the coroner's discretion.

35. The person or organisation to whom the report is made must respond in writing and coroners must send all reports and responses to them to the Chief Coroner. We are proposing to reduce the time limit for such responses from 56 days to one month to reflect the importance of the reports and the urgency with which these should be treated.

36. The Lord Chancellor currently publishes a six-monthly summary of the reports and responses received to them. The Chief Coroner will assume this responsibility under the 2009 Act and will also be required to include the summary in his annual report.

37. The Chief Coroner is also keen to review the whole process of reports to prevent deaths. In particular, he would like to see greater consistency in the number and quality of reports, particularly given regional variations, with some coroners issuing no such reports at all. The new duty on coroners to report such matters should help to ensure greater consistency of practice. We will work with the Chief Coroner to implement the findings from his review.

6. Summary of proposed regulations on investigations

1. Our draft section 43 regulations on investigations are at **Annex A**, and are summarised below. We have titled them the Coroners (Investigations) Regulations 2013 to distinguish them from the Coroners (Inquests) Rules 2013, as the latter will cover only the inquest part of the investigation process.

2. As noted at Chapter 2, paragraph 9 above, the Ministry of Justice's approach to implementation is to replicate and update, as far as possible, the existing Coroner Rules 1984. However, there are some changes to the 1984 Rules which we have been waiting to implement, as well as some changes arising from the March 2010 consultation. The main substantive changes we are proposing are summarised below.

General regulations

3. The 2009 Act introduces the new concept of an 'investigation' into a death, of which the inquest only forms part. This requires a new formal process to be captured in our proposed regulations. In practice it will differ little from current procedure.

Coroner availability

4. The proposed regulation says that a coroner must be available at all times to undertake urgent matters, relating to post-mortem examinations or organ donation, which cannot wait until the next working day. This refines the current 1984 rule 4 (which referred to inquests and post-mortem examinations) to align it more with current coroner practice, by reflecting that organ donation and post-mortem examinations are invariably the only issues which need to be addressed out of hours.

Question 8: Are you aware of a time when a coroner has in practice needed to be available out of hours for duties not relating to a post-mortem examination or organ donation? If so, please give details.

Delegation of coroner functions

5. We propose a new regulation to provide for coroners to delegate administrative – but not judicial – functions to their officers and other support staff.

6. This regulation is needed because the Shipman Inquiry noted that coroners' officers dealt with queries from doctors in relation to some of Shipman's victims and had on occasion advised that the coroner would not be interested in a particular death, without consulting the coroner. We are aware that some coroners still delegate these functions. This regulation therefore acts as a safeguard to ensure that the coroner is aware of all

deaths and makes the decision whether or not an investigation is necessary. The regulation will help to clarify the boundaries for delegation.

7. We anticipate that the Chief Coroner will issue guidance on the functions that coroners can delegate to coroners' officers and other staff, as in practice the distinction between judicial and administrative functions can be blurred and open to interpretation. We envisage that the functions that could be delegated include contacting bereaved people, but would not include judicial decision-making functions (such as deciding whether to order a post-mortem examination).

Post-mortem investigations

8. The regulations on post-mortems broadly replicate the existing provisions in rules 5, 7, 9, 9A and 10 of the 1984 Rules, although we have taken the opportunity to simplify the provisions. In particular the regulations omit detail relating to the premises for post-mortem examinations and no longer differentiate between post-mortem examinations and 'special examinations' as the 2009 Act removes this distinction.

Question 9: Are you content with this approach to the drafting of the regulations on post-mortem examinations? If you are not, please give your reasons.

Transfer of investigations

9. Regulations under section 43 provide that when coroners transfer investigations from one coroner area to another, or where the Chief Coroner directs that another coroner should conduct an investigation, all relevant documents, evidence and relevant information (such as contact details for the next of kin) should normally be transferred within five working days, and all known interested persons should be notified of the transfer within five working days.

10. Regulations about fees and expenses regarding such transfers are made under Schedule 7 of the 2009 Act.

Discontinuance of investigations

11. The new regulations say that when the post-mortem examination reveals the cause of death, the coroner must record this. They also say that when an investigation is discontinued for any other reason, the coroner must record the date of, and the reason for, the discontinuance, and notify all known interested persons. There will be a new coroner form on which to record this information.

Coroner certificates

12. The proposed regulation states that when a coroner suspends an investigation because of a possible homicide charge relevant to the death, he or she must give the registrar of births and deaths the details required to register the death. Where an investigation has been suspended for reasons other than possible criminal proceedings, the coroner may, on request, give a bereaved person or personal representative a certificate confirming the fact of death. This replicates rules 29 and 30 of the 1984 Rules.

Release of bodies for burial or cremation

13. We have added a new regulation requiring coroners to release bodies for burial or cremation within 30 days of being notified of the death or, where this is not possible, to explain this to the next of kin or personal representative.

Question 10: Are you content with the draft regulation which says that a body should normally be released within 30 days, and that if this is not possible, the coroner must explain why? If not, please explain your answer.

Burial order

14. Draft regulation 22 updates the existing rule 14. It permits the coroner to authorise burial where the coroner is under a duty to conduct an inquest and believes that the body does not need to be retained for any post-mortem or further post-mortem examination.

15. The process in relation to cremation will remain unchanged and continue to be regulated by the Cremation Regulations 2008. In April 2014 the Department of Health plans to introduce its new death certification regime, which will include the introduction of medical examiners. Nevertheless, certain aspects of the current cremation authorisation process currently carried out by medical referees, namely the scrutiny and authorisation for the cremation of stillborn babies and parts, will not transfer to the proposed role of the medical examiner. The Department of Health is consulting on these proposals separately.

Exhumation

16. Schedule 5 to the 2009 Act provides for a coroner to order an exhumation in certain circumstances. Our proposed regulation simply stipulates that the prescribed form must be used when the coroner does so.

Disclosure of information

17. The detail on what information coroners may disclose will be contained in the rules (rather than regulations). On this issue, the regulations say only that coroners must disclose information in accordance with Part 2 of the Coroners (Inquests) Rules 2013.

Local Safeguarding Children Boards

18. The proposed regulation replicates current rule 57A regarding the coroner's duty to provide information to the Local Safeguarding Children Board, when he or she is investigating a child's death.

Power for the Chief Coroner to require information

19. We propose a new regulation allowing the Chief Coroner to, at any time, request information from a coroner in relation to any particular investigation, or investigations more generally. The Chief Coroner might use this in his annual report or if he has concerns about a particular coroner's service.

Investigations lasting more than 12 months

20. The 2009 Act requires a coroner to notify the Chief Coroner of any investigation lasting more than 12 months. The proposed regulation says the coroner must include reasons for this and notify the Chief Coroner of the date on which an investigation that he or she has previously notified him of is subsequently concluded and the reasons for any further delays. This will help the Chief Coroner to fulfil his functions under section 36 of the 2009 Act (annual report to the Lord Chancellor).

Retention of documents

21. The proposed regulation replicates rule 56 of the 1984 Rules which says that a coroner must retain documents for 15 years. We consulted on this issue in March 2010 and the majority of respondents felt that the current 15 year retention period was appropriate and should remain. The new regulation does, however, allow the Chief Coroner to direct a coroner to keep a document for a different length of time. In addition, the Chief Coroner intends to issue joint guidance with the Keeper of Public Records to coroners on retention of documents.

Reports to prevent deaths

22. The proposed regulations replicate rule 43 of the 1984 Rules (as amended), but with some important changes.

23. The new regulations strengthen the existing provisions by requiring any person responding to a coroner's report of action to prevent other deaths to include in the response to the coroner a timetable for the action proposed to be taken to prevent other deaths.

24. The regulations reduce the time limit for responding to the coroner's report from 56 days to one month (although an extension can be requested).

25. In addition the regulations say that all reports and responses to them must be sent to the Chief Coroner; and that the Chief Coroner may publish these or summaries of them. The coroner may also send copies to anyone whom he or she thinks will find it useful.

Question 11: Do you agree that one month (with the possibility of seeking an extension) should be sufficient for a person to respond to a coroner's reports of actions to prevent other deaths? If you do not, please explain your reasons.

Question 12: Do you agree that the draft regulations to be made under section 43 (Annex A) will ensure more consistent standards in the coroner investigation process? If not, please give details.

7. Summary of proposed rules on inquests

1. We are proposing to largely replicate the provisions in the 1984 Rules that relate to inquests, where needed under section 45 of the 2009 Act, such as those on formalities and management of inquests, juries and witnesses. Our draft rules are at **Annex B**, and are summarised below.

Opening of the inquest

2. Rule 5 requires the coroner to open an inquest as soon as is reasonably practicable and at the opening to set the dates for any future hearings where this is possible. This reflects good practice.

Pre-inquest review hearing

3. New Rule 6 formally recognises that coroners often hold pre-inquest hearings (sometimes called pre-inquest reviews) before the main inquest hearing.

Days on which an inquest may be held

4. New rule 7 provides that inquest hearings must be held on working days unless there are urgent reasons for conducting the inquest at a weekend or on a bank holiday.

Timing of an inquest

5. As set out above, new rule 8 requires a coroner to hold an inquest within "[x] months of the date that the coroner is made aware of the death, or as soon as is reasonably practicable thereafter".

Notification of inquest arrangements

6. New Rule 9 requires a coroner to notify interested persons of the time, date and location of the main inquest hearing at least one month before the inquest commences. This is to allow such persons time to prepare for the inquest hearing. However, there may be occasions when it is in the interest of interested persons – and bereaved people in particular – to hold the inquest within one month of the death. Rule 9(2) therefore allows coroners some flexibility with the notice period.

7. The rule also requires the coroner to make publicly available the date, time and place of the main inquest hearing. This could be on the coroner's website or on a published list at the coroner's court and will allow the media – and members of the public who may have an interest in a particular death – to attend the inquest hearing.

Question 13: Do you agree with the time limit for notifying interested persons of the arrangements for the inquest hearing? And do you agree with the requirement on coroners to publish the arrangements for an inquest hearing? If you do not, please explain your reasons.

All hearings to be held in public

8. Current rule 17 requires every inquest to be held in public, although the coroner may direct that the public should be excluded from all or part of an inquest in the interests of national security. New Rule 11 similarly requires coroners to hold all inquest hearings – including the opening of an inquest and any pre-inquest review hearing – in public, reinforcing the message that there should be transparency in the coronial process.

9. As with current rule 17, a coroner may exclude the public from an inquest – or part of the inquest – on the grounds of national security.

Disclosure of information

10. As explained in the '**Improved services for bereaved people'** chapter above, we have proposed new rules governing the disclosure of information to interested persons.

11. In summary, the proposed rules will mean that a coroner must normally disclose copies of relevant documents to an interested person on request, at any time during or after an investigation. There is no charge for disclosure during an investigation but there may be a charge for disclosure after the investigation is finished.

12. Disclosure should be by electronic means wherever possible. In addition, a coroner should allow an interested person inspect a relevant document free of charge.

13. See the '**Improved services for bereaved people'** chapter for more details. Details of fees chargeable for providing copies of documents are in the '**Summary of proposed regulations on fees, allowances and expenses'** chapter below.

Question 14: Are you content that our proposed rules on disclosure will help bereaved people and other interested persons play a more active part in the investigation process (where they choose to do so)?

Question 15: Do you have any suggestions as to how the rules on disclosure could be improved? If so, please explain your answer.

Evidence by video-link

14. This rule expressly allows the coroner to agree to a witness giving evidence from behind a screen or via video link when the coroner decides this will improve the quality of evidence or where there is another suitable reason (for example where the witness is incarcerated in a high security

prison, or cannot travel to the inquest for health reasons). The coroner's decision on whether to accept video evidence will be final.

Screened evidence

15. This rule allows the coroner to agree to a witness giving evidence from behind a screen when the coroner decides this will improve the quality of evidence. When making a decision the coroner must consider all the circumstances of the case, for instance the views of the witness, and the impact on the questioning of the witness if he or she is behind a screen.

Written evidence

16. Our proposed new rule says that a coroner may admit written evidence as to how the deceased came by his or her death in certain circumstances, notably where the maker of the evidence cannot or will not give evidence in person.

17. Our proposed rule replaces 1984 rule 37 on documentary evidence[a]. Details are in the '**A more efficient system of investigations and inquests'** chapter above.

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[a] Rule 37 of the 1984 Rules

(1) Subject to the provisions of paragraphs (2) to (4), the coroner may admit at an inquest documentary evidence relevant to the purposes of the inquest from any living person which in his opinion is unlikely to be disputed, unless a person who in the opinion of the coroner is within Rule 20(2) objects to the documentary evidence being admitted.
(2) Documentary evidence so objected to may be admitted if in the opinion of the coroner the maker of the document is unable to give oral evidence within a reasonable period.
(3) Subject to paragraph (4), before admitting such documentary evidence the coroner shall at the beginning of the inquest announce publicly–
(a) that the documentary evidence may be admitted, and
(b) (i) the full name of the maker of the document to be admitted in evidence, and
(ii) a brief account of such document, and
(c) that any person who in the opinion of the coroner is within Rule 20(2) may object to the admission of any such documentary evidence, and
(d) that any person who in the opinion of the coroner is within Rule 20(2) is entitled to see a copy of any such documentary evidence if he so wishes.
(4) If during the course of an inquest it appears that there is available at the inquest documentary evidence which in the opinion of the coroner is relevant to the purposes of the inquest but the maker of the document is not present and in the opinion of the coroner the content of the documentary evidence is unlikely to be disputed, the coroner shall at the earliest opportunity during the course of the inquest comply with the provisions of paragraph (3).
(5) A coroner may admit as evidence at an inquest any document made by a deceased person if he is of the opinion that the contents of the document are relevant to the purposes of the inquest.
(6) Any documentary evidence admitted under this Rule shall, unless the coroner otherwise directs, be read aloud at the inquest.

Question 16: Are you content with the proposed rules on evidence – a) written evidence; b) video link; c) screened evidence? If not, please explain your answer.

Notes of evidence and recording proceedings

18. Under current rule 39 a coroner must take 'notes of evidence' at an inquest. Rule 57 then requires the coroner to provide to any interested person, on application and on payment of a fee, a copy of such notes of evidence. The High Court has said that a recording can be used in lieu of the coroner making notes.[a]

19. It is necessary for there to be some record in order to satisfy the need of interested persons such as solicitors, insurance companies and on occasions a bereaved family member to review the detail of the proceedings. Current practice among coroners varies. Some record inquest proceedings (either in addition to or as an alternative to taking notes) while others use a stenographer or short-hand writer.

20. The Chief Coroner is keen to see practice standardised and for coroners to record digitally all proceedings (in addition to taking notes of evidence). This would allow coroners to provide recordings to interested persons, as an alternative to providing transcripts, which can be time-consuming and expensive.

21. Draft rule 25 therefore requires a coroner to take notes of evidence and make a recording of proceedings. The duty to record proceedings relates to the main inquest hearing and all other public hearings including the opening of the inquest and any pre-inquest review.

22. Read alongside rule 13 the coroner should, on request, provide copies of the recording to interested persons. Some have expressed concerns about misuse of recordings. When providing a recording of an inquest to a coroner should place limitations on its use. The Chief Coroner has it in mind to issue guidance to coroners that each recording must be supplied with a written notice warning that misuse may be a contempt of court[b]. An alternative would be to include sanctions for misuse in the rules themselves.

23. Disclosure would not be appropriate in all circumstances (for example where members of the public are excluded from the hearing on grounds of national security) and care would have to be taken by coroners not to release a recording which could reveal personal details of a child or anonymous witness.

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[a] Ex parte Thompson (1982).

[b] See A-G v Scarth (CA) (24.01.13).

Question 17: Do you agree with new rule 25 and the requirement for a coroner to record inquest proceedings? Should the rules contain sanctions for misuse of recordings? Please give your reasons.

Witnesses, juries, Inquiry findings

24. We propose to replicate the substance of the 1984 Rules on witnesses, juries and inquiries, with language updated as appropriate.

25. We have also taken this opportunity to remove duplication with provisions in the Juries Act 1974 and to simplify the relevant form for summoning jurors (see Schedule 1 of **Annex B** of this document).

Determinations and findings

26. At present, the coroner, or jury where there is one, completes an 'inquisition' at the end of an inquest, including a 'verdict' that sets out the conclusions of the coroner of jury as to the death in question. This can include a 'short form' verdict (such as 'accidental death') or a 'narrative' verdict, where the coroner or jury sets out a written 'narrative' to express their conclusions.

27. Under the 2009 Act, the coroner (or jury, where there is one) will instead make a 'determination' in respect of questions about the identity of the deceased and how, when and where the deceased came by his/her death (and for cases where Article 2 of the ECHR applies, the circumstances in which the deceased came by his/her death); and shorter 'findings' in respect of matters that need to be ascertained to enable a death to be registered, including the cause of death. These will be recorded in a 'Conclusion of the Inquest' form.

28. The March 2010 consultation sought views on whether to establish a new list of short form findings as to the cause of death; and if so, what the categories should be. The consultation also asked whether there should be a requirement in the rules in relation to the recording of narrative findings; and if so, what.

29. In response, there was general support for a new list of short form findings to be introduced along the lines of the new categories proposed in the consultation paper. There was also support for the use of what are currently narrative verdicts, although there was acknowledgment of the problems this can cause for statisticians.

30. The new rules on determinations and findings require the coroner or jury to complete the relevant form in Schedule 2 to the Rules (**Annex B** of this document) which replaces the 'Inquisition' form (currently Form 22). The new form permits the coroner or jury to use one of the following short-form conclusions as to the cause of death:

    - accident or misadventure
    - drink/drug related
    - industrial disease
    - lawful/unlawful killing
    - natural causes
    - open
    - road traffic collision
    - stillbirth
    - suicide

31. Alternatively the form allows the coroner or jury to record a narrative conclusion as to the cause of death.

32. Most of the conclusions listed above are currently used by coroners. Two new additions are 'drink/drug related' and 'road traffic collision'. The latter reflects the fact that road traffic deaths constitute a significant part of every coroner's annual inquest caseload and the 'accident' conclusion may not adequately capture the circumstances of such deaths. A similar form of words was proposed in the 2010 consultation.

Question 18: Are you content with the draft rule and form on conclusions, determinations and findings? If not, how could they be improved? Do you agree with the addition of the new short-form conclusions 'drink/drug related' and 'road traffic collision'? Please give your reasons.

Question 19: Do you agree that the draft rules on inquests to be made under section 45 (Annex B) will help make inquests more consistent? If not, please give details.

Forms

33. The 1984 Rules (rule 60 and Schedule 4) set out forms that a coroner may use during the course of his or her duties. When we implement the 2009 Act we propose to keep the substance of these forms, but to update terminology as required. For that reason the forms are not presented in this document. The exceptions are the proposed revised 'Juror Summons' form and new 'Conclusion of the Inquest' form which are presented at Schedules 1 and 2 of **Annex B** of this document.

8. Summary of regulations on fees, allowances and expenses

1. Our draft fee regulations are at **Annex C**, and are summarised below.

Post-mortem examination fees and allowances

2. Our proposed regulations set out the fees and allowances payable to those carrying out post-mortem examinations.

3. As explained in the '**A more efficient system of investigations and inquests'** chapter above, and given the work underway to review the use of post-mortem examinations, and the fact that no new funding is available, in these regulations we propose to keep the current fees payable for coroners' post-mortem examinations (set under Section 24(1) of the Coroners Act 1988).

4. The British Medical Association website[a] has a useful summary of current fees and allowances.

Jurors and witnesses

5. Our proposed regulations set out the maximum allowances payable to coroner jurors and witnesses. Witnesses are divided into ordinary witnesses, professional witnesses (i.e. members of the medical profession – such as GPs or pathologists – who give medical evidence based on action taken in a professional capacity in relation to the death of the deceased) and expert witnesses (who may be called to give an expert opinion or advice in their own specialist field).

6. In summary, our proposals aim to make the allowances consistent with those for their equivalents in criminal courts, wherever this will not impose an additional burden on local authorities. Where consistency would mean a new burden we propose to keep the current rate of coroner juror and witness allowances. Current rates of allowances for coroner and witnesses attending an inquest are set in the July 2008 Coroners' Circular, made under sections 25 and 24 of the 1988 Act respectively.[b] GOV.UK[c] has details of court juror allowances and the Crown Prosecution Service website[d] has details of court witness allowances.

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[a] http://bma.org.uk/practical-support-at-work/pay-fees-allowances/fees/coroners-work/home-office-pathologists

[b] http://www.legislation.gov.uk/ukpga/1988/13/contents

[c] https://www.gov.uk/jury-service/what-you-can-claim

[d] www.cps.gov.uk/legal/v_to_z/witnesses_expenses_and_allowances/#P113_5610

Overnight allowance

7. Our proposed regulations set out maximum amounts payable for overnight accommodation away from home for an inquest. We propose that overnight allowances should be the same for all jurors and witnesses, to match the rate currently payable to criminal court jurors.

Financial loss allowance

8. We propose the same financial loss allowances for jurors and ordinary witnesses attending an inquest. These will match the current allowances for criminal court jurors which are slightly lower than current coroner juror rates (and current criminal court witnesses). There will continue to be specific allowances for those attending an inquest as a professional or expert witness. We propose reducing professional witness allowances to match the equivalents in criminal courts. We also propose to keep expert witness allowances at the discretion of the coroner, as is the case at present in coroners' and criminal courts.

Subsistence allowance

9. We propose that subsistence allowances for jurors will increase slightly to match the rates for criminal court jurors. The change would include a 0-10 hour band to replace the current 0-5 hours and 5-10 hour rates. We believe this would be a more accurate reflection of a juror's likely hours in court. Ordinary witness allowances would reduce slightly, to match criminal court rates. There would continue to be no subsistence allowance for professional and expert witnesses.

Travel expenses

10. We propose that travel allowances will be made consistent across all jurors and witnesses (and post-mortem examination practitioners). They would be aligned to current criminal court witness travel allowances. Notably for coroner jurors this means there will an increase in the bicycle rate per mile to match current criminal witness rate and to encourage sustainable travel.

Question 20: Would any of the proposed regulations for juror and witnesses allowances lead to increased costs for local authorities? If you think so, please give details.

Transferred investigations – payment of coroner's expenses

11. The 2009 Act enables coroners to transfer investigations and introduces a new power for the Chief Coroner to direct a coroner to conduct an investigation.

12. Under the current system, coroners can agree between themselves the transfer of a case. In such circumstances it is generally the 'receiving' coroner's ('coroner B's') local authority that pays the costs of the investigation/inquest.

13. The March 2010 consultation had envisaged that as a general principle the transferring coroner's ('coroner A's') local authority should be responsible for meeting the receiving coroner's expenses even after transfer. The main rationale behind this approach was that it would be unfair on the receiving authority for it to pay in the event that the Chief Coroner had decided to use his power of direction to reallocate investigations away from a coroner who had built up a backlog of cases. It was also felt that this could give coroners an incentive to handle their caseload less efficiently if investigations – and the funding of them – could be transferred elsewhere. This would not, however, seem to apply to most instances where investigations are likely to be transferred i.e. those that are agreed between coroners.

14. Following discussions with the Coroners' Society we have agreed a revised approach, and regulations are based on the following principles:

    - If the transfer between two coroners is voluntary, then responsibility for the costs associated with the investigation that are incurred after the point of transfer will fall to the receiving coroner's (coroner B's) local authority (thereby mirroring current practice).
    - In a case where the Chief Coroner directs a coroner to conduct an investigation, the cost will remain with the transferring coroner's (coroner A's) local authority.
    - We believe that this will be workable as the only significant change to current practice is where the Chief Coroner exercises his new power of direction.

15. The draft regulations also say that:

    - when the transferring authority pays, that authority's schedule of fees under paragraph 7(1) of Schedule 7 will apply to the coroner who receives the investigation. The receiving coroner will be accountable to the transferring relevant authority for expenses incurred, as he or she would normally be accountable to his or her own authority.
    - when the transferring authority pays, the receiving coroner should provide accounts and evidence to that authority, where that authority is meeting his or her expenses.
    - when the receiving authority pays, it is responsible for costs only from the point when the transfer happens.

Fees for copies of reports

16. Our proposed regulation provides for a coroner to charge a fee for copying documents and disclosing them to interested persons. This regulation will replace the Coroners' Records (Fees for Copies) Rules 2002,[a] simplifying them (for instance by referring to number of pages rather than words) and bringing the provisions in line with Civil Proceedings, Family Proceedings and Magistrates' Courts fees.[b] This will also allow coroners to charge for a compact disc or memory stick containing documents, such as a recording of the inquest proceedings.

Record-keeping and indemnities

17. Our proposed regulations set out that a coroner must retain records of expenditure for three years and give the Chief Coroner copies if requested.

18. The regulations also provide that a coroner should notify the local authority if he or she thinks the local authority will be required to indemnify him or her in respect of potential costs. The regulations then replicate Section 27A of the Coroners Act 1988[c] with regard to the costs and damages that are covered.

Question 21: Do you have any comments on the draft regulations to be made under Schedule 7 (Annex C) in addition to your answer to question 20 above? If so, please give details.

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[a] http://www.legislation.gov.uk/uksi/2002/2401/pdfs/uksi_20022401_en.pdf

[b] Civil Proceedings Fees Order 2008, as amended; Family Proceedings Fees Order 2008, as amended; Magistrates Courts Fees Order 2008, as amended. Available at http://www.justice.gov.uk/courts/fees/si-in-force

[c] http://www.legislation.gov.uk/ukpga/1988/13/section/27A

Questionnaire

We would welcome responses to the following questions set out in this consultation paper.

Question 1: Do you agree that the proposals set out in this consultation paper will impose no significant new burdens on local coroner's services or others? If you disagree, what new costs would arise? And how could these be mitigated?

Question 2: Do you have any views on the proposed changes to coroner areas under the 2009 Act, as set out in the table at Annex E? If so, please give details.

Question 3: Do you support the proposal to amend the Judicial Appointments Order 2008 so that Fellows of CILEX are eligible for coronial appointments? Please give reasons for your response.

Question 4: In your experience what difference has the current *Guide to coroners and inquests and Charter for coroner services* made since it was published?

Question 5: The new *Guide to coroner services* (at Annex D) revises the *Guide to coroners and inquests and Charter for coroner services,* so that it is consistent with the 2009 Act. Do you think the new document is a helpful summary of what to expect during a coroner investigation? If not, please explain your answer.

Question 6: Is there anything else we should cover in the *Guide to coroner services,* or cover differently? If so, please explain your answer.

Question 7: Should the new coroners rules include a target date for completing inquests? If so, what should this target be? Would three months be appropriate? Please give your reasons.

Question 8: Are you aware of a time when a coroner has in practice needed to be available out of hours for duties *not* relating to a post-mortem examination or organ donation? If so, please give details.

Question 9: Are you content with this approach to the drafting of the regulations on post-mortem examinations? If you are not, please give your reasons.

Question 10: Are you content with the draft regulation which says that a body should normally be released within 30 days, and that if this is not possible, the coroner must explain why? If not, please explain your answer.

Question 11: Do you agree that one month (with the possibility of seeking an extension) should be sufficient for a person to respond to a coroner's reports of actions to prevent other deaths? If you do not, please explain your reasons.

Question 12: Do you agree that the draft regulations to be made under section 43 (Annex A) will ensure more consistent standards in the coroner investigation process? If not, please give details.

Question 13: Do you agree with the time limit for notifying interested persons of the arrangements for the inquest hearing? And do you agree with the requirement on coroners to publish the arrangements for an inquest hearing? If you do not, please explain your reasons.

Question 14: Are you content that our proposed rules on disclosure will help bereaved people and other interested persons play a more active part in the investigation process (where they choose to do so)?

Question 15: Do you have any suggestions as to how the rules on disclosure could be improved? If so, please explain your answer.

Question 16: Are you content with the proposed rules on evidence – a) written evidence; b) video link; c) screened evidence? If not, please explain your answer.

Question 17: Do you agree with new rule 25 and the requirement for a coroner to record inquest proceedings? Should the rules contain sanctions for misuse of recordings? Please give your reasons.

Question 18: Are you content with the draft rule and form on conclusions, determinations and findings? If not, how could they be improved? Do you agree with the addition of the new short-form conclusions 'drink/drug related' and 'road traffic collision'? Please give your reasons.

Question 19: Do you agree that the draft rules on inquests to be made under section 45 (Annex B) will help make inquests more consistent? If not, please give details.

Question 20: Would any of the proposed regulations for juror and witnesses allowances lead to increased costs for local authorities? If you think so, please give details.

Question 21: Do you have any comments on the draft regulations to be made under Schedule 7 (Annex C) in addition to your answer to question 20 above? If so, please give details.

Thank you for participating in this consultation exercise.

Annex A

S T A T U T O R Y I N S T R U M E N T S

2013 No. xx

CORONERS, ENGLAND AND WALES

The Coroners (Investigations) Regulations 2013

Made - - - -	***
Laid before Parliament	***
Coming into force - -	***

The Lord Chancellor, in exercise of the powers conferred by section 43 of the Coroners and Justice Act 2009(**a**), and with the agreement of [the Lord Chief Justice][judicial title (the judicial office holder nominated by the Lord Chief Justice)] makes the following Regulations:

Citation and interpretation

1. (1) These Regulations may be cited as the Coroners (Investigations) Regulations 2013 and shall come into force on [x] 2013.

(2) These Regulations extend to England and Wales.

2. In these Regulations—

"the 2009 Act" means the Coroners and Justice Act 2009;

"the 1953 Act" means the Births and Deaths Registration Act 1953(**b**);

"bank holiday" means a day designated as a bank holiday in England and Wales under the Banking and Financial Dealings Act 1971(**c**);

"document" means any medium in which information of any description is recorded or stored;

"coroner" means:

(a) a senior coroner, area coroner or assistant coroner;

(b) the Chief Coroner when conducting an investigation under Chapter 1 of Schedule 10 to the 2009 Act; and

(c) a judge, former judge or former coroner conducting an investigation under Chapter 2 of Schedule 10 to the 2009 Act;

"enforcing authority" has the same meaning as in section 18(7) of the Health and Safety at Work etc. Act 1974(**a**);

(a) 2009 c.25.
(b) 1953 c.20.
(c) 1971 c.80.

"working day" means a day that is not a Saturday, a Sunday, a bank holiday, Christmas Day or Good Friday.

Application

3. These Regulations shall have effect in relation to any investigation which has not been completed on [x] 2013. Any decision made by the coroner in relation to the investigation including any post-mortem examination, before the date these Regulations come into force, shall be valid.

PART 1

General

Coroner availability

4. A coroner must be available at all times to undertake urgent matters relating to a post-mortem examination or organ donation which cannot wait until the next working day.

Date of reported death and preliminary information

5. (1) The coroner must keep a register of all reported deaths.

(2) The register must record the date on which a death was reported under section 1 of the 2009 Act.

(3) The coroner must also record in the register any information which identifies the deceased and record the place of death or the place where the body was found, if this is known.

Informing the deceased's personal representative or next of kin

6. Where a coroner is under the duty to investigate a death under section 1(1) of the 2009 Act, a coroner must attempt to identify the deceased's personal representative or next of kin and inform them of the coroner's decision to begin an investigation.

Delegation of certain coroner's functions to officers and other staff

7. A coroner may delegate administrative functions, but not judicial functions, to coroner's officers and other support staff.

PART 2

Post-mortem examinations

Delay in post-mortem examination to be avoided

8. Where a coroner requests that a post-mortem examination is made under section 14 of the 2009 Act, the coroner must ensure that the suitable practitioner is directed, and the post-mortem examination made as soon as reasonably practicable.

Post-mortem examination where homicide offence is suspected

9. Where a coroner is informed by a chief officer of police that a homicide offence is suspected in connection with the death of the deceased, the coroner must consult the chief officer of police in regards to who should make the post-mortem examination.

(d) 1974 c. 37

Notification of post-mortem examination

10. (1) Where a coroner has directed a suitable practitioner to make a post-mortem examination, the coroner must notify the persons listed in paragraph (2) of the date, time and place at which the post-mortem examination will be made unless to do so would cause the post-mortem examination to be unreasonably delayed.

(2) The persons to be notified by the coroner are—

(a) any relative of the deceased or other interested person who has notified the coroner of his or her desire to be represented at the post-mortem examination;

(b) the deceased's regular medical practitioner;

(c) if the deceased died in hospital, that hospital;

(d) if the death of the deceased may have been caused by any accident or disease which must be reported to—

(i) an enforcing authority, the appropriate inspector appointed by, or representative of, that authority; or

(ii) an inspector appointed by an enforcing authority;

(e) a Government department which has notified the coroner of its desire to be represented at the examination; and

(f) if the chief officer of police has notified the coroner of his or her desire to be represented at the examination, the chief officer of police.

(3) Any person or body listed in paragraph (2) shall be entitled to be represented at a post-mortem examination by a medical practitioner, or if any such person is a medical practitioner he or she is entitled to attend the examination in person. The chief officer of police may be represented by a member of the police force of which he or she is chief officer.

(4) A coroner, coroner's officer, trainee doctor, medical student or other medical practitioner may observe a post-mortem with the consent of the suitable practitioner who is making the post-mortem examination.

Retention and preservation of material from a post-mortem examination

11. (1) Where a suitable practitioner who is directed by a coroner to conduct a post-mortem examination preserves or retains material, which in his or her opinion relates to the cause of death or the identification of the deceased, he or she must notify the coroner of that fact in writing.

(2) A notification under paragraph (1) must—

(a) identify the material being preserved or retained; and

(b) explain why the suitable practitioner is of the opinion set out in paragraph (1).

(3) A notification under paragraph (1) may—

(a) specify the period of time for which the suitable practitioner believes the material should be retained or preserved; and

(b) specify any different periods of time that relate to different preserved or retained material.

(4) Where a coroner receives a notification under paragraph (1), he or she must notify the suitable practitioner of the period of time for which the coroner requires the material to be preserved or retained for the purposes of fulfilling the coroner's functions under the 2009 Act. The coroner may specify different periods of time in relation to different preserved or retained material.

(5) On making the notification under paragraph (4) the coroner must also notify, where known—

(a) one of the persons listed in section 47(2)(a) or (b) of the 2009 Act; and

(b) any other relative of the deceased who has notified the coroner of his or her desire to be represented at the post-mortem examination,

that the material is being preserved, the period or periods for which it is required to be preserved under paragraph (4), and the options for dealing with the material on expiry of a period notified under that paragraph.

(6) The options referred to in paragraph (5) are—

(a) disposal of the material by burial, cremation or other lawful disposal by the suitable practitioner;

(b) return of the material to a person referred to in that paragraph who requests that the material be returned to him or her; or

(c) retention of the material with the consent of a person referred to in paragraph (5) for medical research or other purposes.

Further provisions relating to preservation of material from post-mortem examinations

12. (1) Where the coroner—

(a) receives a request under paragraph 1 of Schedule 1 to the 2009 Act on the ground that a person may be charged with an offence in relation to the death of the deceased; or

(b) is informed under paragraph 2 of Schedule 1 to the 2009 Act that a person has been charged with an offence in relation to, or connected with, the death of the deceased,

the coroner must notify the chief officer of police or, in the case of a notification made under paragraph 2 of Schedule 1 to the 2009 Act, the prosecuting authority, of any period for which he or she requires material to be preserved under paragraph (4) of regulation 11.

(2) Where the coroner is informed that a public inquiry is to be held instead of an inquest, the coroner must consult the person chairing the inquiry before deciding any period for which material should be preserved or retained.

(3) A coroner may from time to time vary a period notified under paragraph (4) of regulation 11 and must notify both the suitable practitioner and any person notified under paragraph (5) of regulation 11 of the variation.

(4) Where a suitable practitioner has received a notification from a coroner under paragraph (4) of regulation 11 and the suitable practitioner believes that the material should be retained for a different period, the suitable practitioner may request that the coroner vary the time by providing a notification in accordance with paragraph (2) of regulation 11.

(5) Where a suitable practitioner has retained material in accordance with regulation 11 and the period notified under paragraph (4) of regulation 11 has expired, that suitable practitioner must record:

(a) that the material has been disposed by the suitable practitioner or on behalf of the suitable practitioner;

(b) that the material has been delivered into the possession of a specified person; or

(c) that the suitable practitioner has retained the material or retained the material on behalf of a specified person.

(6) Any record made by a suitable practitioner under paragraph (5) should be retained by the suitable practitioner.

Post-mortem examination report

13. A suitable practitioner, on completion of a post-mortem examination, must report to the coroner using the form set out in the Schedule as soon as practicable after the examination has been made.

14. Unless authorised in writing by the coroner, the suitable practitioner who made the post-mortem examination will not supply any other person with the post-mortem examination report or any copies of that report.

PART 3

Management of investigations

Transfer of investigations

15. Where Coroner A and Coroner B agree to transfer an investigation in accordance with section 2 of the 2009 Act:

(a) Coroner A ceases to have any further jurisdiction in respect of the investigation from the time the agreement is made and must provide Coroner B with all necessary evidence, documents and information within five working days of the agreement to transfer, unless there are exceptional circumstances.

(b) Coroner B must notify in writing all known interested persons of the transfer within five working days of the agreement to transfer, unless there are exceptional circumstances.

(c) Any expenses payable in respect of the transferred investigation and any subsequent inquest must be paid in accordance with regulations made under Schedule 7 to the 2009 Act.

16. Where the Chief Coroner directs a coroner to conduct an investigation in accordance with section 3 of the 2009 Act:

(a) Coroner A must provide Coroner B with all necessary evidence, documents and information within five working days of receiving the Chief Coroner's direction, unless there are exceptional circumstances.

(b) Coroner B must notify in writing all known interested persons of the transfer within five working days of receiving the Chief Coroner's direction, unless there are exceptional circumstances.

(c) Any expenses payable in respect of the transferred investigation and any subsequent inquest should be paid in accordance with regulations made under Schedule 7 to the 2009 Act.

Discontinuance of investigation where cause of death is revealed by post-mortem examination

17. Where a coroner discontinues an investigation because the cause of death is revealed by a post-mortem examination, in accordance with section 4 of the 2009 Act, the coroner must record the cause of death in the form set out in the Schedule.

Discontinuance of investigation for any other reason

18. (1) Where a coroner discontinues an investigation for any reason other than under section 4 of the 2009 Act, the coroner must record the date on which the investigation was discontinued and the reason for the discontinuance.

(2) The coroner must inform all known interested persons of the date on which the investigation was discontinued and the reason for the discontinuance.

Certificate of death when investigation is suspended

19. (1) Where a coroner suspends an investigation under paragraph 1, 2 or 3 of Schedule 1 to the 2009 Act the coroner must provide the registrar with the particulars required to register the death under the 1953 Act.

(2) Where a coroner suspends an investigation under paragraph 5 of Schedule 1 to the 2009 Act the coroner may, if requested to do so by an interested person falling within section 47(2)(a) or 47(2)(b) of the 2009 Act, provide that person with a certificate of the fact of death.

Resumption of investigation

20. Where a coroner resumes an investigation that had previously been discontinued in accordance with paragraph 7 of Schedule 1 to the 2009 Act, the coroner must notify all known interested persons of the resumption and the reason for the resumption.

PART 4

Powers in relation to bodies

Release of bodies

21. (1) A coroner must, subject to paragraph (2), endeavour to release the body for burial or cremation within 30 days of being made aware that the body is within his or her area.

(2) Where a coroner cannot release the body within 30 days, the coroner must notify the next of kin or personal representative of the deceased of the delay.

Burial Order

22. (1) A coroner may only issue an order authorising the burial of a body where the coroner is under a duty to hold an inquest under section 6 of the 2009 Act.

(2) A burial order must not be made until the coroner is satisfied that no post-mortem examination or further post-mortem examination is required.

Exhumation

23. Where a coroner issues a direction to exhume a body lying within England and Wales, the coroner must use the prescribed form set out in the Schedule.

PART 5

Disclosure

24. Part 2 of the Coroners (Inquests) Rules 2013 applies to any disclosure of documents to an interested person made by the coroner at any time during the course of an investigation.

Providing information to a Local Safeguarding Children Board

25. (1) Where a coroner makes the decision to conduct an investigation into a death under section 1 of the 2009 Act or directs that a post-mortem examination should be made under section 14 of the 2009 Act, and the coroner believes the deceased was under the age of 18 years old, the coroner must notify the appropriate Local Safeguarding Children Board within 3 days of making the decision or direction.

(2) A coroner must provide information to a Local Safeguarding Children Board for use for the purposes of its functions.

Power of the Chief Coroner to require information

26. The Chief Coroner may at any time request information from a coroner in relation to any particular investigation, or investigations conducted more broadly.

PART 6

Record keeping

Investigations lasting more than a year

27. (1) Where an investigation has not been completed or discontinued within a year, the coroner must notify the Chief Coroner of the fact and reasons for the delay on the date that that outstanding investigation becomes a year old.

(2) A coroner who completes or discontinues an investigation that the coroner has previously notified to the Chief Coroner under paragraph (1), must notify the Chief Coroner of the date the investigation is completed or discontinued and the reasons for any further delay in completing or discontinuing the investigation.

Retention of documents

28. (1) Any document in the possession of a coroner in connection with an investigation or post-mortem examination must, unless a court or the Chief Coroner otherwise directs, be retained by the coroner for at least fifteen years.

(2) The coroner may provide any document or copy of any document to any person who in the opinion of the coroner is a proper person to have possession of it.

(3) A coroner may charge for the provision of any document or copy of any document in accordance with any regulations made under Schedule 7 to the 2009 Act.

Forms

29. The forms set out in the Schedule must be used in the cases to which they apply.

PART 7

Action to prevent other deaths

Report on action to prevent other deaths

30. (1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to the 2009 Act to make a report to prevent other deaths.

(2) A report to prevent other deaths may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner is relevant to the investigation.

(3) The coroner—

(a) must send a copy of the report to prevent other deaths to the Chief Coroner and all interested persons who in the coroner's opinion should receive it;

(b) must send a copy of the report to prevent other deaths to the Local Safeguarding Children Board where the coroner believes the deceased was under the age of 18 years old; and

(c) may send a copy of the report to any other person who the coroner believes may find it useful or of interest.

(4) On receipt of a report to prevent other deaths the Chief Coroner may—

(a) publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit; and

(b) send a copy of the report to any person who the Chief Coroner believes may find it useful or of interest (other than a person who has been sent a copy of the report under paragraph (3)).

Response to a report on action to prevent other deaths

31. (1) This regulation applies where a person is under a duty to give a response to a report to prevent other deaths made in accordance with paragraph 7(1) of Schedule 3 to the 2009 Act.

(2) A response to a report must contain—

(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.

(3) A response must be provided to the coroner who made the report within one month of the date on which the report is sent.

(4) The coroner who made the report may extend the period of one month referred to in paragraph (3) (even if an application for extension is made after the time for compliance has expired).

(5) On receipt of a response to a report to prevent other deaths the coroner—

(a) must send a copy of the response to the report to the Chief Coroner;

(b) must send a copy to any interested persons who in the coroner's opinion should receive it; and

(c) may send a copy of the response to any other person who the coroner believes may find it useful or of interest.

(6) On receipt of a copy under paragraph (5)(a) the Chief Coroner may—

(a) publish a copy of the response, or a summary of it, in such manner as the Chief Coroner thinks fit; and

(b) send a copy of the response to any person whom the Chief Coroner believes may find it useful or of interest (other than a person who has been sent a copy of the response under paragraph (5)(b) or (c)).

(7) A person giving a response to a report to prevent other deaths may make written representations to the coroner about—

(a) the release of the response; or

(b) the publication of the response.

(8) Representations under paragraph (7) must be made to the coroner no later than the time when the response to the report to prevent other deaths is provided to the coroner under paragraph (3).

(9) The coroner must pass any representations made under paragraph (7) to the Chief Coroner who may then consider those representations and decide whether there should be any restrictions on the release or publication of the response.

Signed by authority of the Lord Chancellor

Parliamentary Under Secretary of State
Ministry of Justice

I agree.

[Signed as the Judicial Office holder nominated for the purposes of section 43(2) of the Coroners and Justice Act 2009 by the Lord Chief Justice.]

[Lord Chief Justice][Judicial title]

SCHEDULE

Forms

Forms replicate those in the 84 rules. Regulations 17, 22 and 28

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations apply to any investigation conducted by a coroner under the Coroners and Justice Act 2009. They govern the practice and procedure relating to coroner investigations and post-mortem examinations. The regulations set out the procedure for holding investigations, informing properly interested persons, releasing bodies and record keeping.

Annex B

S T A T U T O R Y I N S T R U M E N T S

2013 No. xx

CORONERS, ENGLAND AND WALES

The Coroners (Inquests) Rules 2013

Made - - - -	***
Laid before Parliament	***
Coming into force - -	***

The Lord Chief Justice, with the agreement of the Lord Chancellor, makes these Rules in exercise of the powers conferred by section 45 of the Coroners and Justice Act 2009(**a**).

Citation, commencement and extent

1. (1) These Rules may be cited as the Coroners (Inquests) Rules 2013 and shall come into force on [x] 2013.

(2) These Rules extend to England and Wales.

Interpretation

2. In these Rules—

"the 2009 Act" means the Coroners and Justice Act 2009;

"bank holiday" means a day designated as a bank holiday in England and Wales under the Banking and Financial Dealings Act 1971(**b**);

"copy" means in relation to a document, anything on to which information recorded in the document has been copied, by whatever means and whether directly or indirectly;

"coroner" means—

(a) a senior coroner, area coroner or assistant coroner;

(b) the Chief Coroner when conducting an inquest; or

(c) a judge, former judge or former coroner conducting an inquest in accordance with Schedule 10 to the 2009 Act;

"document" means any medium in which information of any description is recorded or stored;

"third party" means anyone who is not the coroner, coroner's officer, juror or interested person in relation to the inquest;

"working day" means a day that is not a Saturday, a Sunday, a bank holiday, Christmas Day or Good Friday.

(a) 2009 c.25.

(b) 1971 c.80.

Application to existing inquests

3. These Rules apply to any inquest which has not been completed before [x] 2013, but any directions, time limits, adjournment or other decision already made by the coroner in relation to any such inquest shall continue to apply.

PART 4

Formalities

4. The Rules in this part apply where a coroner is under a duty to hold an inquest under section 6 of the 2009 Act.

Opening of an inquest

5. (1) An inquest must be opened as soon as reasonably practicable after the date the coroner is made aware of the death.

(2) At the opening of the inquest, the coroner must where possible set the dates on which any subsequent hearings are scheduled to take place.

Pre-inquest review hearing

6. A coroner may at any time during the course of an investigation and before an inquest hold a pre-inquest review hearing.

Days on which an inquest may be held

7. An inquest must be held on a working day, unless the coroner considers that there is an urgent reason for holding it on some other day.

Timing of an inquest

8. A coroner must complete an inquest within [X] months of the date on which the coroner is made aware of the death, or as soon as is reasonably practicable after that date.

Notification of inquest arrangements

9. (1) A coroner must subject to paragraph (2) notify all interested persons of the date, time and place of the inquest hearing at least one month before the inquest commences.

(2) Where an inquest hearing is held less than one month from the date the coroner is made aware of the death, or it is not possible to provide notification in accordance with paragraph (1), the coroner must notify all known interested persons as soon as reasonably practicable of the date, time and place of that inquest.

(3) Where an inquest hearing is held, the coroner must make details of the date, time and place of the inquest publicly available before the inquest commences.

Coroner to notify interested persons of any alteration of arrangements for an inquest

10. (1) Where the date, time or place of the inquest is altered the coroner must notify all known interested persons, in writing, of the alteration within one week of the decision to alter having been made.

(2) The coroner must make the details of any alteration to the arrangements for an inquest publicly available within one week of the decision to alter the arrangements having been made.

Inquest hearings to be held in public

11. (1) Any inquest hearing including the opening of an inquest and any pre-inquest review hearing must be held in public.

(2) The coroner may direct that the public be excluded from an inquest hearing or any part of an inquest hearing if the coroner considers it would be in the interests of national security to do so.

PART 2

Disclosure

12. This Part applies to the disclosure of documents by the coroner at any time during or after the course of an investigation, pre-inquest review or inquest.

Disclosure of documents at the request of an interested person

13. (1) Where an interested person asks for disclosure of a document held by the coroner, the coroner must provide that document or a copy of that document, or make the document available for inspection to that person, as soon as is reasonably practicable unless rule 15 applies.

(2) Documents to which this rule applies include—

(a) any post-mortem examination report;

(b) any other report that has been provided to the coroner during the course of the investigation;

(c) the coroner's notes of evidence given at the inquest;

(d) any recording of the inquest; or

(e) any other relevant document provided for the purposes of the inquest.

Managing disclosure

14. The coroner may:

(a) disclose an electronic copy of the document instead of, or in addition to a paper copy;

(b) disclose a redacted version of all or part of the document; or

(c) make a document available for inspection at a particular time and place.

Restrictions on disclosure

15. Where one or more of the following are applicable a coroner may refuse to provide a document or a copy of that document requested under rule 13 where:

(a) there is a statutory or legal prohibition on disclosure;

(b) the consent of any author or copyright owner cannot reasonably be obtained;

(c) the request is unreasonable;

(d) the document relates to contemplated or commenced criminal proceedings; or

(e) the coroner considers the document irrelevant to the investigation.

Costs of disclosure

16. (1) A coroner may not charge a fee for any document or copy of any document, disclosed to an interested person before an inquest is completed.

(2) A coroner may charge a fee for any document or copy of any document disclosed to an interested person after the inquest has been completed in accordance with any regulations made under Schedule 7 to the 2009 Act.

PART 3

Management of the inquest hearing

Evidence by video link

17. (1) A coroner may direct that a witness may give evidence at an inquest through a live video link.

(2) A direction may not be given under paragraph (1) unless the coroner determines that giving evidence in the way proposed would allow the inquest to proceed more expediently.

(3) Before giving a direction under paragraph (1), the coroner must consider all the circumstances of the case, including in particular—

(a) any views expressed by the witness, interested persons or any third party; and

(b) whether in the opinion of the coroner, giving evidence by video link would impede the effectiveness of the questioning of the witness.

(4) A direction may be given under paragraph (1)—

(a) on an application of the witness, or in the case of a child witness the parent or legal guardian of that witness;

(b) on an application of an interested person or a third party; or

(c) on the coroner's own initiative.

Screened evidence

18. (1) A coroner may direct that a witness may give evidence at an inquest from behind a screen.

(2) A direction may not be given under paragraph (1) unless the coroner determines that giving evidence in the way proposed would be likely to improve the quality of the evidence given by the witness.

(3) In making that determination, the coroner must consider all the circumstances of the case, including in particular—

(a) any views expressed by the witness, interested persons or any third party; and

(b) whether giving screened evidence impedes the effectiveness of the questioning of the witness by an interested person or a representative of such a person.

(4) A direction may be given under paragraph (1)—

(a) on the application by the witness, or in the case of a child witness the parent or legal guardian of that witness;

(b) on an application of an interested person or a third party; or

(c) on the coroner's own initiative.

Entitlement to examine witnesses

19. (1) A coroner must allow any interested person who so requests, to examine any witness either in person or by that interested person's representative.

(2) A coroner must disallow any question put to the witness which the coroner considers irrelevant.

Examination of witnesses

20. Unless the coroner otherwise determines, a witness at an inquest must be examined in the following order—

(a) by the coroner;

(b) by any interested person who has asked to examine the witness; and

(c) if the witness is represented at the inquest, lastly by that person's representative.

Self incrimination

21. (1) No witness at an inquest is obliged to answer any question tending to incriminate him or her.

(2) Where it appears to the coroner that a witness has been asked such a question, the coroner must inform the witness that he or she may refuse to answer it.

Written evidence

22. (1) Written evidence as to how the deceased came by his or her death is not admissible unless the coroner is satisfied that—

(a) it is not possible for the maker of the written evidence to give evidence at all, or within a reasonable time;

(b) there is a good and sufficient reason why the maker of the written evidence should not attend;

(c) there is a good and sufficient reason to believe that the maker of the written evidence will not attend; or

(d) the coroner is of the opinion that the written evidence is unlikely to be disputed.

(2) Before admitting such written evidence the coroner must at the beginning of the inquest announce publicly—

(a) what the nature of the written evidence to be admitted is;

(b) the full name of the maker of the written evidence to be admitted in evidence;

(c) that any interested person may object to the admission of any such written evidence; and

(d) that any interested person is entitled to see a copy of any written evidence if he or she so wishes.

(3) A coroner must admit as evidence at an inquest any document made by a deceased person if the coroner is of the opinion that the contents of the document are relevant to the purposes of the inquest.

(4) A coroner may direct that all or parts only of any written evidence submitted under this Rule may be read aloud.

Inquiry findings

23. (1) A coroner may admit the findings of an inquiry, including any statutory inquiry held in accordance with paragraph 3 of Schedule 1 to the 2009 Act if the coroner considers them relevant to the purposes of the inquest.

(2) Before admitting such inquiry findings as evidence, the coroner must announce publicly—

(a) that the findings of the inquiry may be admitted as evidence;

(b) the title of the inquiry, date of publication and a brief account of the findings; and

(c) that any interested person is entitled to see a copy of the inquiry findings if he or she so wishes.

Adjournment and resumption of an inquest

24. (1) A coroner may adjourn an inquest if the coroner is of the view that it is reasonable to do so.

(2) The coroner must inform all interested persons as soon as reasonably practicable of the decision to adjourn, the proposed date of adjournment and the reason for the adjournment.

(3) The coroner must inform all interested persons as soon as reasonably practicable of the date, time and place at which an adjourned inquest is to be resumed.

(4) A coroner must adjourn an inquest and notify the Director of Public Prosecutions, if during the course of the inquest, it appears to the coroner that the death of the deceased is likely to have been due to a homicide offence and that a person may be charged in relation to the offence.

Notes and records of evidence

25. (1) A coroner must take notes of evidence at every inquest.

(2) A coroner must keep a recording of any inquest hearing.

No address as to facts

26. No person shall be allowed to address the coroner or the jury as to the facts.

PART 4

Jury inquests

27. This Part applies to inquests heard or to be heard with a jury.

Method of summoning jurors

28. A juror must be summoned using the prescribed form in Schedule 1 sent by post to him or her or delivered by hand at his or her address as shown in the electoral register.

Summoning in exceptional circumstances

29. If it appears to the coroner that a jury will be, or probably will be, incomplete, the coroner may require any persons up to the number needed who are in, or in the vicinity of, the place of the inquest to be summoned (without any written notice) for jury service.

Certificate of attendance

30. A person duly attending an inquest to serve on a jury in compliance with a summons issued under rule 28 or rule 29 is entitled on request to the coroner, to a certificate recording that fact.

Validity of proceedings where jury not present

31. Where an inquest begins without a jury, but a jury is subsequently summoned, the validity of anything done before the jury was summoned by the coroner is not affected.

Summing up and directions to the jury

32. Where the coroner sits with a jury, the coroner must direct the jury as to the law and then provide the jury with a summary of the evidence.

PART 5
Conclusion

Recording of the conclusion of the inquest

33. A coroner or in the case of an inquest heard with a jury, that jury, must make a determination and any findings required under section 10 of the 2009 Act using the prescribed form in Schedule 2.

Signed by authority of the Lord Chancellor

Parliamentary Under Secretary of State
Ministry of Justice

I agree.

Signed as the Judicial Office holder nominated for the purposes of section 43(2) of the Coroners and Justice Act 2009 by the Lord Chief Justice.

[Lord Chief Justice][Judicial title]

EXPLANATORY NOTE

(This note is not part of the Rules)

These Rules apply to any inquest conducted by a coroner under the Coroners and Justice Act 2009. They govern the practice and procedure relating to an inquest. The Rules set out the procedure for managing the proceedings at an inquest, provision relating to the disclosure of documents at an inquest and provision relating to inquests heard with a jury.

SCHEDULE 1

Rule 28

Juror Summons

By virtue of a warrant of A.B., one of Her Majesty's coroners for the of you are hereby summoned to appear before him or her as a juror on (*state day of week*) the (*state date*) day of 20 , at a.m./p.m. at (*state place*) until you are no longer needed.

You must attend at the time and place shown above unless you are told by the officer authorised by the Coroner that you need not do so.

Dated this day of 20 .

Signature .. ..

Coroner's Officer/Constable .. ..

YOU MUST COMPLETE THE ATTACHED FORM AND RETURN IT TO (*insert name of officer authorised by the Coroner*) IN THE ENVELOPE PROVIDED WITHIN THREE DAYS OF THE RECEIPT OF THIS SUMMONS.

WARNING: IT IS AN OFFENCE TO SERVE ON A JURY AT AN INQUEST IF YOU ARE DISQUALIFIED FROM JURY SERVICE (SEE DETACHABLE FORM BELOW), AND KNOW THAT YOU ARE DISQUALIFIED FROM JURY SERVICE.

A person guilty of such an offence is liable on summary conviction to a fine not exceeding level 5 on the standard scale.

IT IS AN OFFENCE TO REFUSE WITHOUT REASONABLE EXCUSE TO ANSWER THE QUESTIONS IN THE DETACHABLE AS TO WHETHER YOU ARE QUALIFIED TO SERVE AS A JUROR AT AN INQUEST, TO GIVE AN ANSWER TO SUCH A QUESTION KNOWING THE ANSWER TO BE FALSE IN A MATERIAL PARTICULAR, OR RECKLESSLY TO GIVE AN ANSWER TO SUCH A QUESTION THAT IS FALSE IN A MATERIAL PARTICULAR.

A person guilty of such an offence is liable on summary conviction to a fine not exceeding level 3 on the standard scale.

IT IS AN OFFENCE FOR A PERSON WHO IS DULY SUMMONED AS A JUROR AT AN INQUEST TO MAKE ANY FALSE REPRESENTATION, OR TO CAUSE OR PERMIT TO BE MADE ANY FALSE REPRESENTATION ON YOUR BEHALF WITH THE INTENTION OF EVADING SERVICE AS A JUROR AT AN INQUEST.

A person guilty of such an offence is liable on summary conviction to a fine not exceeding level 3 on the standard scale.

IT IS AN OFFENCE FOR A PERSON TO MAKE OR CAUSE TO BE MADE, ON BEHALF OF A PERSON WHO HAS BEEN DULY SUMMONED AS A JUROR AT AN INQUEST, ANY FALSE REPRESENTATION WITH THE INTENTION OF ENABLING THE OTHER PERSON TO EVADE SERVICE AS A JUROR AT AN INQUEST.

A person guilty of such an offence is liable on summary conviction to a fine not exceeding level 3 on the standard scale.

A coroner may impose a fine not exceeding £1000 on you if you fail without reasonable excuse to attend in accordance with the summons, or attend in accordance with the summons but refuse

without reasonable excuse to serve as a juror. A fine may not be imposed under this paragraph unless the summons was served on you not later than 14 days before the day on which you were/are required to attend.

<Detachable>

Information as to Qualification to Serve or Entitlement to Excusal

This form should be returned in the envelope provided within three days of receiving it.

Surname .. ..

Forename(s) .. .. Date of Birth .. ..

Address .. .. Telephone number .. ..

(If possible please give a telephone number where you can be contacted between 9 am and 5 pm)

INFORMATION GIVEN WILL BE TREATED IN THE STRICTEST CONFIDENCE

YOU ARE QUALIFIED for jury service if you—

(a) are [not less than eighteen nor more than seventy years of age];

(*If you will be under eighteen on or have reached your* [*seventieth*] *birthday by the date on which your appearance is required you will NOT be eligible to serve as a juror.)*

(b) are registered as a parliamentary or local government elector;

(c) have lived in the United Kingdom, the Channel Islands or the Isle of Man for a period of at least five years since attaining the age of thirteen; and

(d) are not one of the persons described in Parts I and II of Schedule 1 to the Juries Act 1974.*

1 Are you QUALIFIED to serve as a juror? Please tick appropriate box.

YES NO

If you have answered NO to question 1, please answer question 2 and sign the form at the end.

If you have answered YES and wish to apply to be excused from jury service on this occasion, please go on to 3 below and then sign the form at the end.

2 I AM NOT QUALIFIED to serve on a jury because—

3 YOU ARE ENTITLED TO BE EXCUSED if you—

(a) are a full time serving member of Her Majesty's navy, military or air forces and your commanding officer certifies that it would be prejudicial to the efficiency of the service if you were required to be absent from duty;

(b) are a coroner within the same coroner area in which you have been summoned to attend as a juror; or

(c) are otherwise excused from attending by the coroner before whom you are summoned.

YOU MAY BE EXCUSED at the discretion of the Coroner or of the officer authorised by the Coroner on grounds such as poor health, illness, physical disability, insufficient understanding of English, holiday arrangements or for any other good reason.

I WISH TO BE EXCUSED from jury service on this occasion because—

(If you are in any doubt as to whether you may be excused from jury service please write to the officer authorised by the Coroner at the address on the front of the summons.)

When you attend as a juror you may be discharged if there is doubt as to your capacity to serve on a jury because of physical disability or insufficient understanding of English.

I HAVE READ THE WARNING IN THE SUMMONS AND THE INFORMATION I HAVE GIVEN IS TRUE.

Signed .. ..Dated .. ..

SCHEDULE 2

Rule 33

Conclusion of the Inquest

The following is the conclusion of the inquest (including the statutory determination and, where required, findings):—

1. Name of deceased (if known):

2. Medical cause of death:

3. How, when and where and, for investigations where section 5(2) of the 2009 Act applies, in what circumstances the deceased came by his or her death: (see note (ii))

4. Conclusion of the coroner/jury as to the death: (see notes (i) and (ii))

5. Further particulars required by the Births and Deaths Registration Act 1953 to be registered concerning the death:

1. Date and place of death	2. Name and surname of deceased	3. Sex	4. Maiden surname of woman who has married	5. Date and place of birth	6. Occupation and usual address

Signature of coroner (and jurors) .. ..

NOTES

(i) One of the following short-form conclusions may be adopted:—

I. accident or misadventure

II. drink/drug related

III. industrial disease

IV. lawful/unlawful killing

V. natural causes

VI. open

VII. road traffic collision

VIII. stillbirth

IX. suicide

(ii) As an alternative, or in addition to one of the short-form conclusions listed under Note (i), the coroner or where applicable the jury, may make a narrative conclusion.

(iii) The standard of proof required for the short-form conclusions of ‘unlawful killing’ and ‘suicide’ is the criminal standard of proof. For all other short-form conclusions and a narrative statement the standard of proof is the civil standard of proof.

Annex C

S T A T U T O R Y I N S T R U M E N T S

2013 No. xx

CORONERS, ENGLAND AND WALES

The Coroners Allowances, Fees and Expenses Regulations 2013

Made - - - -	***
Laid before Parliament	***
Coming into force - -	***

The Lord Chancellor, in exercise of the powers conferred by section 34 of and Schedule 7 to the Coroners and Justice Act 2009(**a**), and with the agreement of [the Lord Chief Justice or (the judicial office holder nominated by the Lord Chief Justice)] makes the following Regulations:

Citation and interpretation

1. (1) These Regulations may be cited as the Coroners Allowances, Fees and Expenses Regulations 2013 and shall come into force on [x] 2013.

(2) These Regulations extend to England and Wales.

2. In these Regulations—

"the 2009 Act" means the Coroners and Justice Act 2009;

"copy" means in relation to a document, anything on which information recorded in the document has been copied, by whatever means and whether directly or indirectly;

"coroner" means:

(a) a senior coroner, area coroner or assistant coroner;

(b) the Chief Coroner when conducting an investigation under Chapter 1 of Schedule 10 to the 2009 Act; and

(c) a judge, former judge or former coroner conducting an investigation under Chapter 2 of Schedule 10 to the 2009 Act, unless the regulation specifically provides otherwise;

"document" means any medium in which information of any description is recorded or stored;

"ordinary witness" means any witness who attends an inquest, to give evidence as a witness to events or circumstances relevant to the particular death being investigated.

(a) 2009 c. 25

PART 1

General

Payable allowances, fees and expenses

3. Any allowance, fee or expense due to a person under these Regulations is to be calculated by the senior coroner, and paid by (or on behalf of) that senior coroner.

4. No allowance, fee or expense is payable under these Regulations to:

(a) a member of a police force attending an inquest in his or her official capacity;

(b) a full time officer of an institution to which the Prison Act 1952(**a**) applies in his or her capacity as such;

(c) a prisoner in respect of an occasion on which he or she is conveyed in custody to appear before a coroner; or

(d) a coroner's officer who attends an inquest in his or her official capacity.

PART 2

Post-mortem examination and suitable practitioner

Fees chargeable for making a post-mortem examination

5. The following amounts shall be paid to a suitable practitioner for making a post-mortem examination in accordance with section 14 of the 2009 Act:

For making a post-mortem examination and reporting the result to the coroner	£96.80
For making a post-mortem examination involving additional skills and reporting the result to the coroner	£276.90

Travel allowances relating to a post-mortem examination

6. A suitable practitioner's travel expenses to the post-mortem examination may be reimbursed in accordance with the Schedule to these Regulations

PART 3

Jurors

Juror overnight allowance

7. Where a person is necessarily absent from his or her place of residence overnight for the purpose of serving as a juror at an inquest, an allowance may be paid in accordance with the Schedule to these Regulations.

Juror financial loss allowance

8. If a person loses earnings or benefit, or incurs other expenses as a direct result of serving as a juror, an allowance may be paid in accordance with the Schedule to these Regulations.

(a) 1952 c.52

Subsistence allowance payable to a juror

9. If a person is necessarily absent from his or her place of residence or work for the purpose of serving as a juror, he or she may be paid a daily subsistence allowance up to a maximum of:

Attendance 10 hours or under	£5.71
Attendance of more than 10 hours	£12.17

Juror travel expenses

10. A person who serves as a juror may have his or her travel expenses reimbursed in accordance with the Schedule to these Regulations.

Juror additional expenses

11. The coroner may reimburse a juror for any additional expenses which the coroner believes have been reasonably incurred.

Explanation of juror expenses

12. If requested to do so by a juror, the coroner shall provide the juror with information on how his or her particular allowances and expenses have been calculated.

PART 4

Ordinary Witness

Ordinary witness overnight allowance

13. Where a person is necessarily absent from his or her place of residence overnight for the purposes of attending an inquest to give evidence as an ordinary witness, an allowance may be paid in accordance with the Schedule to these Regulations.

Ordinary witness financial loss allowance

14. If a person loses earnings or benefit, or incurs other expenses as a direct result of appearing as an ordinary witness, an allowance may be paid in accordance with the Schedule to these Regulations.

Subsistence allowance payable to an ordinary witness

15. If a person is necessarily absent from his or her place of residence or work for the purpose of attending an inquest as an ordinary witness, he or she may be paid a maximum subsistence allowance of:

Attendance of up to and including 5 hours	£2.25
Attendance of more than 5 hours up to and including 10 hours	£4.50
Attendance of more than 10 hours	£9.75

Ordinary witness travel expenses

16. An ordinary witness's travel expenses may be reimbursed in accordance with the Schedule to these Regulations.

Ordinary witness additional expenses

17. The coroner may reimburse an ordinary witness for any additional expenses which the coroner believes have been reasonably incurred.

Explanation of ordinary witness expenses

18. If requested to do so by an ordinary witness, the coroner shall provide him or her with information on how his or her particular allowances and expenses have been calculated.

PART 5
Professional witness

Professional witness allowance

19. Where a witness who is practising as a member of the medical profession or as a dentist attends to give professional evidence on any one day the maximum fee payable is as follows:

If the practitioner does not employ a person to take care of his or her practice during his or her absence:

Up to and including 2 hours	£83.50
Of more than 2 hours up to and including 4 hours	£117.00
Of more than 4 hours up to and including 6 hours	£174.00
Of more than 6 hours	£234.00

Or: If the practitioner necessarily incurs expense in the provision of a person to take care of his or her practice during his or her absence:

Up to 2 hours	£89.00
Of more than 2 hours up to and including 4 hours	£125.00
Of more than 4 hours	£250.00

Professional witness overnight allowance

20. Where a professional witness is necessarily absent from his or her place of residence overnight for the purposes of attending an inquest to give evidence, an allowance may be paid in accordance with the Schedule to these Regulations.

Professional witness travel expenses

21. A professional witness travelling to an inquest for the purpose of giving evidence may be reimbursed for travel expenses in accordance with the Schedule to these Regulations.

Professional witness additional expenses

22. The coroner may reimburse a professional witness for any additional expenses which the coroner believes have been reasonably incurred.

PART 6

Expert witness

Expert witness to give evidence at an inquest

23. An expert witness is a person of any calling, profession or trade who gives evidence because of his or her expertise, excluding a professional witness.

24. Where an expert witness has carried out preparatory work related to giving evidence at an inquest, an allowance may be paid of an amount that the coroner considers reasonable having regard to the nature and difficulty of the case and the work necessarily involved.

Expert witness overnight allowance

25. Where an expert witness is necessarily absent from his or her place of residence overnight for the purposes of attending an inquest to give evidence, an allowance may be paid in accordance with the Schedule to these Regulations.

Expert witness travel expenses relating to an inquest

26. An expert witness's travel expenses may be reimbursed in accordance with the Schedule to these Regulations.

Expert witness additional expenses

27. The coroner may reimburse an expert witness for any additional expenses which the coroner believes have been reasonably incurred.

PART 7

Costs of a transferred investigation

Costs of a transferred investigation

28. Where Coroner A and Coroner B agree to transfer an investigation in accordance with section 2 of the 2009 Act, the local authority with funding responsibility for Coroner B's area will be responsible for all costs incurred in relation to that transferred investigation, and any associated inquest, from the point at which the transfer is agreed.

29. Where the Chief Coroner directs Coroner B to conduct an investigation in accordance with section 3 of the 2009 Act, the local authority with funding responsibility for Coroner A's area shall be responsible for all costs relating to that transferred investigation and any associated inquest.

PART 8

Record keeping, unusual costs and indemnities

Requesting a record of receipts and expenses

30. A coroner may request receipts, invoices or other evidence proving the expense incurred before making any payment under these Regulations.

Keeping a record of receipts and expenses

31. A coroner must retain all receipts and invoices of expenses submitted under regulation 30, in a format and for a period agreed by the local authority with funding responsibility for that coroner area.

32. A coroner and the local authority with funding responsibility for that coroner area must keep a record of expenditure under these Regulations for 3 years.

33. A coroner and the local authority with funding responsibility for that coroner area must if so requested by the Chief Coroner, provide the Chief Coroner with a copy of any records held under this part.

34. A coroner and the local authority with funding responsibility for that coroner area must, if so requested by a person who has submitted a request under these Regulations, return any receipts or invoices submitted by that person.

Fee for disclosure after an inquest

35. (1) A coroner may charge a fee for any document requested and disclosed to an interested person after the inquest.

(2) The fee payable for such a paper copy shall be £5 for a document of l0 pages or less, with an additional 50p payable for each subsequent page.

(3) No fee will be payable where a document is provided by email.

(4) A fee of £5 shall be payable where a document is disclosed in any other medium.

Unusual fee or expense

36. A coroner must report any unusual fee or expense that has been incurred in relation to the inquest, to the local authority with funding responsibility either on the date that such an expense is incurred or as soon as is reasonably practicable.

Indemnity

37. (1) The local authority with funding responsibility for that coroner area must indemnify the coroner in respect of—

(a) any costs which the coroner reasonably incurs in or in connection with proceedings in respect of anything done or omitted in the exercise (or purported exercise) of the coroner's duty;

(b) any costs which the coroner reasonably incurs in taking steps to dispute any claim which might have been made in such proceedings;

(c) any damages awarded against or ordered to be paid by the coroner in any such proceedings;

(d) any sums payable by the coroner in connection with any reasonable settlement of any such proceedings or claim.

(2) Paragraph (1) applies in relation to proceedings brought by a coroner only if and to the extent that the local authority with funding responsibility for that coroner area agrees in advance to indemnify the coroner.

(3) A coroner may appeal to the Secretary of State or any person appointed by the Secretary of State for the purpose, from any decision of the local authority with funding responsibility for that coroner area under paragraph (2).

Signed by authority of the Lord Chancellor

Parliamentary Under Secretary of State
Ministry of Justice

I agree.

[Signed as the Judicial Office holder nominated for the purposes of section 43(2) of the Coroners and Justice Act 2009 by the Lord Chief Justice.]

[Lord Chief Justice][Judicial title]

SCHEDULE

Tables of allowance

Regulations 7, 13, 20 and 25

Overnight allowance

1. Where a juror, ordinary witness, professional witness or expert witness is necessarily absent from his or her place of residence overnight for the purposes of attending an inquest in accordance with regulation 7, 13, 20 or 25, an allowance may be paid in respect of each night not exceeding:

Within a 5 mile radius of Charing Cross	£100.70
Elsewhere in England and Wales	£69.20

Regulations 8 and 14

Financial loss allowance

2. If a juror or ordinary witness loses earnings, benefit or incurs other expense as a direct result of attending an inquest in accordance with regulation 8 or 14, the coroner may pay up to the maximum allowance as follows:

Length of attendance	**Time spent each day**	**Maximum daily allowance**
First 10 days	4 hours or under	£32.47
First 10 days	Over 4 hours	£64.95
On the 11th and any subsequent day	4 hours or under	£64.95
On the 11th and any subsequent day	Over 4 hours	£129.91

Regulations 10, 16, 21 and 26

Travel expenses

3. When a juror, ordinary witness, professional witness or expert witness travels to an inquest his or her travel expenses must be reimbursed up to the following allowances:

(1) Where travel is by air or train or public transport, the coroner must reimburse the actual fare paid (economy fare only, unless the coroner otherwise dictates).

(2) Where travel is by taxi or other privately hired vehicle, such expense may only be reimbursed where the coroner considers that the use of such transport was reasonable.

(3) Where travel is by private transport a fixed allowance per mile each way must be paid as follows:

Car / motorcycle public transport rate	25p
Car / motorcycle standard rate	45p
Bicycle rate	20p

4. Public transport rate should be paid unless the coroner is satisfied that no adequate public transport was available on the date on which the journey was made.

5. Any parking fees reasonably incurred may be reimbursed.

6. The allowances set out in paragraph (3) for car travel may be increased by 2p per mile each way if a passenger is carried to whom an allowance would otherwise have been payable for travel to and from an inquest, and by an additional 1p per mile for any further additional passenger so carried.

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations set out the procedure for calculating allowances, fees and expenses relating to an inquest or investigation carried out under the Coroners and Justice Act 2009. These Regulations set out the allowances, fees and expenses to be paid by a coroner to a juror, witness or medical practitioner who provides evidence at an inquest.

Annex D

GUIDE TO CORONER SERVICES

This booklet has been given to you because someone close to you has died and their death has been reported to the coroner. The law states that certain types of deaths have to be notified to a coroner. Many people find it helpful to have information in a written format as well as being given information face to face or over the phone. Please ask the coroner's staff as many questions as you need.

You may also find this information helpful if you are called as a witness at an inquest or are interested in the coronial process.

This booklet is issued under section 42 of the Coroners and Justice Act 2009. It is guidance and does not cover every possible situation that may arise.

Please be aware that in most legal situations a person who has died is referred to as the deceased. This convention has been used in this booklet. Coroners and their staff understand that the person who has died was a unique individual.

Note on donation of tissue and organs for transplantation

If you wish to consider organ or tissue donation after a death, immediate advice is essential as, in order for donation to take place, the organs and tissues for transplantation have to be removed very soon after death.

You should seek advice from a hospital or from the local Donor Transplant Co-ordinator (DTC), who will be able to discuss the options in more detail. The DTC must seek the agreement of the coroner in any case which has been or is likely to be referred to the coroner, since donation could affect evidence. These decisions are usually made very quickly.

In some cases, for example where too much time has elapsed since the death, or where there is a criminal investigation, organ donation may not be possible.

CONTENTS

SECTION 1

1. General standards that you can expect during a coroner investigation

1.1 The coroner's office

The coroner's office will:

- explain the role of the coroner and answer your questions about coroner investigations;
- give you contact details for the office, i.e. a named individual and his or her phone number or email address (you may wish to make a note of this in section 16 of this booklet);
- help you understand the cause of death;
- inform you of your rights and responsibilities;
- take account where possible of your views and expectations, including family and community preferences, traditions and religious requirements relating to mourning, post-mortem examinations and funerals;
- provide a welcoming and safe environment and treat you with fairness, respect and sensitivity;
- treat children and young people involved in an investigation in an age-appropriate way in co-operation with the adult(s) responsible for their care;
- make reasonable adjustments, wherever possible, to accommodate your needs if you have a disability (including a learning disability);
- help you to find further support where needed;
- during a long investigation, unless otherwise agreed with you, contact you at least every three months to update you on the progress of the case, and explain reasons for any delays;
- explain, where relevant, why the coroner intends to take no further action in a particular case.

The coroner's office cannot give any legal advice.

1.2 Your role

Your role in a coroner's investigation is very important and you do have certain responsibilities. You should:

- co-operate fully with the coroner's office and promptly provide all information that is relevant to the investigation;
- inform the coroner's office of any concerns or worries you may have about the death;
- treat the coroner and his or her officers and other staff with respect;
- nominate one individual as the 'next of kin' for communication with the coroner's office. This helps ensure prompt and accurate sharing of information;
- inform the coroner's office of any change of circumstances, such as address or contact number, so you can be contacted promptly;
- not share information that the coroner's office gives you if you are told that it is confidential;
- inform the coroner's office as soon as possible of any relevant considerations for the inquest, e.g. a disability, so that reasonable adjustments can be made.

> *Specific standards of service that you can expect at particular stages of a coroner investigation are set out in 'Standards of service you can expect' boxes throughout this document.*

SECTION 2

2. OVERVIEW OF CORONERS AND INVESTIGATIONS

2.1 What is a coroner?

A coroner is an independent judicial office holder, appointed by the local authority council). Some coroners cover more than one local authority. Coroners are usually lawyers but sometimes doctors.

2.2 What do coroners do?

Coroners investigate deaths that have been reported to them if they have reason to think that:

- the deceased died a violent or unnatural death;
- the cause of death is unknown; or
- the deceased died while in prison, police custody, an immigration centre or while detained under the Mental Health Act 1983 (see Glossary).

When a death is reported to a coroner, he or she:

- establishes whether an investigation is required;
- if so, investigates to establish the identity of the person who has died; how, when, and where they died; and any information required to register the death; and
- will use information discovered during the investigation to assist in the prevention of other deaths where possible.

2.3 What is a coroner's investigation?

The coroner's investigation is the process by which the coroner establishes who has died, and how, when, and where they died. The coroner may decide, as part of the investigation, to hold an inquest (see section 9 below).

In some cases a death may be referred to the police for investigation on behalf of a coroner. This may be because the police have expertise, e.g. relating to a road traffic accident; or criminal activity may be relevant to the death.

In some cases other organisations such as the Health and Safety Executive,[27] the Prisons and Probation Ombudsman,[28] the Care Quality Commission,[29] or

[27] www.hse.gov.uk/aboutus/index.htm

the Independent Police Complaints Commission[30] are required to conduct a separate investigation. This investigation usually takes place first and the coroner will be given the results so he or she can use the information in the inquest (see section 9 below).

2.4 What is a coroner's officer?

Coroners' officers work under the direction of coroners and liaise with bereaved people as well as with the police, doctors, witnesses, mortuary staff, hospital bereavement staff and funeral directors. Most coroners' officers are civilians, but some are serving police officers.

Some coroners have staff with other titles such as a secretary or clerk.

2.5 Who pays for the local coroner service?

The costs of providing a local coroner's service are usually met by the local authority for that area. In some areas the local police force employs the coroner's officers but the officers' work is carried out under the authority of the coroner.

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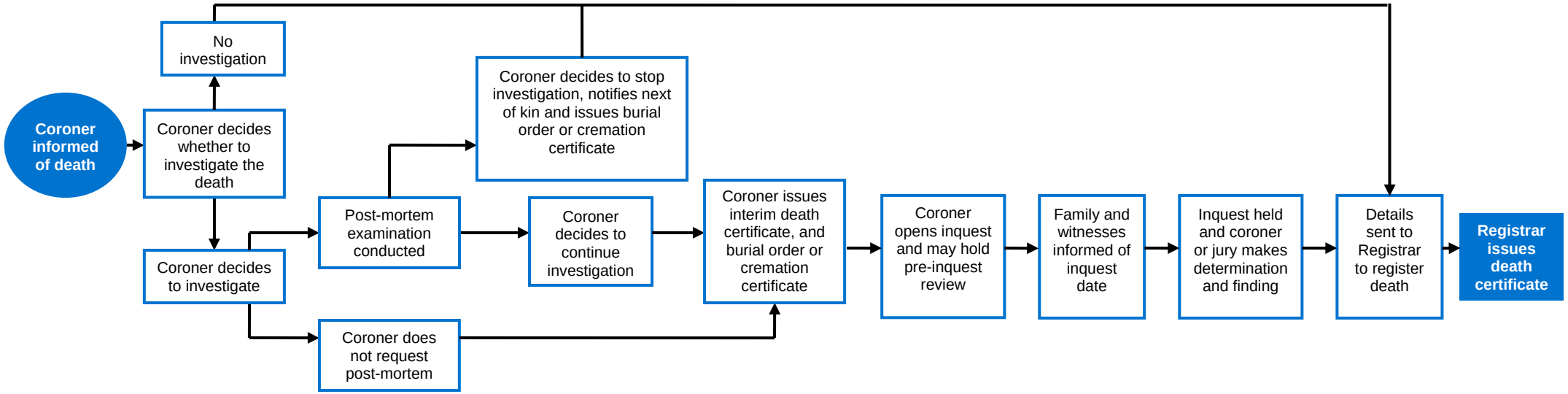
[28] www.ppo.gov.uk/about-us.html

[29] www.cqc.org.uk/aboutcqc.cfm

[30] www.ipcc.gov.uk/en/Pages/about_ipcc.aspx

SECTION 3

3.1 FLOWCHART – A CORONERS INVESTIGATION (NB The process may vary depending on the circumstances of the death.)



SECTION 4

4. STARTING AN INVESTIGATION

4.1 Are all deaths reported to a coroner?

No, less than half of all deaths are reported to the coroner.

4.2 When is a death reported to a coroner?

Registrars of Births and Deaths, doctors or the police must report deaths to a coroner in certain circumstances. These include where it appears that:

- no doctor saw the deceased during his or her last illness;
- although a doctor attended the deceased during the last illness, the doctor is not able or available, for any reason, to certify the death;
- the cause of death is unknown;
- the death occurred during an operation or before recovery from the effects of an anaesthetic;
- the death occurred at work or was due to industrial disease or poisoning;
- the death was sudden and unexplained;
- the death was unnatural;
- the death was due to violence or neglect;
- the death was in other suspicious circumstances; or
- the death occurred in prison, police custody or another type of state detention (see Glossary).

If you believe that a death of this kind has not been reported to the coroner, you may report it yourself. You should do this as soon as possible and before the funeral. The coroner will then inform you what action he or she proposes to take.

The coroner does not become involved in the many cases when the deceased's own doctor, or a hospital doctor who has been treating him or her during the final stages of an illness, is able to certify the cause of death.

4.3 What will a coroner do when a death is reported?

A coroner may conduct initial enquiries in order to decide whether to investigate the death. In some cases those enquiries, such as a discussion with the deceased's doctor, make it clear that the deceased died from a known and natural disease. The coroner does not need to investigate further and the doctor will be asked to sign a Medical Certificate of the Cause of Death

(MCCD). In these cases the coroner will advise the Registrar of Births and Deaths that, although he or she was made aware of the death, no further investigation is needed. An appointment can then be made by the family to register the death.

If the coroner decides that an investigation is necessary, he or she may ask a suitable practitioner, normally a pathologist, to examine the body and carry out a post-mortem examination (See section 5 for more details).

4.4 Viewing the body

You, or a representative of your choice, may be asked to formally identify the body. You may also ask to see the person who has died. The buildings where viewings take place vary in design and in some cases you will see the person through a glass window rather than being in the same room.

If, for example, the body has been damaged through involvement in a traffic accident, this will be explained to you with sensitivity and you will be given a choice as to whether you want to see the deceased or have some other form of identification used if possible.

4.5 When can a death be registered?

When the deceased's doctor, or hospital doctor, certifies the cause of death without referring it to a coroner, the death can be registered by the Registrar of Births and Deaths, who issues the death certificate.

Sometimes a doctor may discuss the case with the coroner and this may result in the coroner deciding that he or she does not need to investigate further, because the death is from natural causes. In light of that discussion, the doctor concerned may be able to issue the MCCD and the coroner will issue a certificate to the Registrar stating that it is not necessary to hold an inquest.

If the coroner decides to investigate the death, the Registrar of Births and Deaths must wait for the coroner to finish the investigation before the death can be registered. This investigation may take time, so it is always best to contact the coroner's office before any funeral arrangements are made. In many cases the decision to investigate will not hold up funeral arrangements or sorting out benefits.

The coroner may issue an interim certificate, confirming the fact of death and where known, the medical cause of death. Although this cannot be used to register the death, it may be used to assist in the administration of the estate (see section 7 for more details on this).

STANDARDS OF SERVICE YOU CAN EXPECT WHEN A DEATH IS REPORTED TO A CORONER

When a death is reported to the coroner, the coroner's office will contact the next of kin, where known, and where possible, within one working day of the death being reported, to explain why the death has been reported and what steps are likely to follow.

SECTION 5

5. THE POST-MORTEM EXAMINATION

5.1 What is a post-mortem examination?

A post-mortem examination is a medical examination of a body after death to find out the cause of death. A coroner's post-mortem examination is independent of any other organisation or person and is carried out by a suitable practitioner such as a pathologist (a doctor who specialises in medical diagnosis by examining body organs, tissues and fluids) of the coroner's choice. It may involve opening and examining the body internally, or using other techniques such as CT (computerised tomography) scanning or MRI (magnetic resonance imaging), although where available these techniques will involve a fee. The coroner will decide on the most appropriate technique to be used, taking account of the circumstances of the death and whether scanning facilities are available.

The coroner decides whether or not a post-mortem examination is needed. By law, he or she is not required to obtain your consent to the examination, but he or she will give you the reason for his / her decision. You can be represented by a doctor of your choice at the examination, although this is not normally necessary (and you would have to pay any fee the doctor may charge). If you choose to be represented you should advise the coroner straight away. The coroner will then tell you when and where the examination will happen.

Where possible, coroners will take account of your religious and cultural needs in deciding whether to order a post-mortem examination and the type of examination to be performed.

Sometimes the coroner will request a further post-mortem examination (for example, in a case of suspected murder) or additional scientific examination of material to assist with establishing the cause of death or, rarely, the identity of the deceased.

If you remain concerned about the cause of death, you can arrange for a separate, additional post-mortem examination, which would be at your own expense, once the coroner has released the body.

STANDARDS OF SERVICE YOU CAN EXPECT REGARDING A POST-MORTEM EXAMINATION

Wherever possible the coroner's office will, on request, tell you when and where an examination will be performed.

If you have queries, or object to the decision to hold a post-mortem examination or carry out additional examination of material, you should let the coroner's office know as soon as possible so your wishes can be considered.

If the coroner decides not to request a post-mortem examination, and you think there should be one, you should discuss this with the coroner's office.

In all cases the final decision about a post-mortem examination and any other tests lies with the coroner.

SECTION 6

6. AFTER A POST-MORTEM EXAMINATION

6.1 Post-mortem examination report

After the post-mortem examination the pathologist will send a report to the coroner. The report will give details of the examination, of any tissues and organs removed, and any tests, such as for drugs and blood alcohol level, which have been carried out to help in finding out the cause of death. You may ask for a copy of the report. See section 14 for more information. You may wish to make a note of the details in section 16 of this booklet.

6.2 What happens with the investigation after the post-mortem examination?

A coroner may stop the investigation if the post-mortem examination has shown the cause of death. The coroner will then release the body so that the funeral can take place (see section 7 for more details on the release of a body).

The coroner will send a form to the Registrar of Births and Deaths stating the cause of death as shown by the post-mortem examination report. When the Registrar has received this form you can make an appointment to register the death (you may wish to make a note of the relevant details at section 16 of this booklet).

Sometimes a coroner may decide that further investigation is needed into the death. The coroner will normally release the body at this point so the funeral can take place. However occasionally this is not possible and, if so, the coroner's office will explain the arrangements to you. See section 7 for more information.

Where further investigation is needed, the coroner will normally open an inquest (see section 9 for more information).

STANDARDS OF SERVICE YOU CAN EXPECT IF A CORONER CONTINUES AN INVESTIGATION AFTER A POST-MORTEM EXAMINATION

If an inquest is required, the coroner will continue the investigation after the post-mortem examination. The coroner's office will contact you regularly and, if the investigation is lengthy, at least every three months to update you on the progress of the case. This will not apply if you have said that you only wish to be contacted when there is progress to report. You may also contact the coroner's office for an update.

SECTION 7

7. RELEASE OF THE BODY FOR A FUNERAL AND ADMINISTRATION OF THE ESTATE

7.1 What happens to the body after the post-mortem examination, if the coroner decides to continue the investigation?

By law a coroner must continue an investigation and hold an inquest if:

- the cause of death remains unknown after the initial post-mortem examination and any subsequent tests;
- there is cause for the coroner to suspect that the deceased died a violent or unnatural death; or
- the death occurred in custody or state detention (see Glossary).

The coroner may legally keep possession of the body until the investigation is concluded. However, the coroner will usually authorise burial or cremation after the post-mortem examination, so that the funeral can be held, even when an inquest is required. If the coroner needs to keep the body for longer than 30 days, he or she will explain the reasons to you.

Once the coroner no longer requires the body for the investigation he or she will keep it only in exceptional circumstances. An example would be where there is a dispute about to whom the body should be released.

Procedures may vary where there is a criminal investigation into the death. See section 11 for details.

7.2 What happens about administration of the deceased's estate if a coroner continues an investigation after a post-mortem examination?

In order to assist the administration of the estate, if an inquest is opened the coroner can issue an interim certificate of fact of death. This certificate should be acceptable to banks and financial institutions unless it is important for them to know the outcome of the inquest (for example, for an insurance settlement). A grant of probate or letters of administration can be obtained using an interim certificate and it can also be used for benefit claims and National Insurance purposes. However, the interim certificate of fact of death cannot be used to register the death, even if the medical cause of death is known.

The Government's Tell Us Once Service is available in most areas of England and the whole of Wales. After the death has been registered Tell Us Once lets you report it to most of the government organisations you need to tell in one go. The Tell Us Once Service can also be offered where the Coroner has called an Inquest and issued an Interim Death Certificate. The service can be

accessed face-to-face at your local council, online (https://www.gov.uk/tell-us-once) or over the phone (the registrar will be able to give you the relevant phone number).

.When the coroner's investigation (including the inquest if one is to be held) has been completed the coroner will notify the Registrar of Births and Deaths so that the death can be registered by the Registrar and a death certificate can then be obtained from the Registrar.

7.3 What happens about administration of the deceased's estate if a coroner continues an investigation after a post-mortem examination?

The coroner has to be notified if a body is to taken out of England and Wales.

If you intend to do this, you must give the coroner written notice as soon as possible. The coroner will then consider whether any (further) investigation is needed and will notify the next of kin of his or her decision within four days. Most funeral directors can give further information on this procedure and the Registrar can give you the necessary form when you register the death.

SECTION 8

8. ORGANS AND TISSUES

8.1 Will organs be retained after a coroner's post-mortem examination?

Small pieces of tissue and, occasionally, organs may sometimes be removed from a body and preserved by a pathologist if they are relevant to the cause of death or the identity of the deceased. If this material is retained for additional examination, the coroner will notify the next of kin, and ask what they wish to happen to the organs or tissue when no longer required.

When the material is no longer needed for the coroner's investigation it will either be returned to the deceased's family or representative, if requested, or disposed of by burial or cremation. If a pathologist believes it would be appropriate to keep organs and tissue, for example for use in research or for training purposes, he or she must obtain your consent. In exceptional cases, e.g. involving murder, the organs may have to be retained for a longer period.

Further general information on tissue retention and the legal requirements relating to consent can be obtained from the Human Tissue Authority on ☎ 020 7269 1900 or online at www.hta.gov.uk.

8.2 Donation of tissue and organs for transplantation

As set out at the start of this booklet, if you wish to consider donation, immediate advice, from a hospital or local Donor Transplant Co-ordinator (DTC) is essential.

The DTC must consult the coroner in any case which has been or is likely to be referred to him or her, and the coroner must agree any donation, as it could affect evidence. These decisions are usually made very quickly. Sometimes organ donation may not be possible.

SECTION 9

9. THE INQUEST

9.1 What is an inquest?

If it was not possible to find out the cause of death from the post-mortem examination, or the death is found to be unnatural, a coroner has to hold an inquest to be able to finish his or her investigation. (The exception is if someone is to be prosecuted for causing the death – there is more information about this in section 11.)

An inquest is a public hearing held by the coroner in order to establish who died and how, when and where the death occurred. The inquest may be held with or without a jury, depending on the circumstances of the death. See below for details on jury inquests. Some coroners have their own courts but some use other types of courts or public buildings.

An inquest is different from any other type of court hearing because there is no prosecution or defence. The job of the inquest is to discover the facts of the death. This also means that the coroner (or jury) cannot blame a person or organisation for the death. However if evidence is found that suggests someone may be to blame for the death the coroner can pass all the evidence gathered to the police or Crown Prosecution Service.

9.2 When will the inquest take place?

The main inquest hearing should normally take place within three months of the death being reported to the coroner, although sometimes this won't be possible due to the complexity of the case or other factors.

9.3 Opening and adjourning an inquest

The coroner will normally open an inquest to confirm the identity of the deceased and confirm that the body is no longer required, and can be released for the funeral. The coroner will then immediately adjourn the inquest until a later date by when the coroner will have the information he or she requires to proceed with the inquest. It may not be necessary for you to attend this opening of the inquest.

9.4 What is a pre-inquest review?

Sometimes the coroner may hold one or more hearings before the inquest, known as pre-inquest reviews. These may be arranged if, for instance, the circumstances of the death are complex and there needs to be a legal discussion about the scope of the inquest. The coroner will invite you to the

pre-inquest review, where you will have the opportunity to put questions, on the scope of the inquest, to the coroner.

STANDARDS OF SERVICE YOU CAN EXPECT BEFORE AN INQUEST

The coroner's office will advise you of the time and location of the inquest at least one month before the start of the inquest (unless there are exceptional circumstances), and normally earlier than this. The coroner's office will, wherever possible, take your views into account on the timing of the inquest. You may wish to make a note of the inquest details in section 16 of this booklet.

The coroner's office will also be able to give you information about others who may be present, and how you can take part, for instance by speaking to the coroner directly or through a representative or asking witnesses questions about the evidence they have given.

If the date or location of the inquest has to be changed, the coroner's office will let you know as soon as possible.

If the coroner decides to hold a pre-inquest review, the coroner's office will tell you the time, date and location of the hearing and its purpose.

Before the inquest, the coroner's office will normally send to you, on request, copies of relevant documents, or allow you to see them. For legal reasons the coroner may not be able to disclose all the documents or parts of a document he or she intends to use at the inquest. If so, the coroner will explain the reasons for this. See section 14 for more details.

9.5 Who can attend an inquest?

All inquest hearings, including the opening of an inquest or a pre-inquest review, should be held in public, unless exceptional circumstances apply.

If you choose to attend the inquest you can be accompanied by a supporter, for example a friend. Some bereaved people prefer not to attend, as the details of the death may be distressing. If you do attend some coroners will offer you the opportunity to leave the court while, for instance, the pathologist gives evidence, if you would find it too difficult to hear this information.

The coroner's office will tell you if the Coroners' Courts Support Service is available in your area and how they can help you. This independent service is provided by trained volunteers and is not available everywhere.

Witnesses (for example a doctor, police officer or eyewitness) may be asked to attend to give evidence. Members of the public and media may normally attend the inquest.

9.6 Will I need to speak at the inquest?

You may be asked to give evidence. This might be to give information about the deceased or the death. If you think this will too difficult you can ask if you can give a written statement and this might be read out by the coroner's officer.

You must give evidence under oath or by affirming that you will tell the truth. The words to do this will be handed to you.

You may ask questions at the inquest (see later in this section for details).

You may wish to make a note of any questions you have in section 16 of this booklet.

9.7 Who decides which witnesses to call?

The coroner decides who should be called to give evidence as a witness and the order in which they give evidence. If you believe that you have evidence, or that a particular witness should be called, you should inform the coroner. The coroner will then decide whether the evidence is relevant to the investigation of the death.

9.8 Must a witness attend the inquest?

If the witness lives in England or Wales they must attend if they are asked to. In many cases the evidence of a witness may be vital in establishing the facts of the death. A witness may either be asked to attend the inquest voluntarily or receive a formal summons to do so. It is an offence not to attend and the coroner can impose a fine or prison sentence.

The coroner may allow someone to give evidence from behind a screen, or by video link, if he or she decides that would improve their evidence.

If the witness lives abroad he or she does not have to attend to give evidence. However, the coroner may decide to accept written evidence from the witness.

9.9 Who can ask witnesses questions?

The coroner will question a witness first. After that you may ask the witness relevant questions, or your representative can ask questions on your behalf, if the coroner agrees.

When asking questions you must remember that the purpose of the inquest is to establish the relevant facts of the death and not to apportion blame. You should not ask questions that appear to blame someone for the death.

It may help you to think about the questions you want to ask before the inquest, and perhaps send them to the coroner in advance so he or she has time to consider them.

It is the coroner who decides whether a question is relevant to the purpose of the inquest. The coroner will also warn a witness that he or she does not have to answer any question which might lead him or her to incriminate him or herself.

9.10 Is there always a jury at an inquest?

Most inquests are held without a jury, but there are particular circumstances when the law states a jury must be called, including:

- if the death occurred in prison, in police custody or another type of state detention (except if the death was from natural causes); or
- if the death resulted from an accident at work.

In every jury inquest the coroner decides matters of law and procedure and the jury decides the facts of the case and comes to a conclusion which must include the legal 'determination' and 'findings', including the cause of death. Like the coroner, the jury cannot blame someone for the death. If there is any blame, this can only be established by other legal proceedings in the civil or criminal courts. However, the jury can state facts which make it clear that the death was caused by a specific failure of some sort or by neglect.

Juries are called in the same way as juries in other courts and consist of between seven and eleven members.

9.11 Do I need a solicitor?

In most cases you will not need to employ a solicitor to represent you at an inquest. An inquest is a fact-finding process and the coroner will ensure that the process is fair and thorough, and that your questions about the facts of the death are answered.

If there is a possibility of other court proceedings after an inquest (such as a claim for medical negligence or compensation for a death from an industrial disease or accident) you may find it helpful to have your solicitor in court. You may also choose to have a legal representative if other witnesses will be represented by lawyers.

If this is the case you may find it helpful to choose a solicitor who has experience and expertise in the conduct of inquests and the areas of concern related to the death, as the detailed rules of evidence and other aspects of a coroner's inquest are different to other courts. A solicitor will advise you on whether he or she can represent you in court or whether it would be better to instruct a barrister.

It is important that you tell the coroner's office if you will have a solicitor present, so that the coroner knows they are there at your request and with your consent. Your solicitor may also attend any pre-inquest review.

9.12 Is Legal Aid available?

Legal advice and assistance before the hearing – via the Legal Help scheme – is available if you qualify financially. Legal Help can be used, for example, to assist you in the preparation of a list of written questions that you wish the coroner to explore with other witnesses. Further information about solicitors who carry out legal aid work is in the Community Legal Service directory on ☎ 0845 345 4345 or online at www.communitylegaladvice.org.uk.

Unlike other proceedings for which Legal Aid might be available, there are no parties in inquests, only 'interested persons' (See Glossary), and witnesses are not expected to present legal arguments. Legal Aid is not generally available for representation at the inquest, but can be provided in exceptional cases. Generally, you must qualify financially and your application must meet strict criteria for representation to be funded exceptionally.

Information about which solicitors undertake legally-aided work is in the Community Legal Services Directory, which you can find in most reference libraries and Citizens Advice Bureaux, or by visiting www.legaladviserfinder.justice.gov.uk/AdviserSearch.do. The Law Society also provides a database of solicitors, which you can access by calling ☎ 020 7242 1222 or by visiting www.lawsociety.org.uk/choosingandusing/findasolicitor.law.

Further information on legal aid is available online at https://www.gov.uk/legal-aid.

9.13 Will the inquest be reported by the press?

Inquests are normally held in open court, where the public can attend. Journalists may also attend and report what has taken place.

Suicide notes and personal letters will not usually be read out at the inquest unless the coroner decides it is important to do so. If they are read out, their contents may be reported. Although every attempt is made to avoid any additional upset to people's private lives, it may be unavoidable if the inquest is to find out the facts about the death. Photographs of the deceased and of the scene of death may also form part of the evidence presented at the inquest. The coroner's office will not release any information to the media which has not already been made public through an inquest, unless the next of kin gives his or her consent.

Those working for newspapers or magazines must abide by the Editor's Code of Practice, upheld by the Press Complaints Commission (PCC). The Code (www.pcc.org.uk) has requirements on accuracy, privacy and discrimination. It

also has rules for cases involving grief and shock. For instance, publication in these circumstances must be handled sensitively; and when reporting suicide care should be taken to avoid excessive detail about the method used.

You may complain to the PCC about published material. You can also seek advice from the PCC on how to prevent harassment by journalists. There is more information on the PCC website or you can call on ☎ 020 7831 0022 (switchboard) or ☎ 0845 600 2757 (helpline). The PCC also operates an out-of-hours number for emergencies only on ☎ 07659 152656.

STANDARDS OF SERVICE YOU CAN EXPECT AT AN INQUEST

Some coroners arrange for the Coroners' Courts Support Service, if available, or other similar service, to be present on days when they hold inquests. If so, the Support Service will welcome you on arrival, explain the process where needed – working jointly with the coroner's officers – and answer any queries you may have.

Some inquest venues have a room that you can use as a private waiting room. If so, the coroner's office will advise you of this.

As an inquest is a formal occasion you should consider dressing quite smartly, but comfortably.

The coroner's office will make the inquest environment as welcoming and safe as possible and treat you with fairness, respect and sensitivity.

SECTION 10

10. AT THE END OF THE INQUEST

10.1 Inquest conclusions – determinations and findings

The coroner (or jury where there is one) comes to a conclusion at the end of an inquest. This includes the legal 'determination', stating formally who died, and where, when and how they died. The coroner or jury may also make 'findings' to allow the death to be registered (see Glossary for details). When recording the cause of death the coroner or jury may use one of the following terms:

- accident or misadventure
- drink/drug related
- industrial disease
- lawful/unlawful killing
- natural causes
- open
- road traffic collision
- stillbirth
- suicide

Alternatively, or in addition, the coroner or jury may make a 'narrative' conclusion setting out the facts surrounding the death in some detail and explaining the reasons for the decision.

You may wish to make a note of the inquest conclusions in section 16 of this booklet.

It is possible to challenge a coroner's decision. More detail on this is at section 12.

10.2 What if future deaths may be prevented?

Sometimes an inquest will show that something could be done to prevent other deaths. If so, the coroner must write a report drawing this to the attention of an organisation (or person) that may have the power to take action. This is called a 'report on action to prevent other deaths'.

The organisation must send the coroner a written response to the report. If it does not respond within one month, stating what action it has taken, the

coroner will follow up the matter with the organisation, and may inform the Chief Coroner of the failure to respond. The coroner must send the report and response to the Chief Coroner. The Chief Coroner issues a summary of these reports, which is published twice a year on the Judiciary website at www.judiciary.gov.uk.

The coroner's office may send you a copy of the report, and the response.

10.3 Civil proceedings

Any civil proceedings will normally follow the inquest. When all the facts about the cause of death are known it is possible that civil proceedings may be brought and a claim for damages made. A lawyer's advice should be sought about the time limits and procedures that apply.

SECTION 11

11 INVESTIGATIONS WHERE THE PROCESS MAY BE DIFFERENT

11.1 When an investigation is transferred to a different coroner

Sometimes an investigation is carried out by a coroner in a different area from where the death occurred. An example could be where someone was injured in a road traffic accident but was then moved to a hospital in a different area for specialised care and later died from their injuries. It may be appropriate to transfer the investigation to the area where the accident happened, especially if it is also near to where the deceased's family live.

If an investigation is transferred to a coroner in a different area, the new coroner will inform you of that decision and the reason for it. The coroner's office will consult you beforehand wherever possible.

11.2 A death abroad

A coroner will investigate a death that occurs abroad if the body is brought back into his or her area and the apparent circumstances of the death would have led him or her to investigate it if it had occurred in England or Wales. The standards of service outlined in this booklet, in particular in relation to post-mortem examinations and inquests, may need to be varied due to arrangements following a death being different in other countries and difficulties receiving information from overseas.

The coroner will issue a certificate for cremation in all cases coming from abroad where the body is to be cremated. If a cremation takes place abroad and the cremated remains are brought back into England or Wales, the coroner cannot become involved.

Deaths that occur abroad are not registered by the Registrar of Births and Deaths when the coroner has finished investigating or has concluded the inquest.

Further information about what to do when a death occurs abroad is on the Foreign and Commonwealth Office's website, at www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/death-abroad.

11.3 Deaths of service personnel overseas

When service personnel have died on operations overseas, the coroner will usually request a post-mortem examination. The coroner will also usually conduct an inquest into the death. The procedures may vary and the coroner's office will provide you with more information.

If you live in Scotland, it may be possible for the investigation (called a Fatal Accident Inquiry) to be held there instead.

11.4 Death of a child

If the death of someone under the age of 18 is reported to the coroner, the coroner must ensure that the appropriate Local Safeguarding Children Board (LSCB) knows of the death within three working days of opening the investigation. Coroners share information with the appropriate LSCB for the purposes of investigating the death of the child and undertaking Serious Case Reviews.

11.5 When there is a criminal investigation into a death

Where there is a criminal investigation into the death, there may be more than one post-mortem examination. The coroner will make every effort for the body to be released for burial or cremation at the earliest opportunity. If, however, no-one has been charged in connection with the death within one month of the discovery of the body, the coroner may arrange a second post-mortem examination by a second pathologist who is independent of the one who carried out the first examination. This will be made available to the defence team if someone is charged with being responsible for the death in the future. The body will then be released at the earliest opportunity.

Where someone has been charged with causing, allowing or assisting a death, for example by murder or manslaughter, any coroner investigation being carried out must be suspended, and any inquest adjourned, until the criminal trial is over. On suspending an investigation, the coroner must send the Registrar of Births and Deaths a certificate stating the information that is needed to register the death and to issue a death certificate.

When the trial is over, the coroner will decide whether to resume the investigation. If, for example, all the facts surrounding the death have emerged at the trial, it is not usually necessary to continue the inquest. However, if the investigation is resumed the finding of the cause of death must be consistent with the outcome of the criminal trial. The coroner's office will be able to provide more information on the process.

11.6 A death in prison or other state detention

When a death has occurred in prison, police custody or other state detention and is not from natural causes,[31] there must be an inquest with a jury. See section 9 for more details on jury inquests.

[31] In cases where the state may have been involved in the death there will be an 'Article 2' inquest. This refers to Article 2 of the European Convention on Human Rights and means that the inquest must decide not only the identity of the deceased and when, where and how the death occurred, but also, more broadly than a standard inquest, in what circumstances the deceased came by his or her death.

SECTION 12

12. FEEDBACK, CHALLENGING A CORONERS DECISION AND COMPLAINTS

12.1 Feedback

Coroners are committed to providing a service which meets your needs. They welcome feedback, including when the service has performed well. You should address this to the coroner.

If you are dissatisfied with all or part of a coroner's investigation the rest of this section sets out what you can do about it.

12.2 How to challenge a coroner's decision or the outcome of an inquest

You may challenge a coroner's decision or an inquest conclusion. If you are thinking about doing this you should first seek advice from a lawyer with expertise in this area of the law. Some bereavement support organisations may also be able to offer advice.

If you decide to proceed, you need to make an application to the High Court for judicial review of the coroner's decision or conclusion. This must normally be done within three months of the end of the investigation.

There is a separate power under which the Attorney General, or someone who has received the Attorney General's permission to do so, may apply to the High Court for an inquest to be held if a coroner has not held one; or for another inquest to be held if this is in the interests of justice (e.g. because new evidence has come to light). There is no time limit for these applications.

12.3 Legal aid for challenges

Legal aid may be available for judicial review proceedings. See section 9 above for more information about which solicitors undertake legally-aided work.

12.4 Complaints about a coroner's conduct

If you are dissatisfied with a coroner's personal conduct you should normally raise this in the first instance with the coroner concerned.

If the coroner is unable to deal with your complaint satisfactorily, you may complain to the Office for Judicial Complaints (OJC). Examples of potential personal misconduct would be the use of insulting, racist or sexist language; or unreasonable delays in holding an inquest or replying to correspondence.

There is no charge for complaining to the OJC and you can do so online via the OJC website at www.judicialcomplaints.judiciary.gov.uk. Further information about complaints about coroners is also on the website.

Alternatively, you can download the OJC complaints form and send it to the OJC by fax, post or email. You can also complain by letter or email. The OJC's contact details are:

The Office for Judicial Complaints
Steel House
11 Tothill Street
3rd Floor, 3.01–3.03
London SW1H 9LJ

Tel: ☎ 020 3334 0145
Email: inbox@ojc.gsi.gov.uk
Fax: 020 3334 0031
Minicom VII: 020 3334 0146 (Helpline for the deaf and hard of hearing)

12.5 Complaints about the standard of service received

If you need to complain about the way a coroner or his/her staff handled an investigation, you should first write to the coroner, and copy your letter to the local authority which funds the service. The coroner's office will be able to advise you of the relevant local authority, if you are unsure of this.

You may also complain direct to the local authority. If you are still dissatisfied after its response you may complain to the Local Government Ombudsman, at www.lgo.org.uk/making-a-complaint, or by calling ☎ 0300 061 0614 or ☎ 0845 602 1983. Alternatively you may complain in writing to:

The Local Government Ombudsman
PO Box 4771
Coventry CV4 0EH

There is no charge to complain about the standard of service from a coroner's office.

12.6 Complaints about a pathologist who conducts the post-mortem examination

The General Medical Council (GMC) deals with the most serious concerns about doctors and would normally expect concerns about a pathologist to be referred by the coroner. However if you have a serious concern about a doctor you can complain direct to the GMC, which can take action to remove or restrict a doctor's right to practise if it considers that there has been a serious or persistent breach of its guidance. You can submit a complaint online at www.gmc-uk.org/patient_online_complaints. For further information, or if you wish to speak to an adviser, please telephone ☎ 0161 923 6602.

SECTION 13

13. MONITORING CORONER SERVICE STANDARDS

13.1 Chief Coroner

The Chief Coroner is responsible for setting the standards of service that coroners are expected to provide across England and Wales.

The Chief Coroner does not investigate complaints about individual coroners. Complaints must be made as described in section 12 above.

The Chief Coroner prepares an annual report on the coroner system, which is presented to Parliament.[32] The aim of the report is to allow the public to be aware of, understand, and comment on the key issues facing the coroner system.

The report focuses on service levels across the system and the consistency of standards between coroner areas. It also includes details of the number of investigations lasting more than a year, and why they are taking this long as well as the actions the Chief Coroner is taking to prevent any unnecessary delays.

The Chief Coroner's report also includes a summary of coroner reports to prevent deaths and the responses to these, highlighting the role that coroners play in public protection. It may also highlight examples of good coroner practice.

In addition the Ministry of Justice publishes annual statistics on deaths reported to coroners. These cover deaths reported, post-mortem examinations ordered, and inquests held, and are used to monitor coroners' workloads, throughput of cases, and percentages of post-mortem examinations and inquests. Details are available at www.justice.gov.uk/statistics/coroners-and-burials/deaths.

[32] The first report is due in 2014.

SECTION 14

14. GETTING MORE INFORMATION AND SUPPORT

14.1 How and when can I get information about my loved one's death?

As an 'interested person' (see Glossary) you may request copies of reports of any post-mortem examination carried out, and of documents to be used in the inquest. The coroner's office will not charge a fee for copies of documents provided before or during the inquest, but may charge after the inquest.

Inquests should be recorded so that everything that has been said can be transcribed (converted to written form) later if necessary. During an inquest the coroner may make notes. You can request these notes later but there may be a charge. Alternatively you can ask for a digital recording of proceedings on a disc or in other electronic form for a fee.

You may also go to the coroner's office to look at a document. There is no charge for this service.

For legal reasons the coroner may not be able to provide all the documents or part of a document he or she intends to use at the inquest. The coroner will be able to explain why he or she has not given you a particular document.

You should be aware that you may find some of the information in the documents distressing. The documents may include detailed reports from the post-mortem examination and information about other illnesses that the deceased was suffering from, of which you may have been unaware. They may also contain information about the deceased's lifestyle which you may not have known about before.

14.2 What about medical records?

Medical records remain confidential after death but may be made available to the deceased's personal representative or anyone who may have a claim arising out of the deceased's death, subject to some restrictions, under the terms of the Access to Health Records Act 1990. These can be viewed online at www.legislation.gov.uk/ukpga/1990/23/contents.

Coroners are entitled to obtain copies of medical information that is relevant and necessary to their investigations. Medical information about the deceased may be disclosed at an inquest hearing if it is relevant to the purpose of the inquest and the determination of the cause of death.

14.3 Where can I get further general information about coroner investigations?

General information is available from GOV.UK at https://www.gov.uk/after-a-death.

Another source of information is the pre-recorded Metropolitan Police Bereavement Information Line on ☎ 0800 032 9996, which is available nationwide 24 hours a day. This information is also available to view online at http://content.met.police.uk/Site/bereavementfamilyliaison.

In addition the Department of Work and Pensions publishes a booklet, 'What to do after death in England and Wales', which covers legal and benefits procedures. Registrars of Births and Deaths will give a copy to people who register a death, and coroners may make copies available to bereaved people. The booklet is available from your local JobcentrePlus Office or online at www.dwp.gov.uk/docs/dwp1027.pdf or by calling ☎ 0845 606 5065.

If you have any general queries about the contents of this booklet please email coroners@justice.gsi.gov.uk or phone ☎ 020 3334 3555 and ask to speak to the coroners, burials, cremation and inquiries team.

14.4 What support can I get during an investigation?

If you would like someone to support you through the investigation process, and liaise with the coroner's office where appropriate, you should discuss this with the coroner's office as soon as possible to agree how best to proceed. (The representative may be someone such as a friend or relative, a legal adviser or a member of a support organisation.)

14.5 What about bereavement support organisations?

The coroner's office will be able to provide information on the main local and national voluntary bodies, support groups and faith groups which help people who have been bereaved, including as a result of particular types of incidents or circumstances, or specific medical conditions. The NHS Choices website also contains details of support organisations: www.nhs.uk/livewell/bereavement/Pages/bereavement.aspx.

SECTION 15

15. GLOSSARY

"Chief Coroner" is the judicial head of the coroner system in England and Wales, responsible for setting national standards of service, training coroners and their officers and other staff and issuing guidance to them. The Chief Coroner has a number of roles but his main responsibilities are to:

- provide support, leadership and guidance for coroners in England and Wales;
- set national standards for all coroners;
- develop training for coroners and their staff;
- approve coroner appointments;
- keep a register of coroner investigations lasting more than 12 months and take steps to reduce unnecessary delays;
- monitor investigations into deaths of service personnel;
- oversee transfers of cases between coroners
- direct coroners to conduct investigations;
- provide an annual report on the coroner system to the Lord Chancellor, to be laid before Parliament; and
- collate and monitor coroners' reports to authorities to prevent further deaths.

"Conclusion" is the document which includes the legal 'determination' and 'findings' (see below). It also may include one of the following 'short form' conclusions as to the cause of death which a coroner or jury may record: accident or misadventure; drink/drug related; industrial disease; lawful/unlawful killing; natural causes; open; road traffic collision; stillbirth; or suicide. Sometimes the coroner or jury may record a more detailed 'narrative' conclusion about the death.

"Coroner's office" includes any member of the office of the coroner who is investigating the death. It could be the coroner, area coroner, assistant coroner, a coroner's officer, or any other member of staff in the office. It also includes a coroner's officer or other staff member who is based on different premises to the coroner they support.

"Determination" is the decision (reached by the coroner or jury as appropriate) about the identity of the deceased and how, when and where they came by their death (as required under sections 5 and 10 of the Coroners and Justice Act 2009).

"Findings" are the particulars about a death that the coroner establishes to enable the death to be registered (under the Births and Deaths Registration Act 1953).

"Inform" means giving information by leaflet, letter, email, telephone call, via a website or in person.

"Inquest" is a fact-finding inquiry conducted by a coroner to establish who has died, and how, when and where the death occurred. It forms part of the coroner's investigation. An inquest does not establish any matter of criminal or civil liability. It does not seek to blame anyone or apportion blame between people or organisations.

"Interested person" is defined in section 47 (2) of the Coroners and Justice Act 2009 as follows:

- a spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half-brother or half-sister;
- a personal representative of the deceased;
- a medical examiner exercising functions in relation to the death of the deceased;
- a beneficiary of a life insurance policy on the deceased;
- an insurer who issued a life insurance policy on the deceased;
- a person who may by any act or omission have caused or contributed to the death, or whose employee or agent may have done so;
- a representative from a trade union to whom the deceased belonged at the time of death (if the death may have been caused by an injury received in the course of the person's employment, or was due to industrial disease);
- a person appointed by, or representative of, an enforcing authority;
- the chief constable (where there may have been a homicide offence);
- a Provost Marshal (where there may have been a service homicide offence)
- the Independent Police Complaints Commission (where the death is the subject of an investigation by the Independent Police Complaints Commission);
- a person appointed by a Government department to attend the inquest or to assist in, or provide evidence to the investigation; or
- anyone else who the coroner thinks has a sufficient interest.

"Investigation" is the process by which the coroner establishes who has died, and how, when and where the death occurred. It may include a post-mortem examination and an inquest.

"Next of kin" means the person identified by the coroner or coroner's office to act as the main point of contact to receive information.

"Other type of state detention" refers to where detainees are compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1998 (www.legislation.gov.uk/ukpga/1998/42/section/6), such as those in mental institutions or immigration centres.

"Pathologist" is a medical professional who specialises in the diagnosis of disease after death and identifying the causes of death. He or she carries out post-mortem examinations.

"Post-mortem examination" is a detailed medical examination of the body that takes place after death and is generally conducted by a pathologist. The purpose of the post-mortem examination is to establish the medical cause of death.

"Pre-inquest review" is a public hearing that the coroner may hold in advance of the inquest hearing in order to decide matters such as the scope and date of the inquest and which witnesses and evidence he or she plans to call and use. The coroner may also set out what else he or she needs in order to complete preparations for the inquest.

"Witness" is someone who gives evidence, or whose statement is read, at an inquest under oath or affirmation in order to establish who the deceased was, and how, when and where they came by their death.

"Working day" means any day, except a designated bank holiday, between Monday and Friday.

SECTION 16

16. YOUR NOTES

You may find it helpful to use this section to jot down some or all of the details on the following pages.

A) Information about the person who has died – in order to register the death

Depending on whether the coroner's investigation leads to an inquest, either you or the coroner will need the following information, in order to register the death.

Surname:

Forenames:

Maiden name:

Any other previous names (e.g. if a woman has been married more than once):

Any other names (e.g. usually known as, even if not their formal name):

Date and place of birth (town and county in England / Wales or country if overseas):

Date and place of death:

Usual address:

Marital status:

Occupation (or former occupation if retired):

Name/address/occupation of spouse or civil partner (if surviving) or name and occupation (if deceased):

National Insurance number:

National Insurance number of any surviving husband, wife or civil partner:

B) Other information about the person who has died, which may be useful

Hospital consultant and contact details:

GP and contact details:

Employment and medical history that may be relevant:

C) Coroner's office details

Contact name:

Phone number:

Fax number:

Email address:

Postal address:

Other information about coroner's office:

Questions to ask the coroner and information to give him/her.

You may wish to use this space to note any questions you have about the death; or information that you feel the coroner should know.

D) Contact with coroner's office

Date / time	Name of person contacted	Note of conversation / email / letter / meeting

Date / time	Name of person contacted	Note of conversation / email / letter / meeting

E) Post-mortem examination (see sections 5 and 6 of this booklet)

Result of post-mortem examination:

Results of any later tests:

F) If no inquest is needed, appointment with Registrar of Births and Deaths (See section 4 of this booklet)

Date/time:

Address:

Reference given or phone/internet completion of Tell Us Once (if applicable, see section 7 of this booklet):

Date Tell Us Once completed (if applicable, see section 7 of this booklet):

G) The Inquest (see section 9 of this booklet)

You may find it useful to note the following information.

Date / time / place:

People who give evidence:

At the end of the inquest, the coroner's conclusion about how the person died:

Anything else the coroner said or recommended:

Details of the Registrar to obtain Certified Copies of the Death Certificate:

Annex E

Proposed new coroner areas for England and Wales

1. Current Coroner Districts	2. Coroner Areas under first Schedule 2 order	3. New areas as a result of second Schedule 2 order
Avon	Avon	
Bedfordshire and Luton	Bedfordshire and Luton	
Berkshire	Berkshire	
Birmingham and Solihull	Birmingham and Solihull	
Black Country	Black Country	
Blackburn, Hyndburn and Ribble Valley	Blackburn, Hyndburn and Ribble Valley	
Blackpool and Fylde	Blackpool and Fylde	
Bournemouth, Poole and Eastern Dorset	Bournemouth, Poole and Eastern Dorset	Dorset
Bridgend and Glamorgan Valleys	Bridgend and Glamorgan Valleys	Powys, Bridgend and Glamorgan Valleys
Brighton and Hove	Brighton and Hove	
Buckinghamshire	Buckinghamshire	
Cardiff and Vale of Glamorgan	Cardiff and Vale of Glamorgan	
Carmarthenshire	Carmarthenshire	Carmarthenshire and Pembrokeshire
Central and South East Kent	Central and South East Kent	
Central Hampshire	Central Hampshire	
Central Lincolnshire	Central Lincolnshire	
Ceredigion	Ceredigion	

1. Current Coroner Districts	2. Coroner Areas under first Schedule 2 order	3. New areas as a result of second Schedule 2 order
Cheshire	Cheshire	
City of London	City of London	
Cornwall	Cornwall	
Coventry	Coventry	Coventry and Warwickshire
Darlington and South Durham	Darlington and South Durham	County Durham and Darlington
Derby and South Derbyshire	Derby and South Derbyshire	Derby and Derbyshire
East Lancashire	East Lancashire	
East London	East London	
East Riding and Hull	East Riding and Hull	
East Sussex	East Sussex	
Essex and Thurrock	Essex and Thurrock	Essex
Exeter and Greater Devon	Exeter and Greater Devon	
Gateshead and South Tyneside	Gateshead and South Tyneside	
Gloucestershire	Gloucestershire	
Gwent	Gwent	
Hartlepool	Hartlepool	
Herefordshire	Herefordshire	
Hertfordshire	Hertfordshire	
Inner North London	Inner North London	
Inner South London	Inner South London	
Inner West London	Inner West London	
Isle of Wight	Isle of Wight	

1. Current Coroner Districts	2. Coroner Areas under first Schedule 2 order	3. New areas as a result of second Schedule 2 order
Isles of Scilly	Isles of Scilly	
Knowsley, St Helens and Sefton	Knowsley, St Helens and Sefton	
Leicester City and South Leicestershire	Leicester City and South Leicestershire	
Liverpool	Liverpool	
Manchester	Manchester	
Manchester North	Manchester North	
Manchester South	Manchester South	
Manchester West	Manchester West	
Mid and North West Shropshire	Mid and North West Shropshire	Shropshire, Telford and Wrekin
Mid Kent and Medway	Mid Kent and Medway	
Milton Keynes	Milton Keynes	
Neath and Port Talbot	Neath and Port Talbot	Swansea, Neath and Port Talbot
Newcastle-upon-Tyne	Newcastle-upon-Tyne	
Norfolk	Norfolk	
Northamptonshire	Northamptonshire	
North and East Cambridgeshire	North and East Cambridgeshire	
North and West Cumbria	North and West Cumbria	
North Derbyshire	North Derbyshire	Derby and Derbyshire
North Durham	North Durham	County Durham and Darlington
North East Hampshire	North East Hampshire	
North East Kent	North East Kent	

1. Current Coroner Districts	2. Coroner Areas under first Schedule 2 order	3. New areas as a result of second Schedule 2 order
North Lincolnshire and Grimsby	North Lincolnshire and Grimsby	
North London	North London	
North Northumberland	North Northumberland	
North Tyneside	North Tyneside	
North Wales (East and Central)	North Wales (East and Central)	
North West Kent	North West Kent	
North West Wales	North West Wales	
North Yorkshire (Eastern)	North Yorkshire (Eastern)	
North Yorkshire (Western)	North Yorkshire (Western)	
Nottinghamshire and Nottingham	Nottinghamshire and Nottingham	
Oxfordshire	Oxfordshire	
Pembrokeshire	Pembrokeshire	Carmarthenshire and Pembrokeshire
Peterborough	Peterborough	
Plymouth and South West Devon	Plymouth and South West Devon	Plymouth, Torbay and South Devon
Portsmouth and South East Hampshire	Portsmouth and South East Hampshire	
Powys	Powys	Powys, Bridgend and Glamorgan Valleys
Preston and West Lancashire	Preston and West Lancashire	
Rutland and North Leicestershire	Rutland and North Leicestershire	
Somerset (Eastern)	Somerset (Eastern)	

1. Current Coroner Districts	2. Coroner Areas under first Schedule 2 order	3. New areas as a result of second Schedule 2 order
Somerset (Western)	Somerset (Western)	
South and East Cumbria	South and East Cumbria	
South and West Cambridgeshire	South and West Cambridgeshire	
South Lincolnshire	South Lincolnshire	
South London	South London	
South Northumberland	South Northumberland	
South Shropshire	South Shropshire	Shropshire, Telford and Wrekin
South Staffordshire	South Staffordshire	
South Yorkshire (East)	South Yorkshire (East)	
South Yorkshire (West)	South Yorkshire (West)	
Southampton and New Forest	Southampton and New Forest	
Southend and South East Essex	Southend and South East Essex	Essex
Stoke on Trent and North Staffordshire	Stoke on Trent and North Staffordshire	
Suffolk	Suffolk	
Sunderland	Sunderland	
Surrey	Surrey	
Swansea	Swansea	Swansea, Neath and Port Talbot
Teesside	Teesside	
The Wrekin	The Wrekin	Shropshire, Telford and Wrekin
Torbay and South Devon	Torbay and South Devon	Plymouth, Torbay and South Devon

1. Current Coroner Districts	2. Coroner Areas under first Schedule 2 order	3. New areas as a result of second Schedule 2 order
Warwickshire	Warwickshire	Coventry and Warwickshire
Western Dorset	Western Dorset	Dorset
West London	West London	
West Sussex	West Sussex	
West Yorkshire (Eastern)	West Yorkshire (Eastern)	
West Yorkshire (Western)	West Yorkshire (Western)	
Wiltshire and Swindon	Wiltshire and Swindon	
Wirral	Wirral	
Worcestershire	Worcestershire	
York	York	

Annex F

Organisations to which this consultation is being sent

2 Hare Court
Action against Medical Accidents
Adath Yisroel Burial Society
Adverse Psychiatric Reactions Information Link
Asbestos Group Forum
Assistance and Support in Surviving Trauma
Association of Chief Police Officers
Association of Personal Injury Lawyers
Bereavement Advice Centre
Board of Deputies of British Jews
Brake
Brethren Christian Fellowship (UK)
British Heart Foundation
British Humanist Association
British Irish Rights Watch
British Lung Foundation
British Medical Association
British Sikh Consultative Forum
Bromley Bereavement Centre
Buddhist Funeral Group
Cardiac Risk in the Young
Child Accident Prevention Trust
Child Bereavement Charity
Childhood Bereavement Network
CO-Gas Safety
College of Emergency Medicine
Commissioner for Victims and Witnesses
Compassionate Friends
Coroners' Courts Support Service
Coroner's Officers and Staff Association

Coroners' Society of England and Wales
Cremation Society of Great Britain
Crown Office and Procurator Fiscal Service
Cruse Bereavement Care
Department for Communities and Local Government
Department for Culture, Media and Sport
Department for Education
Department of Health
Department for Transport
Department of Work and Pensions
Disaster Action
Edmonton Baptist
English Heritage
Epilepsy Bereaved
Evangelical Alliance
Families against Corporate Killing
Fire Service
Foundation for the Study of Infant Deaths
Funeral Service Times
Furnival Chambers
General Medical Council
General Register Office
Health and Safety Executive
Hempsons Solicitors
Hindu Forum of Britain
Home Office
Human Tissue Authority
Independent Police Complaints Commission
INQUEST
Interfaith Network
JUSTICE
Justice for Victims
Lees Solicitors – Wirral and Chester
Liberty

Local Government Association
Local Government Employers
Local Government Regulations
London Borough of Croydon
Tom Luce CB (author of the Luce Report)
Marchioness Action Group
Media Lawyers' Association
Medical Defence Union
Medical Protection Society
MENCAP
Merseyside Asbestos Victim Support Group
Mesothelioma UK
Metropolitan Police
Mind
Ministerial Council on Deaths in Custody
Ministry of Defence
Mosques and Imams National Advisory Board
Mothers against Murder and Aggression (MAMAA)
Muslim Burial Council of Leicestershire
Muslim Council of Britain
Myeloma UK
National Association of Funeral Directors
National Bereavement Partnership
National Concern for Healthcare Infections
National Health Service
National Mental Health Development Unit
National Offender Management Service
National Patient Safety Agency
National Policing Improvement Agency
National Spiritual Assembly of Baha'is of the UK
National Union of Journalists
Network of Buddhist Organisation UK
Network of Sikh Organisations
Newspaper Society

Northern Ireland Court Service
National Society for the Prevention of Cruelty to Children
Office for Judicial Complaints
Office of Rail Regulation
Office of National Statistics
Pagan Federation
Police Federation
Press Association
Press Complaints Commission
Prison and Probation Ombudsman
Michael Redfern QC (Chairman of the Redfern Inquiry)
Refuge
Rethink
Road Peace
Royal British Legion
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of Edinburgh
Royal College of Surgeons (England)
Royal Society for the Prevention of Accidents
Saad Foundation
SAFE Justice Foundation
Samaritans
SAMM Abroad
Scottish Government
Society of Editors

Soldiers, Sailors, Airmen and Families Association
Southampton City Council (Legal and Democratic Services)
Stillbirth and Neonatal Death Society
Sudden Adult Death Trust (Sudden Arrhythmic Death Syndrome) UK
Sudden Death Police Complaints
Support after Murder and Manslaughter (SAMM)
Survivors of Bereavement by Suicide
Trades Union Congress
Union of Orthodox Hebrew Congregations
Unitarian and Free Churches
Victim Support
Victims' Voice
Welsh Assembly Government, Department of Health and Social Services
War Widows' Association of Great Britain
Welsh Local Government Association
Youth Justice Board of England and Wales
Zoroastrian Trust Funds of Europe

About you

Please use this section to tell us about yourself

Full name	
Job title or capacity in which you are responding to this consultation exercise (e.g. member of the public etc.)	
Date	
Company name/organisation (if applicable):	
Address	
Postcode	
If you would like us to acknowledge receipt of your response, please tick this box	☐ (please tick box)
Address to which the acknowledgement should be sent, if different from above	

If you are a representative of a group, please tell us the name of the group and give a summary of the people or organisations that you represent.

Contact details/How to respond

Please send your response by 12 April 2013 to:

Reshma Bhudia
Coroner Reform Team
Ministry of Justice
Area 4.38
102 Petty France
London SW1H 9AJ

Tel: 020 3334 5259

Fax: 020 3334 2233

Email: coroners@justice.gsi.gov.uk

Extra copies

Further paper copies of this consultation can be obtained from this address and it is also available on-line at http://www.justice.gov.uk/index.htm.

Alternative format versions of this publication can be requested from 020 3334 5259 or coroners@justice.gsi.gov.uk.

Publication of response

A paper summarising the responses to this consultation will be published in within three months of the closing date of the consultation. The response paper will be available on-line at http://www.justice.gov.uk/index.htm.

Representative groups

Representative groups are asked to give a summary of the people and organisations they represent when they respond.

Confidentiality

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will

take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Ministry.

The Ministry will process your personal data in accordance with the DPA and in the majority of circumstances, this will mean that your personal data will not be disclosed to third parties.

Consultation principles

The principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation are set out in the consultation principles:

http://www.cabinetoffice.gov.uk/sites/default/files/resources/Consultation-Principles.pdf.

Consultation Co-ordinator contact details

Responses to the consultation must go to the named contact under the How to Respond section.

However, if you have any complaints or comments about the consultation **process** you should contact Sheila Morson on 020 3334 4498, or email her at consultation@justice.gsi.gov.uk.

Alternatively, you may wish to write to the address below:

Ministry of Justice
Consultation Co-ordinator
Better Regulation Unit
Analytical Services
7th Floor, 7.02
102 Petty France
London SW1H 9AJ

Alternative format versions of this report are available on request from 020 3334 5259 or coroners@justice.gsi.gov.uk.