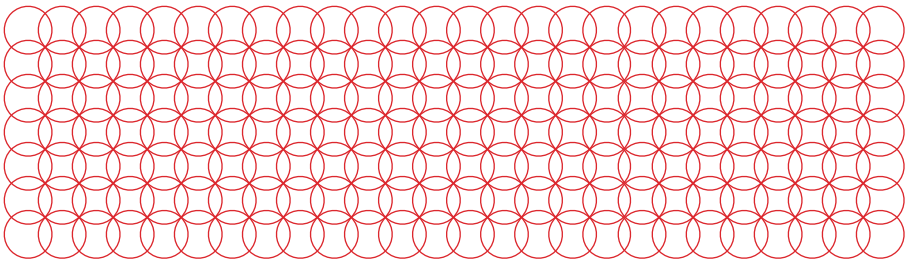




Ministry
of Justice

Guide to Coroner Services



www.gov.uk/moj

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.

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SECTION 1

1. General standards that you can expect during a coroner's 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 15 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;
- act with compassion and without judgement about the deceased and the cause of death;
- 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 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;
- wherever possible 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 specific needs you have for the inquest, e.g. relating to a disability, or if English is not your first language, so that reasonable measures can be taken.

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 a local authority (council) within the coroner area. Some coroners cover more than one local authority. Coroners are usually lawyers but sometimes doctors. Coroners work within a framework of law passed by Parliament. The Chief Coroner heads the coroner service and gives guidance on standards and practice.

2.2 What do coroners do?

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

- the death was violent or unnatural;
- the cause of death is unknown; or
- the deceased died while in prison, police custody or another type of state detention such as 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:

- firstly establishes whether an investigation is required;
- if yes, 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
- uses 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 8 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 collision; or criminal activity may be relevant to the death.

In some cases other organisations such as a hospital, the Health and Safety Executive¹, the Prisons and Probation Ombudsman², the Care Quality Commission³, or the Independent Police Complaints Commission⁴ are required to conduct a separate investigation into the death. 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 8 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. However the officers' work is always carried out under the authority of the coroner who works independently from both the local authority and the local police force.

¹ www.hse.gov.uk/aboutus/index.htm

² www.ppo.gov.uk/about-us.html

³ www.cqc.org.uk/aboutcqc.cfm

⁴ www.ipcc.gov.uk/en/Pages/about_ipcc.aspx

SECTION 3

3. Starting an investigation

3.1 Are all deaths reported to a coroner?

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

3.2 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 of the 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 diagnose and certify a natural cause of death.

3.3 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 or condition and there are no unusual circumstances. 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. The family can then make an appointment with the registrar to register the death.

However the coroner may decide that he or she needs to ask a suitable practitioner, normally a pathologist, to examine the body and carry out a post-mortem examination to help find out the cause of death (see section 4 for more details).

3.4 Viewing the body

You, or a representative of your choice, may be asked to formally identify the body. You are also entitled to view the deceased should you wish to do so. 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 collision, 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.

3.5 When can a death be registered?

When the deceased's doctor, or a 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. You will need to pay for copies of the death certificate.

Sometimes a doctor may discuss the case with the coroner. This may result in the coroner deciding that he or she does not need to investigate, 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 for the coroner to investigate the death.

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, for instance if there is to be an inquest (see section 8), so it is always best to contact the coroner's office before any funeral arrangements are made. In most cases the decision to investigate will not hold up funeral arrangements or sorting out benefits.

The coroner may issue a 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 6 for more details on this).

Standards of service you can expect when a death is investigated by a coroner

When a death is investigated by a 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 actions are likely to follow.

SECTION 4

4. The post-mortem examination

4.1 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 and is carried out by a suitable medical practitioner such as a pathologist (a doctor who specialises in medical diagnosis by examining body organs, tissues and fluids) of the coroner's choice.

The coroner decides whether or not a post-mortem examination is needed and what type of examination is most appropriate. By law, the coroner is not required to obtain your consent to the examination, but he or she will give you the reason for his or her decision (which will be one or more of the factors set out in 3.2 above).

Usually a post-mortem examination involves opening and examining the body internally. In some parts of the country other techniques such as CT (computerised tomography) scanning or MRI (magnetic resonance imaging) are available and may be preferred by people who have a strong objection to an invasive examination of the body. It is the coroner who will decide if a scanning technique is appropriate (if available), depending on the circumstances of the death. Where a scanning technique is used, the family or other next of kin will be required to pay a fee (for this and for any additional tests that the coroner decides are needed). The use of a scanning technique may not avoid the need for a full post-mortem examination if the scan does not identify the cause of death.

Where possible, coroners will take account of your religious and cultural needs whilst acting in accordance with the law when ordering a post-mortem examination and the type of examination to be performed.

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's office will tell you when and where the examination will happen.

Sometimes the coroner will request a 'forensic post-mortem examination' (for example, in a case of suspected murder; see Glossary) 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. This 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 tissue, 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 is the responsibility of the coroner.

SECTION 5

5. After a post-mortem examination

5.1 The 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 retained, 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.

Sometimes the pathologist's report may not be available for several weeks because of the complexity of the examination (especially if there has been a forensic examination, organs need very specialist examination, or the examination has been carried out on an infant).

You may ask for a copy of the pathologist's report. See section 13 for more information. You may wish to make a note of the details in section 15 of this booklet.

5.2 What happens after the post-mortem examination?

A coroner may decide the investigation is either unnecessary or complete 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 6 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 15 of this booklet).

Sometimes a coroner may decide that further investigation is needed into the death. The coroner will still usually release the body at this point so the funeral can take place if he or she no longer needs the body for the investigation. However occasionally this is not possible and, if so, the coroner's office will explain the arrangements to you. See section 6 for more information.

Occasionally, while the coroner can release a body for funeral purposes, it may not be possible to release a particular organ (or organs) immediately because a specialist and lengthy examination is required. Again the coroner's office will advise you of the various options available to you.

You may wish to find a funeral director through one of the industry's trade associations, the National Association of Funeral Directors (NAFD) (<http://www.nafd.org.uk/funeral-advice/funeral-advice-home.aspx>) or the National Society of Allied and Independent Funeral Directors (SAIF) (<http://www.saif.org.uk/website/index.html>).

SECTION 6

6. Release of the body for a funeral and administration of the estate

6.1 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 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 must release the body for burial or cremation as soon as possible. If the coroner cannot release the body within 28 days then he or she must notify the known next of kin or personal representative of the reasons for the delay. (An example might be if 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 10 for details.

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

In order to assist with the administration of the estate, if a coroner has begun but not yet completed or discontinued an investigation the coroner may issue a coroner's certificate of the 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 investigation (for example, for an insurance settlement). A grant of probate or letters of administration can be obtained using a certificate of the fact of death and it can also be used for benefit claims and National Insurance purposes. However, the certificate of the 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 issued a certificate of the fact of death. 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 of births and deaths 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 purchased from the registrar.

6.3 What happens if I want to take a body abroad?

The coroner has to be notified if a body is to be 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 as soon as possible and 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 7

7. Organs and tissue

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

Small pieces of tissue and, occasionally, organs may 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 kept as part of the pathology record or 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 retained tissue may have to be kept 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 <http://www.hta.gov.uk>.

SECTION 8

8. The inquest

8.1 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 (or occurred in state detention) or the coroner thinks there is a good reason to continue the investigation, 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 10.)

An inquest is a public court 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 other types of court hearing because there is no prosecution or defence. The purpose of the inquest is to discover the facts of the death. This means that the coroner (or jury) cannot find a person or organisation criminally responsible 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.

8.2 When will the inquest take place?

The main inquest hearing should normally take place within six months or as soon as practicable after the death has been reported to the coroner. Sometimes you may need to wait longer than six months for the inquest due to the complexity of the case or other factors (for instance an investigation by another organisation such as the Health and Safety Executive for a death at work). If so, the coroner's office will be able to keep you updated on progress.

8.3 Opening and adjourning an inquest

Where an inquest is required the coroner must open the inquest as soon as possible. This hearing is typically very brief but is usually held in public. The press or media may be present and report details afterwards, though these will inevitably be rather limited. 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. At the opening of the inquest, the coroner must, where possible, set the dates of subsequent hearings.

It is not necessary for you to attend the opening of the inquest but you can ask the coroner if you would like to do so.

8.4 What is a pre-inquest review?

Sometimes the coroner may hold one or more hearings before the inquest, known as pre-inquest reviews or directions hearings. 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 raise issues, on what you consider the inquest should cover, with the coroner.

Pre-inquest reviews are normally held in public, but in certain circumstances, such as when complex issues are being discussed, this will not be the case.

Standards of service you can expect before an inquest

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.

The coroner's office must notify you of the time and location of the inquest within a week of arranging the inquest. 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 15 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 within a week.

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.

You may request copies of relevant documents from the coroner's office, before the inquest. See section 13 for more details.

8.5 Who can attend an inquest?

Inquest hearings are almost always held in public.

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 or a similar support service is available in your area and how they can help you. These independent services are provided by trained volunteers and are 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 are normally allowed to attend the inquest.

8.6 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 be 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. You should tell the coroner's office of your religious or other requirements, so that the appropriate text can 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 15 of this booklet.

8.7 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, if possible, inform the coroner well before the hearing date. The coroner will then decide whether the evidence is relevant to the investigation.

8.8 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.

In exceptional circumstances the coroner may allow someone to give evidence from behind a screen, or by video link, if he or she decides that it would improve evidence, allow the inquest to go ahead more quickly or would protect a particularly vulnerable witness who may be at risk of harm from others.

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.

8.9 Who can ask witnesses questions?

The coroner will question a witness first. After that you (and other 'interested persons' – see Glossary) 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 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.

8.10 Is there always a jury at an inquest?

No, 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.

8.11 What does the jury do?

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' (see Glossary), 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 (from the Electoral Register) and consist of between seven and eleven members.

8.12 Do I need a solicitor?

In most cases you will not need to instruct a solicitor to represent you at an inquest, although you may do so if you wish. 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 want this 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. The Law Society website may help you find a solicitor at <http://www.lawsociety.org.uk/>

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.

8.13 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.

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.

To find out if you qualify for legal aid you will need to contact the Civil Legal Advice advice line 0845 345 4345.

You can find information about which solicitors undertake legally-aided work by visiting <http://find-legal-advice.justice.gov.uk/>. The Law Society also provides a database of solicitors, which you can access by calling 020 7242 1222 or by visiting <http://www.lawsociety.org.uk/find-a-solicitor/>.

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

8.14 Will the inquest be reported by the press?

Inquests are almost always 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 only be read out at the inquest if 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 Editors' Code of Practice, upheld by the Independent Press Standards Organisation (IPSO). The Code (<https://www.ipso.co.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. IPSO has also produced detailed guidance on harassment from journalists, which is available on its website.

You may complain to IPSO about published material. You can also seek advice from IPSO on how to prevent harassment by journalists. There is more information on the IPSO website or you can call on 0300 123 2220. IPSO also operates an out-of-hours number for emergencies only on 07659 152656.

For matters relating to broadcasting, you may also complain to the communications regulator, Ofcom (<http://www.ofcom.org.uk> or 0300 123 3333 or 020 7981 3040) or to the BBC (<http://www.bbc.co.uk/complaints> or 03700 100 222).

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 9

9. At the end of the inquest

9.1 Inquest conclusions – determinations and findings

The coroner (or jury where there is one) comes to a conclusion (see Glossary) 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
- alcohol/drug related
- industrial disease
- lawful/unlawful killing
- natural causes
- open (used when there is insufficient evidence for any other outcome)
- road traffic collision
- stillbirth
- suicide

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

You may wish to make a note of the inquest conclusions in section 15 of this booklet.

It is possible to challenge a coroner's decision. More detail on this is at section 11.

9.2 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 to prevent future deaths'.

The organisation must send the coroner a written response to the report. If it does not respond within 56 days, 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 on the Judiciary website at <http://www.judiciary.gov.uk>.

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

9.3 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 10

10 Investigations where the process may be different

10.1 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 collision 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 incident 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.

10.2 A death abroad

A coroner will investigate a death 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 abroad are not registered by the registrar of births and deaths when the coroner has finished his or her investigation, but are registered in the country where the death occurred.

Further information about what to do when a death occurs abroad is at <https://www.gov.uk/government/publications/coping-with-death-abroad>.

10.3 Deaths of service personnel overseas

When service personnel have died on operations or exercises 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.

10.4 Death of a child

The deaths of children under the age of 18 are reviewed by a Child Death Overview Panel on behalf of the Local Safeguarding Children Board (LSCB). The Child Death Overview Panel reviews information in order to prevent future deaths and is accountable to the LSCB. The LSCB has responsibility for safeguarding and promoting the welfare of children in its area.

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

10.5 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.

10.6 A death in prison or other state detention

When a death has occurred in prison, police custody or other state detention there must be an inquest. Unless the death is from natural causes⁵, the inquest must be held with a jury. See section 8 for more details on jury inquests.

⁵ 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 11

11. Feedback, challenging a coroner's decision and complaints

11.1 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.

11.2 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. You should do this as soon as possible and 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 investigation to be carried out if a coroner has not held one; or for another investigation 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.

11.3 Legal aid for challenges

Legal aid may be available for judicial review proceedings. See section 8 above for more information about which solicitors undertake legally-aided work.

11.4 Complaints about a coroner's personal 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 Judicial Conduct Investigations Office (JCIO) (formerly known as the Office for Judicial Complaints). 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 JCIO and you can do so online via the JCIO website at <http://judicialconduct.judiciary.gov.uk/making-a-complaint.htm>. Further information about complaints about coroners is also on the website.

Alternatively, you can download the JCIO complaints form and send it to the JCIO by fax, post or email. You can also complain by letter or email. The JCIO's contact details are:

The Judicial Conduct Investigations Office
81 - 82 Queens Building
Royal Courts of Justice
Strand
London WC2A 2LL
Tel: 020 7073 4719
Email: inbox@jcio.gsi.gov.uk
Fax: 020 7073 4725

11.5 Complaints about the standard of service received

If you need to complain about the way a coroner or his or her staff handled an investigation (for example if you feel the standards in the booklet are not being met), 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 <http://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.

11.6 Complaints about a pathologist who conducts the post-mortem examination

If you wish to complain about a pathologist you should tell the coroner. Serious complaints should also be made to the General Medical Council (GMC). The GMC 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 https://www.gmc-uk.org/patient_online_complaints. For further information, or if you wish to speak to an adviser, please telephone 0161 923 6602.

A complaint about a registered forensic pathologist (see Glossary) should be made to the GMC and the Home Office. Details for the Home Office are at <https://www.gov.uk/forensic-pathology-role-within-the-home-office>.

SECTION 12

12. Monitoring coroner service standards

12.1 Chief Coroner

The Chief Coroner is responsible for setting the standards of service that coroners are expected to provide. The Chief Coroner also provides support and judicial leadership for coroners across England and Wales.

The Chief Coroner does not investigate complaints about individual coroners. Complaints must be made as described in section 11 above.

The Chief Coroner prepares an annual report on the coroner system, which is presented to Parliament.⁶ 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 may include 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 <http://www.gov.uk/government/publications/coroners-statistics>.

⁶ The first report is due in 2014.

SECTION 13

13. Getting more information and support

13.1 How and when can I see the documents that are relevant to 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 that are relevant to the investigation. 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.

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.

All inquests must be recorded and you may request a recording of proceedings on a disc or in other electronic form for a fee. You may also request a transcript although the fee for this is likely to be higher than for an electronic copy. Any recording or transcript is for your own information only and must not be used for any other purpose.

13.2 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 <http://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.

13.3 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 general information on what to do after a death at www.gov.uk/after-a-death.

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.

13.4 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.)

13.5 What about bereavement support?

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:
<http://www.nhs.uk/livewell/bereavement/Pages/bereavement.aspx>.

You may find the publication *Help is at Hand* useful. This is a guide for people bereaved by suicide and other sudden, traumatic death and is available on the NHS Choices website, at
<http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf>.

SECTION 14

14. Glossary

“**Chief Coroner**” is the judicial head of coroner services 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 future deaths.

“**Conclusion**” is the decision the coroner (or jury) reaches at the end of an inquest about how someone died. The conclusion is recorded on a ‘record of an inquest’ form which includes the legal ‘determination’ and ‘findings’ (see below). It may comprise one of the following ‘short form’ conclusions: accident or misadventure; alcohol/drug related; industrial disease; lawful/unlawful killing; natural causes; open; road traffic collision; stillbirth; or suicide. An open conclusion may be given if there is insufficient evidence to enable the coroner or the jury to reach one of the other conclusions. 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 he or she came by his or her 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).

“Forensic post-mortem examinations” are carried out by Home Office-registered forensic pathologists to assist in the investigation of violent or suspicious deaths. These pathologists work within regional group practices, which are independent of the police, coroners and the Home Office. They may be self-employed or employed by a university hospital or a hospital trust.

“Inform” means giving information by leaflet, letter, email, telephone call, via a website or in person.

“Inquest” or **“inquest hearing”** is a fact-finding inquiry in court (or alternative premises) 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 (<http://www.legislation.gov.uk/ukpga/1998/42/section/6>), such as those in a mental health hospital/establishment or immigration centre.

“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 hearing (usually held in public) that the coroner may hold in advance of the inquest 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 he or she died.

“Working day” means any day, except a designated bank holiday, between Monday and Friday.

SECTION 15

15. 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 spouse 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 or 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 4 and 5 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 3 of this booklet)

Date/time:

Address:

Reference given or phone/internet completion of Tell Us Once (if applicable, see section 6 of this booklet):

Date Tell Us Once completed (if applicable, see section 6 of this booklet):

G) The Inquest (see section 8 of this booklet)

You may find it useful to note the following information.

Date inquest opened:

Date/time/place of any pre-inquest hearing(s):

Date/time/place of inquest:

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 of births and deaths to obtain copies of the death certificate:

You can request further copies of this document
from coroners@justice.gsi.gov.uk
or by calling 020 3334 3555

