



Ministry of
JUSTICE

**Guide to Coroners and
Inquests
and
Charter for coroner
services**

March 2012



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and
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Part 1: Guide to Coroners and Inquests

Some questions answered and issues explained

This Guide is for information purposes only and is not intended to be an exhaustive explanation of current coroner law in England and Wales. If you are a 'properly interested person' in a specific inquest (see Part 3, Glossary) and have questions about it, you should raise these with the coroner's office.

The Coroners and Justice Act 2009 received Royal Assent on 12 November 2009. Further information about the Coroner Change Programme can be found at www.justice.gov.uk/publications/coroners-justice-bill.htm. A revised version of this guidance will be published when relevant provisions of the Act are implemented.

1. What is a coroner?

- 1.1 A coroner is an independent judicial office holder, appointed and paid by the relevant local authority. A coroner must be a lawyer or a doctor, and in some cases is both. Each coroner has a deputy and usually one or more assistant deputies, and either personally or through a deputy he or she must be available at all times. The costs of coroners' services are met by local authorities, not by central Government. In some districts the local police force may also contribute towards a coroner's resources, usually by providing and paying the costs of the coroner's officers.

2. What do coroners do?

- 2.1 Coroners inquire into violent or unnatural deaths, sudden deaths of unknown cause, and deaths which have occurred in prison. A coroner's authority to inquire flows from the report of a body being within the coroner's district and not from where

the death occurred. The coroner's inquiries may take one of several forms and may result in the holding of an inquest.

- 2.2 The purposes of the coroner service, when a death is reported to it, are:
- to establish whether a coroner's inquest is required;
 - if so, to establish the identity of the person who has died, and how, when, and where the person came by their death;
 - to assist in the prevention of future deaths; and
 - to provide public reassurance.
- 2.3 After an inquest the coroner will send the necessary details to the Registrar of Births and Deaths for the death to be registered if it occurred in England and Wales.
- 2.4 In some cases a death may be referred to the police for investigation on behalf of a coroner. In other cases a separate investigation into a death may be undertaken by an independent body such as the Health and Safety Executive (www.hse.gov.uk/aboutus/index.htm), the Prisons and Probation Ombudsman (www.ppo.gov.uk/about-us.html), the Care Quality Commission (www.cqc.org.uk/aboutcqc.cfm) or the Independent Police Complaints Commission (www.ipcc.gov.uk/en/Pages/about_ipcc.aspx). The coroner will be given the results of the investigation.

3. What is the role of a coroner's officer?

- 3.1 Coroners' officers work under the direction of coroners and liaise with bereaved families, the police, doctors, witnesses, mortuary staff, hospital bereavement staff and funeral directors. They receive reports of deaths and make inquiries at the direction, and on behalf, of a coroner.

4. Are all deaths reported to a coroner?

- 4.1 No, less than 50% of deaths are reported to the coroner. In many cases the deceased's own doctor, or a hospital doctor who has been treating him or her during the final illness, is able to issue a Medical Certificate of the Cause of Death (MCCD) without reference to a coroner. The death can then be registered by the Registrar of Births and Deaths, who will issue the death certificate. Sometimes doctors may discuss the case with the coroner and this may result in the coroner deciding that he or she does not need to make further inquiries, because the death is from natural causes. In the 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.
- 4.2 However, if the coroner has decided to inquire into a death the Registrar of Births and Deaths must wait for the coroner to finish his or her inquiries before the death can be registered. These inquiries 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 inquire will not hold up funeral arrangements or sorting out benefits.

5. When is a death reported to a coroner?

- 5.1 Registrars of Births and Deaths, doctors or the police report deaths to a coroner in certain circumstances. These include where it appears that:
- no doctor attended the deceased during his or her last illness;
 - although a doctor attended during the last illness the deceased was not seen either within fourteen days before death nor after death;
 - the cause of death appears to be 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 or unexpected;
- 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 other state detention.

5.2 If someone believes that a doctor, or other relevant professional, has not reported a death to the coroner when they should have done, they may report the death to the coroner themselves. This should normally happen before there has been any interference with the body and before a funeral takes place. The coroner will inform the person what action he or she proposes to take when reports are made in this way.

6. What will a coroner do when a death is reported?

- 6.1 The coroner may ask a pathologist to examine the body and carry out a post-mortem examination (also known as an autopsy). If so, the examination must be made as soon as possible.
- 6.2 The coroner may, however, decide that a post-mortem examination and inquest are unnecessary because the cause of death is evident and natural and there is a doctor who can sign an MCCD to that effect. In such cases the coroner will advise the Registrar of Births and Deaths that no further investigation is needed.

7. What is a post-mortem examination?

- 7.1 A post-mortem examination is a medical examination of a body after the death. A coroner's post-mortem examination is carried out for a coroner by a pathologist, a doctor who

specialises in medical diagnosis, of the coroner's choice, in order to establish the cause of death.

- 7.2 The coroner is not required to obtain the consent of the relatives for a post-mortem examination to be carried out, but is required to inform certain persons of when and where the examination will take place, if they have previously notified the coroner that they would like to be present or represented at the post-mortem examination. These include the deceased's relatives and the deceased's usual medical practitioner. These persons can be represented at the examination by a doctor of their choice, but they have to pay any fee the doctor may charge. Where possible, coroners will take account of religious and cultural needs. See the Charter (paragraph 1.1) for more information.
- 7.3 If concerns remain about the cause of death, relatives can arrange for a separate, additional post-mortem examination, which would be at their own expense, once the coroner has released the body.

8. Post-mortem examination report

- 8.1 The post-mortem report gives details of the examination made of the body, and is sent to the coroner by the pathologist. It will also give details of tissues and organs removed from the deceased, and any tests, such as for drugs and alcohol blood level, which have been carried out to help determine the cause of death. Copies of the report are normally available only to properly interested persons. A fee for the copies may be payable. See the Charter (paragraph 3.8) for more information.
- 8.2 A coroner may decide not to hold an inquest after a post-mortem examination if there is no reason to suspect that the person died a violent or unnatural death, and that he or she did not die in prison. The coroner will release the body for the funeral and send a form to the Registrar of Births and Deaths stating the cause of death as disclosed by the post-mortem examination report, so that the death can then be registered.

Generally this will happen when the post-mortem examination establishes that the person died of natural causes and the coroner decides no further investigation into the death is necessary.

9. Medical records

9.1 Medical records remain confidential after death but may be made available to the deceased's personal representatives or any person 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.

9.2 Coroners are entitled to obtain copies of medical information that is relevant and necessary to their inquiries. Medical information about the deceased may be disclosed at the inquest hearing if it is relevant to the purpose of the inquest and the determination of the cause of death.

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

10.1 Organs and, more commonly, small pieces of tissue may sometimes be removed from a body and preserved by a pathologist if they have any bearing on the cause of death or the identity of the deceased. When the material no longer needs to be preserved 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 retain organs and tissue, for example for use in research or for training purposes, the consent of the relatives must be obtained. In some exceptional cases, e.g. involving murder, the organs may have to be retained for a longer period. See the Charter (paragraph 3.12) for more information.

10.2 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.

11. Donation of tissue and organs for transplantation

- 11.1 If the next of kin wishes to consider donation, immediate advice is essential. This can be sought from a hospital or from the local Donor Transplant Co-ordinator (DTC), who will be able to discuss the options for donation in more detail. 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 before a donation can take place, since the removal could affect important evidence. These decisions are usually made very quickly. In a small number of cases, for example where there is a criminal investigation, organ donation may not be possible.

12. What happens after the post-mortem examination if the coroner decides to hold an inquest?

- 12.1 A coroner must hold an inquest if the cause of death remains unknown after the initial post-mortem examination and subsequent tests, or if there is cause for the coroner to suspect that the deceased died a violent or unnatural death, or died in prison. However, after the post-mortem examination is completed the coroner will normally issue the necessary authority permitting burial or cremation, so that the funeral can be held, even though an inquest may be required but has not been concluded.
- 12.2 In such circumstances the death cannot be registered. In order to assist the administration of the estate an interim certificate of fact of death can be issued by the coroner. 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). This interim certificate can also be used for benefit claims and National Insurance purposes. When the inquest 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.

- 12.3 If criminal charges have been brought against somebody for causing the death, it may be necessary for a second post-mortem examination to take place or for further investigation, and the release of the body and the funeral arrangements may then have to be delayed.

13. Taking the body abroad or bringing it back to this country

- 13.1 In every case where someone wishes to take a body out of England or Wales, written notice must be given to the coroner in whose area the body is located. The coroner will then consider whether an inquest or post-mortem examination is needed and will notify the next of kin of his or her decision within four days.
- 13.2 If a body is being brought into England or Wales, the coroner in the area to where the body is brought may need to be involved. The coroner may need to determine the cause of death and will be required to hold an inquest if the death was unnatural, or violent, or sudden and of unknown cause. The coroner will issue a certificate for cremation in all cases coming from abroad where the body is to be cremated. See the Charter (paragraph 4.2) for more information.
- 13.3 When death has occurred outside England and Wales and the body is returned to England or Wales, the death is 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 can be found on the Foreign and Commonwealth Office's website, at: www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/death-abroad.
- 13.4 If a cremation takes place abroad and the cremated remains are brought back into England or Wales, coroners will not have jurisdiction and therefore an inquest cannot take place.

14. What is an inquest?

- 14.1 An inquest is a limited, fact-finding inquiry to establish who has died, and how, when and where the death occurred. An inquest does not establish any matter of liability or blame. Although it receives evidence from witnesses, an inquest does not have prosecution and defence teams, like a criminal trial; the coroner and all those with “proper interests” simply seek the answers to the above questions.
- 14.2 An inquest is usually opened soon after a death to record that the death has occurred, to identify the deceased, and to enable the coroner to issue the authority for burial or cremation to take place without any unnecessary delay. It will then be adjourned until any other investigations (see paragraph 2.4 of the Guide) and any inquiries instigated by the coroner have been completed. It will usually take an average of 27 weeks to conclude this work, but some cases can take longer than this if the inquiries prove to be complicated. The inquest will then be resumed and concluded. See the Charter (paragraphs 3.14 to 3.25) for more information.
- 14.3 Sometimes the coroner may hold one or more hearings before the inquest itself, known as pre-inquest hearings (or pre-inquest reviews), where the scope of the inquest and any matters of concern, including about the arrangements for the hearing, can be considered. The coroner usually invites the properly interested persons and/or their legal representatives to the pre-inquest hearing, where they have the opportunity to make representations to the coroner.

15. What happens if somebody has been charged with causing the death?

- 15.1 Where a person has been sent for trial for causing, allowing or assisting a death, for example by murder or manslaughter, any inquest is in most cases adjourned until the criminal trial is over. On adjourning an inquest, the coroner must send the Registrar of Births and Deaths a certificate stating the

particulars that are needed to register the death and for a death certificate to be issued. When the trial is over, the coroner will decide whether to resume the inquest. There may be no need, for example, if all the facts surrounding the death have emerged at the trial. If the inquest is resumed, however, the finding of the inquest as to the cause of death cannot be inconsistent with the outcome of the criminal trial. See the Charter (paragraphs 4.5 to 4.7) for more information.

15.2 Paragraph 25 of the Guide sets out the position where civil proceedings have been brought in connection with a death.

16. Attending an inquest

16.1 When a coroner's investigations into a death are complete, a date for a full inquest will be set. The properly interested persons (essentially the relatives and others closely connected with the deceased – see Glossary) will be informed of the date by the coroner's officer and any witnesses will be asked to attend to provide evidence. The process is held in the public interest and not on behalf of any individual. It is not always necessary for the bereaved relatives to attend the inquest, and some prefer not to, as the details of the death may need to be dealt with in graphic terms. If bereaved relatives do wish to attend the inquest they can be accompanied by a supporter, for example a friend.

17. Is there always a jury at an inquest?

17.1 No, most inquests are held without a jury, but there are particular circumstances when a jury is called, including:

- if the death occurred in prison or in police custody; or
- if the death resulted from an accident at work.

17.2 In every jury inquest the coroner decides matters of law and procedure and the jury decides the facts of the case and reaches a verdict. 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, although the jury can state facts which make it clear that the death was caused by a specific failure of some sort or by neglect.

18. Who decides which witnesses to call?

18.1 The coroner will decide who should be called to give evidence as a witness and the order in which they give evidence. However, anyone who believes they may be of help or believes a particular witness should be called should inform the coroner. The coroner will then decide whether the evidence is relevant to the investigation of the death.

19. Must a witness attend court?

19.1 Yes, if they live in England or Wales. 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, but if they live abroad they cannot be compelled to attend or to give evidence.

20. Who can ask witnesses questions?

20.1 Witnesses will be first questioned by the coroner and then additional relevant questions may be asked by any properly interested person or their legal representative. Whether a question is relevant to the purpose of the inquest is something the coroner decides. Where relevant, the coroner will warn a witness that he or she is not obliged to answer any question which might incriminate him or herself. See the Charter (paragraphs 3.23 and 3.24) for more information.

21. Is Legal Aid available?

21.1 Legal Aid is not generally available for representation at inquests because an inquest is a fact-finding process. Unlike other proceedings for which Legal Aid might be available, there are no parties in inquests, only the properly interested

persons, and witnesses are not expected to present legal arguments. The coroner ensures that the process is impartial and thorough, and he or she should assist families to ensure that their relevant questions are answered. See the Charter (paragraphs 5.6 to 5.8) for more information.

21.2 Legal Aid may, however, be available to cover representation at the inquest in very exceptional cases. Generally, applicants must qualify financially and applications must meet strict criteria for representation to be funded. These criteria are that:

- 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).

21.3 Legal advice and assistance – via the Legal Help scheme – is available to those who qualify financially. Further information about solicitors who carry out legal aid work can be found in the Community Legal Service directory on ☎ 0845 345 4345 or online at www.communitylegaladvice.org.uk.

22. Inquest conclusions

22.1 Possible conclusions as to how the death occurred as suggested by the Coroners Rules 1984 include:

- natural causes;
- accident or misadventure;
- he or she killed him/herself (i.e. suicide);
- unlawful killing;
- lawful killing;

- industrial disease; or
- open verdict (where there is insufficient evidence for any other verdict).

22.2 Alternatively, the coroner can give a narrative verdict which sets out the facts surrounding the death in more detail and explains the reasons for the decision.

22.3 It is possible to challenge a coroner's decision. More detail on this is at section 5 of the Charter.

23. What if future deaths may be prevented?

23.1 Sometimes an inquest will show that something could be done to prevent other deaths. If so, at the end of the inquest the coroner may announce that he or she will draw this to the attention of any person or organisation that may have the power to take action. This is something referred to as a "Rule 43 Report" – as the power to make such a report is found in Rule 43 of the Coroners Rules 1984. This Rule was significantly changed in 2008. Now anyone who receives such a report must send the coroner a written response. These reports, and the responses to them, are copied to all properly interested persons and to the Lord Chancellor. A summary of the reports is published twice a year, by the Ministry of Justice. See the Charter (paragraph 3.25) for more information.

24. Will the inquest be reported by the media?

24.1 All inquests must be held in public in accordance with the principle of open justice, and so members of the public and journalists have the right to, and indeed may, attend (although parts of a very small number of inquests may be held in private for national security reasons). Whether journalists attend a particular inquest – and whether they report on it – is a matter for them. If any such report is fair and accurate it cannot be used to sue for defamation. See the Charter (paragraph 3.22) for more information.

24.2 Those working on newspapers or magazines must abide by the Editor's Code of Practice, upheld by the Press Complaints Commission (PCC), which sets out the guidance for print journalists in the UK. The Code, which can be seen at www.pcc.org.uk, has requirements on accuracy, privacy and discrimination. It also has specific rules in cases involving grief and shock. For instance, publication in such circumstances must be handled sensitively and, when reporting suicide, care should be taken to avoid excessive detail about the method used.

24.3 The PCC mostly deals with complaints about published material. However, it can also help to prevent physical harassment by journalists and will sometimes be able to assist with problems related to material that has not yet appeared in print. Its staff are always happy to discuss matters informally; the PCC can be contacted on ☎ 020 7831 0022 or ☎ 0845 600 2757. It also operates an out-of-hours number for emergencies only on ☎ 07659 152656.

24.4 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 upset to people's private lives, sometimes, in the interest of justice, it is unavoidable. Photographs taken of the deceased and of the scene of death may also form part of the evidence presented in court.

25. What about other proceedings?

25.1 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. Inquest evidence cannot be used directly in other proceedings.

26. How can you find out further information?

- 26.1 A source of general 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 www.met.police.uk/bereavement/index.htm.
- 26.2 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 families. The booklet is available from your local JobcentrePlus Office or it can be viewed online at www.dwp.gov.uk/publications/catalogue-of-information/all-products or by calling ☎ 0845 606 5065.
- 26.3 Further information about coroners, death registration and related matters are available online at www.direct.gov.uk/en/governmentcitizensandrights/death/index/htm.
- 26.4 If you have any general queries about the contents of this Guide please email coroners@justice.gsi.gov.uk or phone ☎ 020 3334 3555.

Part 2: Charter for Coroner Services

This Charter is for bereaved family members and other properly interested persons (defined in the Glossary) in a coroner's inquiry. Except where otherwise indicated it sets out the standards of service that all properly interested persons can expect from a coroner service in England and Wales. A witness in a coroner's inquiry is not a 'properly interested person', unless a coroner specifically defines them as such, but we hope that witnesses will also find the Charter helpful in setting out what to expect during an inquiry.

This is a Charter for coroner services as they are currently structured and currently operate. It will be revised as and when relevant provisions in the Coroners and Justice Act 2009 are implemented.

Section 1 – General standards that you can expect during a coroner's inquiry

The coroner's office

1.1 The coroner's office will, on request:

- explain the role of the coroner;
- try to help you understand the cause of death of the person who has died (but will not be able to give any legal advice);
- explain, where relevant, why the coroner intends to take no further action in a particular case;
- answer your questions about coronial procedures as promptly and effectively as possible;
- provide you with contact details for the office i.e. a named individual with his or her phone number and email address;
- inform you of your rights and responsibilities;

- take account where possible of your wishes, feelings and expectations, including family and community preferences, traditions and religious requirements relating to mourning, post-mortem examinations and to funerals;
- unless otherwise agreed, contact you at least every three months to update you on the progress of the case, and explain reasons for any delays;¹
- have respect for individual and family privacy;
- provide a welcoming and safe environment;
- treat you with fairness, respect, dignity and sensitivity;
- treat children and young people involved in an inquiry in a way appropriate to their age;
- make reasonable adjustments, where possible, to accommodate the needs of those with disabilities;
- help you to find further support where this is needed; and
- give you information about how to make a complaint about a coroner's conclusion or if a particular service is not delivered.

Responsibilities of bereaved family members, other properly interested persons and witnesses

1.2 You should:

- co-operate fully with the coroner's office and provide promptly all information that is relevant to the inquiry;
- treat with confidence any information or documents that the coroner's office discloses to you;

¹ In 2010 the average length of time from a death being reported to an inquest finishing was estimated as 27 weeks. A flow chart setting out the process is at Section 2 of this Charter.

- 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;
- inform the coroner's office of any change of circumstances, such as a change of address or contact number, so you can be contacted promptly;
- inform the coroner's office of any concerns or worries you may have about the death;
- dress appropriately for the inquest;
- treat the coroner and his or her officers and other staff with courtesy; and
- in the case of bereaved family members, nominate an appropriate representative as the 'next of kin' for communication with the coroner's office. (See section 3 of this Charter for more details.)

Support during an inquiry

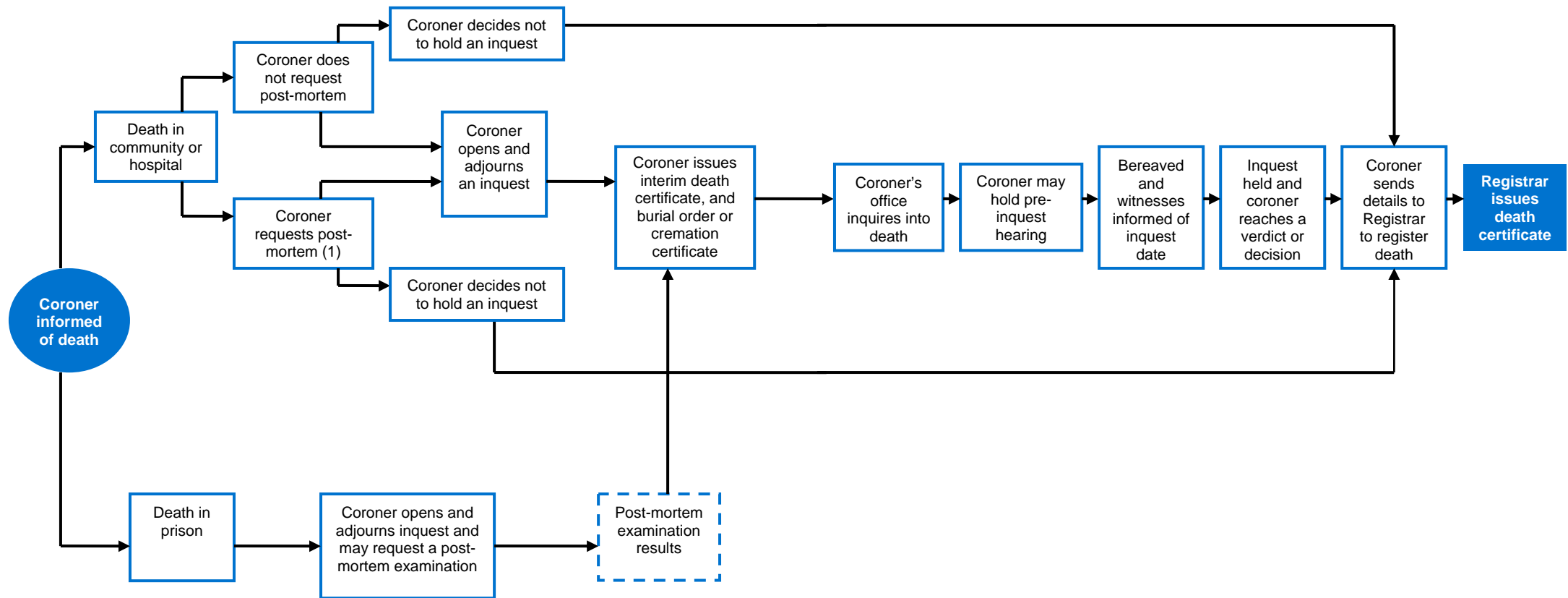
- 1.3** If you are a bereaved family member, you may wish for someone to support you through the inquiry process, and liaise with the coroner's office where appropriate. (The representative may be someone such as a friend or relative, a legal adviser or a member of a support organisation.) If so you should discuss this with the coroner's office as soon as possible to agree how best to proceed.
- 1.4** Other properly interested persons and witnesses may also wish for support. You should discuss this with the coroner's office.
- 1.5** Useful information for everyone involved in a coroner's inquiry is available from Directgov:
www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDoAfterADeath/DG_066713

Bereavement support organisations

- 1.6** 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/Pages/HomePage.aspx.

Section 2 – Overview of the coroner inquiry process after a death is reported

(NB: This flow chart only applies in non-criminal cases. Where there is a criminal case, the inquest may be opened and adjourned until the outcome of the criminal trial, and in such cases the coroner's office will explain the arrangements.)



(1) The Coroner may open the inquest before receiving the post-mortem examination results.

Section 3 – Standards properly interested persons can expect throughout the inquiry process

When a death is reported

- 3.1 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.
- 3.2 Where viewing arrangements are available at the mortuary, the coroner's office will give the next of kin information, as soon as possible, on arrangements for viewing the body, if they wish to do so. In all cases, the coroner's office will advise the next of kin or their representative of the procedure for viewing the body.

Post-mortem examinations

- 3.3 Where a coroner directs or requests a post-mortem examination, you can ask the coroner's office to tell you when and where it will be performed, unless it is impracticable to do so or would delay the examination. See the Guide (paragraph 7) for more information.
- 3.4 If you wish to be represented at the examination by a doctor, you should inform the coroner at the earliest opportunity. If you have queries or are unhappy with the decision to hold a post-mortem examination, you should let the coroner's office know as soon as possible. However, it is the coroner who is responsible for deciding whether or not to hold a post-mortem examination.
- 3.5 When the coroner requests additional scientific examination of material, his or her office will inform you, if possible. Additional examination may be needed to assist with establishing the cause of death or, rarely, the identity of the person who has died. Again, if you have queries or concerns you should direct

these to the coroner's office at the earliest opportunity. However, the coroner is ultimately responsible for deciding whether these examinations should take place.

- 3.6** In the unusual event of the coroner agreeing to a request for a further post-mortem examination (for example, in a case of suspected murder) you may express any concerns to the coroner. However, it is the coroner who is responsible for deciding whether to request the second examination.
- 3.7** If the coroner decides not to request a post-mortem examination, and you wish to challenge the decision, you should discuss this with the coroner's office. However, it is the coroner who is responsible for deciding whether or not to hold the post-mortem examination.
- 3.8** You have a right to request copies of reports of any post-mortem examinations carried out. You may, however, find the details distressing. The coroner's office may charge a fee for copies of documents that have been used in an inquest, but may not charge for disclosing documents before an inquest. A fee will also not be payable where a coroner permits a properly interested person to come to the coroner's office and inspect the post-mortem examination report. See the Guide (paragraph 8) for more information.
- 3.9** Different arrangements may apply in the event of certain types of deaths. In such cases, the coroner's office will explain the arrangements to you. See section 4 for some examples.

Release of a body and organs or tissues

- 3.10** The coroner is entitled to have possession of the body until the inquest is concluded, though almost always releases the body much earlier.
- 3.11** Once the coroner no longer requires the body for his or her inquiry he or she will retain the body only with the consent of the family, except in exceptional circumstances. An example

would be where there is a dispute about to whom the body should be released. Arrangements may vary where there is a criminal investigation into the death. See paragraph 4.5 below for details,

- 3.12** Sometimes material is retained for additional examination. In this instance, the coroner will notify the appropriate next of kin of this and ask them what they wish to happen to the organs or tissues when he or she no longer requires them. See the Guide (paragraph 10) for more information.

Keeping in touch

- 3.13** If an inquest is required, meaning that the coroner continues his or her inquiry following the post-mortem examination, the coroner's office will usually contact you at least every three months to update you on the progress of the case. This will not apply if you have indicated that you only wish to be contacted when there is progress to report. You may also contact the coroner's office for an update.

Inquests

Before the inquest

- 3.14** When there is to be an inquest, the coroner's office will advise you of the time and location of the inquest, as well as the facilities available at the venue, wherever possible at least four weeks before the start of the inquest. See the Guide (paragraph 14) for more information.
- 3.15** The coroner's office will, wherever possible, take your views into account on the timing of the inquest. The office will also be able to give you information about, for example, the purpose of the inquest, others who may be present, and how you can participate in the proceedings, for instance by addressing the coroner directly or through a legal or other representative.
- 3.16** If the date or location of the inquest has to be changed, the coroner's office will let you know as soon as possible.

- 3.17** In advance of the inquest, the coroner's office will normally be able to disclose to you, on request, relevant documents to be used in the inquest. You should be aware that for legal reasons the coroner may not be able to disclose 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 disclosed a particular document, or part of a document. See section 3.8 for more details on disclosing documents.
- 3.18** Where the coroner decides to hold a pre-inquest hearing, the coroner's office will tell you the time, date and location of the hearing and the purpose of the hearing.
- 3.19** As an inquest is a formal occasion it is advisable to dress quite smartly, but comfortably.

At the inquest

- 3.20** Some coroners arrange for the Coroners' Courts Support Service, or other similar services, to be present on days when they hold inquests. If so, the support service will welcome you on arrival at the inquest, explain the process where needed – working jointly with the coroner's office – and answer any queries you may have before and immediately after the inquest.
- 3.21** Some inquest venues may have a room that you can use as a private waiting room. If so, the coroner's office will advise you of this.
- 3.22** Except in rare circumstances where national security issues are raised, inquests are held in public. The media therefore have a right to attend and may report inquest proceedings. The coroner's office will not release any information to the media which has not already been made public through an inquest, without the consent of the next of kin. You may wish

to read the Editor's Code of Practice,² administered by the Press Complaints Commission. This code sets out the ethical standards that all members of the press should meet. See the Guide (paragraph 24) for more information.

- 3.23** You may ask witnesses relevant questions at the inquest, or have a legally qualified representative do so on your behalf. You may also have a non-legally qualified representative speak on your behalf, if the coroner so agrees.
- 3.24** If you wish to ask a question (either yourself or via a representative) the coroner will decide whether the question is relevant or otherwise proper. When asking a question you should bear in mind that the purpose of the inquest is to establish the relevant facts of the death and not to apportion blame.

After the inquest

- 3.25** If the coroner writes a report to prevent future deaths (known as a "Rule 43" Report) at the end of the inquest the coroner's office will send you a copy of the report, and any response, or a summary of the response which the relevant person or organisation makes. (See the Guide (paragraph 23) for more information or download the guidance on Rule 43 at www.justice.gov.uk/guidance/docs/coroners-reports-future-deaths.pdf.) If the organisation does not respond within 56 working days the coroner will follow up the matter with the person or organisation, and may inform the Lord Chancellor of a failure to respond to the report. A summary of reports by coroners to prevent future deaths and responses from organisations is also published twice a year on the Justice website at www.justice.gov.uk/publications/policy-reports.htm.

² <http://www.pcc.org.uk/cop/practice.html>

Section 4 – Inquiries where the process may be different

Transferring an inquiry

- 4.1** If the coroner decides to transfer an inquiry to a different coroner, he or she will inform you of that decision and the reason for it. The coroner's office will consult you beforehand wherever possible.

Deaths abroad

- 4.2** A coroner inquires into a death that occurs abroad if the body is brought back into his or her district and the apparent circumstances of the death would have led him or her to do so had the death occurred in England or Wales. See the Guide (paragraph 13) for more information. The standards of service outlined in this Charter, in particular (but not exclusively) in relation to post-mortem examinations and inquest hearings, may need to be varied because of the additional administrative difficulties in receiving information from overseas.

Service personnel deaths

- 4.3** For deaths of service personnel 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 for service personnel killed on operations overseas and the coroner's office will provide you with more information.

Deaths of children

- 4.4** When someone under the age of eighteen dies, the coroner must, within three working days of the date on which the coroner decides to hold an inquest or request a post-mortem examination, ensure the appropriate Local Safeguarding Children Board (LSCB) knows of the death. Coroners share information with the appropriate LSCB for the purposes of carrying out their functions of investigating the death of the child and undertaking Serious Case Reviews.

Criminal investigations

- 4.5** Where there is a criminal investigation into the death, there may be a further post-mortem examination. The coroner will make every effort for this decision to be taken as soon as possible, and the body will be released for burial or cremation at the earliest opportunity. If, however, no charges have been made in connection with the death within 28 days of the discovery of the body, the coroner will arrange a second post-mortem examination by a pathologist independent of the first, to be used by any future defence. The body will then be released at the earliest opportunity.
- 4.6** Where there is a criminal trial against a person for causing the death, by murder or manslaughter, the coroner will open and adjourn the inquest until the criminal trial is over.
- 4.7** When the criminal trial is over, the coroner will decide whether to resume the inquest. The coroner's office will be able to provide more information on the process. See the Guide (paragraph 15) for more information.

Section 5 – Feedback, challenging a coroner decision and complaints

Feedback

- 5.1** Coroners are committed to providing a service which meets your needs. They welcome feedback, including where the service has performed well. You should direct this to the coroner who dealt with the case.
- 5.2** If you are dissatisfied with an aspect of a coroner inquiry and want to seek redress, the rest of section 5 will guide you as to where to direct your challenge or complaint.

How to challenge a coroner's decision or the outcome of an inquest

- 5.3** You may challenge a coroner's decision or an inquest conclusion. If you wish to do this you should first seek advice from a lawyer with expertise in this area of the law. Bereavement support organisations may be able to help bereaved people in deciding whether a coroner's decision could be challenged in this manner.
- 5.4** If you decide to proceed, you may make an application to the High Court for judicial review of a coroner's decision or conclusion. This must normally be done within three months of the coroner's decision or conclusion.
- 5.5** There is a separate power under which the Attorney-General may initiate an application to the High Court for an inquest to be held if a coroner has neglected or refused to hold one, or for another inquest to be held on the grounds that it is necessary or desirable (e.g. because new evidence has come to light).
- 5.6** Legal aid is available for most public law challenges (including judicial review proceedings), subject to the statutory tests of the client's means and the merits of the case. See the Guide (paragraph 21) for more information.
- 5.7** 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.
- 5.8** Further information on legal aid is available online at www.direct.gov.uk/en/Governmentcitizensandrights/GettingLegalAdvice/DG_195314.

Complaints about a coroner's conduct

5.9 If you are unhappy with a coroner's personal conduct you may complain to the Office for Judicial Complaints (OJC). Examples of possible personal misconduct are using insulting, racist or sexist language in court, failing to fulfil judicial duties or inappropriate behaviour outside the court such as a coroner using his or her judicial title for personal advantage or preferential treatment.³

5.10 There is no charge for complaining to the OJC and it can be done online via the OJC website at www.judicialcomplaints.judiciary.gov.uk. 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:

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: 020 334 0146
(Helpline for the deaf and hard of hearing)

5.11 If you wish to complain about the personal conduct of a **deputy coroner or assistant deputy coroner** you may write to the coroner whom the deputy or assistant deputy supports. If you think that the coroner's handling of a complaint about his or her deputy or assistant deputy amounts to personal misconduct of the coroner then you can refer the matter to the OJC. However, the OJC cannot deal with the actual complaint against the deputy or assistant deputy coroner.

³ www.judicialcomplaints.judiciary.gov.uk/complaints/complaints_mag.htm

5.12 Further information about complaints about coroners can be found on the OJC website at www.judicialcomplaints.gov.uk/index.htm.

Complaints about the standard of service received

5.13 If you believe the service you have received falls short of the standards set out in this Charter or wish to complain about the way an inquiry was handled or about the conduct of coroners' officers, you should first write to the coroner. You should 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.

5.14 You may also complain direct to the local authority. If you are dissatisfied with the council's response the next step is to 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 a complaint may be made 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.

Complaints about a pathologist who conducts the post-mortem examination

5.15 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 6 – Monitoring the service standards contained in this Charter

Monitoring service standards

- 6.1** At the time of publishing this Charter the Ministry of Justice is preparing to set up a Bereavement Organisations Committee. The Committee will have the specific remit of assessing the impact that the Charter is having on coroner services. The assessment will be based on an analysis of complaints and feedback information that the Committee receives and will be reported to Ministers. Further details will be available on www.justice.gov.uk when the Committee is convened.
- 6.2** 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/publications/coronersannual.htm. The Committee will also be able consider such information when assessing the standards of service being provided.

Part 3: Glossary

Glossary of terms used in the Guide and Charter

1. **“Bereaved family member”** means a person who is a parent, child, sibling, spouse, civil partner or partner of the deceased. They also have status of a ‘properly interested person’ under Rule 20 of the Coroners Rules 1984.
2. **“Coroner’s office”** includes any member of the office of the coroner who is investigating the death. It could be the coroner, deputy coroner, assistant deputy 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.
3. **“Inform”**, or **“informed”** means the giving of information by leaflet, letter, email, telephone call, via a website or in person.
4. **“Inquest”** is a fact-finding inquiry to establish who has died, and how, when and where the death occurred. An inquest does not establish any matter of liability or blame.
5. **“Next of kin”** means the person identified by the coroner or coroner’s office to act as the main contact point to receive information.
6. **“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 a post-mortem examination.
7. **“Post-mortem examination”** is a detailed medical examination of the body that takes place after death and is conducted by a pathologist. It is also known as an autopsy. The purpose of the post-mortem examination is to establish the medical cause of death.

8. **“Pre-inquest hearing or review”** is a public hearing that the coroner may choose to hold in order to decide matters such as scope and date of the inquest and 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.

9. **“Properly interested person”** is defined in rule 20 of the Coroners Rules 1984 as follows:

- a parent, child, spouse, civil partner, partner and any personal representative of the deceased;
- any beneficiary of a life insurance policy on the deceased;
- any insurer having issued such a policy;
- 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);
- anyone whose action or omission may, in the coroner’s view, have caused or contributed to the death;
- the Chief Officer of Police (who may only ask witnesses questions through a lawyer);
- any person appointed as an inspector or a representative of an enforcing authority or a person appointed by a government department to attend the inquest; or
- anyone else who the coroner may decide also has a proper interest.

It is the coroner who decides who will be given properly interested person status.

10. **“Witness”** is someone who, under oath or affirmation at an inquest gives evidence in order to establish who the deceased was, and how, when and where they came by their death.

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

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