



CHIEF CORONER

GUIDANCE No.18

SECTION 1(4) REPORTS: INVESTIGATION WITHOUT A BODY

Introduction

1. This guidance is intended to assist coroners who believe that there should be an investigation into a death in circumstances where there is no body.
2. Normally, the jurisdiction of a coroner arises in the first instance only where the coroner is 'made aware that the body of a deceased person is within that coroner's area': section 1(1), Coroners and Justice Act 2009 (2009 Act).
3. But where there has been no investigation (or an investigation has been commenced but discontinued under section 4 of the 2009 Act) and the body has been cremated, destroyed or never found, a coroner may, where appropriate, report to the Chief Coroner under section 1(4) of the 2009 Act requesting a direction to commence an investigation.
4. Where the body has been buried within the coroner area, the coroner has jurisdiction to investigate without making a section 1(4) report.
5. A section 1(4) report may be made by any coroner from the local area - the senior coroner, an area coroner or an assistant coroner, although senior coroners are encouraged to deal with them for the sake of consistency.
6. Three pre-conditions must be satisfied before a report can be made by a coroner (see below).
7. When the report is received the Chief Coroner will consider it and may direct a coroner to investigate the death: section 1(5). The Chief Coroner will in the ordinary course of events respond to a report within seven days of receipt. The direction to investigate will usually be given to the coroner who made the report, but it may be made to another coroner: section 1(5).¹

¹ From July 2013 to December 2015 (29 months) the Chief Coroner received 138 reports and issued 121 directions. 10 were directed to a coroner who had not made the report.

Report to the Chief Coroner

8. A report to the Chief Coroner under section 1(4) should be made in the format set out at Annex A.
9. The coroner may 'make whatever enquiries seem necessary' for the purpose of deciding whether a report may be made: section 1(7)(b).
10. There is no need to submit to the Chief Coroner all the information available. Often a succinct report addressing the statutory criteria will be sufficient. Sometimes it may be necessary to attach a police or other report, for example, to explain the details about a missing person. But usually quantities of supporting information will not be necessary.

'Reason to believe'

11. For the coroner to exercise this power, the coroner must have 'reason to believe' that all three pre-conditions (see below) have been met. The coroner will decide upon 'reason to believe' from the information provided; it does not have to be based upon admissible evidence. The belief must be 'reasonable' in the sense that judged objectively it is based on something tangible, not speculative. This is therefore a two-stage test, both subjective and objective. The coroner must be satisfied that he/she has reason to believe that all three pre-conditions are met, and there must be material before the coroner upon which the coroner is entitled to be so satisfied.
12. It was said in another context (search warrants) that a reasonable belief is more than a reasonable suspicion, with the threshold for the latter being a relatively low one.²

The three pre-conditions

13. There are three pre-conditions to making a report. The coroner must have reason to believe that all three have been satisfied before making a report: section 1(4).

Pre-condition (a): a death has occurred in or near the coroner's area

14. Section 1(4)(a) provides that the coroner must have reason to believe that the death has occurred 'in or near the coroner's area'.
15. Unlike section 1(1) which provides that the coroner's duty to investigate arises in the first instance because the body is within the coroner area, section 1(4)(a) requires the coroner to have 'reason to believe' that the death occurred in or near the coroner area.
16. Usually this provision will cause little difficulty. The coroner will have information about the death from the police or a hospital or the family or from other sources which makes it clear that the death occurred within the coroner's area.

² *R (Eastenders Cash and Carry plc) v South Western Magistrates' Court* [2011] EWHC 937 (Admin) per Sullivan LJ at [13] and [18]. See also *R(Fullick) v HM Senior Coroner for Inner London* [2015] EWHC 3522 (Admin) at [34]-[37], and Chief Coroner's advice to coroners on *The Meaning of 'Reason to Suspect'* (2 October 2013) in relation to the section 1 duty to investigate..

Has there been a death?

17. The coroner must have reason to believe that there has been a death and that the death has occurred in or near the coroner's area: section 1(4)(a).
18. Sometimes the position about the death may not be entirely clear, for example, where the body has never been found. In those circumstances the coroner will have to consider all of the information available, usually from a police or other investigation report, in order to decide whether he/she has reason to believe that a death has occurred.³
19. For example, the person in question may have left home and never been seen again. If the person had left home by car and had driven to a well-known suicide spot in the coroner's area, having had mental health problems for some time and leaving his phone and wallet in the car, and with no record of subsequent existence through banking, benefits or other information, then the coroner would be entitled to have 'reason to believe' that there had been a death and that the death had occurred in the coroner's area even though no body was recovered.
20. Similarly, where the person had driven to a well-known suicide bridge over an estuary between two coroner areas, leaving phone and wallet in the car with the driver's door open and flashing lights on (an actual case), the coroner would be entitled to conclude that he/she had 'reasonable belief' that the death was 'in or near the coroner's area' even though no body was recovered.
21. It will be more difficult for the coroner to have 'reason to believe' that the death was 'in or near the coroner's area' if the car is traced to a coroner area some miles away or never traced at all. In the absence of further information it may be difficult to have the necessary reasonable belief.

What does 'near the coroner's area' mean?

22. The meaning of '[in or] near the coroner's area' in section 1(4)(a) has never been defined by statute or case law. The wording of section 1(4) of the 2009 Act derives from similar wording in previous legislation, section 15 of the Coroners Act 1988 and before that section 18 of the Coroners (Amendment) Act 1926. None of these sections has ever defined the word 'near' or described the limits of a coastal coroner's jurisdiction from the shore.
23. However, it has been held that 'near' is an ordinary English word in this context, 'indicating a short distance or close proximity' and is to be 'applied by the coroner in a common sense manner ... it is a matter to be judged initially by the coroner': *Ex parte Healy, per Woolf LJ*.⁴
24. It is therefore for the coroner to determine in all the circumstances whether the death was likely to have occurred 'in or near the coroner's area'. 'It will not always have exactly the same application in yards, feet or inches or longer distances than that': *ibid*.

³ The fact of death does not have to be 'established with certainty': *R v Secretary of State for the Home Department, ex parte Weatherhead* (1996) 160 JP 627. Ultimately, that may be a matter for an inquest to decide.

⁴ *R v Coroner for East Sussex, ex parte Healy* [1988] 1 WLR 1194, 1201.

Bodies lost at sea

25. The concept of 'near' is perhaps best illustrated by cases where the body is lost at sea, bearing in mind that the normal limit of the coroner's jurisdiction in coastal areas is the point of low tide. In *Ex parte Healy*, for example, upholding the coroner's decision, the death while diving eight or nine miles off shore was held 'unhesitatingly' to be outside the jurisdiction.
26. At the time of the death in *Healy* the nation's territorial waters were limited to three miles from the shore, but had been extended to 12 miles by the time of the decision. The judgment suggests that the limit of territorial waters has never provided the answer to what is 'near'.
27. Woolf LJ in *Healy*⁵, accepting that a coroner's jurisdiction was 'normally land-based', did allow for the fact that where the event had some sufficient nexus with the land over which the coroner had jurisdiction it could in some cases provide jurisdiction within the meaning of 'in or near'. Examples given were where somebody swims from shore and is never seen again or where somebody goes out from shore in a rowing boat. The examples given were of cases where the person would not normally be expected to go far from the shore.
28. Taking another example (an actual case), an older man, who had health problems and, went out to sea regularly in his own boat to fish, went out one Wednesday, in the same week that he had been complaining of chest pains, and failed to return home. The next day the coastguard found his boat with its engines running some 14 miles from the coastline of the coroner's area. The boat was unattended and there was no sign of the fisherman. His body was never found.
29. There was no evidence as to how he died. The comprehensive police report stated: 'All lines of inquiry have been reviewed and completed ... I can find no proof of life throughout the inquiries conducted. There is no suggestion of any third party involvement. I can only conclude that [he] suffered a tragic accident on [that date].'
30. The question which therefore arose for decision was as follows: Did the death occur in or near the coroner's area? Or put more precisely for the purposes of the case and section 1(4) of the 2009 Act: Did the coroner have reason to believe that the death occurred near the coroner's area?
31. There was good reason to believe that he had died at sea. Precisely where he fell into the sea, a fact reasonably presumed, was not clear. The engines of the boat were still running and there was no evidence as to how far the boat could have drifted unattended and in what direction. In those circumstances, as the law now stands, it could not be said that his death was '[in or] near the coroner's area'.
32. But in the case above, although it could be said that the fisherman's journey started from the shore, his was a sea-faring craft, which would not necessarily be expected to stay close to the shore. And indeed the boat was found some 14 miles out to sea, well beyond the limits of any territorial waters. The precise location of the place where he came by his death was not known, but it was likely to be on the high seas, in this context far from land. In those circumstances the presumed death was not likely to have 'occurred in or near the coroner's area'.

⁵ *Ibid.* at 1200-1201.

The coroner had no 'reason to believe' that the death 'occurred in or near the coroner's area'.

33. This means, unfortunately, under the law as presently stated, that in the absence of the finding of a body in such circumstances, either on land or being brought back to land, there can be no investigation and no inquest. The Chief Inspector of Marine Accidents may be able to carry out a safety investigation where appropriate into the death under the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012. But the coroner lacks jurisdiction.
34. By contrast in some other countries coroner jurisdiction has been extended by statute beyond the confines of territorial land. For example, section 18 of the Coroners Act 2009 No 41 of New South Wales, Australia, provides for jurisdiction where a 'death or suspected death occurred outside the State but the person had a sufficient connection with the State ... [including] if the person ... was last at some place in the State before the circumstances of his or her death or suspected death arose'.⁶ [emphasis added]

Pre-condition (b): the circumstances of the death are such that there should be an investigation into it

35. The coroner must also state on the form (Annex A) why the coroner has reason to believe that an investigation into the death should be held. The coroner must, in the usual way, have reason to suspect that the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in state detention: section 1(2).
36. For example, where a person has died 'in state detention' as a result of being subject to Deprivation of Liberty Safeguards (DoLS)⁷ and this was not known and reported to the coroner until after cremation, the coroner would have 'reason to believe ... that there should be an investigation' under section 1(4)(b).

Pre-condition (c): the duty to conduct an investigation into the death does not arise because of the destruction, loss or absence of the body

37. The coroner must also have 'reason to believe' that there is no body within the coroner's area, as a result of cremation or other loss or destruction, or because the body is absent and cannot be found.
38. There is no need for the coroner to identify which of 'destruction, loss or absence' applies. The senior coroner must merely state on the form (at Annex A) that the body has been cremated, destroyed or never found, whichever is the case.
39. Where the body has been buried within the coroner's area, the coroner has jurisdiction without making a section 1(4) report. A body that is buried is not destroyed, lost or absent.

Discretion of the coroner

40. Once the coroner has reason to believe that the three-preconditions have been met, he/she may report the matter to the Chief Coroner. There is therefore no requirement to do so. The coroner has a discretion whether to do so or not. This

⁶ See also section 59, Coroners Act 2006 (New Zealand).

⁷ See Chief Coroner's Guidance No.16 *Deprivation of Liberty Safeguards*.

discretion must be exercised reasonably and fairly as with the exercise of any judicial discretion.⁸

41. Where, however, pre-condition (b) has been met, and the coroner therefore has reason to believe that there should be an investigation into the death, normally a report should be made.
42. But there may be circumstances in which the coroner decides, in the exercise of discretion, not to make a report. There may have been some other form of inquiry into the death which the coroner considers is sufficient. Criminal or civil proceedings may have investigated the death sufficiently. A public inquiry may have investigated a number of deaths including the death in question.
43. It will be a matter for the coroner in each case to decide how to exercise this discretion, but only after the three pre-conditions have been satisfied. If the coroner decides against making a report in the exercise of discretion, the coroner must have reasons for the decision which can be provided on reasonable request.

Contents of the coroner's report

44. The coroner should make a section 1(4) report in the standard form at Annex A and email it to the Chief Coroner's office. Illustrations of reports are provided at Annex B and Annex C.
45. In some cases the coroner will rely upon a police or accident investigator's report, which should be copied for the Chief Coroner. This applies, for example, where the coroner relies upon a police report as the basis for presumed proof of death.

The Chief Coroner's direction to investigate

46. Where a report is received the Chief Coroner will first consider whether the three pre-conditions are satisfied. Sometimes this will involve asking the coroner for further information or explanation.
47. If one or more of the pre-conditions are not met, no direction will be made.
48. When satisfied that the three pre-conditions are met, the Chief Coroner has a discretion ('may') whether to direct a coroner to conduct an investigation: section 1(5).
49. The direction, if made, will be in the Chief Coroner's standard form CC11.
50. The Chief Coroner will direct that the investigation into the death be conducted 'as soon as practicable': section 1(6).
51. The Chief Coroner may direct a coroner other than the one making the report to conduct the investigation: section 1(5). For example, it may be more convenient for bereaved relatives if the investigation takes place in an alternative area.⁹

⁸ See Chief Coroner's Law Sheet No.5 *The Discretion of the Coroner*.

⁹ See *Explanatory Notes* to the 2009 Act, paragraph 66.

Presumption of Death Act 2013

52. The process under the Presumption of Death Act 2013 (2013 Act) whereby certain persons may apply to the High Court in certain circumstances for a declaration that a missing person is 'presumed to be dead' is completely separate from the section 1(4) report provisions.
53. Where, however, an application for a declaration in the High Court under the 2013 Act has failed, coroners will look closely at a subsequent request to them to make a section 1(4) report in relation to the same 'death'. Where such a request is supported by similar information as previously put before the High Court, coroners will consider with care the exercise of their discretion whether to make a report.

**HH JUDGE PETER THORNTON QC
CHIEF CORONER**

**8 April 2015
14 January 2016 revised**

ANNEX A

REPORT TO THE CHIEF CORONER UNDER SECTION 1(4) CORONERS AND JUSTICE ACT 2009

1	CORONER I am ABC, senior/area/assistant coroner for the XYZ coroner area.
2	REPORT I am making this report under section 1(4) of the Coroners and Justice Act 2009 in respect of [NAME], [AGE if known], who died on or around [DATE] in or near XYZ coroner area.
3	I HAVE REASON TO BELIEVE THAT (a) the death occurred in or near my coroner area because : <i>eg Mrs Smith died at her home at [PLACE] which is within my area</i> AND (b) the circumstances of the death are such that there should be an investigation into it because : <i>eg the cause of death is now unknown; the case was not reported to me; see report attached</i> AND (c) the duty to conduct an investigation into the death under section 1(1) of the Coroners and Justice Act 2009 does not arise because of the destruction, loss or absence of the body. This is because : <i>eg the body was cremated on [DATE]</i>
4	I therefore invite the Chief Coroner to make a direction under section 1(5) of the Coroners and Justice Act 2009 for me to conduct the investigation into the death. OR [WHERE APPROPRIATE] I am inviting the Chief Coroner to direct another coroner, namely [NAME] of the [NAME OF CORONER AREA] to conduct this investigation for the following reason(s): Attached document(s):
5	[DATE] [SIGNED BY CORONER]

ANNEX B ILLUSTRATION DoLS CASE

REPORT TO THE CHIEF CORONER UNDER SECTION 1(4) CORONERS AND JUSTICE ACT 2009

1	<p>CORONER</p> <p>I am ABC, senior/area/assistant coroner for the XYZ coroner area.</p>
2	<p>REPORT</p> <p>I am making this report under section 1(4) of the Coroners and Justice Act 2009 in respect of [NAME], [AGE if known], who died on or around [DATE] in or near XYZ coroner area.</p>
3	<p>I HAVE REASON TO BELIEVE THAT</p> <p>(a) the death occurred in or near my coroner area because:</p> <p>Mrs Smith died at the [NAME] Care Home at [PLACE] which is within my coroner area</p> <p>AND</p> <p>(b) the circumstances of the death are such that there should be an investigation into it because:</p> <p>the death was certified as natural causes; it was not reported to me; I have now been informed by the local authority that at the time of her death Deprivation of Liberty Safeguards were in place and she was therefore 'in state detention' for the purposes of the 2009 Act</p> <p>AND</p> <p>(c) the duty to conduct an investigation into the death under section 1(1) of the Coroners and Justice Act 2009 does not arise because of the destruction, loss or absence of the body. This is because:</p> <p>the body was cremated on [DATE]</p>
4	<p>I therefore invite the Chief Coroner to make a direction under section 1(5) of the Coroners and Justice Act 2009 for me to conduct the investigation into the death of Mrs Smith.</p> <p>OR</p> <p>[WHERE APPROPRIATE] I am inviting the Chief Coroner to direct another coroner, namely [NAME] of the [NAME OF CORONER AREA] to conduct this investigation for the following reason(s):</p> <p>Attached document(s):</p>
5	<p>[DATE] [SIGNED BY CORONER]</p>

ANNEX C ILLUSTRATION ABSENCE OF BODY

REPORT TO THE CHIEF CORONER UNDER SECTION 1(4) CORONERS AND JUSTICE ACT 2009

1	<p>CORONER</p> <p>I am ABC, senior/area/assistant coroner for the XYZ coroner area.</p>
2	<p>REPORT</p> <p>I am making this report under section 1(4) of the Coroners and Justice Act 2009 in respect of [NAME], [AGE if known], who died on or around [DATE] in or near XYZ coroner area.</p>
3	<p>I HAVE REASON TO BELIEVE THAT:</p> <p style="padding-left: 40px;">(a) the death occurred in or near my coroner area because:</p> <p style="padding-left: 40px;">the circumstances outlined in the police report (attached) give me reason to believe that she died at or near Reckless Point, in particular her mental health history, her disappearance on [DATE], the finding of her car unlocked near the Point the following day, her possessions left in the car, and no trace of any activity of her since</p> <p style="padding-left: 40px;">AND</p> <p style="padding-left: 40px;">(b) the circumstances of the death are such that there should be an investigation into it because:</p> <p style="padding-left: 40px;">the cause of death is unknown</p> <p style="padding-left: 40px;">AND</p> <p style="padding-left: 40px;">(c) the duty to conduct an investigation into the death under section 1(1) of the Coroners and Justice Act 2009 does not arise because of the destruction, loss or absence of the body. This is because:</p> <p style="padding-left: 40px;">the body has never been found</p>
4	<p>I therefore invite the Chief Coroner to make a direction under section 1(5) of the Coroners and Justice Act 2009 for me to conduct the investigation into the death of Mrs Smith.</p> <p style="text-align: center;">OR</p> <p>[WHERE APPROPRIATE] I am inviting the Chief Coroner to direct another coroner, namely [NAME] of the [NAME OF CORONER AREA] to conduct this investigation for the following reason(s):</p> <p>Attached document(s): Police report</p>
5	<p>[DATE] [SIGNED BY CORONER]</p>