CHIEF CORONER

GUIDANCE No.24
TRANSFERS

INTRODUCTION[1]

1. Transfers of cases from one jurisdiction to another, often between neighbouring coroner areas, are made by coroners on a regular basis. Nearly all transfers are made by agreement. In a few cases agreement is not reached, and the transfer issue is referred to and decided by the Chief Coroner.

2. This Guidance sets out the legal position on transfers and provides advice on when it is appropriate to request a transfer. It is intended to assist coroners on the process to be followed and with a view to providing greater consistency in practice.

3. This guidance supplements paragraphs 62-70 of *The Chief Coroner's Guide to the Coroners and Justice Act 2009* and the Chief Coroner's advice to coroners of 3 October 2013, which states as follows:

   (i) Section 2 of the Coroners and Justice Act 2009 requires a coroner to give notice in writing to me (my office) electronically of **all** requests made for a transfer, whether the request is agreed or not.
   (ii) I do not need lengthy details but simply the bare outlines, as set out in my standard form, Form CC9. Coroners are reminded to include the relevant coroner area at the top of the form as well as the other details. Form CC9 must be completed by both Coroner A and Coroner B before being submitted by Coroner A to my office.
   (iii) Where there is disagreement between Coroner A and Coroner B and a request is made to me to order a transfer under section 3, I may sometimes need to know a little bit more so that I can adjudicate. I will consider each case on its merits, but I expect that I will not interfere too readily when Coroner B has refused to conduct the investigation for good reason. I will usually only give a direction under section 3 if I take the view that Coroner B has refused unreasonably or if there is some compelling reason for transfer.

[1] My special thanks to senior coroner Louise Hunt and area coroner Emma Brown, both of Birmingham. This Guidance is based very much upon their first draft. Thanks, too, to other coroners for their valuable input in the updating of the document.

THE LAW

4. Transfers may be effected either by agreement or by direction of the Chief Coroner. The relevant law is set out in sections 2 and 3 of the Coroners and Justice Act 2009 (the 2009 Act) and regulations 18 and 19 of the Coroners (Investigations) Regulations 2013.

5. The language of the 2009 Act and the Regulations refer to coroner A (the coroner under a duty to conduct an investigation) and coroner B (the coroner for another area).

6. As the law requires, all transfer requests and responses should be from coroner to coroner (although a request in writing which is signed by a coroner may be forwarded to another jurisdiction by a coroner's officer without the two coroners needing to speak to one another direct). Direct discussions between coroners can be fruitful if there is a disagreement.

7. Good working relationships between coroners' officers may be part of the collaborative approach directed by the coroner to get the balance of convenience right for the families and witnesses with the exercise of common sense and without delay.

8. This Guidance cannot elucidate every possible situation in which a transfer may be appropriate. Cases must be assessed on an individual basis. Coroners are encouraged to use common sense, including finding out which inquest location may be most suitable for a family, to ensure that matters are resolved expediently.

Coroner A's request

9. A coroner (coroner A) who is under a duty under section 1(1) of the 2009 Act to conduct an investigation into a person's death (i.e. is made aware that the body is within their area and has reason to suspect etc) may request a coroner for another area (coroner B) to conduct the investigation: section 2(1).

10. It should be noted, therefore, that a request for a transfer may not be made <u>until</u> the duty to investigate the death arises: section 2(1). If coroner A wishes to make preliminary inquiries, even to request a post-mortem examination (as envisaged by section 14(1)(b)), in order to decide whether the death is one into which the coroner has a duty under section 1(1) to investigate, the time for requesting a transfer has not yet arisen.

11. But in most cases where a request is made, the formal duty to investigate will have been obvious from the start, for example where death is the consequence of a road traffic collision. In these cases the post-mortem examination, where necessary, will be conducted at the request of coroner B.

12. Where coroner A makes a request for a transfer to coroner B, coroner B may agree to conduct the investigation or refuse: section 2(2). Coroner A must give the Chief Coroner notice in writing of the request, stating whether it has been agreed to or not: section 2(5). The notice should be brief and in standard form CC9.

13. The Chief Coroner encourages dialogue between coroners directly. The decision to request a transfer is a judicial decision that can be made only by a coroner. The mechanics of the transfer may be dealt with by a coroner's officer.

Coroner B accepts the request

14. If coroner B agrees to coroner A's request for transfer,

    (a) Coroner A must provide coroner B with 'all relevant evidence, documents and information' within 5 days of the agreement: regulation 18(1)(a) and 18(2). Coroner A should, where reasonably practicable, secure proper identification evidence for inclusion in the paperwork.
    (b) Coroner B must conduct the investigation into the death 'as soon as practicable': section 2(2).
    (c) Coroner B must notify the next of kin or personal representative of the deceased, and any other interested persons who have made themselves known to the coroner, of the transfer within 5 days of the agreement: regulation 18(1) and (2).

Coroner B refuses the request

15. If coroner B does not agree to the request for transfer, coroner A may ask the Chief Coroner to direct a transfer: section 3. See below.

REASONS FOR A REQUEST

16. There may be a number of good reasons for a request for transfer. Those set out below are cases where a transfer request should normally be accepted. This list is not intended to be exhaustive.

17. If the circumstances giving rise to the death occurred in another coroner area, the normal course will be that the case will be transferred to that area. For example, where a road traffic collision occurs in coroner B's area and the patient is taken to a hospital for treatment in coroner A's area and later dies there, the case should normally be transferred to coroner B. This is usually better for the family, the investigation and witnesses. The issue of transfer might, however, in such circumstances be less straightforward if there were complications from surgery which may have contributed to the death.

18. When the death arose from or was substantially contributed to by medical treatment or surgery in a hospital different from that in which the death occurred, transfer may be appropriate.

19. If there are a number of deaths arising out of one event or one set of circumstances, the deaths should normally be dealt with by one coroner.

20. In the event of a mass fatality incident with deaths in, or bodies repatriated to, more than one coroner area, the Chief Coroner will advise on the appointment of a lead coroner and transfers will either be effected by agreement under section 2 or on the Chief Coroner's direction under section 3.

21. A transfer may exceptionally be appropriate when there is an apparent conflict of interest within the jurisdiction of coroner A.

22. If the family request a transfer for good reason, there should normally be a transfer.

IN TRANSIT

23. Where a body is repatriated to a port or airport (in coroner A's area) and the body, at the request or with the agreement of the family, is in transit to the family area (i.e. usually where the family live) (coroner B's area), there should be no need for a formal transfer request. The body should be treated as being in transit to the final destination.

24. If in such cases the body is stored temporarily for whatever reason at a funeral director's premises in coroner A's area or that of another coroner before onward transmission to the family area, normally the body should be treated as in transit or a request for transfer by coroner A or the other coroner should be accepted by coroner B.

TIMELINESS

25. Coroner A should make the request at the earliest opportunity, but only after the duty to investigate has been triggered (see paragraph 10 above). The request should usually be made as soon as the report of the death is received by the coroner's officer and the coroner is made aware of it.

26. There will be some cases where it will be clear as soon as the coroner (coroner A) is made aware of a death within their area and that an investigation into the death will need to take place, that they are likely to invite a neighbouring coroner to accept a transfer. In such a case there must be immediate dialogue between the two coroners so that no decision is made about whether a post-mortem is required or the release of a body. In such a case the senior coroners (or area coroners) for both areas should liaise. Consideration should be given by the coroner A and coroner B to Guidance No 28 on decision making and expedited decisions.

27. Timeliness is important but does not provide an absolute rule. Under section 2, a request for transfer may be made at any time after the duty to investigate has been triggered. A delay in requesting the transfer may, however, lend weight to the validity of the transfer being refused.

IN THE EVENT OF DISAGREEMENT

28. Where coroner B does not at first agree to the transfer request, there should be an early discussion (by telephone or email) between coroner A and coroner B in an attempt to resolve the issue.

29. If following discussion there is still disagreement, coroner A should either decide to conduct the investigation or ask the Chief Coroner to direct a transfer under section 3.

30. In some circumstances the Chief Coroner may be willing to host a telecon between coroners to attempt to resolve the situation.

SECTION 3 DIRECTIONS

31. The Chief Coroner may make a section 3 direction when requested to do so by coroner A or in response to an emergency incident or for the purpose of using a special cadre.

32. Any request to the Chief Coroner by coroner A should be in writing by email, setting out the facts briefly and the reasons for the request. No lengthy documentation is necessary.

33. In some cases the Chief Coroner will express a provisional view to coroner A or coroner B and ask them to reconsider their position.

34. In any event the Chief Coroner will invite coroner B to explain the refusal briefly.

35. Where appropriate, and having considered the written submissions of both coroners, sometimes with a request for further information, the Chief Coroner will either make no direction or make a direction for a transfer to coroner B, informing both coroners in writing of the decision, giving brief reasons. The standard form for a direction is CC10.

36. The Chief Coroner will not interfere too readily when coroner B has refused to accept the transfer for good reason. The Chief Coroner will, however, usually make a direction where it is concluded that coroner B has acted unreasonably or there is a compelling reason for a transfer.

37. If directed, the transfer will take immediate effect from the time of the Chief Coroner's direction. In practice the Chief Coroner makes very few directions under section 3[2] because sensible agreement between coroners invariably takes place.

38. Once a section 3 direction has been made by the Chief Coroner, the requirements set out in paragraph 14 above (as in the case of an agreed transfer) must be followed.

39. In addition to the simple direction for a transfer under section 3, the Chief Coroner may also make a 'subsequent direction'.

40. The Explanatory Notes to the 2009 Act make it clear that the government intended this provision to be used by the Chief Coroner to aid in global case management. Any requests to the Chief Coroner made by interested persons which fall outside this administrative function will not be entertained.

COSTS OF TRANSFERRED INVESTIGATION

Transfer by agreement (section 2)

41. Where coroner B accepts the request for transfer by coroner A, the relevant authority for coroner B's area will be responsible for all costs related to the

[2] The number of directions each year is reported in the Chief Coroner's annual report to the Lord Chancellor.

investigation (and inquest) from the date the transfer is made (accepted): regulation 19(1).

42. In other words, coroner A's area will bear the costs up until the transfer, including the costs of any preliminary inquiries, and coroner B's area will bear the costs thereafter.

Transfer on Chief Coroner's direction (section 3)

43. Where the Chief Coroner directs coroner B to conduct an investigation, the relevant authority for coroner A's area shall be responsible for all costs from the date of transfer (with coroner A's local authority's schedule of fees applying), unless the Chief Coroner otherwise directs: regulation 19(2).

44. In practice, where the Chief Coroner decides that coroner B should have accepted the transfer request, the Chief Coroner will often direct that costs should be borne by coroner B's area from the date of the direction for transfer.

45. But all cases brought before the Chief Coroner are considered on a case by case basis, with the merits weighed in each case. Both coroners will be given the opportunity to make representations on costs as well as the decision should they choose to do so. The Chief Coroner is always grateful for the swift assistance of coroners in these cases.

46. In all of these cases where a section 3 direction may be made, the Chief Coroner will proceed quickly, bearing in mind the need for the investigation to progress promptly. Discussion, representations and decision will take place by email over a short period of time.

HH JUDGE MARK LUCRAFT QC
CHIEF CORONER

22 September 2016
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