CHIEF CORONER

GUIDANCE No.44

DISCLOSURE

INTRODUCTION

1. This Guidance does not seek to duplicate legal textbooks and other sources of specialist advice for lawyers on the law of disclosure. Its aim is to provide practical advice for coroners on:
   a) obtaining disclosure; and
   b) providing disclosure to Interested Persons at a timely stage in the investigation process.

2. Guidance on disclosing documents to the public following requests under regulation 27(2) of the Coroners (Investigations) Regulations 2013 can be found in Guidance No. 25 Coroners and the Media.

OBTAINING DISCLOSURE

3. The following are key points to note when coroners are in the process of obtaining disclosure:

   a) Marshalling evidence is a judicial function;
   b) Evidence needs to be relevant, reasonable, sufficient, and proportionate to the scope of the inquest;
   c) The coroner should set clear dates for disclosure of material, and should monitor and act upon any non-compliance;
   d) Paragraph 1 of Schedule 5 to the Coroners and Justice Act 2009 gives a coroner the power, by way of a written notice, to compel the production of evidence for the purposes of an investigation;
   e) Coroners should only use Schedule 5 notices to compel disclosure where the disclosure is necessary and, unless there are exceptional circumstances, should attempt to obtain the disclosure by agreement before issuing a notice;
   f) The General Medical Council has issued guidance on confidentiality, which confirms doctors should disclose information to help a coroner with an inquest[1]

[1] See Paragraph 135 of the GMC's guidance for doctors entitled: 'Confidentiality: good practice in handling patient information'

4. The following direction is an example of wording coroners could use when ordering Interested Persons to provide disclosure:

   I direct that:
   (i) By [date] all Interested Persons, having conducted reasonable and proportionate searches, must assure the Court in writing that all potentially relevant documents identified by their searches have been disclosed to me; and
   (ii) By [date] all Interested Persons must indicate with precision and in writing any suggested shortcomings in disclosure made to them (within the scope of the Inquest)

DISCLOSURE BY THE CORONER TO INTERESTED PERSONS

5. Deciding what to disclose is a judicial decision.

6. Disclosure can be provided electronically, by sending out printed documents, or by allowing inspection. It is preferable to provide disclosure electronically, unless there is a reason why that format would be difficult for the recipient.

7. It is advisable for a warning to be given about the use of disclosed documents, for example by endorsing documents as follows:

   'This document is confidential. It should not be disclosed to a third party without the written consent of the coroner.'

8. Where documents are being sent electronically, an email signature could also be added, explaining that confidential documents are attached for the purposes of disclosure, and that the recipient of the email must immediately notify the sender if they have received the email in error.

9. Care should be taken to ensure that disclosure is provided to the correct person within a bereaved family. Where the coroner's office has had contact with more than one family member, it would be sensible to obtain written confirmation of who should receive disclosure on the family's behalf.

Extent and timing of disclosure

10. It is imperative that, subject to the restrictions on disclosure (which are beyond the remit of this Guidance), Interested Persons are given sufficient information at an early enough stage for them to participate fully in the investigation process. Where Interested Persons are unrepresented, this includes ensuring that they understand how disclosure works. Coroners are advised to provide unrepresented Interested Persons with guidance on disclosure, both orally and in writing, as early as possible in the investigation process. As the Justice Select Committee report dated 27 May 2021 stated:

‘Bereaved people are at a disadvantage when they do not have access to the evidence. It is important that the process for obtaining evidence is explained clearly to them as this is important for the fairness of the Inquest.’

11. The requirement to disclose information to Interested Persons is ‘as soon as reasonably practicable[2]’, but it may be reasonable to provide disclosure as a bundle rather than piecemeal, depending on the circumstances of the case.

12. In relation to pre-inquest review hearings, Interested Persons should be given sufficient disclosure of relevant statements and documents before the hearing, so that they can address the agenda on an informed basis[3].

13. Where there is to be an inquest in writing, Interested Persons should be provided with a copy of any document relevant to the inquest that would be disclosed to them at their request.

Requests by Interested Persons

14. Rule 13 Coroners (Inquests) Rules 2013 provides: *“...where an Interested Person **asks** for disclosure of a document held by the coroner, the coroner must provide that document or a copy of that document or make the document available for inspection by that person as soon as is reasonably practicable.”*

15. The Interested Person MUST be informed that they have a right to ask and that there is no cost to disclosure whilst the investigation is ongoing. At the same time, it should be made clear that there is no obligation to accept an offer of disclosure.

Post-Mortem Examination Reports

16. Interested Persons have the right to be informed of the date, time and place of a post-mortem examination (PME), unless that is impracticable or would cause the examination to be unreasonably delayed. They are also entitled to be represented by a medical practitioner at the examination (or if they are a medical practitioner, to attend the examination themselves)[4].

17. Whether or not Interested Persons are represented at a PME, they are entitled to disclosure of the PME report. This is often the first report to be provided to the coroner, and it is likely it will need to be disclosed without delay[5].

18. It is important to discuss with the Interested Persons how they would like to receive the PME report. Under no circumstances should a family or

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[2] Rule 13 of the Coroners (Inquests) Rules 2013.

[3] *Brown v Norfolk Coroner [2014] EWHC 187 (Admin).*

[4] See Regulation 13 of the Coroners (Investigations) Regulations 2013 and Chief Coroner’s Guidance No. 32 on Post-Mortem Examinations, including Second Post-Mortem Examinations.

[5] *(R (McLeish) v HMC Northern District of Greater London [2010] EWHC 5624 (Admin).*

other Interested Person be sent an unsolicited copy without some sensitive degree of preparation with them, ideally by telephone.

19. As PME reports can be difficult to interpret, some bereaved families may prefer that their copy is sent to their GP, so the GP can discuss it with them in person. Families should be told that this is an option, and if they would find it helpful, their preference should be accommodated.

20. In the case of a child's death, it is particularly important for coroners to ensure that families are offered face-to-face support with reading the PME report for the first time. As well as the option of sending the report to a GP, there will usually be a lead health professional working with the family who will already know the background to the case and could provide the same support. A copy of the PME Report should also be sent to the local Child Death Overview Panel[6].

21. If an Interested Person chooses to receive a PME report by post, the report should be in an envelope inside the addressed envelope, endorsed: 'CAUTION: This envelope contains a PME Report, the contents of which the reader may find distressing.'

22. If the PME report is sent by email, the same caution should be entered in the subject field.

Medical Records

23. Reference to GP/hospital notes during an inquest is common. It will usually be unnecessary for all the deceased's medical records to be disclosed. They are often voluminous and there is a risk that such disclosure may overwhelm any recipient.

24. Coroners, when exercising their judicial discretion, may wish to limit disclosure to the relevant periods of healthcare within the scope of the inquest, and to place in the bundle only those records that will feature at the inquest.

25. If an Interested Person seeks wider disclosure than the coroner considers relevant to an inquest, it may be appropriate to remind them about the Access to Health Records Act 1990.

Redactions

26. In complex cases, thorough disclosure can place a significant burden on the coroner and their team. Such disclosure exercises can be lengthy and resource-intensive. Care and time are needed to deal with any necessary redactions, for example, it would be easy to miss the contact details of

[6] Regulation 24 of the Coroners (Investigations) Regulations 2013 requires the Coroner to provide PME information to the Local Safeguarding Children Board (or Safeguarding Children Board in Wales). As these bodies no longer exist, coroners should instead provide the information to the local Child Death Overview Panel (https://www.gov.uk/government/publications/child-death-overview-panels-contacts).

witnesses that are frequently found on the reverse side of police witness statements.

27. There are software packages and tools that can make the redaction process less labour-intensive by automating the redaction of keywords within a document. Such tools can also help prevent references from being missed. Coroners may wish to explore the options with their relevant local authority.

28. Where redaction is done by electronic means, care must be taken to ensure that the redactions are not capable of removal by the recipient. Documents can look different on different types of devices, so coroners should take advice on the methods they use, to ensure that any redactions are permanent before transmission.

29. Local coroner services often lack the support staff and IT tools to be able to cope properly with disclosure. If an area is struggling, the Senior Coroner must raise this with the relevant Local Authority. If matters do not improve then the Senior Coroner should notify the Chief Coroner's Office providing full particulars about the difficulties and the attempts made to resolve them.

HHJ THOMAS TEAGUE QC
CHIEF CORONER

13 September 2022