# 2025 Protocol and Good Practice Model

# Disclosure of information between Coroners and the Family Court in cases involving fatality

24 March 2025

# Executive Summary

A. The purpose of this protocol is to provide guidance on good practice for Family Court Judges and Coroners where there are parallel proceedings in their jurisdictions.

B. When proceedings are issued in the Family Court that concern the death of a child or adult that is relevant to the issues to be determined by that Court, the Family Court Judge should contact the Coroner to notify them of the proceedings and the Family Court's timetable.

C. When the Coroner is informed of the Family Court proceedings, the Coroner should seek to accommodate the timetable of the Family Court proceedings and the requirement that care proceedings must be completed within 26 weeks of the date on which the application was issued.

D. Coroners and Family Court Judges should make requests of each other for disclosure of information, documents and materials to assist to avoid delay and duplication of work in each jurisdiction.

E. The Family Court is likely to need interim and final post-mortem examination reports, toxicology reports and other reports generated as a result of the Coroner's investigation. Coroners should use their best endeavours to provide prompt disclosure to avoid delay in the Family Court proceedings.

F. Coroners may choose to adopt Family Court findings to avoid evidence being called again at Inquest. Coroners may also be assisted by Family Court judgments, which may highlight agency failings and other material issues that the Coroner may consider relevant to the investigation of a death.

G. Coroners and Family Court Judges may wish jointly to request that pathology reports are expedited in cases where there are Family Court proceedings.

H. Requests for DNA testing of a deceased person cannot be determined by Coroners. Coroners can assist the Family Court by retaining a blood sample which could be used for testing in Family Proceedings to establish paternity.

# Contents

# 1. Parties

1.1 The signatories to the 2025 Protocol and Good Practice Model (**hereinafter the "2025 Protocol**") are Sir Andrew McFarlane (President of the Family Division) and HHJ Alexia Durran (Chief Coroner).

1.2 This 2025 Protocol is issued with the support of the Lady Chief Justice and the Pathology Delivery Board.

# 2. Introduction

## (a) Scope and purpose of the protocol

2.1 This 2025 Protocol applies from 24 March 2025 to cases:

a) Involving the death of a child or adult where the circumstances of the death may be relevant to, and/or has the potential to inform, the assessment of risk concerning the subject children in family proceedings.
b) Where an applicant seeks to use samples from a deceased person for the purposes of establishing paternity of a child.

2.2 Where there are parallel family and coronial proceedings concerning the fatality of a child or adult, this 2025 Protocol provides guidance on good practice for Family Court Judges and Coroners in relation to information-sharing, disclosure requests and the avoidance of delay.

2.3 This 2025 Protocol is not to be used to obtain material from the Police. The Family Justice System uses the "Disclosure of Information Between Family and Criminal Agencies and Jurisdictions: 2024 Protocol" for this purpose.

## (b) Family Court findings and the Coroner's Court

2.4 Coroners may choose to adopt findings made in the Family Court. Family Court findings are admissible in the Coroner's Court and may be relied upon by the Coroner when reaching conclusions. All Family Court findings are made on the civil standard of proof, the same standard as all Coronial conclusions and findings.

2.5 There are good reasons why evidence heard in the Family Court should not have to be heard again at the inquest:

a) The inquiry in the Family Court will have been thorough.
b) Usually, the respondents in the Family Court will have been publicly funded (unlike at the inquest) and therefore represented, giving them the opportunity to challenge any evidence should they wish to.
c) It would be time-consuming, costly, and stressful for the same evidence to be reheard. There is therefore a public interest in relying upon the findings and not rehearing the evidence.
d) If there is a fresh inquiry by way of inquest, the findings of fact by the Coroner could be different to the Family Court's findings and therefore produce inconsistency. One court should always be reluctant to depart from the opinion or decision of another.

## (c) Communication and co-operation

2.6 To enable this guidance to be effective, Coroners and Family Court Judges, sitting within the same region, are encouraged to meet each other on a regular basis (annually) to discuss issues of mutual interest and establish a local cross jurisdictional network. Contact details are provided at Annex F to enable local Leadership Judges and Senior Coroners to make these arrangements.

2.7 There should be good co-operation between Coroners and Family Court Judges, keeping lines of communication open. The Judge may require material from the Coroner or vice-versa. The Coroner may require a judgment and sometimes additional material for the purposes of the Coroner's investigation. Judges and

Coroners are expected to make requests of each other, not orders. Informal requests may sensibly precede more formal requests for judgments or other information. Reasons for requests should also be given. In complex cases it will help if the Coroner and the Judge set out a joint timetable providing for the timing of disclosure and the sharing of conclusions and determinations.

2.8 Where disclosure is provided between the jurisdictions, whether on a formal or informal basis, it is important to consider the position of any parents who are the subject of proceedings under Part IV of the Children Act 1989. Family Court Judges should consider whether it is appropriate to notify the parents of any intended disclosure between the jurisdictions and to give them the opportunity to object.

## 3. Aims and Objectives

3.1 The principal aims and objectives of this Protocol are:

a) The sharing of relevant material to aid the proper discharge of the Family Court's function for the protection of children in accordance with the paramountcy principle.
b) The sharing of relevant material to aid the proper discharge of the Coroner's function for the expeditious investigation of deaths falling within section 1 of the Coroners and Justice Act 2009 (the 2009 Act).
c) The confirmation of communication arrangements and the mechanism for disclosure requests to enable:
    (i) Early notification to the Local Authority that a death may be relevant for child protection purposes.
    (ii) Early notification to the Coroner that there are surviving children who are the subject of Family Court proceedings.
    (iii) Early notification to the Family Court of the details and timescales for the Coroner's Investigation.
    (iv) Sharing of information by timely and early notification to the Coroner of the timescales of the Family Court Proceedings.

(v) The adoption of an agreed procedure for timely and consistent disclosure of information and documents by the Coroner into the Family Court.

(vi) Subject to the Family Procedure Rules 2010 (and relevant Practice Directions) and the common law duty of confidentiality, the timely and consistent disclosure of information and documents from the Family Justice System to the Coroner.

(vii) Cross jurisdictional communication, collaboration and liaison between Coroners and Family Judges.

(viii) The formulation of a procedure for linked directions hearings or a joint timetable in concurrent Family Court proceedings and Inquests.

(ix) The expeditious provision of post-mortem examination reports where they are identified as having potential relevance to Family Court proceedings.

d) To provide guidance when the Family Court requires samples taken at post-mortem examination to allow expert analysis within Family Court proceedings.

# 4. Disclosure into the Family Justice System from Coroners

4.1 In the event of the death of a child or adult, where the cause of death is unknown or unnatural or if the death occurred in state detention, the death will be reported to the Coroner.

4.2 Reports to the coroner will usually be received from the Police where death occurred in the community, and from a treating hospital doctor where the deceased died in hospital.

4.3 All unexpected child deaths will be referred to the Police. The investigation and management of these cases follows a multi-agency approach. It is vital that

information is shared between relevant agencies at an early stage following the report of the unexpected death of a child. This is important when issues may be relevant for the protection of other children and/or the prevention of future deaths.

4.4 As part of a coronial investigation, the Coroner has a duty to establish and record the cause of death. This will usually involve requesting a post-mortem examination. When it is suspected that death may be as a result of homicide, the Coroner is provided with information from the Police and other relevant agencies.

4.5 In homicide cases, the Coroner requests that a Home Office approved forensic pathologist carries out the post-mortem examination (Home Office register). It is usual practice that post-mortem examinations in violent or suspicious deaths involving children are performed by a forensic and a paediatric pathologist working together.

4.6 The post-mortem examination is carried out as soon as reasonably practicable. This is usually within a few days of the death. Other forensic specialists may also be asked to report. It may also be appropriate for imaging to be undertaken urgently in hospital, with the agreement of treating clinicians. This may include a CT head scan, a skeletal survey and/or an MRI of the torso, in accordance with the SUDIC Protocol.

4.7 On occasion, the Coroner will approve a second post-mortem examination. Where a second post-mortem examination is considered necessary, notice will always be given to the Police and the pathologist who conducted the initial examination. This notice will identify the second pathologist and provide further details of where and when the second examination will be undertaken.

4.8 Information obtained from these examinations is key to the police investigation. It may also be relevant to current and/or prospective safeguarding decisions regarding other children.

4.9 Following completion of a forensic post-mortem examination, the Coroner should use their best endeavours to expedite the production of necessary interim and final post-mortem examination reports.

4.10 Final post-mortem examination reports may not be available for many months following the post-mortem examination. An interim post-mortem examination report is provided to the Coroner and to the Police as soon as is reasonably practicable and usually within 14 days. This may include a provisional cause of death where this can be provided, and a provisional view on whether the death is natural or unnatural.

4.11 The Code of Practice and performance standards for forensic pathology in England, Wales and Northern Ireland provides:

"7.2.2 Rapid interim account

Where the pathologist has agreed with the coroner, the police, or the CPS that a rapid briefing, in the locally agreed format, should be provided he shall submit one within 14 days of the post-mortem examination to both the Coroner and the Senior Investigating Officer.

The rapid interim account shall, normally, set out the following information:

- A summary of the main findings of fact determined at the post-mortem examination.
- The provisional cause of death (if this can be provided at that time).
- The samples retained at the post-mortem examination.
- Any samples retained at the post-mortem examination which were left at the mortuary.
- Any additional examinations/investigations which are to be undertaken (with estimated timescales if known).

It shall make clear the briefing contains information which may change as investigations progress and additional information becomes available. It may contain advice to the police on matters that may be relevant to the investigation.

It shall not contain any final conclusions and, consequently, is not subject to the requirement for critical conclusions check."

4.12 Where abuse or neglect of the deceased is suspected, the Pathologist should provide an interim written report for child protection purposes setting out any provisional opinions identifying those matters which, in the opinion of the Pathologist, might indicate or give rise to safeguarding issues.

4.13 The parents of a deceased child and any other interested persons are entitled to a copy of the post-mortem examination report. This is subject to Rule 15 of The Coroners (Inquests) Rules 2013 ('the Coroner Rules'). If there is no objection raised by the Police to the disclosure of the interim post-mortem examination report, and other material relating to the cause of death, the Coroner should offer to share this information with the family.

4.14 Where parallel proceedings are issued in the Family Court**,** the information provided to the pathologist and the opinions expressed by them in the interim post-mortem examination report are highly likely to be relevant to the determinations to be made by the Family Court.

4.15 When the Coroner is informed that proceedings in the Family Court are commenced or contemplated, the Coroner should seek to accommodate the timetable of the Family Court proceedings (as far as it is known) and the requirement that care proceedings must be completed within 26 weeks of the date on which the application was issued.

4.16 The Coroner should usually disclose the outcome of all interim investigations, the interim post-mortem examination report and any further information, witness statements and final or interim reports relating to the cause of death to the Family Court within 20 working days of a request for disclosure of this information from the Family Judge. If this material is urgent, the allocated Judge will inform the Coroner and a shorter timescale may be requested and agreed. Family Court

Judges should note paragraph 2.8 above when preparing to receive disclosure from Coroners.

4.17 Coroners should note that material provided by the Coroner to the Family Judge cannot be provided on a "Judge to Judge" basis. Material provided to the Family Judge will need to be made available by the Family Judge to the parties in the Family Court proceedings.

4.18 The Coroner should notify the Police and the relevant Local Authority of any request for disclosure by the Family Court, setting out the information to be disclosed and the date when disclosure will take place. This will enable the Police and/or Crown Prosecution Service to make timely representations to the Family Court if there is any objection to disclosure pursuant to the Disclosure of Information Between Family and Criminal Agencies and Jurisdictions: 2024 Protocol.

## 5. Disclosure from the Family Justice System to Coroners

5.1 The timetable for public law family proceedings is as follows:

- First hearing (if there is an urgent application for orders to safeguard the child): week 1.
- Case Management Hearing (CMH): 12-18 days from the date the proceedings are issued.
- Issues Resolution Hearing (IRH): week 18-20.
- Final Hearing (FH) within 26 weeks.

5.2 If an investigation into the cause of a death is relevant to the outcome of the substantive Family Court proceedings, the Court will make directions for provision of witness statements, police disclosure and expert reports. This should happen at the Case Management Hearing. The Family Court may decide to

conduct a separate Fact-Finding hearing to establish facts on the balance of probabilities that are relevant to the assessment of risk in respect of the subject children. A judgment and/or findings will be produced at the conclusion of that process. All findings in the Family Court are made on the balance of probabilities, except in relation to contempt and committal proceedings when the criminal standard of proof applies.

5.3 The witness statements, expert reports, and the resulting judgment and findings of the Family Court may be relevant to a parallel investigation by the Coroner.

5.4 The Coroner may decide to adopt the findings made in the Family Court, where they are relevant to the questions that the Coroner is required to answer in fulfilling their statutory obligations. Doing so may:

a) Enable the Coroner to reach conclusions more expeditiously in cases where there are to be no Criminal Proceedings, and
b) Avoid the need for the Coroner to hear evidence and make decisions that have already been determined following a full hearing.

5.5 This may save time, resources and avoid further unnecessary distress for families. This is especially important where the prospective witnesses may have impairments, vulnerabilities or otherwise have been exposed to trauma which may be exacerbated by further participation in court proceedings.

5.6 Even where the Coroner decides not to adopt findings, the Family Court Judgment may assist the Coroner in their investigation. Family Courts can criticise agencies and this can be relevant to whether a death may have been preventable.

5.7 As a result of the confidential nature of family proceedings, the Family Judge should notify the Coroner of the existence of the family proceedings. The Family Judge should contact the Coroner to make them aware of the issues arising for

determination. Contact details for Coroners and an explanation in respect of their jurisdiction are provided in Annex F.

5.8 To facilitate requests for disclosure between parallel proceedings the following procedure should be followed:

a) The Local Authority legal department should notify the Family Judge of which Coroner has jurisdiction in respect of the death at the first hearing of a family case or at the Case Management Hearing, whichever is sooner.
b) The Family Judge should provide notice to the Coroner that care proceedings having been issued, together with the timetable of hearings and an index of documents (See the draft letter at Annex A attached).
c) The Coroner should acknowledge receipt and confirm the timescales for the Coronial investigation and any dates listed for Pre-Inquest Review and/or Inquest if possible and confirm whether they are likely to seek disclosure once available (See the draft letter at Annex B).
d) At the Case Management Hearing the Family Judge should notify the parties in the Family Proceedings of the Coroner's interest and invite submissions on disclosure. If all agree, the order can reflect the parties' consent and Court's approval of an order disclosing relevant documents which should then be listed in the order.
e) There may be situations in which the Family Court provides an up-to-date bundle index from the care proceedings. This may be appropriate where:
   (i) The Family Court considers the disclosure request may be premature.
   (ii) The Coroner is not able to make a properly formulated request for disclosure.
f) The Family Court may also:
   (i) Provide a copy of the Judgment and/or Findings.
   (ii) Ask the Coroner to set out any further documentation they require.
   (iii) Direct that the issue of disclosure be dealt with on notice to the parties to the family proceedings. This may be at an oral hearing or administratively depending on whether the matter is contentious.

5.9 The privacy of the child/children and therefore relevant family members, can be protected in Family Court proceedings and the media can be prevented from publishing information that may identify relevant children, as follows:

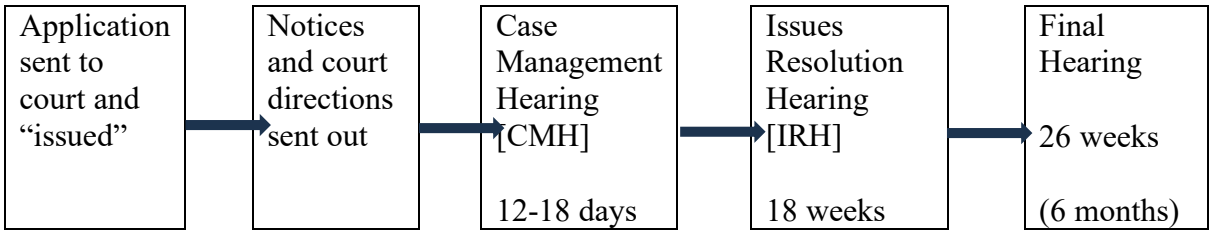
a) The attendance of media representatives or duly authorised lawyers at Family Court proceedings is governed by Practice Direction 27B Family Procedure Rules 2010 (https://www.justice.gov.uk/courts/procedure-rules/family/practice_directions/pd_part_27b).
b) s.97(2) Children Act 1989 prohibits the publishing of material intended to or likely to identify a child during the Family Court proceedings (https://www.legislation.gov.uk/ukpga/1989/41/section/97).
c) s.12 of the Administration of Justice Act 1960 applies during and after proceedings and relates to proceedings brought under the Children Act 1989 and the exercise of the Inherent Jurisdiction of the High Court in respect of minors (https://www.legislation.gov.uk/ukpga/Eliz2/8-9/65/section/12).
d) The Family Court/High Court can make Transparency Orders and Reporting Restriction Orders to protect the identity of children.

5.10 None of these provisions or orders prevent the Coroner from holding an inquest in public, nor do they preclude the Coroner from complying with his or her statutory duties. These provisions and orders restrain publication, not the carrying out of judicial functions in other jurisdictions.

5.11 When a Family Court Judge makes a Transparency Order or a Reporting Restriction Order in a case where there is a parallel coronial investigation and/or inquest, a copy of the order should be provided to the Coroner. The Coroner should provide these orders to the media, to ensure that the media is aware that these orders exist and can comply with them.

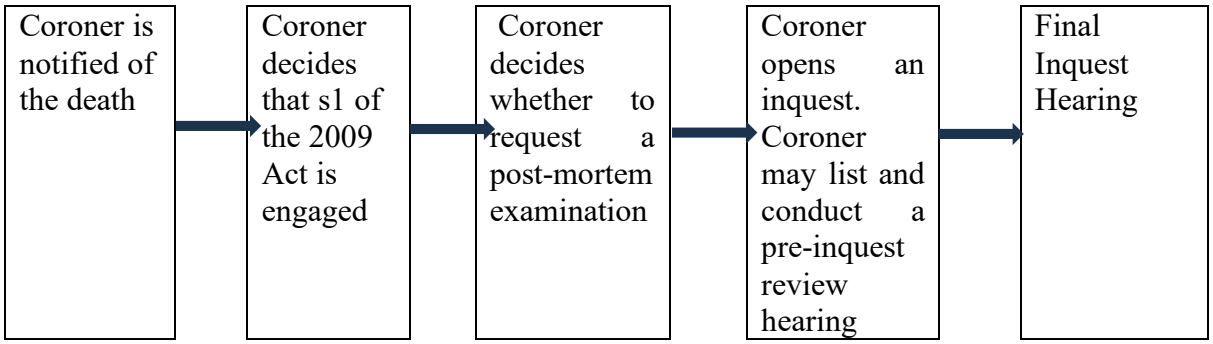
# 6. Linked Directions: Inquests and Care Proceedings – Flow Charts of the Coronial Investigation Process and Family Care Cases

6.1 Family Care Case flow chart:




6.2 Where there has been the death of a child or other relevant family member and there is an application for a care order in respect of a sibling and/or another relevant child the death may be investigated fully by the Family Court, with evidence called and examined closely. After a thorough hearing the judge will make findings of fact on the balance of probabilities. The timetable above and awareness of the findings of fact made in the Family Court should be considered by the Coroner in any linked inquest.

6.3 Typical Coroner's investigation flow chart where a case proceeds to inquest:




6.4 For more detailed information on the coronial investigation process and how it interacts with other parts of the death management system, see this infographic

that has been published by NHS England: https://www.england.nhs.uk/wp-content/uploads/2024/07/death-certification-reform-A4-v1.pdf.

6.5 The date for the inquest must normally be set within **six months** of the date on which the Coroner is made aware of the death. This is because the Coroner has a duty where possible to complete the inquest within six months: Rule 8 the Coroner Rules. Where it will not be possible to set the date within six months for some good reason, such as delay likely to be caused by for example a Police investigation or concurrent criminal or family proceedings, there is still a duty on the Coroner to complete the inquest as soon as is reasonably practicable after the date of notification of the death: Rule 8 the Coroner Rules. If there is likely to be such a delay, the Coroner should fix a date within a reasonable time for a Pre-Inquest Review (PIR) hearing (see Rule 6 the Coroner Rules). In a complex or difficult case there may be more than one PIR hearing before the inquest.

6.6 The Coroner is under a duty to complete the inquest as soon as is reasonably practicable after the date of notification of the death. The Family Court Judge is throughout applying the "no delay" principle to concurrent Family Court proceedings and has a statutory duty to conclude proceedings within **26 weeks**. The Coroner and the Family Court Judge should communicate and share directions made as to the timescale of their proceedings and share an index of documents from each set of proceedings to enable targeted disclosure requests. In addition, the Coroner should consider seeking disclosure of the findings of fact and judgment made within the family court proceedings.

## Family Court procedure

6.7 The Family Court's case management involves interim hearings in care proceedings: a case management hearing ('CMH'), a further case management hearing ('FCMH') if required, and an issues resolution hearing ('IRH'). It is hoped that by the IRH the issues will have been narrowed sufficiently to allow some cases to conclude without any further hearings. If that is not possible, the matter will be listed for a final hearing ('FH') so that the matter can be fully heard and concluded. In complex cases involving fatalities the Family Court may determine

that a separate Fact-Finding Hearing should take place prior to welfare decisions being taken at Final Hearing.

6.8 The Children Act 1989 sets a statutory timescale within which applications for care and supervision orders must be concluded without delay and within a timetable of 26 weeks, running from the date of the local authority's application (s32 Children Act 1989). Rule 12.22 of the Family Procedure Rules 2010 also provides that care and supervision order applications should be concluded within 26 weeks (excluding emergency protection orders or recovery orders).

6.9 Section 32(1) of the Children Act 1989 requires the Family Court to draw up a timetable with a view to disposing of the application without delay and within 26 weeks from the date of issue, ensuring the court grapples with the timetable head on and enforces the spirit of the 'no delay' principle.

6.10 The statutory timescale can only be extended in exceptional circumstances, as per s32(5) of the Children Act 1989:

"A court in which an application under this part is proceeding may extend the period that is for the time being allowed under subsection (1)(a)(ii) in the case of the application but may do so only if the court considers that the extension is necessary to enable the court to resolve the proceedings justly."

6.11 The Family Court will require a clear understanding from the Coroner as to timescale for provision of the post-mortem examination report and any other reports that feed into the final post-mortem examination report. These will include toxicology reports or other reports relevant to the medical cause of death. The Family Court should note that although Coroners request post-mortem examinations, the timescales involved in obtaining reports depend on the availability of pathologists and other relevant experts. Delays caused by the national shortage of pathologists are outside Coroners' control.

6.12 Single Joint Experts instructed by the Family Court may need to examine samples taken during the post-mortem examination. The Family Court Judge should notify

the Coroner of this when the expert is instructed and ask for permission to use samples taken. Usually, Single Joint Experts will be instructed by the solicitor representing the children, they will arrange for the expert to have any case papers and access to material required. There should be open communication and close liaison between Children's Services, the Children's Solicitor, and the Coroner to ensure that arrangements are made for the expert analysis of samples taken at post-mortem examination, that are compliant with The Human Tissue Act 2004.

6.13 The Family Court may wish to instruct the Home Office Pathologist and/or Paediatric Pathologist who conducted the Coroner's post-mortem examination as a Single Joint Expert in the Family Court. This can assist to avoid delay, if the Pathologist agrees to be instructed on this basis and report within a timeframe directed by the Family Court. If the Family Court is considering such an instruction, the Coroner should be notified in advance.

## Coronial procedure

6.14 Where the Coroner makes preliminary inquiries under section 1(7) of the 2009 Act and concludes that he/she has no duty to investigate the death, there will be no investigation. An inquest is the final hearing within an investigation, so there cannot be an inquest without an investigation: section 6.

6.15 Coroners have powers to release a body for burial or cremation without having to open an inquest and must do so as soon as is reasonably practicable: regulation 20.

6.16 When a Coroner is under a duty to conduct an investigation into a death under section 1 of the 2009 Act, they must hold an inquest into the death as part of the investigation. unless the investigation is discontinued because a natural cause of death becomes clear before inquest: sections 4 and 6 of the 2009 Act.

6.17 The Coroner must open an inquest as soon as reasonably practicable after the date on which the coroner considers that the duty to hold an inquest applies: rule 5(1) of the Coroner Rules.

6.18 In all cases it is good practice for the family of the deceased to be notified of the time, date, and place of the opening: Regulation 6 of the Coroners (Investigations) Regulations 2013. This requires Coroners to inform the deceased's next of kin, or their personal representative, of the Coroner's decision to begin an investigation. In cases involving the death of a child, the child's parents and/or those with parental responsibility will be next of kin and are entitled to be treated as Interested Persons in the inquest.

6.19 It may also be good practice, where practicable, to notify others who appear at that stage to be likely to have an interest in the proceedings. Consideration should be given to notifying the relevant Local Authority making an application in the Family Court proceedings of the opening so they can attend should they wish.

6.20 The Coroner must open an inquest in public unless the Coroner does not have immediate access to a court room (rule 11 of the Coroner Rules). The Chief Coroner's guidance is, however, that rule 11(2) should not routinely be relied upon because of the importance of open justice. Although the public, including the press, may not often attend, an opening is a public hearing. It constitutes the formal commencement of the court proceedings, so the public are entitled to attend if they wish to.

### Identification and other evidence

6.21 The Coroner will receive evidence of identification of the deceased, either oral evidence on oath or in written form complying with Rule 23. Identification is an important first stage towards the inquest 'determination' as to who the deceased was: sections 5(1)(a), 10(1)(a) of the 2009 Act. Identification will include as a minimum, where known, the name, age, and address of the deceased.

6.22 Identification evidence taken at the opening need not be repeated at the final hearing (although it is usually referred to).

6.23 Subject to the issue of the scope of the inquest (as defined by the Coroner) the Coroner may also hear brief evidence of the general circumstances of the death, the finding of the body, whether a post-mortem examination has taken place and the provisional medical cause of death (if known). But care should be taken not to give the impression at an opening or PIR hearing that a final conclusion has been reached on any issue.

6.24 Where there is a police investigation, brief evidence (oral or in writing, as above) may be received from a police officer about its progress.

### Setting date for inquest

6.25 At the opening hearing the Coroner must, where possible, either set the date for the inquest or the date for a PIR hearing: rule 5(2) of the Coroner Rules.

6.26 The date for the inquest must normally be set within six months of the date on which the Coroner is made aware of the death. This is because the Coroner has a duty where possible to complete the inquest within six months. Where it will not be possible to set the date within six months for some good reason, such as delay likely to be caused by a police investigation or linked family proceedings, there is still a duty on the Coroner to complete the inquest as soon as is reasonably practicable after the date of notification of the death: rule 8 of the Coroner Rules.

6.27 If there is likely to be such a delay, the Coroner should fix a date within a reasonable time for a PIR hearing (see rule 6). In a complex or difficult case there may be more than one PIR hearing before the inquest.

6.28 Whenever a Coroner sets a date for a PIR hearing, the Coroner should state the purpose of the hearing, if necessary, by giving directions which should be confirmed subsequently in writing. It may be necessary to draft an agenda for a PIR hearing and/or invite written submissions from interested persons in advance

of the hearing. Or it may only be necessary to state that the review hearing will try and fix a date for the inquest or report on progress of any other relevant investigation.

6.29 In addition to fixing a date the Coroner should give directions, when feasible, including a timetable for the provision of reports and statements, particularly those of a medical nature. In the normal course of events, with the duty to hear and complete inquests within six months, the coroner should direct that specific reports and statements should be provided within six weeks (except where further reports from toxicologists etc. are required). The Coroner should provide a letter of request to the Pathologist, making clear the timescales upon which reports should be provided, (see draft letter of request at Annex C).

6.30 As the Family Court will require the final post-mortem examination report, dialogue should take place with the pathologist in advance of the inquest opening as to when the final report will be available, but also to make the Pathologist aware of the timetable that has been set by the Family Court to ensure no delay and appropriate prioritisation. The Pathologist may be invited to expedite their report in order to comply with the timescales of the Family Court (see draft invitation to expedite at Annex D).

6.31 The Coroner's Court is a Court of Record, and the Coroner is entitled to give reasonable directions for the good and fair management of the proceedings. This applies to openings and PIR hearings. This aspect of the Coroner's duty to investigate is particularly important in an inquisitorial process where the aim is to make objective determinations and findings in the public interest. Coroners should ordinarily fix the date of the inquest after the conclusion of the Final Hearing or Fact-Finding Hearing in Family Court Proceedings. At that point, the findings of fact made by the Family Judge and the Judgment may be available and can be requested for disclosure and then considered by the Coroner. Having access to the index of material in the Family Court may also inform any other applications for disclosure that the Coroner may wish to make. Similarly, the Coroner should make available to the Family Judge, if requested, the index of material of evidence as gathered by the Coronial Investigation.

6.32 Coroners must notify the Chief Coroner of any investigation not completed within 12 months of the date of being made aware of the body within the coroner's area: section 16 of the 2009 Act and regulation 26 of the Coroners (Investigations) Regulations 2013.

# 7. Paternity testing where the putative father is deceased

7.1 In any case where the paternity of a child is unresolved and there is a request for a sample from the deceased to be retained for the purposes of DNA testing, the Coroner must notify the individual making the request that an application for a Declaration of Parentage pursuant to Section 55 Family Law Act 1986 must be made in the Family Court. The Coroner does not have jurisdiction to make decisions in respect of these issues.

7.2 The Coroner cannot release a sample from the deceased to enable paternity testing to be carried out unless requested to do so by the Family Court. Upon being made aware of an application for a Declaration of Parentage in the Family Court or an intention to issue such an application, the Coroner should retain a blood sample from the deceased to allow DNA testing to be carried out pending determination by the Family Court as to whether scientific testing is necessary to resolve the issue of paternity.

7.3 When the Family Court receives an application for a Declaration of Parentage in respect of a deceased putative father, the Family Judge shall arrange for the Coroner to be notified and invite the Coroner to retain a blood sample from the deceased for the purposes of scientific testing.

7.4 If the Coroner is not prepared to retain a sample for the purposes of paternity testing, they must provide reasons to the family and to the Family Court.

7.5 If the Family Judge determines that scientific testing is necessary to resolve paternity, before a Declaration of Parentage can be made, the Family Judge shall arrange for the Coroner to be notified and invite the Coroner to release the retained blood sample to allow DNA testing to be carried out.

7.6 If the Coroner refuses to release a blood sample to allow DNA testing to be carried out, they must provide reasons for this to the family and the Family Court.

7.7 If the Family Judge concludes that DNA testing is not required, the Family Judge shall arrange for the Coroner to be notified to enable the Coroner to release the sample.

# 8. Annexes

## Annex A: Draft letter from Family Judge to Coroner

Dear Coroner,

This letter is to notify you that in relation to …… (deceased's name), there are related Family Court proceedings under case number…… at ……. Family Court. The proceedings have been allocated to [insert Judge] for case management. [The trial judge is [insert name if different to the allocated Judge]. The primary issue to which those proceedings are directed is: …….

The likely timetable in these proceedings is as follows:

CMH

IRH

FACT FINDING

FINAL HEARING

If you require disclosure of documentation from the family court, please acknowledge this letter by……. (in advance of the CMH) and provide a timetable for your investigation with dates of any hearings.

I attach an index of documents in the bundle thus far. An updated index can be provided at a later stage as requested.

[Judge X] will raise any disclosure requests that you make with the parties at the CMH hearing and will thereafter update you as to a timetable for providing any approved/agreed disclosure. Please let them know if you would like a bundle index to inform your requests.

At the conclusion of proceedings, [Judge X] will let you know that a judgment has been handed down in respect of any findings made and will ask whether you wish to request a copy of the judgment and/or findings.

Please reply to this letter using this ejudicary email address [insert].

Signed

Dated…

## Annex B: Draft Letter from Coroner to Family Judge

Dear Family Judge

Thank you for notifying me of proceedings in your court relating to……. deceased……

I confirm that there is a related Coronial investigation/ there will be an inquest/ I am conducting preliminary enquiries relating to…….

The timetable for those proceedings is as follows:

…….

I confirm interest in disclosure of some documents from the family proceedings.

Having seen the index of documents, I request disclosure of the following:

……..

I invite the Family Court to consider my request for disclosure at the next listed hearing in the Family Court (or I request that the matter is considered by the court on paper / at a further convened hearing given the next hearing in the Coroners' Court is on…….).

If any issues arise, please contact ……on……

Signed

Coroner

Dated

## Annex C: Draft Letter of Request to Pathologist

Dear Dr [insert name],

1. You are requested to carry out a post-mortem examination in respect of [insert name] and to provide a report setting out your conclusions.

2. You are required to comply with Pages 43-44 paras 7.8-7.11 of the SUDIC Protocol in respect of your interim findings. I attach a copy of this guidance for your reference. If you suspect abuse/neglect, please provide a short-written report setting out these initial findings for child protection purposes. This report will be shared with the Police and Children's Services and may be provided to the Family Court to enable interim safeguarding decisions to be made.

3. I am required to conclude any death investigation (including conducting an inquest, where appropriate) within 6 months of the date of the death. [Insert

name]'s death was reported to me on [insert date], I am therefore required to conclude this case by no later than [insert date]. To enable me to comply with this timetable, you must provide me with your final report by no later than [insert date].

4. If you recommend that further investigations and/or subspecialty reports are required, please inform me without delay. Should you consider that any of these further investigations and/or reports may result in you being unable to file your report on time, please notify me immediately.

5. If related Family Court proceedings are commenced, you will be notified of them and the timetable for those proceedings. A further joint letter will then be provided inviting you to expedite your report to prevent delay in the family proceedings.

HM Coroner [insert name] [insert date]

## Annex D: Joint letter to Pathologist

Dear Dr [insert name]

On [insert date] you were requested by HM Coroner [insert name] to carry out a post-mortem examination in respect of [insert name] who sadly died on [insert date].

[Insert name] has [insert number] of surviving sibling(s) who are the subject of care proceedings in the [insert name] Family Court. They are aged [insert ages]. The allocated Judge for those proceedings is [insert name].

The siblings were removed from the care of their parents/ carers on [insert date] and are now placed [in foster care/ with family members]. Care Proceedings were issued on [insert date]. The Family Court is required to conclude the care proceedings within 26 weeks, by [insert date].

Final care and welfare decisions for these children cannot be made until the cause of [insert name]'s death is determined.

We invite you to expedite the filing of your report in respect of [insert name] to allow [his/her] siblings to have their future care and welfare arrangements determined without delay. To prevent delay, you are invited to file your report by [insert date].

Please inform us of any additional specialist investigations that are taking place, which could have an impact on your filing date.

Many thanks for your assistance

HM Coroner [Insert name]
[Insert name of Family Judge]

[Date]

## Annex E: Summary of opening procedures: good practice for linked family and coronial proceedings

1. Where there is a duty to investigate, an inquest must be opened and later held (unless the investigation is discontinued).
2. Notify the family in advance of the opening hearing. Consider the age of any relevant related living children and give thought to the necessity of reporting restrictions and/or any reporting restrictions already made by the Family Court.
3. Notify others, where possible, including the relevant local authority (LA) who has made the application to the Family Court and seek to identify the allocated Family Judge via the LA. Consider if the relevant LA needs to be made an Interested Person.
4. Open the inquest as soon as possible.
5. Ask the allocated Family Judge to provide the timetable set for the family proceedings and the dates for CMH, IRH and any Fact Finding and Final Hearing. Record these dates on the inquest file.

6. Receive evidence including identification.

7. Give directions setting a timetable for reports and seek to identify the date when the final post-mortem examination report will be available. Update the Family Court with the anticipated date when the final post-mortem examination report will be available. Provide any interim post-mortem examination report and final post-mortem examination report to the Family Court, after allowing any representations or objections to this to be made by the Police and Interested Persons.

8. Consider the stage of any linked care proceedings and, if known, the timetable set by the Family Court should be taken into consideration when fixing the dates for a PIR and the date of the final inquest.

9. Set a date for the inquest (or PIR) with reference to the timetable set by the Family Court. The date for a final inquest will usually be listed after any Fact Finding / Final Hearing in the Family Court.

10. Ask the allocated Family Judge to arrange for an index from the Family Court bundle to be provided and made the Family Judge aware that you are likely to request disclosure of any Findings of Fact made and the Court's Judgment.

11. Share directions made at the inquest opening with the Family Court and relevant LA.

12. Consider writing to the Family Judge on conclusion of the opening to make a formal request for disclosure of the bundle index, Findings of Fact and Judgment. You could provide disclosure of any interim/ final post-mortem examination report at the same time, or if no final post-mortem examination report is available, provide an indication as to when the pathologist has confirmed that this will be available.

# Annex F: Coroners' contact information

## Identifying the coroner area

It may not be immediately clear to Family Judges which Coroner area has responsibility for investigating a death linked to particular care proceedings. The following information is intended to help Family Judges to identify the correct Coroner.

1. The Coroner service is a local service.
2. There are many Coroner areas throughout England and Wales, which vary in size and do not usually correspond with local authority areas.
3. Each Coroner area has a Senior Coroner who is primarily responsible for the provision of coronial services in that area.
4. It is generally the location of the body that determines which area has jurisdiction over a death. This means that in most cases, the coroner area with jurisdiction will be the area in which the deceased died.
5. In some circumstances, the Chief Coroner will transfer a case to a different coroner area, or Coroners will agree between themselves to transfer cases between their areas. A transfer might be justified where the area in which the deceased died does not have the strongest links with the circumstances of the death, or because a different geographical location would be easier for the family.
6. When a body is repatriated, the Coroner for the area where the body is to be buried or cremated will normally take jurisdiction.
7. Coroners and Family Judges are encouraged to use the following contact details to establish local meetings with each other on a regular basis to discuss matters of mutual interest.

## Coroners' contact details

Here is a link to an interactive map that sets out how coroner areas are arranged geographically and provides contact details for each coroner area: CSEW website.

## Regional Coroner contact details

If a Family Judge is unable to ascertain which area is responsible for investigating a relevant death, the Regional Leadership Coroner might be able to assist. Contact details

for the regional coroners can be found here: https://intranet.judiciary.uk/guidance-and-resources/contact-details-chief-coroners-office-and-regional-leads/.

## Annex G: Family Judges' Contact Information

Here is a judicial intranet link to information about:

- the Designated Family Judges: https://www.judiciary.uk/about-the-judiciary/who-are-the-judiciary/leadership-judges/designated-family-judges/; and
- the Family Presiding Judges: https://www.judiciary.uk/about-the-judiciary/who-are-the-judiciary/leadership-judges/family-presiding-judges/

Their contact details are searchable on ejudiciary.net.