



GUIDANCE No.7

A CADRE OF CORONERS FOR SERVICE DEATHS

Status: This guidance replaces and updates the 26 July 2013 version. It should be read alongside the Coroners and Justice Act 2009, the Coroners (Inquests) Rules 2013, and other applicable law and guidance.

Purpose: To set out the role, deployment and operation of a specialist cadre of coroners for investigations and inquests into service deaths, and to provide a clear process for notification and applications.

1. The Chief Coroner maintains a cadre of designated coroners in England and Wales to conduct or provide support to those conducting investigations and inquests into the deaths of service personnel. In broad terms, this relates principally to a death on active service (including training and preparation).
2. While many such deaths occur overseas, the cadre's jurisdiction extends to relevant deaths in England and Wales, and to deaths overseas where the body is repatriated such that an inquest would have been held had the death occurred domestically.
3. Under section 17 of the Coroners and Justice Act 2009, the Chief Coroner has a statutory responsibility for monitoring and training in relation to investigations into service deaths.

Definitions

4. Service death has the meaning given in section 17(2) of the Coroners and Justice Act 2009 (the 2009 Act)¹: In this section "service death" means the death of a person who at the time of the death was subject to service law by virtue of section 367 of the Armed Forces Act 2006 (c. 52)² and was engaged in:
 - (a) active service,
 - (b) activities carried on in preparation for, or directly in support of, active service, or
 - (c) training carried out in order to improve or maintain the effectiveness of those engaged in active service.

¹ Section 17 of the [Coroners and Justice Act 2009](#)

² section 367 of the [Armed Forces Act 2006](#)

5. Service linked death (non-statutory): a death not occurring during “active service” but where evidence suggests a material link to the deceased’s military service (for example, a training related- incident during routine duties; a death involving specialist equipment used in service; or circumstances where recent service may be causally relevant). This category informs when the cadre may be deployed in support.

Scope and Objectives of the Cadre

6. Consideration will be given by the Chief Coroner for the use of the cadre to extend to deaths where the deceased has a service link, even if the death did not occur on active service as outlined in paragraph 4 above.
7. Deployment of the cadre will be proportionate and flexible, taking account of operational need, the complexity of military evidence, continuity, and the reasonable wishes of the bereaved family, where practicable.

Selection and Training

8. The Chief Coroner selects cadre members based on experience with service deaths, relevant expertise (including where applicable previous military experience), and to ensure geographic coverage. Membership is reviewed periodically to maintain capability and resilience.
9. Cadre coroners receive training as is deemed appropriate under the direction of the Chief Coroner focusing on service death investigations, inquests, disclosure, and working with defence and overseas agencies.

Use of the Cadre

10. The cadre will operate as follows:
 - (a) consideration will be given by the Chief Coroner to each service death as and when it occurs.
 - (b) mandatory deployment (default expectation) of the cadre for investigations and inquests into service deaths within s.17(2) of the 2009 Act (active service, including training and preparation). The Chief Coroner may, in an appropriate case, determine that the local coroner should retain conduct.
 - (c) discretionary deployment or support for service linked deaths that raise complex or sensitive military issues but fall outside “active service”. The Chief Coroner may deploy a cadre coroner to conduct the investigation, or to support the local coroner.

Notification and Early Engagement

11. Immediate notification - the coroner first becoming aware of a potential service death should notify the Chief Coroner within 24 hours by email, even where preliminary enquiries are ongoing.

12. Where applicable, the Ministry of Defence (MOD) Defence Inquests Unit (DIU) or other service authority should also notify the Chief Coroner as soon as practicable. The DIU is the MOD's departmental focal point for the coordination and management of all Defence-related inquests. The DIU's role is to assist coroners so that inquests can be completed fully, thoroughly and as quickly as possible.
13. Written notification to the Chief Coroner should include (so far as known) the deceased's particulars, circumstances of the death and whether "active service" is confirmed or suspected, destination of repatriation, service police contacts; known Interested Persons; any early views from next of kin.
14. The notifying coroner should ensure early, clear communication with the bereaved family, ensuring they understand the decision making process on cadre deployment, venue, and any transfer, and they should be provided with clear routes to raise questions or make representations.

Chief Coroner's Assessment and Direction

15. On receipt of notification the Chief Coroner will determine whether to:
 - (a) deploy a cadre coroner to conduct the investigation
 - (b) direct that a specific coroner conducts the investigation (including a cadre member) under section 3 of the 2009 Act.
 - (c) direct that the coroner where original jurisdiction retains conduct of the case with cadre support, where appropriate.
16. The criteria the Chief Coroner will have regard to in making their decision includes: statutory scope; complexity and sensitivity (e.g., technical military evidence, multiagency coordination, security/classified material); location and continuity; the family's reasonable preferences; views of the local senior coroner; and the interests of efficiency and justice.
17. Where appropriate, the investigation (and inquest) may be transferred to another coroner area, including to the area of the next of kin, consistent with Section 3 of the 2009 Act.
18. The Chief Coroner may make an early, provisional decision to preserve continuity and welfare support for families, revisiting the position as evidence develops.
19. Consideration will be given to the use of remote participation where it is lawful and appropriate to facilitate effective and efficient case management and welfare.
20. Where an investigation and inquest are transferred to be conducted in another coroner hosting area, the receiving Local Authority bears the costs of the

investigation unless the Chief Coroner directs otherwise. It is expected that the nominated coroner area's Local Authority will appreciate the importance of ensuring these investigations are conducted appropriately.

21. Local authority cooperation is essential to release nominated cadre coroners and to ensure adequate cover within their jurisdiction areas. Practical arrangements should be agreed at the earliest opportunity.
22. Cadre or assigned coroners will continue to work with relevant Ministry of Defence teams (including the Defence Inquests Unit, service police and JCCC) to secure timely disclosure, technical briefings and witness coordination.
23. Where an incident occurred overseas, coroners should make early enquiries about foreign jurisdiction processes and available material, liaising with the Ministry of Defence and other authorities as needed.
24. The Chief Coroner's powers do not extend to Scotland or Northern Ireland. If circumstances require the coordination or transfer of cases relevant conversations with appropriate authorities will take place.
25. The Chief Coroner's Office will maintain a record of notifications and decisions under this guidance. Aggregate information may be included in the Chief Coroner's Annual Report.

**HHJ ALEXIA DURRAN
CHIEF CORONER**

26 July 2013
Revised 15 April 2026

Annex A Process map for service death notifications to the Chief Coroner

Annex A

Process Map for Service Death Notifications and Deployment

1. Death reported / coroner becomes aware

Identify potential *service death* or *service linked* death (check “active service” definition; obtain basic facts; confirm point of entry if overseas).

2. Within 24 hours: Notify Chief Coroner

Local senior coroner emails the Chief Coroner’s Office inbox.

3. Initial family contact

Explain that cadre deployment is under consideration; invite early views on venue and any welfare issues.

4. Chief Coroner

Review notification along with any attachments, consult local coroner and MOD if needed whilst considering the criteria.

5. Decision

- (a) **Cadre coroner appointed** to conduct; or
- (b) **Direction under s.3** that a named cadre coroner conduct; or
- (c) **Local coroner retains conduct** with cadre support.

6. Communication of decision

Written notice to applicant/local coroner; explain venue/transfer position; direction to notify family and MOD.

7. Case management

Nominated coroner conduct investigations and inquest.

Deployment/venue will be kept under review if circumstances change discussion with the Chief Coroner to take place.