Chief Coroner

GUIDANCE NUMBER 49 : MAJOR INCIDENTS: The Role Of The Chief Coroner And Incident Coroner

Introduction

1. This document sets out the role of the **Chief Coroner** in the event of a major incident involving mass fatalities in England and Wales.

2. This document is not intended to set out in detail all relevant procedures, hence it should be read in conjunction with other relevant supporting documentation, whether national or local in nature. To assist, on the members section of the CSEW, on the grey section at the bottom is a link 'Disaster Victim Identification'. If you click here, and again on 'Generic Draft DVI Documents (January 2026)' there are checklists, a Coroner action card and an MFCG agenda, amongst other documents. The contact list for the CC's Major Incident Cadre is also in the grey section.

3. For the purpose of this document a major incident/mass fatality incident is defined as:

   - An incident involving mass fatalities which is likely to overwhelm existing local procedures for managing fatalities and/or
   - An incident which occurs overseas involving the repatriation and identification of multiple UK nationals
   - An act of terrorism in the UK where the number of fatalities may be relatively small in number.

Role of the Chief Coroner

4. Once the coroner informed of a major incident likely to involve mass fatalities and/or terrorism event requiring the activation of special arrangements the coroner shall inform the **Chief Coroner**. The coroner with jurisdiction for the deaths will be known as the 'incident' coroner.

5. Where bodies are located or likely to be located in more than one coroner area, a 'lead' coroner will be appointed pursuant to one of three alternative procedures (see paragraph 6). Before a decision is made the **Chief Coroner** will consult with all affected coroners. The lead coroner will therefore become the incident coroner.

6. If necessary the lead coroner will agree to conduct the investigation pursuant to section 2 of the Coroners and Justice Act 2009 (the 2009 Act) or the **Chief Coroner** will direct the lead coroner to conduct the investigation pursuant to section 3 of the 2009 Act. Alternatively, the **Chief Coroner** in consultation with the relevant authority will consent to the appointment of the lead coroner as an Assistant Coroner for the relevant area.

7. The **Chief Coroner** will ensure that the incident coroner has access to appropriate advice and assistance from one or two members of the CC's Major Incident Cadre. This will be the case even if the incident coroner is himself or herself a member of the Cadre.

8. The incident coroner will keep the **Chief Coroner** regularly advised of actions taken.

9. The **Chief Coroner** and her office will be available to provide advice and support to coroners, but it is not the statutory function of the **Chief Coroner** to inform, review or alter any judicial decision (as in any case) which is within the discretion of the coroner.

Role of the Incident Coroner

10. Once the coroner has decided that activation of special arrangements is required the coroner will activate the Mass Fatalities Co-ordinating Group (MFCG) as soon as possible. The MFCG, chaired by the coroner, will include the relevant local authority, police, lead pathologist, Senior Identification Manager (SIM), Senior Investigating Officer (SIO) and others as required. Depending on the incident there may be a wide range of organisations present. Key decisions, for example in relation to mortuary facilities, will be made by the coroner after consultation with the MFCG.

11. The Coroner should also make arrangements to be represented at Gold Command.

12. In consultation with the relevant authority and police the coroner will initiate the establishment of the emergency mortuary. The relevant authority is responsible under the Civil Contingencies Act 2004 for the emergency mortuary facilities. Where local measures are considered insufficient the coroner and relevant authority may request additional facilities through the Home Office managed Central Assistance Programme (CAP). These may include, for example, the National Emergency Body Storage capability and the provision of supplementary equipment.

13. The coroner, who has from the start legal responsibility for the bodies of victims, will authorise the removal of bodies and ultimately when appropriate their release or disposal.

14. Particular consideration should be given to prompt release of information, to bereaved families and then to the public, about the identity of those who have died, including to what extent and indication of identity can be given before the formal DVI processes are completed. This is a complex issue and will depend significantly on the nature of the incident. In some incidents, early release of information may be impossible.

15. The coroner will appoint a supervising pathologist, agree a forensic strategy and oversee the examination of the bodies.

16. The forensic strategy will include consideration of the appropriate techniques to establish identity, based on the circumstances of the incident. This will include the use of post-mortem imaging and specialists such as odontologists and anthropologists.

17. The coroner will, where necessary, chair an Identification Commission and take all reasonable steps to identify the deceased. The role of the Identification Commission, which is a central concept in internationally agreed Interpol DVI procedures, is to

provide a formal forum to confirm, where possible, the identity of each of the deceased, although of course the Identification Commission does not replace the formal opening of an inquest into a death.

18. The coroner will organise the collection of data concerning those whose bodies may be irrecoverable but who were believed to be victims of the event.

19. The coroner will liaise and co-operate with the **Chief Coroner** and other relevant coroners who may also have bodies of victims arising from the same or related event(s).

20. After appropriate examination and documentation is complete the coroner will authorise the release or disposal of bodies to those who are lawfully entitled.

21. The coroner will at all times liaise with the relevant emergency services and Government departments. In incidents involving the deaths of foreign nationals, the incident coroner should ensure they liaise with the Foreign and Commonwealth Development Office.

22. The coroner will ensure that detailed records are kept of all relevant meetings, actions and information received.

Investigation and inquest process

23. The coroner's duty to investigate under section 1 of the 2009 Act will be engaged from the start.

24. Inquests should be opened and adjourned as soon as reasonably practicable.

25. Where necessary the **Chief Coroner** will make directions under the 2009 Act for a coroner who is not the coroner under the statutory duty to investigate the deaths to conduct the investigation (section 3) or for a judge to conduct the investigation (paragraph 3, Schedule 10 to the 2009 Act).

Communication

26. The **Chief Coroner** in conjunction with the coroner may arrange to speak to bereaved family members in order to explain the coroner process face-to-face although in many incidents this is best managed by the coroner and the SIM as part of their overall strategy. Where the Independent Public Advocate (IPA) is deployed the Chief Coroner will liaise with the IPA to ensure that the IPA can provide any bereaved family members or survivors with appropriate information.

27. The **Chief Coroner** will provide general advice to Government departments and will if required attend meetings of COBRA.

28. Media inquiries are likely to be handled by a range of organisations including the coroner in consultation with the local authority press office, the police and the **Chief Coroner**'s office. The incident coroner should engage proactively with their SIM, other police representatives, local authority and others as necessary to develop a clear communications strategy. The guidance provided by Lord Justice Clarke in his report on the *Marchioness* disaster about providing information in the identification process should be borne in mind: honest and, as far as possible, accurate information at every stage; respect for the deceased and bereaved persons; a sympathetic and caring approach; and the avoidance of mistaken identification.

Guidance and training

29. The **Chief Coroner**, who has a statutory obligation in relation to the training of coroners, will liaise with the Home Office. This is to ensure that continued training opportunities are made available to coroners who are members of, or who wish to volunteer to join, the Chief Coroner's Major Incident Cadre. The Cadre will meet on an annual basis for training. In addition training will be provided to all coroners on the approach to mass fatality incidents. The most recent training has taken place in 2025 and is likely to be repeated at regular intervals to ensure all have guidance on best practice in such eventualities.

HHJ ALEXIA DURRAN
The Chief Coroner
May 2026