



CHIEF CORONER

## THE CHIEF CORONER'S GUIDE TO THE CORONERS AND JUSTICE ACT 2009

*This Guide for Coroners, prepared by the Chief Coroner in association with the Ministry of Justice, is intended to be a quick learning and reference document, an introduction and summary of the main areas of change. It is not intended to be complete, dealing with all the fine details, nor is it intended to be legal guidance.*

### INTRODUCTION

1. Part 1 of the Coroners and Justice Act 2009 ('the 2009 Act') provides for a number of structural changes to the coroner system. It creates the new national head of the coroner system, the office of Chief Coroner. It introduces the new concept of 'investigations' into deaths, which where appropriate includes an inquest, as well as making new provisions relating to coroner areas, creating new titles for coroners, and removing barriers to where investigations can be held.
2. The Act also provides for a new system of death certification (medical examiners) but these changes are not covered by this Guide.
3. This Guide summarises the main changes under the 2009 Act and the secondary legislation made under it:
  - The Coroners (Investigations) Regulations 2013 ('the Investigations Regulations');
  - The Coroners (Inquests) Rules 2013 ('the Inquests Rules'); and
  - The Coroners Allowances, Fees and Expenses Regulations 2013 ('the Allowances, Fees and Expenses Regulations').
4. Unless otherwise stated, references in this Guide to 'sections' and 'Schedule' are to sections and Schedules of the 2009 Act, references to 'regulations' are to the Investigations Regulations and references to 'rules' are to the Inquests Rules.

5. Attached to this Guide are the following Annexes which summarise some of the main changes under the 2009 Act, how the new processes should work and the new rules and regulations:
  - **Annex A** – Summary of the early stages of the investigation process;
  - **Annex B** – Comparison between the 2009 Act and the Coroners Act 1988 ('the 1988 Act'); and
  - **Annex C** - Comparison between the Coroners Rules 1984 ('the 1984 Rules') and the Investigations Regulations and Inquests Rules.
6. The provisions of the 2009 Act, as well as the rules and regulations made under it, came into force on 25 July 2013. From this date, all investigations, including deaths which were already being investigated by a coroner including those which had reached the inquest stage, are dealt with under the new regime.
7. The Investigations Regulations and the Inquests Rules both contain transitional provisions which mean that any decision taken by a coroner before the new arrangements came into force (including any post-mortem examinations or any directions, time limits, adjournments or other decisions taken by the coroner) remains valid. This means that any deaths that had been reported before the new arrangements came into force need no longer be dealt with under the 1984 Rules.

## **BLOCK 1 CHIEF CORONER**

### **Chief Coroner**

8. The 2009 Act creates the new post of Chief Coroner to provide judicial oversight of the coroner system. The Chief Coroner's main responsibilities are to:
  - provide support, leadership and guidance for coroners;
  - set national standards for all coroners;
  - develop training for coroners and their staff;
  - approve all future coroner appointments;
  - keep a register of coroner investigations lasting more than 12 months and take steps to reduce unnecessary delays;
  - monitor investigations into deaths of service personnel overseas;
  - oversee transfers of cases between coroners;
  - direct coroners to conduct investigations;
  - provide an annual report on the coroner system to the Lord Chancellor, to be laid before Parliament; and
  - collate, monitor and publish coroners' reports to authorities to prevent other deaths.
9. The Chief Coroner must be a senior judge appointed after an open competition by the Lord Chief Justice (after consulting the Lord Chancellor) for a term

decided by the Lord Chief Justice, with a retiring age of 70: Section 35, Schedule 8.

10. The Lord Chief Justice has no plans to appoint Deputy Chief Coroners at this stage.

## **BLOCK 2 AREAS AND CORONERS**

### **Coroner areas**

11. The 2009 Act changes the name of 'coroner districts' to 'coroner areas'. Schedule 2 to the Act allows the Lord Chancellor to make an order setting and then altering the boundaries of coroner areas for England and Wales. Under the Act each coroner area corresponds to one or more local authority areas.
12. The first area order under Schedule 2, the Coroners and Justice Act 2009 (Coroner Areas and Assistant Coroners) Transitional Order 2013, simply maps all previously existing 'districts' across into the new structures, renaming them as coroner 'areas'. This is in line with the requirements of paragraph 1 of Schedule 22. The second order, the Coroners and Justice Act 2009 (Alteration of Coroner Areas) Order 2013 then merges a number of areas, primarily where one of those areas covers a unitary authority.
13. The intention behind Schedule 2 is to move towards fewer, larger coroner areas over time, each of which supports a full-time coroner caseload. This approach follows the recommendation of the Luce Review in 2003 to reduce the overall number of coroner areas. Larger coroner areas will mean economies of scale for local authorities through, for example, sharing of staff and other resources, while full-time coroners will be able to focus entirely on their coronial duties, and thus develop their skills and experiences more fully. This will also help bring about greater consistency of practice between areas.
14. Where a coroner area covers one or more local authority areas, Schedule 2 requires those authorities to agree which of them will be the 'relevant authority' (formerly known as the 'lead authority') for the purposes of the 2009 Act.
15. Local authorities have been issued with advice on the process for amalgamating coroner areas. Although the first amalgamations have all been made by agreement, it should be noted that the Lord Chancellor has power to alter coroner areas, after consultation, without consent.

### **Coroner appointments**

16. The 2009 Act changes the titles of the office of coroner and amends the eligibility requirements and the appointment process.
17. The hierarchy of coroners under section 6 of the 1988 Act consisted (in descending order) of coroners, deputy coroners and assistant deputy coroners. Under the 2009 Act, there are senior coroners, area coroners and assistant coroners.
18. Under paragraph 3 of Schedule 22 to the 2009 Act, coroners who were in post at the time the main provisions of the 1988 Act were repealed (which was at the same time as the 2009 Act was implemented) became senior coroners for their

respective areas. Similarly, anyone who was a deputy coroner or an assistant deputy coroner became an 'assistant coroner' for the corresponding area.

19. Area coroners are an entirely new post and under the transitional provisions in the 2009 Act, deputy coroners have **not** automatically become area coroners (paragraph 3(3) of Schedule 22). Full-time salaried deputy coroners have become salaried assistant coroners, but it has been expected that local authorities may consider designating them as area coroners.
20. Under the 2009 Act there is one senior coroner per coroner area (paragraph 1 of Schedule 3). Senior coroners appointed to coroner areas in Wales are still treated as a coroner for the whole of Wales as section 4A(8) of the 1988 Act has been saved.
21. Schedule 3 allows the Lord Chancellor, by order, to require the appointment of an area coroner or specified number of area coroners for each coroner area. There are no plans to use this power at this stage and so the decision whether to appoint an area coroner is for the relevant authority. Area coroners could, for example, be appointed within a particularly large coroner area to assist the senior coroner with his or her duties.
22. The Coroners and Justice Act 2009 (Coroner Areas and Assistant Coroners) Transitional Order 2013 also specifies that each area should have a minimum of one assistant coroner (in accordance with paragraph 1(4) of Schedule 22).

#### Appointment process

23. Under the previous system, the lead local authority appointed a coroner and the coroner appointed deputy and assistant coroners with the local authority's approval. The Secretary of State for Justice approved only certain coroner appointments.
24. The Ministry of Justice has implemented the changes in Schedule 3 of the 2009 Act so that local authorities have become responsible for **all** coroner appointments (i.e. including area and assistant coroners). There is also now a requirement for local authorities to seek the consent of the Lord Chancellor and Chief Coroner to the appointment of new coroners. It is hoped that this will introduce much greater transparency to the process and greater consistency of standards. The Chief Coroner intends to take an active role in the appointments process: see the Chief Coroner's Guidance No.6 *The Appointment of Coroners*, 24 July 2013.
25. Where a vacancy arises at senior coroner or area coroner level, the relevant authority must give notice in writing to the Chief Coroner and Lord Chancellor as soon as practicable (paragraph 5 of Schedule 3) and appoint a person to fill the vacancy within three months (although the Lord Chancellor can extend this).
26. The relevant authority must also give notice in writing to the Chief Coroner and Lord Chancellor of the appointment of a person to fill the vacancy as soon as practicable after it is filled.
27. Local authorities have been issued with guidance on the appointments process by the Ministry of Justice. The Chief Coroner is also designing for local authorities a standard package dealing with announcements, advertisements, application forms, selection, interviewing, appointments, terms and conditions.

### Person to act as senior coroner in case of a vacancy: deputy

28. In case of a vacancy, the following applies (paragraph 7 of Schedule 3):
- The area coroner for the area will act as senior coroner;
  - Where there is more than one area coroner, the relevant authority must nominate an area coroner to act as senior coroner;
  - Where there is no area coroner for the area, the relevant authority must nominate one of the assistant coroners to act as senior coroner.
29. In the case of a coroner area which consists of two or more local authority areas, the relevant authority must consult the other authority(ies) before nominating.
30. For continuity purposes, it would be helpful for the senior coroner and the relevant authority to agree which coroner should act as deputy when the senior coroner is unavailable or incapacitated. When doing so, the criteria above should apply.

### Eligibility

31. Schedule 3 also changes the qualifications of senior, area and assistant coroners. Previously, coroners had to either have a five year legal qualification or be a medical practitioner of at least five years' standing. Under the 2009 Act, all newly appointed coroners must be legally qualified. Transitional arrangements apply to medical practitioners already in post when the changes came into effect (paragraph 3 of Schedule 22). These also apply where a coroner area is subsequently merged with another area. However a person who became an assistant coroner by virtue of the transitional provisions and only holds a medical qualification cannot become a senior coroner for a merged area.
32. Additionally a person who is a councillor for a local authority, or has been during the previous six months, may not be appointed as a senior coroner, area coroner or assistant coroner.

### Retirement

33. The 2009 Act also introduces a new mandatory retirement age of 70 for all coroners appointed under the new provisions, although there are transitional arrangements that disapply this retirement age for those in post when the 2009 Act came into force (paragraph 3(7) of Schedule 22).

### **Coroner terms and conditions**

34. The new posts of senior coroner, area coroner and assistant coroners are not regarded as freehold offices (i.e. no longer considered offices for life) (paragraph 9 of Schedule 3). This applies to all coroners, whether appointed before or after the 2009 Act provisions came into force.
35. Since all coroners become creatures of statute, either as new appointments or as existing coroners under the transitional provisions, and not holding freehold offices (above), there is some doubt whether coroners are any longer entitled to call themselves **HM Coroner**. In the short term coroners should not be troubled about it (e.g. when using existing stocks of notepaper). 'Coroner' or 'HM Coroner' are acceptable. But the Chief Coroner and the Ministry of Justice will be considering this part of the nomenclature for the future.

36. Paragraph 19 of Schedule 3 provides that senior coroners, area coroners and assistant coroners hold office on whatever terms are agreed by the coroner and the relevant authority from time to time, although this is subject to the other provisions of Schedule 3.
37. Senior coroners and area coroners are entitled to a salary (paragraph 15 of Schedule 3), while assistant coroners are entitled to a fee (paragraph 16 of Schedule 3). However, anyone who was a deputy coroner or an assistant deputy coroner immediately before the new provisions came into force and was paid a salary is still entitled to a salary (paragraph 3(4) of Schedule 22).
38. Senior coroners and area coroners are also entitled to a local authority pension (paragraph 17 of Schedule 3).
39. The 2009 Act says that it is for the coroner and the local authority to agree the coroner's remuneration (either salary or fee). The practice has been for a Joint Negotiating Committee of the Local Government Association to set out a salary scale for coroner appointments. The Chief Coroner has announced his desire to move towards a standardised set of terms and conditions. In the interim the latest JNC circular – JNC51 – still applies.

#### **Coroner disciplinary arrangements**

40. The 2009 Act changes the disciplinary arrangements in relation to coroners. Previously, only coroners were subject to the disciplinary arrangements under the Constitutional Reform Act 2005 ('the 2005 Act') and came within the scope of the Office for Judicial Complaints (OJC). Coroners were previously responsible for appointing their deputies and assistant deputies as well as for disciplining them, and potentially revoking the appointments.
41. Paragraph 14 of Schedule 3 to the 2009 Act extends the current judicial disciplinary arrangements (as set out in chapter 3 of Part 4 of the 2005 Act) to **all** coroners. The Lord Chancellor, with the agreement of the Lord Chief Justice, has the power to remove a senior coroner, area coroner or assistant coroner from office if that coroner is incapable of performing his or her functions or for misbehaviour. The 2009 Act also makes senior coroners, area coroners and assistant coroners subject to the disciplinary provisions of the 2005 Act (which includes the power for the Lord Chief Justice to issue formal warnings or reprimands).
42. In practice, this means that the OJC has taken on responsibility for investigating complaints about conduct against **any** coroner in England and Wales.

#### **Provision of local services**

43. Local authorities have retained responsibility for funding local coroner services under the 2009 Act. Where a coroner area spans more than one local authority, one of those authorities is known as the 'relevant authority' (formerly the 'lead authority').
44. Section 24 of the 2009 Act requires the relevant authority for a coroner area to provide 'whatever officers and other staff are needed by the coroners for that area to carry out their functions'. The authority must provide accommodation that is 'appropriate to the needs of those coroners'.

45. Section 24 says that the duty on local authorities to provide coroners' officers and other staff applies only where the police authority does not provide such officers and staff. As the Explanatory Notes to the 2009 Act make clear, where police authorities (now "local policing bodies") have previously provided coroners' officers they are expected to continue to do so, unless the local authority and police authority agree to the contrary.

### **Coroner availability**

46. Regulation 4 of the Investigations Regulations says that a coroner must be available at all times to undertake urgent matters, which cannot wait until the next working day. This is based on rule 4 of the 1984 Rules, although rule 4 was drafted more widely and required a coroner to be available to be ready to undertake any duties in connection with inquests and post-mortem examinations. The Chief Coroner will be issuing guidance on out-of-hours availability.

### **Delegation of coroner functions**

47. New regulation 7 allows coroners to delegate administrative – but not judicial – functions to their officers and other support staff. This regulation was needed because the Shipman Inquiry noted that coroners' officers dealt with queries from doctors in relation to some of Shipman's victims and had on occasion advised that the coroner would not be interested in a particular death, without consulting the coroner. It was believed that some coroners still delegated these functions. This regulation therefore acts as a safeguard to ensure that the coroner is aware of all deaths and makes the decision whether or not an investigation is necessary. The regulation helps to clarify the boundaries for delegation.
48. Functions that could be delegated to staff include such things as contacting bereaved relatives and making inquiries on behalf of the coroner. This would not, however, extend to judicial decision-making functions, such as deciding whether to order a post-mortem examination or using pre-signed forms. The Chief Coroner will issue guidance on the functions that coroners can delegate to coroners' officers and other staff, as in practice the distinction between judicial and administrative functions can be blurred and open to interpretation.
49. There is no need for the Investigations Regulations to cover delegation of functions from senior coroners to area or assistant coroners. Paragraph 8 of Schedule 3 to the 2009 Act provides that an area coroner or assistant coroner may perform any of the functions of the senior coroner for that area during a period when the senior coroner is unavailable or at any other time with the consent of the senior coroner.

## **BLOCK 3 THE INVESTIGATION**

### **Investigations**

50. The 2009 Act introduces the new concept of the coroner's 'investigation' into a death (section 1) of which the inquest only forms part (section 6). This recognises that much of the coroner's work actually takes place before the formal inquest hearing. It also allows the coroner time to consider whether the duty to hold an inquest applies, rather than having to open an inquest as soon as practicable (section 8(1) of the Coroners Act 1988). The Coroners Act 1988

focused on the inquest; the 2009 Act focuses upon the investigation (including the inquest).

51. Taken with the new Investigations Regulations and Inquests Rules, coroners do not have to open an inquest at a very early stage to allow for release of bodies and other such functions. This could help to reduce the number of natural cause deaths that previously had to proceed to inquest as an inquest had been opened at the outset. These changes are explored in further detail below and set out in more detail in **Annex A**, together with a high-level flow chart summarising these steps.

## **Coroners**

52. An investigation may be carried out by a senior coroner, an area coroner or an assistant coroner. It may also be carried out by the Chief Coroner or a nominated judge, former judge or former coroner: section 41; Schedule 10.

## **Duty to investigate**

53. A coroner has a duty under section 1 of the 2009 Act to investigate a death if:
  - (1) the coroner is made aware that the body is within that coroner's area (section 1(1)), and
  - (2) the coroner has reason to suspect that -
    - (a) the deceased died a violent or unnatural death,
    - (b) the cause of the death is unknown, or
    - (c) the deceased died while in custody or state detention (section 1(2)).
54. This is similar to the wording of section 8(1) of the 1988 Act, except the requirement to investigate where the death is 'sudden' has been removed. Section 1 also refers to deaths in 'state detention', which is defined by section 48(2) as meaning a person who is 'compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1988'. This, in effect, extends the definition of state detention to institutions such as immigration detention centres and secure mental health hospitals. It would also appear to extend to deprivation of liberty orders (Schedule A1, Mental Capacity Act 2005). All deaths in custody or state detention must be investigated (section 1(2)(c)) and go to inquest (section 4(2)(b)), but not necessarily with a jury (section 7(2) – see paragraphs 152-153 below).

## Preliminary inquiries

55. The new statutory regime permits a coroner to make preliminary inquiries to see whether the duty to investigate is engaged. The coroner may make 'whatever inquiries seem necessary' in order to see whether the duty arises: section 1(7)(a). This could include cases such as suspected death from mesothelioma, where it might be necessary to determine the deceased's employment history before deciding that the duty to investigate applies. These preliminary inquiries could also include a post-mortem examination under section 14(1)(b).
56. Special provisions are made in the event of 'the destruction, loss or absence of the body' believed to have died 'in or near the coroner's area', including the discretion to make a report to the Chief Coroner (rather than the Lord Chancellor under section 15 of the 1988 Act): section 1(4)-(6).

## Purpose of the investigation

57. As under the 1988 Act, the matters to be ascertained (section 5(1)) are:
- (a) who the deceased was;
  - (b) how, when and where the deceased came by his or her death;
  - (c) the particulars (if any) required by the 1953 Act to be registered concerning the death. (These particulars are referred to as 'findings' for the conclusion of an inquest: section 10.)
58. In deaths where Article 2 of the European Convention on Human Rights is engaged, the question of 'how' is treated more broadly and is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death (section 5(2)). This follows the principle set out in *Middleton (R (Middleton) v HM Coroner for Western Somerset* [2004] 2 AC 182).

## Beginning the investigation

59. The coroner must consider whether the duty in section 1(1) to investigate a death applies ('reason to suspect' etc). If it is necessary to begin an investigation, the coroner must attempt to identify the deceased's personal representative or next of kin and inform them of the decision (regulation 6). The Chief Coroner has provided checklists (including a checklist for notifications) for coroners' officers to use.

## Interested persons

60. Section 47 of the 2009 Act lists those who come within the definition of the term "interested person". This expands slightly the list of "interested persons" in rule 20(2) of the 1984 Rules and is intended to capture, for example, the role of the Independent Police Complaints Commission in conducting and managing some investigations. In addition to the specific list of those that fall into the category of "interested person", there is power for the coroner to determine that any other person is an interested person.
61. It is not intended that the coroner has to contact all family members listed in section 47(2)(a). In practice the coroner needs one point of contact with the family (or occasionally more than one when the family is divided) and any other interested persons that have made themselves known to the coroner.

## Transfers

62. The 2009 Act provides new mechanisms for the transfer of cases. A transfer of an investigation may be effected both by agreement (section 2 of the 2009 Act), as under section 14 of the 1988 Act, or by direction of the Chief Coroner (section 3).
63. The 2009 Act provisions and the equivalent regulations refer to **Coroner A** (the senior coroner who is under a duty to conduct the investigation) and **Coroner B** (the senior coroner for another area). Where Coroner A requests a transfer by asking Coroner B to conduct the investigation, Coroner A must give the Chief Coroner notice in writing of the request and the outcome (section 2(5)). A standard form has been provided.

64. The Chief Coroner may direct Coroner B to conduct an investigation (even though Coroner A was by virtue of section 1 under a duty to investigate): section 3(1). The Chief Coroner must give Coroner A notice in writing of the direction: section 3(4).
65. Where Coroner B conducts the investigation following a transfer by agreement or on the Chief Coroner's direction, Coroner B must do so 'as soon as practicable': section 2(2) (transfer by agreement) and section 3(2) (transfer by Chief Coroner's direction).
66. Note that the Act does not use the word 'transfer', but neither did section 14 of the Coroners Act 1988. 'Inquest out of jurisdiction' (section 14 of the 1988 Act) has become 'investigation by other coroner' (heading before section 2, Coroners and Justice Act 2009).
67. The Secretary of State no longer has any role in the transfer process (cf section 14(2), Coroners Act 1988).
68. Sections 2 and 3 of the 2009 Act should be read alongside new regulation 18. This provides that when Coroner A and Coroner B agree a transfer, or where the Chief Coroner directs Coroner B to conduct the investigation, Coroner A must provide Coroner B with all relevant paperwork within five working days, unless there are exceptional circumstances preventing this. Coroner B must then notify all known interested persons of the transfer, again within five working days.
69. Sections 2 and 3 should also be read alongside regulation 19 on costs of transferred investigations. In the case of a transfer by agreement under section 2, responsibility for the costs associated with the investigation that are incurred after the point of transfer falls to the receiving coroner's (Coroner B's) local authority (mirroring previous practice).
70. However, for cases under section 3 where the Chief Coroner directs a coroner to conduct an investigation, the costs associated with that investigation remain with the transferring coroner's (Coroner A's) local authority (unless the Chief Coroner directs otherwise). In such cases, Coroner A's local authority's schedule of fees will apply. Coroner B is then accountable to Coroner A's authority for expenses incurred, as he or she would normally be accountable to his or her own authority.

#### Transfers of service personnel deaths to and from Scotland

71. Sections 12, 13 and 50 of the 2009 Act contain provisions which allow for investigations into the deaths of service personnel killed abroad on active service to be transferred from England and Wales to Scotland. A protocol has been agreed between the Ministry of Justice, Ministry of Defence, Scottish Government and the Chief Coroner on the process governing this. The Chief Coroner's office will co-ordinate any transfers under these arrangements.

#### **Post-mortem examinations**

72. Section 14 of the 2009 Act sets out the arrangements for ordering post-mortem examinations and makes slightly different provisions to sections 19 and 20 of the 1988 Act. It gives a coroner power to ask 'a suitable practitioner' to make a post-mortem examination of a body if either the senior coroner is responsible for conducting an investigation into the death of the deceased or requires a post-

mortem examination to determine whether the duty to investigate the death applies.

73. The term 'post-mortem examination' is not defined. It is expressed in such a way that it can include other forms of examination other than the so-called invasive post-mortem examination (autopsy). Cross-sectional imaging (the results of a CT scan or MRI scan) may also be used where appropriate. See the Chief Coroner's Guidance No.1 *The Use of Post-Mortem Imaging (Adults)*, 4 September 2013. The term "post-mortem examination" also includes the examination or testing of organs, tissue or fluids (which may be requested after the initial autopsy has been carried out).
74. Section 14 no longer differentiates between post-mortem and 'special examinations' and leaves it to the coroner to determine what sort of examination he or she would like the practitioner to make.
75. A 'suitable practitioner' is defined in section 14(3) as either a registered medical practitioner (i.e. a suitably qualified and experienced person on the General Medical Council's list of Registered Medical Practitioners with a licence to practise – this includes suitably qualified and experienced radiologists) or, where a particular form of examination is required, a practitioner who is of a type or description the Chief Coroner has designated as suitably qualified and competent to carry out such examinations. There are no plans at this stage to designate anyone other than registered medical practitioners as suitable practitioners.
76. Section 15 of the 2009 Act removes the previous restriction on where a post-mortem examination may take place, so this no longer needs to be within the coroner's district or a neighbouring district. The coroner has the same functions in relation to the body once it has been removed (paragraph 4 of Schedule 2). Wherever the examination takes place the coroner must at all times keep 'possession or control' of the body<sup>1</sup>, meaning for these purposes that wherever the body (including organs, tissues and fluids) is it must be kept at the coroner's direction and in circumstances within his or her knowledge.
77. These provisions should be read alongside regulations 11-17 of the Investigations Regulations. The new regulations on post-mortem examinations broadly replicate the previous provisions in rules 5, 7, 9, 9A and 10 of the 1984 Rules, although these have been simplified.
78. The coroner must request that the suitable practitioner conduct the post-mortem examination (P-M) as soon as reasonably practicable (regulation 11). This is a judicial decision, to be made by the coroner, although the administrative arrangements for the examination may be made by others. If a coroner decides that a P-M is necessary, he or she will notify relevant persons (regulation 13(3)). Regulation 13 also sets out who may attend the P-M. In addition, the coroner or the coroner's officer may also attend, but as a matter of everyday practice the coroner's officer should not be required to attend.
79. If the coroner has to request further tests (such as toxicology or histology) he or she should consider whether to release the body (see below). If the coroner has not already begun the investigation (i.e. the initial P-M was requested as part of the initial inquiries under section 1(7)) the coroner should now formally begin the

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<sup>1</sup> *R v Bristol Coroner, ex parte Kerr* [1974] 1 QB 652.

investigation, because the reason to suspect threshold in section 1(2) would have been passed. At that stage the coroner must inform the personal representative or next of kin, where known, that he or she has decided to begin an investigation (regulation 6).

### **Process following post-mortem examination (as part of investigation)**

80. Once the P-M process (including any histology or toxicology) has concluded, the coroner must decide whether to continue the investigation. There are three main options:
- **The P-M reveals that the deceased died of natural causes and the coroner thinks that it is not necessary to continue the investigation** (section 4(1)). The coroner must therefore discontinue the investigation (section 4(1)) and, on request, give an interested person an explanation of this decision in writing (section 4(4)). The coroner completes Form 100B, notifies the next of kin using Form 2 and takes no further action (regulation 17). No inquest will be held;
  - **The P-M reveals that the deceased died of natural causes but the coroner considers that it is necessary to continue the investigation** (section 4(1)). This could include cases where neglect might be a factor and the coroner wishes to test this at inquest. The coroner must then hold an inquest (section 6) and must open the inquest as soon as practicable (rule 5(1)); or
  - **After the P-M the coroner (still) has reason to suspect that the deceased died a violent or unnatural death, or the cause of death is unknown (section 1(2)(b))** or the deceased died while in custody/state detention (section 4(2)). The coroner must hold an inquest (section 6) and must open the inquest as soon as practicable (rule 5).
81. The Chief Coroner wishes to emphasise that there should be **no** use of pre-signed forms (Forms 100A and 100B).

### **Releasing the body for burial or cremation**

82. The Investigations Regulations require a coroner to release the body for burial or cremation as soon as practicable. If the coroner cannot release the body within 28 days of being made aware that the body is within his or her area then he or she must notify the known next of kin or personal representative of the deceased of the reasons for the delay (regulation 20).

### Burial and cremation

83. As previously, where the initial P-M indicates the cause of death (and the coroner decides not to investigate or to discontinue an investigation), the coroner will complete Form 100B and the registrar may authorise burial. If the body is to be cremated, the coroner will issue Cremation 6.
84. Where the initial P-M is inconclusive and the coroner is awaiting further test results, the coroner should formally start an investigation if he or she has not done so already. The coroner may at this stage authorise burial (using Form 3) or cremation, without having to open an inquest (regulation 21). In such cases a coroner may only issue an order authorising burial or cremation once he or she

is satisfied that the body is no longer needed for the purposes of the investigation. For those cases where the subsequent tests have revealed the cause of death and the coroner discontinues the investigation, the coroner should complete Form 100B and indicate that burial has already been authorised so that the registrar is aware.

85. Cremation can take place if a coroner's certificate is given where:
- (a) a post-mortem examination has been made and the cause of death has been certified by the coroner;
  - (b) an investigation has been commenced and the coroner is satisfied that he or she no longer needs the body for the purposes of the investigation; or
  - (c) the death of the deceased person occurred outside the British Islands and no post-mortem examination or inquest is necessary.

(Regulations 16 and 18 (as amended) of the Cremation (England and Wales) Regulations 2008.)

Annex A contains a detailed explanation of the process of release of bodies during pre-investigation stage and after an investigation has been commenced.

86. The important effect of these changes is that a coroner is now able to release a body, where appropriate, during the investigation stage of the process, without having to first open an inquest.

#### **Interim certificate of fact of death**

87. If an investigation has been commenced, the coroner may, on request, provide the next of kin or personal representative with a Coroner's certificate of fact of death (regulation 9). The coroner must use Form 1.

#### **Suspending the investigation (and adjourning an inquest)**

88. Schedule 1 to the 2009 Act sets out when a coroner can or must suspend and resume investigations. There are three specific situations where there is a duty to suspend and one general power.
89. (1) Paragraph 1 provides that a coroner must suspend an investigation if asked to do so by a prosecuting authority because someone may be charged with a homicide or related offence involving the death of the deceased. Homicide and related offences are defined in paragraph 1(6) of Schedule 1.
90. The suspension must be for at least 28 days. The coroner has the power to extend (more than once if needed) the period of the suspension if asked to do so by the person or authority which requested the original suspension.
91. (2) Paragraph 2 of Schedule 1 sets out the arrangements for suspension of the coroner's investigation when criminal proceedings have been brought in connection with the death. It is based on section 16 of the 1988 Act.
92. (3) Paragraph 3 (and 4) of Schedule 1 sets out the circumstances in which a coroner's investigation must be suspended where there is an inquiry under the Inquiries Act 2005. It is based on section 17A of the 1988 Act. Paragraph 4

further provides that in such circumstances, the terms of reference of that inquiry must include the purposes set out in section 5(1) of the 2009 Act – that is who the deceased was and how, when and where the deceased came by his or her death.

93. (4) Paragraph 5 of Schedule 1 provides a general power to a coroner to suspend an investigation where appropriate. This may be used, for example, if another investigation is being conducted into the death by the Independent Police Complaints Commission, the Health and Safety Executive or an Accident Investigation Branch, or if an investigation is being conducted in another jurisdiction, for example, if the death occurred abroad. Where this power is exercised, the coroner may resume the investigation at any time with sufficient reason (paragraph 10, Schedule 1).
94. Where an investigation is suspended under Schedule 1, it is highly likely that an inquest will have been opened, given the requirement in rule 5(1). (See also paragraph 101 below on registration.) The inquest must also be adjourned and if it is being held with a jury, the coroner may discharge the jury.
95. New rule 25 sets out the arrangements for adjourning and resuming inquests (see below). The coroner must notify interested persons of the decision to adjourn (and then resume) as soon as reasonably practicable. Additionally, rule 25 requires a coroner to adjourn and notify the Director of Public Prosecutions if during the course of an inquest it appears as though the deceased died due to a homicide offence.

### **Resuming the investigation**

96. If the coroner suspends an investigation because someone may be charged with a homicide or related offence, the investigation must be resumed once the relevant period has expired (paragraph 7 of Schedule 1).
97. Where the coroner has suspended the investigation because certain criminal proceedings have been brought, he or she can only resume an investigation if he or she thinks there is sufficient reason to do so. The investigation cannot be resumed until the criminal proceedings which triggered the suspension have come to an end in the court of trial, unless the prosecuting authority has confirmed it has no objection to this. The outcome of such an investigation resumed must be consistent with the result of the criminal proceedings which triggered the suspension. (Paragraph 8 of Schedule 1.)
98. Where the investigation was suspended because of an inquiry under the Inquiries Act 2005, the coroner can resume an investigation only if he or she thinks that there is sufficient reason for resuming it. It cannot be resumed until after 28 days have passed since either the date that the Lord Chancellor has notified the coroner as the date of conclusion of the inquiry or, where the coroner has received no such notification, the date of publication of the findings of the inquiry. Again, the coroner's investigation cannot reach a conclusion which is inconsistent with the outcome of the inquiry which triggered the suspension. (Paragraph 9 of Schedule 1.)

99. Where a coroner resumes an investigation under Schedule 1, the coroner must resume any inquest that was adjourned. If the inquest was started with a jury and then adjourned and the coroner decides to hold the resumed inquest with a jury, if at least seven members of the original jury are available to serve, then they will form the jury for the resumed inquest. If not, or if the original jury was discharged, a new jury must be summoned. (Paragraph 11 of Schedule 1.)
100. Where the coroner resumes an inquest as part of a resumed investigation, the coroner must notify the interested persons of the details of the resumed inquest hearing (rule 25(3)).

#### **Coroner certificate after suspension/adjournment**

101. When suspending an investigation (and adjourning an inquest) under Schedule 1, the coroner must provide the registrar with the particulars required to register the death (regulation 8). This replicates the effect of rule 29 of the 1984 Rules and section 16(4) of the 1988 Act. Before issuing a Form 120, the coroner must have opened an inquest. This is in line with regulation 45 of the Registration of Births and Deaths Regulations 1987. The coroner should also provide a certificate stating the result of any criminal proceedings or the outcome of the inquiry if the coroner considers it not necessary to resume the investigation. The coroner should use the revised (non-statutory) Form 121 for these purposes.

#### **Exhumation**

102. Paragraph 6 of Schedule 5 to the 2009 Act sets out the powers of a coroner to order the exhumation of a body. This largely replicates section 23 of the 1988 Act and enables a coroner to order the exhumation of the body of a person buried in England and Wales for the purposes of a post-mortem examination or for the purpose of any criminal proceedings or possible criminal proceedings in respect of the death of that person, or another person who died in circumstances connected to that person's death. New regulation 22 stipulates that the prescribed form (Form 4) must be used when the coroner orders an exhumation.

### **BLOCK 4 THE INQUEST**

103. Technically, the inquest is 'part of the investigation' (section 6). But for the purposes of the Rules and Regulations they are treated separately.
104. When the coroner conducts an investigation he must hold an inquest into the death: section 6. The duty to hold an inquest ceases when there is discontinuance under section 4.

#### **Timescale**

105. Under new rule 8 the inquest must be completed within six months from 'the date on which the coroner is made aware of the death, or as soon as is reasonably practicable after that date'.

#### **Opening of the inquest**

106. As noted above, it will not always be necessary to open an inquest at the beginning of the investigation process. A coroner should only open an inquest when the section 6 duty applies, and not while making preliminary inquiries under section 1(7). There will be some instances – such as natural cause deaths

in state detention – where a P-M may not be necessary and a coroner may choose to open the inquest immediately, but such instances should be rare.

107. New rule 5 requires the coroner to open an inquest as soon as is reasonably practicable after the date on which he or she considers the section 6 duty applies. It also requires the coroner, at the opening, to set the dates for any future hearings where this is possible. This reflects previous good practice. The Chief Coroner will also give guidance that coroners should give, where possible, directions at openings for the production of post-mortem and other expert or factual reports within a timescale.

#### **Pre-inquest review hearing**

108. New rule 6 formally recognises that pre-inquest review hearings (PIRs) are often held before the main inquest hearing. Where possible coroners should set out in advance of the hearing for all interested persons an agenda in writing and, where appropriate, invite written submissions to be considered at the hearing.

#### **Days on which an inquest may be held**

109. New rule 7 provides that inquest hearings must be held on working days unless there are urgent reasons for conducting the inquest at a weekend or on a bank holiday.

#### **Notification of inquest arrangements**

110. Rule 9 requires a coroner to notify relevant interested persons of the time, date and location of the main inquest hearing within one week of the hearing date being set. This is to allow such persons time to prepare for the inquest hearing. However, there may be occasions when it is in the interest of interested persons – and bereaved people in particular – to hold the inquest quickly, and rule 9 also permits this.

111. The rule also requires the coroner to make publicly available the date, time and place of the main inquest hearing. This could be on the coroner's website, in an e-mail to local media outlets, or on a regularly published list displayed at the coroner's court and will allow the media – and members of the public who may have an interest in a particular death – to attend the inquest hearing.

112. Where the hearing date changes, the coroner must notify relevant interested persons of the new arrangements within one week of the decision. The coroner must also make publicly available the revised arrangements within one week of the decision (rule 10).

#### **All hearings to be held in public**

113. Previously, rule 17 of the Coroners Rules 1984 required every inquest to be held in public, although the coroner might direct that the public should be excluded from all or part of an inquest in the interests of national security. New rule 11 similarly requires coroners to hold all inquest hearings – including the opening of an inquest and any pre-inquest review hearing – in public, reinforcing the message that there should be transparency in the coronial process.

114. As with old rule 17, a coroner may exclude the public from any inquest hearing – or part of a hearing – on the grounds of national security. This rule applies to inquest openings and any pre-inquest hearing held by a coroner.

115. Additionally, under new rule 11(5) the coroner may direct that the public be excluded from any part of a pre-inquest review hearing if he or she considers it would be in the interests of justice to do so. The Chief Coroner will give guidance about the scope of this provision in due course.
116. Where a coroner is under a duty to investigate a death and therefore open an inquest 'as soon as is reasonably practicable' (rule 5), but, exceptionally, the coroner does not have immediate access to a public court or other public room to use as a court for the purposes of opening, the coroner may open the inquest in private and then state publicly that fact in open court at the first available opportunity thereafter.

### **Disclosure of information**

117. Part 3 of the Inquests Rules sets out new arrangements for the disclosure of information to interested persons. Under these new provisions a coroner must normally disclose copies of relevant documents to an interested person, on request, at any stage of the investigation process.
118. The term 'document' is defined in rule 2 as 'any medium in which information of any description is recorded or stored'. This includes such items as photographs and CCTV footage, as well as paper documents.
119. Disclosure should be by electronic means wherever possible, particularly where scanning equipment is available. If it is not possible to send documents to an interested person, then the coroner should allow such persons to inspect the documents. Documents may be redacted where appropriate (rule 14).
120. The new rules list the documents that should be disclosed (rule 13):
- Any post-mortem examination report;
  - Any other report that has been provided to the coroner during the course of the investigation;
  - Any recording of the inquest; or
  - Any other document which the coroner considers relevant to the inquest.
121. Importantly, there are restrictions on disclosure (rule 15). A coroner may refuse to provide a document or a copy of that document where:
- There is a statutory or legal prohibition on disclosure (for example police reports<sup>2</sup>);
  - The consent of any author or copyright owner cannot reasonably be obtained;
  - The request is unreasonable;
  - The document relates to contemplated or commenced criminal proceedings; or
  - The coroner considers the document irrelevant to the investigation.
122. In particular, the last restriction means that a coroner may refuse to disclose a document that is not relevant to an investigation (i.e. something that he or she does not intend to rely on at inquest).

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<sup>2</sup> See, for example, *Lagos v HM Coroner for the City of London* [2013] EWHC 423 (Admin).

123. Rule 13(1) requires a coroner to disclose documents as soon as reasonably practicable. This allows coroners some leeway if an interested person is likely to make a number of requests for documents in succession. A coroner may be entitled to wait, but not unreasonably, for a point where a bundle of documents could be disclosed together.
124. There is no charge for disclosure during an investigation but there may be a charge for disclosure after the investigation is finished (rule 16 and regulation 12 of the Allowances, Fees and Expenses Regulations 2013).
125. The Chief Coroner will be issuing guidance on disclosure.
126. The Chief Coroner may also request information from any coroner at any time about a particular investigation or investigations generally (regulation 25).

### **Location of inquest hearing**

127. The restriction on holding an inquest within the coroner's district was lifted when section 5(2) of the 1988 Act was repealed in February 2013. There is no equivalent provision in the 2009 Act, which allows inquests to be held anywhere in England and Wales. The Chief Coroner's Guidance No.2 *Location of Inquests* should, however, be followed.
128. This makes clear that inquests should normally be held within the coroner's area unless there are exceptional circumstances, such as a lack of available and appropriate court space for a jury inquest, or where it may be in the best interests of bereaved relatives to hold the inquest at a different location.
129. In reaching a decision on the venue for an inquest, as with all the other inquest arrangements, the coroner should take due account of the views of interested persons including bereaved relatives and the distances they may have to travel to attend the inquest.

### **Power to require evidence to be given or produced**

130. Paragraph 1 of Schedule 5 to the 2009 Act gives a coroner power to summon witnesses and to compel the production of evidence for the purposes of an investigation (paragraph 1(2)) or an inquest (paragraph 1(1)) by way of written notice. A new non-statutory form is available for these purposes.
131. Paragraph 2 makes it clear that the coroner does not have the power to require anything to be provided to him or her that a person could not be required to provide to a civil court, mirroring the restriction on many information gathering powers contained in other statutes. The coroner also does not have the power to require evidence to be provided if this would be incompatible with European Union law. It is also made clear that the rules of law in relation to public interest immunity apply equally in relation to investigations or inquests.
132. The 2009 Act does not remove or alter the powers of a coroner under the common law to summon witnesses, require evidence to be given and punish for contempt of court.
133. Coroners should not be too hasty to exercise these powers. They should only be used where necessary and where other methods have failed. Much can be

achieved by agreement with, for example, local hospitals, on regular procedures for the production of witness statements, medical notes and reports.

### **Offences relating to witnesses and evidence**

134. Schedule 6 to the 2009 Act sets out offences relating to witnesses and evidence and the penalties. The offences include failure to comply with a notice under paragraph 1 of Schedule 5 requiring evidence to be given or produced, altering evidence, preventing evidence from being given, destroying or concealing documents, and giving false evidence. These offences are new, as the coroner is given the power to compel evidence in these provisions.

### **Evidence by video-link**

135. New rule 17 expressly allows the coroner to direct that a witness may give evidence via a live video link when it will allow the inquest 'to proceed more expediently' or where this is otherwise in the interests of justice.

136. This will apply, for example, when the coroner decides this is likely to improve the quality of evidence or where there is another suitable reason (for example where the witness is in a prison, or cannot travel to the inquest for health or other reasons).

### **Screened evidence**

137. New rule 18 allows the coroner to direct that a witness may give evidence from behind a screen when the coroner decides this would be likely to improve the quality of the witness's evidence or is in the interests of justice or national security. When making a decision the coroner must consider all the circumstances of the case, for instance the views of the witness, and the impact on the questioning of the witness if he or she is behind a screen.

### **Evidence**

#### Evidence under oath

138. Witnesses at an inquest must give evidence under oath (or affirmation) unless they are too young to do so (rule 20).

#### Written evidence

139. The old rule 37 of the Coroners Rules 1984 on documentary or written evidence had been criticised by some as being unduly complicated and restrictive. The old rule permitted the coroner to admit documentary evidence if it was not, and was unlikely to be, disputed. The coroner might also accept documentary evidence, even if it was objected to, if the maker of the document could not give oral evidence within a reasonable timescale or had died. Such evidence normally had to be read aloud at the inquest.

140. New rule 23 expands old rule 37 by saying that written evidence should be admissible where the coroner is satisfied that:

- the maker of the written evidence cannot attend the inquest to give evidence at all, or within a reasonable time (perhaps due to a severe disability);
- there is good and sufficient reason why the maker of the written evidence should not attend (for instance where the person is abroad or ill);

- there is good and sufficient reason to believe that the maker of the written evidence will not attend (even though there may not be a justified reason for non-attendance); or
- the coroner considers the evidence is unlikely to be disputed.

141. New rule 23 also provides for the coroner to have such evidence, or part of it, read aloud. It allows written evidence to be provided in admissions form and permits the coroner to admit written evidence that comes to light during the inquest hearing. Admissions (as in civil and criminal proceedings) are admitted facts which the interested persons agree, either before the inquest or during it, and put in writing, so that the coroner can read them out and where appropriate give to a jury.

142. The Chief Coroner wishes to encourage coroners to admit written evidence wherever possible, as in other courts, particularly where the evidence is unlikely to be disputed. Without in any way jeopardising the process of justice, reading statements can save money and court time, and avoid the inconvenience of witnesses being brought to court unnecessarily.

### **Inquiry findings**

143. New rule 24 allows a coroner to admit the findings of a public inquiry if the coroner considers them relevant to the purposes of the inquest. This is based on old rule 37A.

### **Recording proceedings**

144. Previously, under rule 39 of the 1984 Rules a coroner had to 'take notes of evidence' at an inquest. Rule 57 then required the coroner to provide to any interested person, on application and on payment of a fee, a copy of such notes of evidence. The High Court has said that a recording can be used in lieu of the coroner making notes<sup>3</sup> and a number of coroners have used this method.

145. New rule 26 recognises this and requires a coroner to make a recording of proceedings. The duty to record proceedings relates to the main inquest hearing and any pre-inquest review.

146. There is therefore no longer any legal requirement to take notes of evidence or provide them after the inquest. As a matter of practice coroners will no doubt continue to take notes for their own purposes, for example to help them make findings of fact leading to a conclusion or in preparation for delivering a summing up.

147. Read alongside new rule 13 on disclosure, the coroner should, on request, provide copies of the recording to interested persons. When providing a recording of an inquest, a coroner should place limitations on its use. The Chief Coroner has issued guidance to coroners that each recording must be supplied with a written notice warning that misuse may be a contempt of court<sup>4</sup>. (See the Chief Coroner's Guidance No.4 *Recordings*, 16 July 2013.)

148. Disclosure will not be appropriate in all circumstances (for example where members of the public are excluded from the hearing on grounds of national

<sup>3</sup> *Ex parte Thompson* (1982), cited in *Jervis on Coroners* 12<sup>th</sup> Edn., 12-148.

<sup>4</sup> See *A-G v Scarth* [2013] EWHC 194 (Admin)..

security) and care will have to be taken by coroners not to release a recording which could reveal personal details of a child or anonymous witness. In such cases, a coroner should consider whether a redacted copy of the recording, or where that is not possible, a redacted transcript should be made available instead.

149. Coroners may charge an administrative fee of £5 (per CD or memory stick) for providing a copy of a recording (rule 16, Inquests Rules; regulation 12(4), Allowances, Fees and Expenses Regulations 2013). Transcripts may be charged for at the rate set out in regulation 12(5) of the Allowances, Fees and Expenses Regulations 2013.

### **No address as to facts**

150. New rule 27 replicates old rule 40 and provides that no person shall be allowed to address the coroner or the jury as to the facts.

### **Jury inquests**

151. An inquest **must** be held **without** a jury unless section 7 applies (section 7(1)). Section 7 sets out the limited circumstances in which a coroner is required to hold a jury inquest. It also gives the coroner the power to decide to hold an inquest with a jury in any case where he or she thinks there is 'sufficient reason'. It is modelled on section 8(3)(d) of the 1988 Act.
152. A jury must be summoned where the deceased died while in custody or state detention, and the death was violent or unnatural, or of unknown cause; where the death resulted from an act or omission of a police officer or member of a service police force (defined in section 48) in the purported execution of their duties; or where the death was caused by an accident, poisoning or disease which must be reported to a government department or inspector. This includes, for example, certain deaths at work.
153. Jury inquests are no longer required where the deceased died in custody but from natural causes.
154. Section 8 sets out the arrangements for summoning and swearing in a jury. There must be no fewer than seven and not more than eleven people. This replicates the minimum and maximum number of jurors under section 8(2)(a) of the 1988 Act.
155. The coroner calls people from the electoral register to attend for jury service by issuing a summons stating the time that they are needed and the place that they must attend. New rule 29 requires a coroner to use the prescribed form (Form 1) in the Schedule to the Inquests Rules.
156. Section 8 also makes qualifications for jury service at a coroner's inquest the same as for the Crown Court, the High Court and the county court, in accordance with section 1 of the Juries Act 1974. This reproduces the requirements of section 9(1) of the 1988 Act. The coroner also has a power to summon a jury in exceptional circumstances (new rule 30, which is based on old rule 48 - traditionally known as *tales* rather than *quales*).
157. Under new rule 33, the coroner must direct the jury as to the law and provide the jury with a summary of the evidence. This is based on old rule 41.

158. A jury will be initially directed by the coroner to reach a unanimous conclusion (section 9). If the coroner thinks that the jury has deliberated for a reasonable time without reaching a unanimous conclusion, he or she may accept a conclusion on which the minority consists of no more than two persons. The jury foreman (man or woman) should announce publicly how many agreed. If the required number of jurors does not agree, the coroner may discharge the jury and summon a fresh jury and the case will be heard again.
159. All jurors (or those in the statutory majority) must sign the completed Record of an inquest form (Form 2 in the Schedule to the Inquests Rules).
160. Part 1 of Schedule 6 to the 2009 Act sets out offences relating to jurors. These include service on a jury by those who know they are disqualified from such service, failure to attend a coroner's jury and making false representations to avoid jury service. These offences reflect those jury-related offences in section 9 of the 1988 Act.

### **Legal assistance**

161. Section 51 of the 2009 Act would have brought advocacy at certain inquests within the scope of the legal aid scheme but this has been repealed by the Legal Aid, Sentencing and Punishment of Offenders Act 2012.
162. As previously, legal aid remains available for representation for individual inquests where there are exceptional circumstances, and the old criteria for funding these inquests remain in place. Legal Help also remains available in inquest proceedings, where applicants qualify financially.

### **Conclusion of the inquest**

163. Previously, the coroner, or jury where there was one, completed an Inquisition at the end of an inquest, including a verdict that set out the conclusions of the coroner or jury as to the death in question (Form 22 of the Coroners Rules 1984). This form was replaced by Form 2 in the Schedule to the Inquests Rules which is entitled 'Record of an inquest'. The words 'inquisition' and 'verdict' are no longer used. 'Inquisition' is considered to be outdated (and section 11(5) of the 1988 Act was repealed) and 'verdict' is considered to be inappropriately close to criminal proceedings.
164. Verdicts are therefore now known as conclusions and are set out on the Record form. Most of the conclusions listed in the Record form were previously used by coroners. Two new additions are 'alcohol/drug related' and 'road traffic collision'.
165. As before, conclusions may 'not be framed in such a way as to appear to determine any question of:
- (a) criminal liability on the part of a named person, or
  - (b) civil liability' (section 10(2)).

166. The Record, in addition to the conclusions (short-form or narrative), includes the statutory 'determinations' and 'findings'. Under section 10 of the 2009 Act, the coroner (or jury, where there is one) must make a 'determination' in respect of the familiar section 5 questions: who the deceased was and how, when and where the deceased came by his/her death. For cases where Article 2 of the ECHR applies, the 'how' becomes 'in what circumstances' the deceased came by his or her death (section 5(2)).

167. The statutory 'findings' are the particulars required by the Births and Deaths Registration Act 1953 for registration of the death, as was required by section 11(3)(b) and (4)(b) of the 1988 Act.

168. All of the conclusions, determinations and findings should be recorded in the 'Record of an inquest' form (see new rule 34 and the prescribed form in the Schedule to the Inquests Rules).

169. The coroner and/or jurors must sign the completed Record.

170. The Chief Coroner will be issuing further guidance on conclusions of the inquest.

### **Treasure**

171. There are no immediate plans to implement the treasure provisions in Chapter 4 of Part 1 of the 2009 Act. Instead, coroners have jurisdiction to investigate treasure finds within their coroner areas, as before.

## **BLOCK 5 POST-INQUEST**

### **Reports to prevent future deaths (PFD reports)**

172. The 2009 Act (paragraph 7 of Schedule 5) elevates the old 'Rule 43' provisions to primary legislation. A coroner is now under a duty to report actions to prevent future deaths (or 'other' deaths in the language of the 2009 Act) to a person who the coroner believes may have the power to take such actions. (Rule 43 only stated that the coroner 'may' make such a report.)

173. The coroner must make a report where the investigation he or she has been conducting reveals something which gives rise to a concern that there is a risk of deaths in the future and that action should be taken to eliminate or reduce that risk (paragraph 7). The coroner may recommend that action should be taken, but not what that action should be: see the Chief Coroner's Guidance No.5 *Reports to Prevent Future Deaths*, 4 September 2013.

174. The new regulations 28 and 29 replicate the detail of the old rule 43 provisions, but with some important changes. The new regulations strengthen the previous provisions by requiring any person responding to a coroner's report of action to prevent future deaths to include in the response to the coroner a timetable for the action proposed to be taken to prevent other deaths.

175. In addition the regulations say that all reports and responses to them must be sent to the Chief Coroner (not the Lord Chancellor), and that the Chief Coroner may publish these or summaries of them. The coroner may also send copies to anyone whom he or she thinks will find it useful.

176. The time limit for responding to the coroner's report remains at 56 days, with the possibility of the coroner extending this.

### **Post-inquest disclosure**

177. As noted above, interested persons can request disclosure of information before, during or after an inquest. For requests made after an inquest, the coroner can charge for disclosure in line with rule 16 of the Inquests Rules and regulation 12 in the Allowances, Fees and Expenses Regulations. Coroners should not retain fees paid for disclosure. These should be submitted to the local authority.

### **Challenging a coroner's decision**

178. The 2009 Act originally set out a number of new rights of appeal to the Chief Coroner against decisions of coroners. During the debates on the Public Bodies Bill in 2011, Parliament however agreed to repeal these provisions.

179. Instead, the means of redress existing previously remain in place, so that decisions are still contested by way of judicial review or by application by, or under the authority of, the Attorney General to the High Court under section 13 of the 1988 Act.

180. Section 13 has been preserved and amended to reflect the terminology of the 2009 Act<sup>5</sup>. The High Court is therefore able to order an 'investigation' into a death (where the coroner has refused or neglected to hold an investigation or an inquest) or a fresh investigation where a coroner has already held one. The High Court can refer cases back to the coroner for the area concerned or another coroner within the area. However, the powers in sections 2 and 3 of the 2009 Act allow the investigation to be transferred to a different coroner.

### **Retention of documents**

181. New regulation 27 replicates old rule 56 of the 1984 Rules. A coroner must retain documents in connection with an investigation or post-mortem examination for 15 years. The new regulation does, however, allow the Chief Coroner to direct a coroner to keep a document for a different length of time.

182. The Chief Coroner intends to issue joint guidance with the Keeper of Public Records to coroners on retention of documents.

## **BLOCK 6 REPORTING**

### **Annual report**

183. Under section 36 of the 2009 Act the Chief Coroner is required to produce an annual report to the Lord Chancellor. The report will be a statement on the coroner system for the previous calendar year. The report must contain an

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<sup>5</sup> The Coroners and Justice Act 2009 (Consequential Provisions) Order 2013

assessment of consistency of standards between coroner areas; information about investigations that have taken over 12 months to complete; and a summary of reports to prevent future deaths and the responses to these.

184. The report must be given to the Lord Chancellor by 1 July the following year. The Lord Chancellor will then publish the report and lay copies in Parliament.

185. In order to allow the Chief Coroner to report on time, it is essential that coroners provide the necessary information – including the annual statistical return to the Ministry of Justice – on time, to allow the 1 July deadline to be met.

### **Statistical returns**

186. Coroners are still required to submit annual statistical returns to the Ministry of Justice. For 2013, the return should be submitted in the normal way. While there have been some changes to terminology as a result of the 2009 Act changes, this should not alter the statistical report.

187. Where coroner areas have merged over the course of a reporting period, the coroner will be expected to provide a single return for the combined area for the calendar year.

### **Power for the Chief Coroner to require information**

188. New regulation 25 allows the Chief Coroner, at any time, to require information from a coroner in relation to any particular investigation, or investigations more generally. A coroner must provide this information (regulation 25(2)). The Chief Coroner might use this in his annual report or if he has concerns about a particular coroner's service.

### **Investigations lasting more than a year**

189. Section 16 of the 2009 Act requires a coroner to notify the Chief Coroner of any investigation that lasts more than a year and to notify the Chief Coroner of the date on which any such investigation was subsequently concluded.

190. The year starts on the date that the death is reported to the coroner. It is essential, therefore, that this date is captured at the outset of the investigation (as it should be under regulation 5 – register of reported deaths). The requirement in section 16 only apply to investigations under the 2009 Act and not to deaths that had been reported before the current provisions came into force. That means, in practice, that the first investigations will not be reported to the Chief Coroner until July 2014.

191. The Chief Coroner will maintain a register of these investigations and the Chief Coroner and the Ministry of Justice are considering how this will work in practice. The Ministry is also considering how reports from coroners will work in practice, and whether this can be automated using IRIS.

192. As part of his annual report to the Lord Chancellor, the Chief Coroner must report on the number and length of investigations reported to him (including those reported in the previous year that are still outstanding), the reasons for the length of these investigations, and the measures he is taking to keep investigations from becoming unnecessarily lengthy.

193. New regulation 26 therefore requires the coroner to include the reasons for the delay when notifying the Chief Coroner of either an ongoing investigation that

has gone beyond a year, or such an investigation that has previously been notified to the Chief Coroner and has now been concluded.

## **BLOCK 7 PROVISIONS REPEALED OR NOT BROUGHT INTO FORCE**

194. The following provisions in the 2009 Act have now been repealed:

- Section 39: Inspection of the coroner system;
- Section 40: Appeals to the Chief Coroner; and
- Section 51: Public funding for advocacy at certain inquests.

195. The Government does not intend to implement the following provisions at this stage:

- Medical examiners and death certification: sections 18-21 (due date October 2014);
- Treasure: sections 25-31, Schedules 4 and 10;
- Deputy Chief Coroners: section 35, Schedule 8;
- Medical Adviser to the Chief Coroner: section 38, Schedule 9; and
- Powers of entry, search and seizure: paragraphs 3-5, Schedule 5

## **BLOCK 8 FORMS**

196. The Investigations Regulations and the Inquests Rules have the following statutory forms attached to them:

### Regulations

- Form 1 – Coroner’s certificate of fact of death
- Form 2 – Notice of discontinuance (under section 4 of the 2009 Act)
- Form 3 Order for burial
- Form 4 – Direction to exhume

### Rules

- Form 1 – Juror summons (with form to be returned by person being summoned)
- Form 2 – Record of an inquest

197. Other, non-statutory forms have been updated on IRIS and new forms have been added. For non-IRIS users, Word or PDF versions are available.

## Summary of investigation process

### Death reported to coroner

- The coroner (or his or her office) is notified that a body is within his/her area (section 1(1)).
- As previously, the coroner records the date that the death is reported to him or her (which is needed to fulfil the section 16 duty - 'Investigations lasting more than a year').
- The identity of the deceased and the place of death or where the body was found must also be recorded when known (regulation 5(2)).
- The coroner decides whether the duty to investigate the death in section 1 applies ('reason to suspect' etc: section 1(2)).

There are then three possible scenarios:

#### 1. Pre-investigation (no further action) cases

- The coroner may make preliminary inquiries to determine whether the section 1 duty applies (section 1(7)). This could include cases such as suspected death from mesothelioma, where it might be necessary to determine the deceased's employment history before deciding that the duty to investigate applies.
- The preliminary inquiries could include a P-M (section 14(1)(b)).
- If the coroner concludes that the duty does not apply, he or she releases the body for burial or cremation and may complete Form 100A (no post-mortem) or Form 100B (with post-mortem) as appropriate.

#### 2. Investigation without inquest

- If the coroner has reason to suspect etc and begins an investigation, he or she must notify the deceased's personal representative or next of kin (where known). This need not be in writing (regulation 6).
- The coroner may request a suitable practitioner to make a post-mortem examination (P-M) of a body (section 14).
- If the coroner requests histology or toxicology but no longer needs the body then this could be released for burial or cremation (regulation 21 and Cremation Regulations (as amended)).
- The coroner may, on request, provide the next of kin or personal representative with a Coroner's certificate of fact of death (regulation 9), using Form 1.
- The P-M reveals that the deceased died of natural causes **and** the coroner thinks that it is not necessary to continue the investigation (section 4(1)). The coroner must discontinue the investigation and notify the next of kin using Form

2 (regulation 17) and, on request, give an interested person an explanation of this decision in writing (section 4(4)) using the new standard form.

- The coroner completes Form 100B and takes no further action (regulation 17). No inquest will be held.

### 3. Investigation with inquest

An inquest may be necessary in the following circumstances:

- If there is no P-M but the coroner considers the duty to investigate still applies, then the coroner must hold an inquest (section 6) and open the inquest as soon as practicable (rule 5).
- A P-M reveals that the deceased died of natural causes but the coroner considers that it is necessary to continue the investigation (section 4(1)). This could include cases where neglect might be a factor and the coroner wishes to test this at inquest. The coroner must then hold an inquest (section 6) and must open the inquest as soon as practicable (rule 5(1)).
- After the P-M the coroner (still) has reason to suspect that the deceased died a violent or unnatural death or the cause of death is unknown (or the deceased died while in custody/state detention) (section 4(2)). The coroner must hold an inquest (section 6) and must open the inquest as soon as practicable (rule 5).

### Release of body for cremation or burial

#### General provisions

- The coroner must release the body as soon as practicable. If the coroner cannot release the body within 28 days of being made aware that the body is within his or her area then he or she must notify the known next of kin or personal representative of the deceased of the reasons for the delay (regulation 20).
- Once a coroner has commenced an investigation, he or she may only issue an order authorising burial or cremation once he or she is satisfied that the body is no longer needed for the purposes of the investigation (regulation 21).

#### Release of body during pre-investigation stage

- If the coroner decides that neither an investigation nor any P-M is necessary, the coroner may issue Form 100A to the registrar. The registrar issues a burial order or the doctors arrange the completion of any necessary cremation forms; **or**
- If the coroner decides a P-M is necessary (and requests one under s.14(1)(b)) then:
  - i. If as a result of the P-M the coroner decides that there is a natural cause of death and that **no** investigation is needed, the coroner issues Form 100B to the registrar. (**NB:** Note that the IRIS version of this form states "I am satisfied that it is not necessary to continue the investigation". This will be amended in due course but coroners should

continue to use this version for now.) If the body is to be cremated, the coroner issues Cremation 6, ticking the box *“a post-mortem examination of the body of the deceased has been made by my direction or at my request and as a result I am satisfied that an inquest is unnecessary.”* If the body is to be buried, then the registrar issues a burial order; **or**

- ii. If the result of the P-M is inconclusive, the coroner will then start an investigation (as s.1(2) is engaged).

Investigation stage (coroner considers that s.1(2) is engaged)

- The coroner decides that a P-M is necessary (and requests one under s.14(1)(a)).
- If as a result of the P-M the coroner decides that there is a natural cause of death and that **no** further investigation is needed, he –
  - i. Issues Form 100B to the registrar;
  - ii. Discontinues the investigation under s.4(1) and issues Form 2 under regulation 17; and
  - iii. If the body is to be cremated, the coroner issues Cremation 6, ticking the box *“a post-mortem examination of the body of the deceased has been made by my direction or at my request and as a result I am satisfied that an inquest is unnecessary.”* If the body is to be buried, then the registrar issues a burial order; **or**
- If the result of the P-M is inconclusive (but s.4(2) requiring an inquest is not necessarily engaged) the coroner can then continue the investigation and:
  - i. Order any additional examinations (what would be s.20 “special examinations” under the 1988 Act); and/or
  - ii. Have further inquiries made using para.1(2) of Schedule 5 if necessary; and
  - iii. When the body is no longer required, issue the Cremation 6 ticking the box *“I have opened an investigation into the death of the deceased person”* or burial order using Form 3 under regulation 21(2), but only if Form 100B cannot yet be issued to the registrar; and
  - iv. Issue a Coroner’s certificate of fact of death (Form 1 under regulation 9), but only if Form 100B cannot yet be issued to the registrar;
- When the full results of the P-M and investigation are known, the coroner decides that there is:
  - i. a natural cause of death and that **no** inquest is necessary –
    - the coroner issues Form 100B to the registrar, indicating whether burial or cremation has already been authorised. (**NB**: The IRIS version of Form 100B only refers to cremation. If burial has been authorised, the coroner should indicate this in the 'Certificate for Cremation' box. The form will be updated in due course.); and
    - discontinues the investigation under s.4(1) and issues Form 2 under regulation 17; **or**

- ii. a cause of death that is either violent or unnatural or otherwise the provisions of s.4(2) are engaged, requiring an inquest to be held, the coroner will open an inquest.

Inquest stage (if at any time the coroner decides that the provisions of s.4(2) are engaged then he or she will open and conduct an inquest)

- When the body is no longer required, the coroner issues Cremation 6 ticking the box "*I have opened an investigation into the death of the deceased person*" or a burial order using Form 3 under regulation 21(2); and
- The coroner issues a Coroner's certificate of fact of death (Form 1 under regulation 9).
- When the inquest is completed the coroner will issue the registrar with Form 99 (Rev).

### **Certificate of fact of death**

- The coroner may, on request, provide the next of kin or personal representative with a Coroner's certificate of fact of death (regulation 9). The coroner must use Form 1.

### **Opening the inquest**

- A coroner who begins an investigation into a person's death must hold an inquest into the death (section 6) unless the coroner discontinues the investigation after a post-mortem examination (section 4(3)(a)).
- An inquest should be opened as soon as reasonably practicable after the date on which the coroner considers he or she is under a duty to hold an inquest (rule 5). It must be opened in public (rule 11) and adjourned to a fixed date (rule 5), which will normally be within 6 months (rule 8).

### **Suspension of investigation/adjournment of inquest**

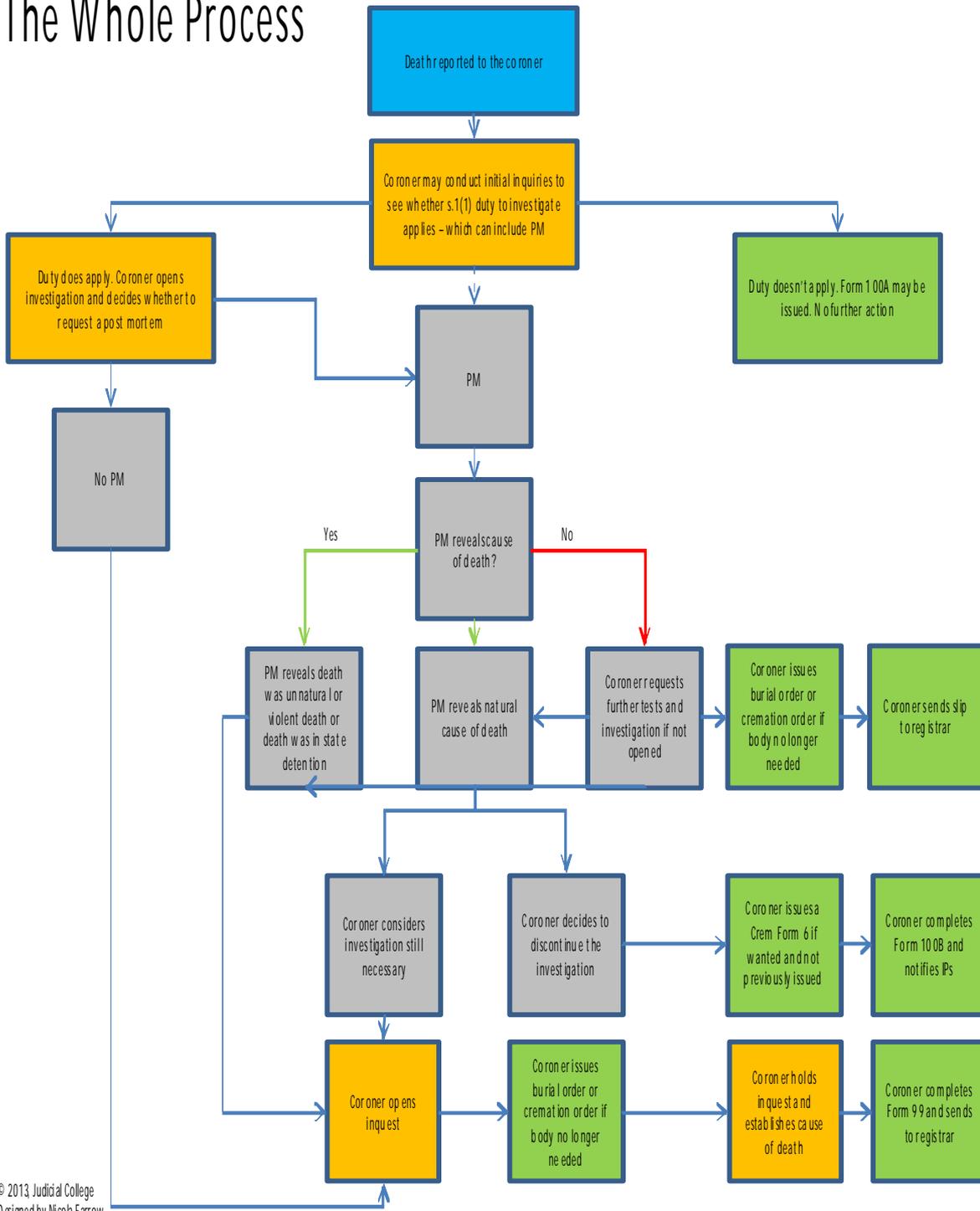
- A coroner must suspend an investigation (and if an inquest has been opened, adjourn that inquest) in the following circumstances:
  - If asked to do so by a prosecuting authority because someone may be charged with a homicide or related offence involving the death of the deceased (paragraph 1 of Schedule 1);
  - When criminal proceedings have been brought in connection with the death (paragraph 2 of Schedule 1);
  - Where there is an inquiry under the Inquiries Act 2005 (paragraph 3 of Schedule 1);
- A coroner may also suspend an investigation if it appears to him or her that it would be appropriate to do so (paragraph 5 of Schedule 1).

### **Registering the death when an investigation is suspended**

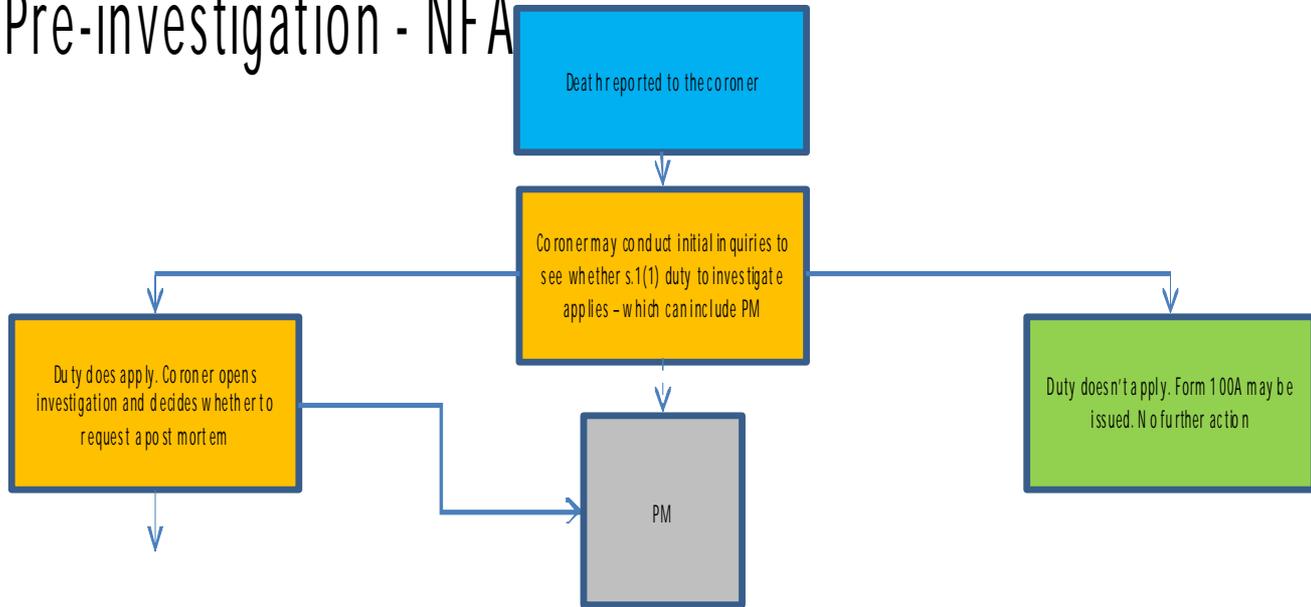
- When suspending an investigation (and adjourning any inquest) under Schedule 1, the coroner must provide the registrar with the particulars required to register the death (regulation 8). The coroner should use revised form 120.

# Overview of Investigation Process

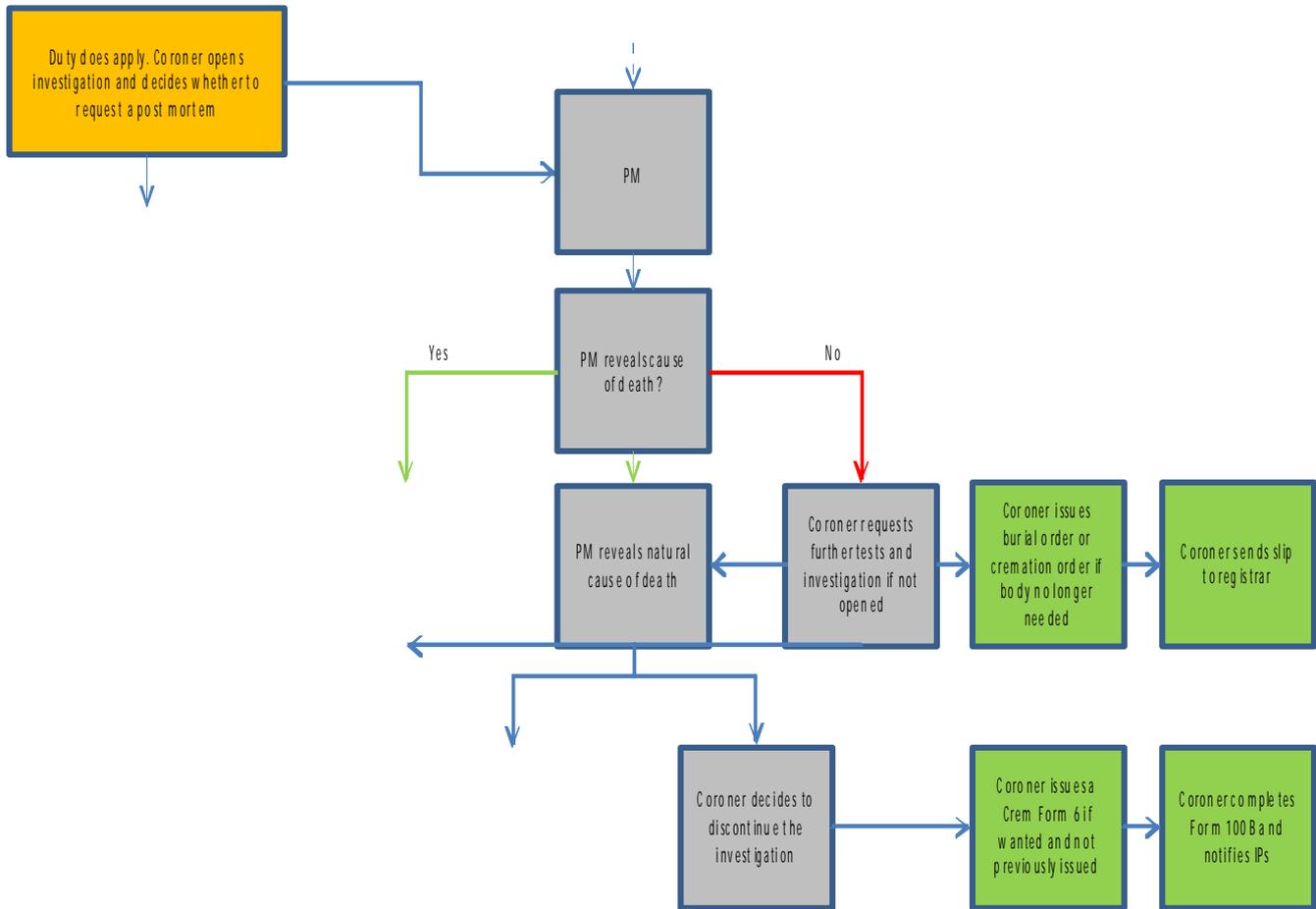
## The Whole Process



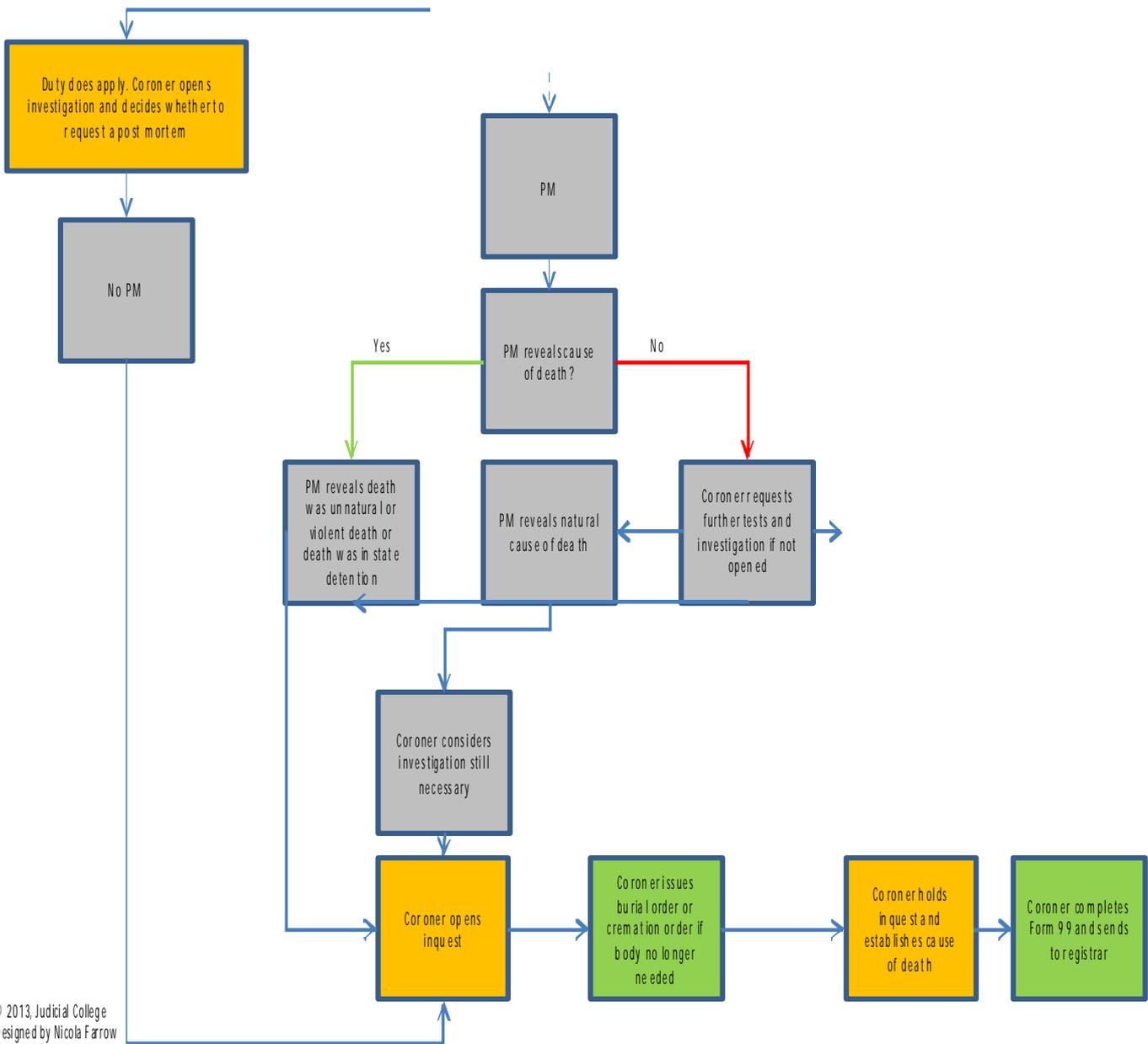
# Pre-investigation - NFA



# Investigation - No Inquest



# Investigation and Inquest



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**Summary of differences between Part 1 of the Coroners and Justice Act 2009 and the Coroners Act 1988**

2009 Act provision		Equivalent in 1988 Act?	Main differences
1	Duty to investigate certain deaths	s.5(1) s.8(1) s.15	<ul style="list-style-type: none"> <li>• New concept of 'investigation'</li> <li>• Requirement in s.8(1)(c) to investigate a "sudden" death where the cause is unknown deleted. Investigation of death "in prison" altered to death "in custody or state detention". (Broader definition of state detention – including immigration detention centres and secure mental health hospitals is contained in s.48(2) of the 2009 Act.) New requirements to investigate are (a) where the deceased "died a violent or unnatural death," or (b) "the cause of death is unknown", or (c) "died while in custody or otherwise in state detention".</li> <li>• Deaths where there is no body – Chief Coroner (rather than the Secretary of State) may direct a senior coroner to conduct an investigation.</li> <li>• New provision in s.1(7) allowing the senior coroner to conduct preliminary inquiries in order to determine whether the duty to investigate arises</li> </ul>
2	Request for other coroner to conduct investigation	s.14	<ul style="list-style-type: none"> <li>• Senior coroner must notify the Chief Coroner of any request made by him/her to transfer an investigation to another senior coroner.</li> </ul>
3	Direction for other coroner to conduct investigation	s.14(2)	<ul style="list-style-type: none"> <li>• Previously, if the coroner who had been requested to assume jurisdiction declined, the Secretary of State might on request designate the coroner who was to hold the inquest. Under the 2009 Act, the CC may direct a senior coroner to conduct an investigation (and this need not be on request).</li> </ul>
4	Discontinuance where cause of death revealed by post-mortem examination	s.19	<ul style="list-style-type: none"> <li>• New requirement for the coroner to explain why an investigation has been discontinued if asked to do so. There is also provision for a fresh investigation to be conducted if, for example, new information comes to light.</li> </ul>

2009 Act provision		Equivalent in 1988 Act?	Main differences
5	Matters to be ascertained	s.11(5)(b) and Rule 36(1)	<ul style="list-style-type: none"> <li>Subsection (2) requires the scope of the investigation to be widened to include an investigation of the broad circumstances of the death, including events leading up to the death in question, where this wider investigation is necessary to ensure compliance with the European Convention on Human Rights (ECHR), particularly Article 2.</li> </ul>
6	Duty to hold inquest	No	<ul style="list-style-type: none"> <li>Recognition of the inquest as the final part of the investigation process.</li> </ul>
7	Whether jury required	s.8(3)	<ul style="list-style-type: none"> <li>Removal of need for a jury where a death in state detention was suspected to be from natural causes.</li> </ul>
8	Assembling a jury	s.8(2)(a) s.9(1) s.9(4)	<ul style="list-style-type: none"> <li>Broadly the same as old provisions.</li> </ul>
9	Determinations and findings by jury	s.12	<ul style="list-style-type: none"> <li>Jury spokesperson to announce how many of the jurors agreed with determination or finding.</li> </ul>
10	Determinations and findings to be made	s.11 and Rule 36	<ul style="list-style-type: none"> <li>New concept of 'determination'. Short 'finding' to allow registration of death.</li> <li>No 'verdicts' or 'inquisitions'. (Coroners now complete a 'Record of an inquest')</li> <li>Where Article 2 engaged, determination must cover circumstances of the death</li> </ul>
11 and Schedule 1	Duty or power to suspend or resume investigations	Rules 26 and 27 s.16 s.17A	<ul style="list-style-type: none"> <li>General power for a coroner to suspend an investigation where he/she believes it would be appropriate to do so.</li> <li>In situations where an investigation has been suspended on the basis that the cause of death is likely to be adequately investigated by an inquiry set up under the Inquiries Act 2005, the terms of reference of that inquiry must include the purposes set out in section 5(1) of the 2009 Act (Matters to be ascertained).</li> </ul>

2009 Act provision		Equivalent in 1988 Act?	Main differences
12	Investigation in Scotland	No	
13	Investigation in England and Wales despite body being brought to Scotland	No	
14	Post-mortem examinations	s.19 s.20	<ul style="list-style-type: none"> <li>• New concept of 'suitable practitioner' – which could be of a type designated by the Chief Coroner.</li> <li>• Post-mortem examination to enable the senior coroner to determine whether duty to investigate arises.</li> <li>• Removal of distinction between P-Ms and 'special examinations' allowing senior coroner to determine the kind of examination he/she would like the practitioner to make.</li> </ul>
15	Power to remove body	s.22(1)	<ul style="list-style-type: none"> <li>• Senior coroner may order that the body be moved to any suitable place removing the restriction that a body can be moved only within a senior coroner's area or to an immediately adjoining district</li> </ul>
16	Investigations lasting more than a year	No	
17	Monitoring of and training for investigations into deaths of service personnel	No	
18	Notification by medical practitioner to senior coroner	No	<ul style="list-style-type: none"> <li>• Previous practice for medical practitioners to refer deaths to coroners where the death is suspected to be suspicious, violent or unnatural but not a statutory duty. New regulations will be introduced at the same time as the Medical Examiner scheme.</li> </ul>

2009 Act provision		Equivalent in 1988 Act?	Main differences
19	Medical examiners	No	<ul style="list-style-type: none"> <li>• Implementation in 2014.</li> </ul>
20	Medical certificate of cause of death		
21	National Medical Examiner		
22 and Schedule 2	Coroner areas	s.4 s.4A s.22(3)	<ul style="list-style-type: none"> <li>• Coroner 'districts' become coroner 'areas'</li> <li>• Lord Chancellor power to merge areas, even where there is a unitary authority</li> <li>• Each coroner area now covers the whole of one or more local authority area(s)</li> <li>• No equivalent provision to s.4A(8) (coroners in Wales have jurisdiction throughout Wales) although we have preserved this section.</li> </ul>
23 Schedule 3	Appointment etc of senior coroners, area coroners and assistant coroners	s.1 s.2 s.3	<ul style="list-style-type: none"> <li>• New titles for coroners</li> <li>• Local authorities responsible for <u>all</u> appointments (with consent of the Chief Coroner and the Lord Chancellor)</li> <li>• Coroners to be legally-qualified only (5 year judicial appointment eligibility condition rather than 5 year general qualification within the meaning of section 71 of the Courts and Legal Services Act 1990).</li> <li>• Lord Chancellor may determine by order whether the coroner area requires one or more area coroners and the minimum number of assistant coroners.</li> <li>• New retirement age of 70.</li> <li>• Extension of removal and discipline arrangements to <u>all</u> coroners.</li> <li>• Transitional arrangements (Schedule 22) apply to pre-2009 Act office holders.</li> </ul>

2009 Act provision		Equivalent in 1988 Act?	Main differences
24	Provision of staff and accommodation	s.31 s.5(2)	<ul style="list-style-type: none"> <li>• New duty on relevant local authority to provide staff and accommodation (s.31 simply stated that local authority 'may provide and maintain proper accommodation for the holding of inquests in their area').</li> <li>• Inquests may be heard anywhere in England and Wales, providing greater flexibility if suitable accommodation is not available in coroner's area (restriction in s.5(2) lifted in February 2013).</li> </ul>
25 and Schedule 4	Coroner for Treasure and Assistant Coroners for Treasure	s.30	<ul style="list-style-type: none"> <li>• Coroner for Treasure – single reporting point for all treasure finds in England and Wales.</li> <li>• Coroners to have no functions in relation to treasure finds.</li> <li>• 'Acquirers' under a duty to notify Coroner for Treasure of objects which might be treasure.</li> </ul> <p><b>There are no plans to implement these provisions at this stage. Instead, treasure inquests continue to be governed by section 30 of the 1988 Act.</b></p>
26	Investigations concerning treasure		
27	Inquests concerning treasure		
28	Outcome of investigations concerning treasure		
29	Exception to duty to investigate		
30	Duty to notify Coroner for Treasure etc of acquisition of certain objects		
31	Code of practice under the Treasure Act 1996		

2009 Act provision		Equivalent in 1988 Act?	Main differences
32 and Schedule 5	Powers of coroners	s.23 Rule 43	<ul style="list-style-type: none"> <li>• New statutory power to require evidence to be given or produced.</li> <li>• New statutory power of entry, search and seizure (although there are no plans to introduce these at this time).</li> <li>• Old rule 43 put on a statutory footing and strengthened (requiring coroners to report actions to prevent future deaths to the relevant person). Reports are copied to the Chief Coroner rather than the Lord Chancellor.</li> </ul>
33 and Schedule 6	Offences	s.9 (in relation to jurors)	<ul style="list-style-type: none"> <li>• New offences relating to witnesses including failure to comply with a notice under paragraph 1 of Schedule 5, altering evidence, preventing evidence from being given, destroying or concealing documents, and giving false evidence.</li> <li>• Common law powers to summon witnesses, require evidence to be given and punish for contempt of court will remain.</li> </ul>
34 and Schedule 7	Allowances, fees and expenses	s.24 - s.27A	<ul style="list-style-type: none"> <li>• Section 27 duty on coroners to produce accounts to the relevant council has been included in regulations instead: regulation 13, Allowances, Fees and Expenses Regulations 2013.</li> </ul>
35 and Schedule 8	Chief Coroner and Deputy Chief Coroners	No	
36	Reports and advice to the Lord Chancellor from the Chief Coroner	No	<ul style="list-style-type: none"> <li>• Coroners were under a duty to provide annual return to the Secretary of State under s.28 of the 1988 Act</li> </ul>
37	Regulations about training	No	

2009 Act provision		Equivalent in 1988 Act?	Main differences
38 and Schedule 9	Medical Adviser and Deputy Medical Advisers to the Chief Coroner	No	<b>No plans to implement this section at this stage.</b>
39	Inspection of coroner system	No	<b>Section now repealed</b>
40	Appeals to the Chief Coroner	No	<b>Section now repealed. Section 13 of the 1988 Act has been retained instead.</b>
41 and Schedule 10	Investigation by Chief Coroner or Coroner for Treasure or by judge, former judge or former coroner	No	<ul style="list-style-type: none"> <li>• A judge conducting an inquest previously had to be appointed as an assistant deputy coroner for the relevant district.</li> </ul>
42	Guidance by the Lord Chancellor	No	<ul style="list-style-type: none"> <li>• The Charter for Coroner Services is non-statutory guidance.</li> </ul>
43	Coroners regulations	s.32	<ul style="list-style-type: none"> <li>• The regulations capture the 'investigation' elements of the 1984 Rules (such as provisions relating to post-mortem investigations).</li> </ul>
44	Treasure regulations	No	<b>No plans to implement this section at this stage.</b>
45	Coroners rules	s.32	<ul style="list-style-type: none"> <li>• Lord Chief Justice (or nominee) to make the rules with the consent of Lord Chancellor, rather than the LC making the rules with the consent of the</li> </ul>

2009 Act provision		Equivalent in 1988 Act?	Main differences
			<p>Secretary of State.</p> <ul style="list-style-type: none"> <li>• Rules may make new provisions including: <ul style="list-style-type: none"> <li>- Power for senior coroner to direct that a person's name should not be disclosed;</li> <li>- Power for senior coroner to exclude specified persons from all or part of an inquest on the grounds of national security.</li> <li>- Power for senior coroner to exclude persons from an inquest during the giving of evidence by a person aged under 18.</li> </ul> </li> </ul>
46	Abolition of the office of coroner of the Queen's household	s.29 and Schedule 2	<ul style="list-style-type: none"> <li>• Office abolished.</li> </ul>
47	"Interested person"	Rule 20(2)	<ul style="list-style-type: none"> <li>• Expands definition to capture role of bodies such as IPCC.</li> </ul>
48	Interpretation: general	n/a	
49	Amendments to the Coroners Act (Northern Ireland) 1959	n/a	<b>No plans to implement at this stage.</b>
Schedule 11			
50	Amendments to the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976	n/a	
51	Public funding for advocacy at certain inquests	n/a	<b>Section now repealed</b>

**Comparison between the Coroner Rules 1984 and the Investigation Regulations 2013 and Inquests Rules 2013**

Rule in Coroners Rules 1984	Equivalent in new regulations or rules?		Comments/Main differences
	Regulations	Rules	
4 Coroner to be available at all times	Regulation 4		Now limited to urgent matters that cannot wait until the next working day.
5 Delay in making post-mortem to be avoided	11		Now specifies that it is the coroner must ask the suitable practitioner to make the P-M as soon as reasonably practicable.
6 Medical practitioner making post-mortem	-		Not required – covered by section 14 of the 2009 Act.
7 Coroner to notify persons of post-mortem to be made	13		No significant changes. The deceased's GP must now inform the coroner if he or she wishes to attend the P-M.
8 Person attending post-mortem not to interfere	-		This is not considered to be necessary.
9 Preservation of material from post-mortem examinations	14		Reference to the Human Tissues Act 2004 now added to 14(6)(c).
9A Further provisions relating to preservation of material from post-mortem examinations	15		No substantive change.
10 Report on post-mortem	16		No substantive change.

Rule in Coroners Rules 1984	Equivalent in new regulations or rules?		Comments/Main differences
	Regulations	Rules	
11 Premises for post-mortem			No equivalent provision. It is assumed that post-mortem examinations will be conducted in suitable premises.
12 Preservation of material from special examination			No equivalent provisions as the 2009 Act does not differentiate between post-mortem examinations and special post-mortem examinations.
12A Further provisions relating to preservation of material from special examinations			
13 Report on special examination			
14 Issue of burial order	21		New regulation adds/clarifies that a burial order can be made only when the coroner is satisfied that the body is no longer required for the purposes of the investigation.
15 Burial order where certificate for disposal of body issued		-	No longer required.
16 Formality		-	Not considered necessary.
17 Inquest in public		11	New requirement for the opening of an inquest and any pre-inquest review hearing to be held in public.
18 Days on which inquest not to be held		7	Became 'days on which an inquest may be held' but no substantive change.
19 Coroner to notify persons		9	Adds a new timescale that the coroner must notify all relevant interested

Rule in Coroners Rules 1984	Equivalent in new regulations or rules?		Comments/Main differences
	Regulations	Rules	
of inquest arrangements			persons of the date, time and place of the inquest within a week of setting the hearing date.  There is also a new requirement for the coroner to make details of the inquest publicly available before the inquest starts.
20 Entitlement to examine witnesses		19	Language simplified but no substantive change.
21 Examination of witnesses		21	No substantive change.
22 Self-incrimination		22	No substantive change.
23 Adjournment where inspector or representative of enforcing authority etc. is not present		25	Coroner now has a general power to adjourn an inquest.
24 Notice to person whose conduct is likely to be called in question		-	Not required as such a person is an interested person and as such will be notified of the inquest details under new rule 9.
25 Adjournment where person whose conduct is called in question is not present		-	Not required as such a person is an interested person and as such will be notified of the inquest details under new rule 9.
26 Request by chief officer of police for adjournment		-	

Rule in Coroners Rules 1984	Equivalent in new regulations or rules?		Comments/Main differences
	Regulations	Rules	
27 Request by Director of Public Prosecutions for adjournment		-	Not required – covered by Part 1 of Schedule 1 to the 2009 Act.
28 Coroner to adjourn in certain other cases		-	
29 Coroner to furnish certificate after adjournment	8		No substantive change.
30 Coroner's interim certificate of the fact of death	9		No substantive change.
31 Coroner to furnish certificate stating result of criminal proceedings		-	
32 Effect of institution of criminal proceedings		-	Not needed – this is covered by paragraph 2 (6) of Schedule 1.
33 Coroner to notify persons as to resumption of, and alteration of arrangements for, adjourned inquest		25	New requirement to notify interested persons 'as soon as reasonably practicable' of the decision to adjourn and the date the inquest is to be resumed (rather than giving 'reasonable notice' of the date).  New requirement to adjourn and notify DPP if during the course of the inquest it appears that the death was due to a homicide offence.
34 Recognizance of witness		-	Covered by paragraph 11 of Schedule 1 and juror summons form under rule

Rule in Coroners Rules 1984	Equivalent in new regulations or rules?		Comments/Main differences
	Regulations	Rules	
or juror becoming void			29.
35 Coroner to notify Crown Court officer of adjournment in certain cases		9, 25	Coroner has discretion to notify anyone he or she decides is an interested person.
36 Matters to be ascertained at inquest		-	Covered by section 5 of the 2009 Act.
37 Documentary evidence		23	Provision expanded to allow written evidence not only when the maker cannot attend but also when he or she will not attend (even though there may not be a justified reason for non-attendance).
37A Public inquiry findings		24	No substantive change.
38 Exhibits		-	Not required as this was considered to be too prescriptive.
39 Notes of evidence		26	The coroner no longer needs to keep notes of evidence. Coroners instead need to keep a recording of any inquest hearing.
40 No addresses as to facts		27	No substantive change.
41 Summing-up and direction to jury		33	No substantive change other than a preferred re-ordering, with directions of law first and summary of the evidence second.
42 Verdict		-	Not required. Section 10(2) of the 2009 Act says that a determination may not be framed in such a way as to appear to determine criminal or civil liability.

Rule in Coroners Rules 1984	Equivalent in new regulations or rules?		Comments/Main differences
	Regulations	Rules	
43 Prevention of future deaths	28		New regulations to be read in conjunction with paragraph 7(1) of Schedule 5 which largely replicates/updates parts 1-4 of the old rule 43. All reports must now be sent to the Chief Coroner rather than the Lord Chancellor. The Chief Coroner may then publish the report and responses or a summary of them.
43A Response to report under rule 43	29		Previously the coroner would decide whether there should be any restrictions on publishing a response, if requested by the respondent. Now the coroner should pass any requests to the Chief Coroner to decide.
43B Extension of time	29		Subsumed into regulation 29.
44 Summoning of jurors		-	No requirement for coroner to have regard to the convenience of the persons summoned and to their respective places of residence, and in particular to the desirability of selecting jurors within reasonable daily travelling distance of the place where they are to attend.
45 Method of summoning		29	Amended to require a coroner to use the prescribed form in the Schedule to the rules.
46 Notice to accompany summons		29 and Form 1	Schedule to the rules contains the former 'notice to accompany summons' regarding excusal.
47 Withdrawal or alteration of summons		-	No provision equivalent to 'If it appears to the appropriate officer, at any time before the day on which any person summoned under [section 8 of the 1988 Act] is to attend, that his attendance is unnecessary, or can be dispensed with, the appropriate officer may withdraw or alter the summons by notice served in the same way as a notice of summons'.
48 Summoning in exceptional circumstances		30	No substantive change.

Rule in Coroners Rules 1984	Equivalent in new regulations or rules?		Comments/Main differences
	Regulations	Rules	
49 Excusal for previous jury service		-	Not replicated.
50 Certificate of attendance		31	No substantive change.
51 Excusal for certain persons and discretionary excusal		29	Form 1 contains provisions regarding excusal.
52 Discharge of summons in case of doubt as to capacity to act effectively as a juror		29	Form 1 contains provisions regarding capacity.
53 Saving for inquests held by the coroner of the Queen's household		-	N/a – post of the coroner of the Queen's household is abolished.
54 Register of deaths	5		
55 Retention and delivery or disposal of exhibits	27		This separate provision is not considered necessary.
56 Retention and delivery of documents	27		Adds that the Chief Coroner may direct a coroner to retain a document for more or less than the standard fifteen years. Confirms that during the retention period the coroner may provide a document to someone who requests it and charge for this in accordance with regulations made under Schedule 7 to the 2009 Act.
57 Inspection of, or supply of copies of, documents etc	27	12 - 16	New provisions on disclosure including new requirement to disclose pre-inquest.

Rule in Coroners Rules 1984	Equivalent in new regulations or rules?		Comments/Main differences
	Regulations	Rules	
57A Supply of information concerning the death of children to Local Safeguarding Children Boards	24		No substantive change. Any superfluous technical detail removed.
58 Deputy or assistant deputy to sign documents in own name	-		Not needed as covered by paragraph 8 of Schedule 3 to the 2009 Act.
59 Transfer of documents etc. to next-appointed coroner	-		Not considered to be necessary.
60 Forms	Schedule	Schedule	Some of the 1984 forms are now statutory (see 'Forms' section above).