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Briefing: The role of the Coroner

Introduction

The Coroner is an independent judicial office holder charged with the investigation of certain deaths, if they have reason to suspect that:

- The death was violent or unnatural;
- The cause of death is unknown; or
- The deceased person died whilst they were in state detention (including custody, immigration detention centres and secure mental health hospitals).

We set out below some of the key points contained in The Coroners (Inquests) Rules 2013 ('the Rules') and The Coroners (Investigations) Regulations 2013 ('the Regulations').

Who are the Coroners?

The Chief Coroner heads up the Coroners Service in England and Wales. Their role includes providing support, leadership and guidance for Coroners.

'Senior Coroners' lead a Coroner area (of which there are 74 across England and Wales). Senior Coroners are supported by 'Area Coroners' and 'Assistant Coroners'. All Coroners must be legally qualified before appointment.

Coroners are supported by Coroner's Officers, who help the Coroner with their investigation and management of the inquest process.

In 2025, the Chief Coroner published guidance to promote consistency and encourage best practice; however, differences of approach are still seen and different Coroners can deal with matters in significantly different ways.

The investigation

The Coroners and Justice Act 2009 ('the 2009 Act') introduced the concept of a 'coronial investigation'. The whole process (including the inquest itself) is known as an investigation which commences as soon as a death is reported to the Coroner. The Coroner will wait until later in their investigation to decide whether or not to hold a formal inquest hearing. In our experience, it is worth noting:

- In recent years, there has been a substantial reduction in the number of inquests which return a conclusion of 'natural causes';

- The Coroner is empowered to issue a 'report to prevent future deaths' at any point during the investigation and, if necessary, without a formal hearing (see below, and our briefing note on 'Preventing future deaths'); and

- Formal inquest hearings can be long and complex with difficult questions to be determined and a number of witnesses called to give evidence.

The Coroner must attempt to identify the personal representative of the deceased's estate or 'next-of-kin' and keep them informed. The Coroner must not comment on or seek to determine matters of civil or criminal liability.

The purpose of the investigation

The 2009 Act says:
Matters to be ascertained

(1) The purpose of an investigation under this Part into a person's death is to ascertain—

(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.

(2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c. 42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.

You may have heard the term 'Article 2 inquest'. If Article 2 of the European Convention on Human Rights is engaged, the Coroner needs to investigate the circumstances surrounding a death. This can lead to an inquest with a significantly wider scope, looking in detail at the care and treatment within (or provided by) a state organisation along with policies and procedures. More witnesses are likely to be called, and a jury may well be empanelled. If Article 2 is engaged, the conclusion of an inquest might use language that is critical of an organisation or an individual, although the Coroner has to take care with drafting, as it would still be unlawful to determine matters of civil or criminal liability.

In our experience, Coroners sometimes determine the application of Article 2 at the conclusion of an inquest, and ensure their inquiry is Article 2-compliant in the meantime.

Interested persons

An inquest involves Interested Persons (IPs), rather than parties. An IP is someone who has the right to participate in the inquest process. They can be said to have an 'interest' in the outcome. This could be because of their relationship to the deceased or their involvement in the circumstances of the death. Both individuals and organisations can be IPs.

An IP is defined in section 47(2) of the 2009 Act. This sets out a long list of classes of people and organisations who may be deemed to be an IP. Amongst other categories, it includes family members, a person who may have caused or contributed to the death of the deceased, and any other person who the Senior Coroner thinks has a sufficient interest.

It is for the Coroner to review the facts of each matter and to identify those who should be IPs. With that said, if an organisation or individual believes they should be an IP, it is appropriate to contact the Coroner highlighting the position.

The rights of IPs during an inquest include:

- to be given advance notice of hearings, and to be informed of adjournments;
- to be provided with documents that are relevant to the inquest;
- to examine witnesses; and
- to make submissions to the Coroner regarding the inquest procedure and conclusions.

Transfers

Investigations can be transferred between Coronial jurisdictions. This can be done by the request of a Senior Coroner or by direction of the Chief Coroner. This can take place in order to transfer an investigation to a Coroner who is more experienced in handling a particular type of inquiry (e.g. a major disaster) but could include transfer for the convenience of the family.

Although it is not likely to be a major problem, this involves organisations, on occasions, dealing with Coroners and attending inquests much further afield than they may be used to.

Suspending the investigation or (if opened) the inquest

Organisations should bear in mind:

- The Coroner **must** suspend an investigation if requested by a prosecuting authority which may involve a charge of homicide or related offence or where such a criminal charge has been brought;
- The Coroner **must** suspend an investigation if there is a public inquiry into the deaths; and
- The Coroner **may** suspend an investigation where they feel it is appropriate (e.g. Health & Safety Executive (HSE) investigation).

The inquest

This is the final part of the investigation, if one is held. Hearings are to be in public unless there are reasons of national security or if it is in the interests of justice not to do so.

Time is of the essence

Coroners are under pressure to deal with matters quickly for the benefit of families. As a 'rule of thumb', inquests should be completed **within six months** from the date the Coroner is made aware of the death. Inquests not completed **within 12 months** must be reported to the Chief Coroner, with an explanation for the delay. In our experience, it is not uncommon for it to take longer than six months for the inquest process to be completed in more complex cases.

An inquest does not have to be opened straightaway but as soon as reasonably practicable once the Coroner determines that the duty to inquire into the death arises. This can be at any time during the investigation but is most likely after the post-mortem report is to hand.

Setting the date

Dates for future hearings should be set **straightaway** as far as possible. Be prepared to get your witnesses and staff lined up immediately. Organisations and their staff are much less likely to receive sympathy from Coroners in relation to unavailability if suitable and convenient dates are not provided upon request.

The Coroner must notify all IPs within a week of setting the inquest hearing date.

Pre-inquest review hearings ('PIRHs')

PIRHs are discretionary, but they are common in more complex inquests. They are supposed to take place in public. The Coroner should set an agenda so all IPs can prepare. Please see our briefing note 'Be prepared for pre–inquest hearings' for more information.

Disclosure

There is a duty of disclosure from the commencement of an investigation and throughout the inquest process, both to and from the Coroner. The basic principle of disclosure is based upon transparency, on the part of the Coroner and the IPs.

There is a significant risk of criticism if 'relevant documents or information' have not been sent to the Coroner. Organisations should be prepared to answer questions in connection with their compliance with their statutory duties.

The following points need to be noted:

- The Coroner **must** disclose relevant documents to IPs upon request. Disclosure should be by electronic means, where possible. The documents are set out in Rule 13 of the Rules:

Disclosure of documents at the request of an interested person

Subject to Rule 15, where an interested person asks for disclosure of a document held by the Coroner, the Coroner must provide that document or a copy of that document or make the document available for inspection by that person as soon as is reasonably practicable.

Documents to which this rule applies include;

a) any post-mortem examination report;
b) any other report that has been provided to the Coroner during the course of the investigation;
c) where available, the recording of any inquest hearing held in public, but not in relation to any part of the hearing from which the public was excluded under Rule 11(4) or (5);
d) any other document which the Coroner considers relevant to the inquest.

The Coroner can refuse to disclose if (Rule 15 of the Rules):

- there is a statutory or legal prohibition (e.g. police reports);
- copyright issues arise and consent cannot be obtained;
- the request is unreasonable;
- the document relates to contemplated or actual criminal proceedings; or
- the Coroner considers the document is irrelevant to the investigation – and where the Coroner does not intend to rely on it.

The Coroner cannot charge for documents disclosed during an investigation.

Organisations should be aware of the Worcestershire case, which described a two-stage process for disclosure and considered a balancing exercise between disclosure and the public interest. In that case, the Court ordered that

documents should be disclosed to the Coroner. It was then for the Coroner to consider whether disclosure to the other IPs was appropriate or not. During the course of the inquest, the information was disclosed to the IPs. More detail can be found in the Chief Coroner's 'Law Sheet No 3'.

Coroners' powers to require evidence

The duty of disclosure from IPs to the Coroner is ongoing throughout the inquest process, but the 2009 Act also gives the Coroner the power to summon witnesses and require the production of documents that already exist (such as clinical notes, internal statements or policy documents) – with a fine of up to £1,000 for default.

The Coroner also has the power to require a person to provide evidence in the form of a written statement. The Coroner may summon a person to come and give evidence in person if they do not produce a statement.

The Coroner has the power (where appropriate) to direct evidence be given by video-link or from behind a screen.

Written evidence: Rule 23

Rule 23 of the Rules reads as follows:

Written evidence

(1) Written evidence as to who the deceased was and how, when and where the deceased came by his or her death is not admissible unless the Coroner is satisfied that:

(a) It is not possible for the maker of the written evidence to give evidence at the inquest hearing at all, or within a reasonable time;
(b) there is a good and sufficient reason why the maker of the written evidence should not attend the inquest hearing;
(c) there is a good and sufficient reason to believe that the maker of the written evidence will not attend the inquest hearing; or
(d) the written evidence (including evidence in admission form) is unlikely to be disputed.

This enables Coroners to read evidence and admit documents, which saves money and time, and avoids witnesses being brought to Court unnecessarily.

In June 2022, separate new provisions came into effect under section 9C of the 2009 Act, which allows inquests to be held 'in writing' in some circumstances. When an inquest is held in writing, the Coroner will open the inquest as usual, but then no further hearings will be held.

Offences: Beware!

There are some offences under the 2009 Act, including:

- failure to comply with a notice requiring evidence to be given or produced;
- altering evidence;
- preventing evidence from being given;
- destroying or concealing documents; and

- giving false evidence.

The rules on contempt of Court apply to Coronial proceedings.

Recording proceedings

The Coroner must record all inquest hearings and must provide a copy of the recording to an IP on request. The Court office can charge £5 per recording.

It is not generally expected that a Coroner will provide post-inquest transcripts.

Submissions: Rule 27 of the Rules

No party can address the Coroner on the facts. Submissions on law only are permitted.

Juries

Inquests must be held without a jury, except in limited circumstances. Most of us who deal with inquests regularly know that Coroners tend to avoid juries, if possible. Cost and time are often cited as the reasons. A jury should be regarded as the exception to the general rule.

A jury must be summoned if:

- The deceased died in custody or state detention and the death was violent, unnatural or the cause was unknown (there is no longer any need for a jury inquest where the deceased died in custody from natural causes);

- Death resulted from an act or omission of a police officer in the execution of duty; or

- Death was caused by accident, poisoning or disease which must be reported to a Government department or inspector / officer.

There is a residuary power enabling the Senior Coroner to call a jury if they believe there is 'sufficient reason'.

Public funding for families

Only in exceptional circumstances will this be available and where applicants qualify financially. Details can be found here.

The conclusion of the inquest

The form which the Coroner or jury complete is called the *Record of Inquest*.

The term 'verdict' is thought to conjure up ideas of criminal proceedings, so the term used is 'the conclusion'. Short form conclusions and narrative conclusions can be given.

No conclusion can be framed as to appear to determine issues of criminal (on behalf of a named person) or civil liability.

The Coroner (or jury) must make a 'determination' (to be recorded on the Record of Inquest) on the following questions:

- Who the deceased was;
- When the deceased came about their death;

- Where the deceased came about their death; and
- How the deceased came about their death (to include 'in what circumstances?' in Article 2 cases).

After the inquest

Appeal?

The means of challenging a Coroner's decisions is by way of judicial review proceedings. Most organisations will not wish to incur the expense or additional publicity of this. Complaints as to the conduct of a Senior Coroner can be made to the Chief Coroner.

Reports to prevent future deaths (PFD reports): Schedule 5 of the 2009 Act

It is worth noting the following points which arise from the Regulations:

- The Coroner is under a duty to report when they feel some action should be taken to prevent or reduce the risk of future deaths. The report should go to the person or organisation with power to take some action.
- Once the Coroner has concerns over an issue that might require action, they have no discretion and must issue a report.
- The duty arises at any time during the investigation. A report could be made even if there is no inquest or, if an urgent problem is identified, before the inquest is held.
- A response to such a report should include any actions proposed (if appropriate) and be accompanied by a timetable for implementation. The time limit for a response is 56 days.
- Reports and responses are sent to the Chief Coroner who will publish further.

PFD reports are sent to other IPs if the Coroner considers they should receive it (including the deceased's family). For health and care providers, they are usually sent to the CQC.

PFD reports are seen as an integral part of protecting the public and good governance. The Chief Coroner can follow up reports with relevant Government departments.

Although the chance to make submissions to the Coroner might be reduced if a PFD report is made before the inquest hearing, organisations are well advised to identify key risks and issues as soon as possible, to demonstrate to the Coroner that action has already been taken before the final inquest hearing. It may be appropriate to provide a statement dealing with organisational learning to the Coroner.

Please see our briefing on 'Preventing future deaths' for more information.

Conclusion

While blame and fault are not in issue at an inquest, it is crucial that organisations assist the Coroner with all proper requests and comply with deadlines.

When it comes to PFD issues, organisations might have excellent investigation reports in place, completed action plans signed off by the board and a senior manager available to explain the changes to the Coroner. However, organisations should also consider whether frontline staff are able to satisfy the Coroner that those changes and improvements to prevent future deaths have been put into practice.

In addition to having robust action plans, organisations need to make sure those plans are implemented and communicated to the staff responsible; audit evidence will be helpful here to show that they are putting the changes into routine practice and can confirm this to the Coroner in the witness box.

Finally, if appropriate, it is essential that each organisation's statutory duties have been complied with. Coroners are at liberty to ask witnesses about this.

What should you do now?

- Keep up to date with developments and the Chief Coroner's guidance.
- Make sure your team knows the rules.
- Contact our experienced inquest team (please see below) if any support is required. If you would prefer more in-depth training, we can put together a session for your team.

Legislation

The Coroners (Inquests) Rules 2013
The Coroners (Investigations) Regulations 2013
Coroners and Justice Act 2009
Human Rights Act 1998

Useful links

The Worcestershire case: Law Sheet No 3
Chief Coroner's Guidance, Advice and Law Sheets
Chief Coroner's Guidance for Coroners on the Bench
Information about funding for representation at inquests

You can access our briefings on pre-inquest hearings, inquest outcomes and preventing future deaths here.

Mills & Reeve inquest support

Visit our inquest support webpage for guidance and short videos to help you prepare for and navigate the coronial process.

Explore our inquest support resources
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