Coroner and inquest information sheet

Updated August 2019

Contents

Aims of this document:

- To provide information around the potential involvement your service may have with coroners
- To provide information on what to expect and how to prepare for an inquest
- Signpost for further information

Why is a coroner involved?

A coroner is likely to be involved in a death when the cause of death is **unknown; sudden, violent, suspicious or unnatural**. A death will also be reported to a coroner when it appears that: no doctor saw the deceased during last illness or the death occurred during an operation or before recovery from the effects of anaesthetic.

A coroner is usually a lawyer, but sometimes will be a doctor. The **coroner will establish whether an investigation is required and will then start collecting information** concerning the death. The coroner's initial enquiries, for instance with the deceased's doctor, may make it clear the deceased died from a known and natural disease and there are no unusual circumstances. In cases like this the coroner will not need to investigate any further.

If further investigations are needed **the coroner may decide a post-mortem examination is required** to help determine the cause of death. After the post-mortem examination the pathologist will send the report to the coroner, which will give details such as drugs and blood alcohol levels to help determine cause of death. The **pathologist's report may not be available for several weeks**.

If the post-mortem determines the cause of death, the investigation may be closed. If the investigation needs to continue the body maybe released for the funeral, but if this is not be possible the funeral will be delayed. The coroner's office will be able to clarify this and explain arrangements.

Pre-inquest reviews and Inquest

An inquest will be required if the cause of death has not been determined from the post-mortem. If the circumstances around the death are complex the coroner may hold **one of more hearings before the inquest**, known as **pre-inquest reviews or directions hearings**. The coroner may invite staff to attend and if needed, there will be an opportunity to raise issues at this time.

An **inquest is a public court hearing** held by the coroner in order to establish the cause of death. Unless the case is extremely complex, the inquest should **normally take place within 6 months after the death**. The coroner's office should notify you of the time and location of the inquest within a week of arranging the inquest.

The inquest could be held **with or without a jury**. There will be no prosecution or defence; **the purpose is to discover the facts of the death**, however, if evidence is found that suggests someone may be to blame for the death the coroner can pass all evidence gathered to the police of Crown Prosecution service.

You may be asked to give evidence as a witness – this might be to give information about the deceased or the death. Additional witnesses may include a doctor, police or eyewitnesses.

Note: if there is a criminal investigation into the death then this will be dealt with differently; there may be two post-mortems and if someone has been charged with murder the coroner investigation will be suspended until the criminal trial is completed. If the facts around the death have emerged during the trial then it will not be necessary to continue the coroner investigation.

What to expect when a coroner is involved

You will need to co-operate fully with the coroner's office and provide all information relevant to the investigation, as well as inform them of any concerns you have about the death. **You may be asked to write a report detailing your organisation's involvement with the deceased.** Please ensure you are mindful about what you include in any report as it will be in the public domain and might be included in national newspapers. It is recommended that you seek advice from your organisation on how best to write the report.

You will need to nominate **one individual as the 'next of kin'** for communication with the coroner's office. If there is a change in contact details you will need to inform them.

A member of staff may need to attend the inquest and may need to give evidence.

An investigation can take several months. It is a good practice to contact the coroner's office for an update if you haven't heard from them. The coroner's office should be in contact at least every 3 months to provide an update on the progress of the case and explain reasons for any delays.

When an inquest has been completed, and the findings reported, you should inform your commissioner so they are aware of the outcome. **The cause of death should be recorded on CHAIN and your organisation's database.**

Preparation for an inquest

It is advisable to **prepare for giving evidence at an inquest** as the court can be an intense environment, with the family, coroners and press attending. As all inquests are an open court you may wish to attend one in advance to see what happens.

When preparing information for the inquest it's important to note the following:

- Always use the deceased's full name (not initials) in any reports
- Keep a clear distinction between records when the person was alive and any documents created after death
- Don't amend any existing documents
- If there are any gaps in service it's always advisable to highlight these, rather than have them pointed out by the coroner

On the day

- Arrive in good time to ensure you are not late, plan your journey in advance. Bear in mind you will need about 15 minutes once you arrive at court to go through security and find the relevant court room
- Dress appropriately (men: jacket/tie or suit and formal shoes, women suit or shirt/skirt and formal shoes)
- Organise the papers you need to bring. You may wish to put them in a ring file with dividers for ease of access whilst you are in the witness box
- Take a notepad and pen for any notes
- Remember to turn off your mobile
- Witnesses read statements under oath, usually within the witness box
- The judge / coroner should be referred to as Sir / Ma'am
- Make sure your replies are audible as the proceedings are taped
- Take your time to answer questions, speak clearly and slowly, be honest, reasonable, courteous, helpful, caring and professional. If you don't understand a question say so. If you are asked a question in a confrontational manner, do not become defensive and answer as fully and simply as possible
- Acknowledge any family attending at the inquest as it will be stressful and upsetting for them
- If your evidence is complex or difficult to explain, consider the use of props or diagrams
- If any media is in attendance, avoid giving any comment to journalists and direct them to your organisation's Communications Team

Contacts

Organisation	Contact details
Westminster Coroner's Court	65 Horseferry Rd, Westminster, London SW1P 2ED **Phone:** 020 7641 1212
Coroners Court Support Service (CCSS)	CCSS is a voluntary organisation whose trained volunteers offer support to people attending an Inquest at a Coroner's Court. **Phone:** 0300 111 2141 (Mon-Fri 9:00-19:00 and Saturday 09:00-14:00) or email: info@ccsupport.org.uk or helpline@ccss.org.uk

Further resources

1. The HHCP 'Supporting staff when a client dies tool kit': http://www.westminsterhhcp.org/Resources(5)/Supporting%20staff%20when%20a%20client%20dies%20tool%20kit.pdf

2. Information sheet 'When a death is reported to a coroner': https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner

3. 'Guide to Coroner services and coroner Investigations – a short guide': https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide

4. 'Guide to Coroner Services – a long guide': https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/363879/guide-to-coroner-service.pdf

5. 'Attending a coroner's inquest': 'https://www.themdu.com/guidance-and-advice/guides/attending-a-coroners-inquest