These notes refer to the Coroners and Justice Act 2009 (c.25) which received Royal Assent on 12 November 2009

CORONERS AND JUSTICE ACT 2009

EXPLANATORY NOTES

THE ACT

Commentary on Sections

Part 1 - Coroners etc

Chapter 1: Investigations into deaths

Section 1: Duty to investigate certain deaths

59. This section sets out the circumstances when a senior coroner must investigate a death. It mirrors the requirements of section 8(1) of the 1988 Act, except that the requirement to investigate where the death is "sudden" or has occurred "in prison" (section 8(1)(c)) has been altered so that it applies to deaths where the deceased "died a violent or unnatural death," or "the cause of death is unknown" or "died while in custody or otherwise in state detention".

60. The location of the body of the deceased will determine which senior coroner has a duty to investigate the death, as was the case under sections 5(1) and 8(1) of the 1988 Act. This is to ensure that more than one coroner does not initiate an investigation. Under the new system, senior coroners will, as now, be allocated to a geographical area, although later sections in Part 1 of the Act set out the circumstances when these boundary restrictions can be relaxed.

61. *Subsection (2)* sets out the types of death that a senior coroner must investigate. A coroner must investigate a death that he or she suspects was violent or unnatural, where for example, the deceased might have been murdered or taken his or her own life, or if the cause of death is unknown. A coroner must also investigate a death, whatever the apparent cause, if it occurred in "custody or state detention" ("state detention" is defined in section 48(2)), such as while the deceased was detained in prison, in police custody or in an immigration detention centre, or held under mental health legislation, irrespective of whether the detention was lawful or unlawful. The circumstances in which a coroner must investigate a death are broadly similar to those in section 8(1) of the 1988 Act. The requirement that a death be "sudden" has been removed. (Where other authorities have a statutory requirement to investigate particular deaths, such as the Health and Safety Executive or the Independent Police Complaints Commission, we anticipate that the coroner will await those authorities' reports before deciding how to proceed. This is apart from the commissioning of post-mortem examinations, where appropriate, and associated duties in relation to the body of the deceased person.)

62. *Subsection (1)* is subject to section 2 (which makes provision for a senior coroner to request another senior coroner to conduct the investigation), section 3 (under which the Chief Coroner may direct that an investigation be conducted by a different senior coroner from the one who would otherwise be under a duty to conduct it), section 4 (which makes provision for an investigation to be discontinued) and Schedule 10 (which

makes provision for persons other than the senior coroner in the area where the body is to conduct the investigation).

63. A senior coroner's initial decision as to whether to conduct an investigation will be subject to appeal to the Chief Coroner under section 40.

64. *Subsections (4)* to *(6)*, which correlate to section 15 of the 1988 Act, set out the arrangements for investigating deaths when the senior coroner thinks that a death has occurred which should be investigated but there is no body; and so the duty to investigate the death in subsection (1) does not apply. This includes circumstances such as where a body has been lost at, or swept away to, sea, or if someone is suspected to have lost their life in a fire and there are no remains, or if the deceased has already been cremated and information previously unavailable comes to light which the senior coroner believes should lead him or her to investigate.

65. These subsections allow a senior coroner to report the details of such a death to the Chief Coroner, who may direct an investigation be held.

66. Under the 1988 Act it was the Secretary of State who could direct a coroner to conduct an inquest in the absence of a body. In the reformed system, the Chief Coroner might also decide that no investigation is necessary. If the Chief Coroner decides that action should be taken, the senior coroner directed to carry out the investigation does not have to be the same coroner that reported the death although in most circumstances it is likely that it would be. An example of a reason the Chief Coroner might have for allocating the case to a different coroner is that it might be more convenient for the bereaved relatives for the investigation to take place in an alternative area.

67. Provision is made in *subsection (7)* enabling a coroner to make whatever enquiries are thought to be necessary in order to help the coroner decide whether the duty under subsection (1) (to conduct an investigation into a death) or the power under subsection (4) (to report a death where there is no body) arises.

Section 2: Request for other coroner to conduct investigation

68. This section gives the senior coroner the power to transfer responsibility for the investigation of a death to another coroner, where that coroner agrees. It is broadly similar to section 14 of the 1988 Act, which allowed a coroner in one district to ask a coroner of another district to assume jurisdiction to hold an inquest into the death.

69. Under *subsection (2)*, a senior coroner who agrees to conduct an investigation on behalf of another coroner must carry out that investigation as soon as possible. No other coroner can conduct the investigation. The coroner who agrees to deal with the investigation will have powers to move the body, in order to ensure a more efficient inquiry. We anticipate that how costs will be apportioned in transferred cases will be dealt with in regulations under section 43.

70. This section does not apply where the Chief Coroner directs another coroner to conduct an investigation under section 3.

71. Examples of cases where the coroner may wish to ask another coroner to conduct the investigation include cases where the bereaved relatives and/or most of the witnesses in the case live in the other coroner's area; and cases where there is a major incident across more than one coroner area, and the Government believes that it is more efficient for only one coroner to lead the investigation and to be seen as the point of contact for bereaved people.

Section 3: Direction for other coroner to conduct investigation

72. This section gives the Chief Coroner the power to direct a senior coroner who is not the coroner under a duty to investigate a death under section 1 to conduct an investigation. It is developed from section 14(2) of the 1988 Act. The Government intends that

this provision will enable the Chief Coroner to respond effectively to an emergency situation, or to reallocate work between coroners in the event of backlogs of work building up in a particular area. Reallocations of this type should take account of the needs of bereaved relatives for both a prompt investigation and one that remains fairly local to them.

73. Under *subsection (2)*, a coroner who is directed by the Chief Coroner to carry out an investigation must do so. No other coroner can conduct the investigation. The coroner directed to deal with the investigation will have powers to move the body, in order to ensure a more efficient inquiry. Again, we anticipate that how costs will be apportioned in transferred cases will be dealt with in regulations under section 43.

74. The Chief Coroner may give more than one direction under section 3. For example, if the coroner who has been directed to conduct an investigation is unable to deal with it, the Chief Coroner may direct another coroner to investigate instead.

Section 4: Discontinuance where cause of death revealed by post-mortem examination

75. This section allows a senior coroner to discontinue an investigation which was started because the cause of death was unknown. The coroner may discontinue such an investigation if a post-mortem examination under section 14 reveals the cause of death, and the coroner thinks that it is not necessary to continue the investigation; an inquest will not therefore be required. This may be because, for example, the death is shown to be due to natural causes and there are no other circumstances (such as state detention) associated with the death which would mean that the investigation needs to continue to an inquest. The coroner may not discontinue the investigation if he or she suspects the deceased died a violent or unnatural death, or died whilst in state detention. This is developed from section 19 of the 1988 Act.

76. If a senior coroner discontinues an investigation under this section he or she is not permitted to go on to hold an inquest into the death or make any determination. The section includes a 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.

Section 5: Matters to be ascertained

77. This section sets out the purpose of a senior coroner's investigation.

78. The two purposes of an investigation are: (1) to establish who the deceased was and how, when and where the deceased came by his or her death, and (2) to establish the details needed to register the death (such as the cause of death). These purposes were previously contained in rule 36(1) of the Coroners Rules 1984 (the 1984 Rules), and in section 11(5)(b) of the 1988 Act.

79. *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), in particular Article 2. Article 2 relates to the State's responsibility to ensure that its actions do not cause the death of its citizens. The Act does not define the precise circumstances where a coroner should conduct an Article 2 investigation. This will allow for flexibility in the future should case law determine that Article 2 inquests should extend to cover additional matters. Such information could, however, be contained in guidance issued by the Chief Coroner.

Section 6: Duty to hold inquest

80. Section 6 provides that the coroner must conduct an inquest as part of the investigation unless he or she has had reason to discontinue it under section 4, following a post-mortem examination

81. The 1988 Act is expressed in terms of a duty to "hold an inquest". This does not reflect the entirety of what coroners do. In 2008, some 235,000 deaths were reported to a coroner, and there were about 31,000 inquests. Under the Act, the inquest will form, when relevant, the final part of the investigation process. The Government does not anticipate that the number of inquests will increase or decrease significantly in a reformed system.

Section 7: Whether jury required

82. This section sets out the circumstances in which a senior coroner is required to hold an inquest into a death with a jury. 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) of the 1988 Act.

83. The general rule is that an inquest must be held without a jury. *Subsections (2)* and *(3)* set out the exceptions to this rule. A jury must be summoned where the deceased died while in custody or otherwise in state detention, and the death was violent or unnatural, or of unknown cause; where the death was as a result of 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. Although a jury is not required in any other case the coroner will be able to summon one in any case where he or she believes there is sufficient reason for doing so.

84. The Government will in secondary legislation make further, more detailed provision about the conduct of inquests (in the Coroners rules to be made under section 45).

85. Under section 40 interested persons, as defined in section 47, will be able to appeal against a coroner's decision to summon a jury or not to do so in those cases where the senior coroner has discretion.

Section 8: Assembling a jury

86. This section sets out the arrangements for summoning and swearing in a jury.

87. *Subsection (1)* sets out the numbers of jurors for a coroner's 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.

88. The senior coroner calls people to attend for jury service by issuing a summons stating the time that they are needed and the place that they must attend *(subsection (2))*, as under the previous arrangements. At the outset the coroner will require jury members to swear they will make a true determination according to the evidence *(subsection (3))*.

89. *Subsection (4)* makes qualifications for jury service at a coroner's inquest the same as for the Crown Court, the High Court and the county courts, in accordance with section 1 of the Juries Act 1974. This reproduces the requirements of section 9(1) of the 1988 Act.

90. *Subsection (5)* enables the coroner to check that a juror meets the qualification requirements, in the same terms as section 9(4) of the 1988 Act.

Section 9: Determinations and findings by jury

91. A jury will be initially directed by the senior coroner to reach a unanimous determination or finding. If the coroner thinks that they have deliberated for a

reasonable time without reaching a unanimous verdict, under *subsection (2)*, he or she may accept a determination or finding on which the minority consists of no more than two persons. Also under *subsection (2)*, the jury spokesperson should announce publicly how many agreed. If the required number of jurors does not agree, under *subsection (3)* the coroner may discharge the jury and summon a completely new jury and the case will be heard again.

Section 10: Determinations and findings to be made

92. This section explains what happens at the conclusion of the inquest. It sets out the possible outcomes and explains their effect.

93. *Subsection (1)(a)* requires the senior coroner – or the jury, where there is one – to make a "determination" at the end of the inquest as to who the deceased was, and how, when, where the deceased came by his or her death. This is broadly equivalent to the requirements under section 11(3)(a) and (4)(a) of the 1988 Act and rule 36 of the 1984 Rules. In an investigation where Article 2 ECHR is engaged, the coroner must also include a determination, or direct a jury to include a determination, as to the circumstances of the death.

94. *Subsection (1)(b)* also requires the coroner or jury to make a "finding" at the end of the inquest about the details required for registration of the death, as was required by section 11(3)(b) and (4)(b) of the 1988 Act. This will normally be, for example, a short finding such as accident or misadventure, suicide, industrial disease, natural causes, drug related or, where no clear cause has death has been established, the finding will be known as "open". Increasingly, coroners make use of "narrative" findings in which they sum up (usually in a few sentences) how the person came to die.

95. *Subsection (2)* makes clear that a determination may not be worded in such a way as to appear to determine any question of criminal liability of any named person or to determine any question of civil liability.

Section 11 and Schedule 1: Duty or power to suspend or resume investigations

96. This section gives effect to Schedule 1 which contains provisions on suspending and resuming investigations in various situations. Schedule 1 sets out when a senior coroner can or must suspend and resume investigations.

Paragraph 1: Suspension of investigation where certain criminal charges may be brought

97. *Paragraph 1* of Schedule 1 contains provision for suspending the senior coroner's investigation in the event that it is likely that criminal proceedings will be brought in connection with the death. It is intended to avoid duplicate investigations. This is based on rules 26 and 27 of the 1984 Rules.

98. This will mean firstly, under *Paragraphs 1(2)* and *1(3)* that the senior coroner will suspend an investigation if asked to do so by a prosecuting authority, including the Provost Marshal or the Director of Service Prosecutions in relation to service equivalents, because someone may be charged with a homicide or other offence directly involving or indirectly related to the death of the deceased.

99. Secondly**,** under *paragraph 1(4)*, if the senior coroner has to suspend an investigation under paragraphs 1(2) or 1(3), the suspension must be for at least 28 days. The senior coroner has the power to extend (more than once if needed) the period of the suspension if asked to do so by the person who or authority which requested the original suspension (through *paragraph 1(5)*) or the Director of Service Prosecutions (in a paragraph 1(4) case).

100. Finally, *paragraph 1(6)* defines "homicide offence","related offence" and the "service equivalent of a homicide offence" as used in this paragraph.

Paragraph 2: Suspension where certain criminal proceedings are brought

101. *Paragraph 2* of Schedule 1 sets out the arrangements for suspension of the senior coroner's investigation when criminal proceedings have been brought in connection with the death. It is developed from section 16 of the 1988 Act.

102. The effect of *paragraph 2(2)* is that a senior coroner must suspend an investigation into a death on becoming aware either that someone has appeared or been brought before a magistrates' court charged with a homicide offence involving the death of the deceased or that they have been charged on indictment in the Crown Court with such an offence. Similarly, under *paragraph 2(4)*, when a coroner becomes aware that someone has been charged with an offence related to the death under investigation (whether it is before the magistrates' court or the Crown Court), the senior coroner is also required to suspend the investigation. As set out in *paragraphs 2(3) and 2(5)*, these duties also apply to the service equivalents of such offences.

103. The senior coroner need not suspend an investigation under paragraph 2(2), (3) or (4) where the prosecuting authority or the Director of Service Prosecutions (as the case may be) has no objection to the investigation continuing or where the senior coroner thinks that there is exceptional reason for not doing so *(paragraph 2(6))*.

104. *Paragraph 2(7)* makes provision for investigations which had been suspended under paragraph 1, and which are then subsequently suspended under paragraph 2.

Paragraphs 3 and 4: Suspension pending inquiry under Inquiries Act 2005

105. *Paragraph 3* of Schedule 1 sets out the circumstances in which a senior 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.

106. *Paragraph 3(1)* requires the senior coroner to suspend an investigation into a death if requested to do so by the Lord Chancellor on the basis that there will be an inquiry under the Inquiries Act 2005 in which the cause of death is likely to be adequately investigated; that a senior judge has been appointed to chair such an inquiry; and that the Lord Chief Justice has approved (for the purposes of paragraph 3) that appointment. The senior coroner does not have to suspend an investigation if he or she thinks there are exceptional reasons for continuing with it (*paragraph 3(2)*). *Paragraph 3(3)* makes provision for investigations which are already suspended under paragraph 1.

107. *Paragraph 4* further provides that 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 this Act – that is who the deceased was and how, when and where the deceased came by his or her death (read with section 5(2) where necessary to comply with Convention rights). As noted above, all such inquiries will be chaired by a senior member of the judiciary – in this case, a High Court judge, a Court of Appeal judge or a Justice of the Supreme Court.

Paragraph 5: General power to suspend

108. *Paragraph 5* of Schedule 1 provides a general power for a senior coroner to suspend an investigation if he or she thinks that it would be appropriate to do so. This may be appropriate if another investigation is being conducted into the death, for example, 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.

Paragraph 6: Effect of suspension

109. Where an investigation is suspended under paragraphs 1, 2, 3 or 5, any inquest being held as part of that investigation must also be adjourned and if it is being held with a jury, the senior coroner may discharge the jury.

Paragraph 7: Resumption of investigation suspended under paragraph 1

110. If the senior coroner suspends an investigation because someone may be charged with an offence, the investigation must be resumed (subject to paragraphs 2(7)(d) and 3(3)(b)) once the relevant period has expired.

Paragraph 8: Resumption of investigation suspended under paragraph 2

111. *Paragraph 8* of Schedule 1 sets out the arrangements for resuming investigations suspended because certain criminal proceedings have been brought.

112. Under *paragraph 8(1)* the senior coroner can resume an investigation only if he or she thinks there is sufficient reason to do so.

113. P*aragraph 8(2)* ensures that the investigation cannot be resumed until the criminal proceedings which triggered the suspension have come to an end in the court of trial.

114. This is qualified by *paragraph 8(3)*, under which the investigation can be resumed, even if the criminal proceedings are continuing, providing the relevant prosecuting authority (as defined in *paragraph 8(4)*) has confirmed it has no objection.

115. *Paragraph 8(5)* makes clear that the outcome of a coroner's investigation resumed under this paragraph must be consistent with the result of the criminal proceedings which triggered the suspension.

116. It could be that the senior coroner resumes the investigation because the criminal investigation did not find all the facts that the senior coroner is required to find or because it did not meet ECHR Article 2 obligations, for example because the defendant pleaded guilty. Indeed the effect of section 6(1) of the Human Rights Act 1998 (HRA) is that the senior coroner, as a public authority, would be legally obliged to resume the investigation if this was necessary in order to secure compliance with Article 2.

Paragraph 9: Resumption of investigation suspended under paragraph 3

117. *Paragraph 9* of Schedule 1 sets out the arrangements for resuming investigations suspended because of an inquiry. Under *paragraph 9(1)* the senior 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 to the senior coroner as the date of conclusion of the inquiry or, where the senior coroner has received no such notification, the date of publication of the findings of the inquiry.

118. *Paragraphs 9(3), 9(5), 9(7) and 9(9)* are relevant where the senior coroner becomes aware during the course of the suspension of his investigation that criminal proceedings are under way of a type that would require a suspension under paragraph 2. Under *paragraphs 9(4), 9(6), 9(8) and 9(10)* the investigation may not be resumed before such criminal proceedings have ended unless a prosecuting authority or the Director of Service Prosecutions (as the case may be) has told the senior coroner that there is no objection to the investigation being resumed.

119. *Paragraph 9(11)* prevents the resumed senior coroner's investigation from reaching a conclusion which is inconsistent with the outcome of the inquiry which triggered the suspension or any criminal proceedings that had to be concluded before it could be resumed. For example, if the outcome of an inquiry was a finding that a particular

individual had committed suicide, a senior coroner's investigation cannot conclude that the particular individual was unlawfully killed.

Paragraph 10: Resumption of investigation under paragraph 5

120. *Paragraph 10* of Schedule 1 states that where an investigation is suspended under paragraph 5, it may be resumed at any time the senior coroner thinks there is sufficient reason for resuming the investigation.

Paragraph 11: Supplemental

121. *Paragraph 11(1)* of Schedule 1 requires that where a senior coroner resumes an investigation under Schedule 1, the senior coroner must resume any inquest that was adjourned under paragraph 6.

122. Where an inquest is resumed, by *paragraph 11(3)* the resumed inquest may be held with a jury if the senior coroner thinks there is sufficient reason for doing so.

123. Under *paragraph 11(4)*, if the inquest was started with a jury and then adjourned and the senior 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 the original jury was discharged, a new jury is required to be summoned.

Section 12: Investigation in Scotland

124. This section makes provision for the Secretary of State or Chief Coroner to notify the Lord Advocate that he or she thinks that it may be appropriate for a service-related death which occurred abroad to be investigated under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. It should be read with section 1A of that Act, which is inserted by section 50(2), discussed at paragraphs 320 to 323

125. *Subsection (1)* provides that the section applies to deaths outside the UK of a person specified in *subsection (2) or (3).*

126. *Subsection (2)* specifies the service personnel that are covered, namely members of the regular and reserve forces who, when they die, are subject to service law (which governs all members of the armed forces) under section 367 of the Armed Forces Act 2006, and are on active service, preparing for or supporting active service, or engaged in training for active service.

127. *Subsection (3)* adds that persons are covered if, when they die, they are not subject to service law but are, under paragraph 7 of Schedule 15 to the Armed Forces Act 2006 (persons designated by or on behalf of the Defence Council), civilians subject to service discipline; and are accompanying service personnel on active service.

128. *Subsection (4)* provides that, if the body (of someone defined in subsections (2) and (3)) is already in Scotland, or is expected to be brought to the UK, and the Secretary of State thinks that it may be appropriate for the death to be investigated under the 1976 Act, he or she may notify the Lord Advocate in Scotland of this. In such circumstances the Secretary of State has no role, other than notifying the Lord Advocate.

129. *Subsection (5)* provides that, if the body is England or Wales, and the Chief Coroner thinks that it may be appropriate for the death to be investigated under the 1976 Act, he or she may notify the Lord Advocate in Scotland of this.

130. "Active service" is defined in section 48(1) to mean service in an action or operation against an enemy; an operation outside the British Islands for the protection of life or property; or the military occupation of a foreign country or territory.

Section 13: Investigation in England and Wales despite body being brought to Scotland

131. There may be cases where the Lord Advocate initially decides that it would be appropriate for a Fatal Accident Inquiry to be held into the circumstances of the death but, for whatever reason, the Lord Advocate reverses this decision. In those circumstances the Lord Advocate can notify the Chief Coroner that it may be appropriate for an investigation to take place in England and Wales. An example may be that the family may have moved to England before the inquiry has taken place or other circumstances have changed which indicate that an investigation in England or Wales is more appropriate.

132. *Subsection (1)* enables the Chief Coroner to direct a senior coroner in England or Wales to conduct an investigation into a death where a body has been brought back to Scotland. The power to make such a direction exists if the deceased is a person who, when he or she died, was subject to service law under section 367 of the Armed Forces Act 2006 and was on active service, preparing for or supporting active service, or engaged in training for active service. It also covers where the deceased was a person not subject to service law but, by virtue of paragraph 7 of Schedule 15 to the 2006 Act, was a civilian subject to service discipline who was accompanying persons subject to service law who were engaged in active service. Secondly, the Lord Advocate must have been notified by the Secretary of State or the Chief Coroner that it may be appropriate for the death to be investigated under the 1976 Act. Thirdly, the body must have been brought to Scotland.

133. Fourthly, no Fatal Accident Inquiry must have taken place (or, if one has been started, it must not yet have finished). Fifthly the Lord Advocate must have advised the Chief Coroner that in the Lord Advocate's view, it may be appropriate for a coroner investigation, in England or Wales, to take place. Lastly, the Chief Coroner must have reason to suspect that the duty to investigate deaths under section 1 (which applies to deaths in England and Wales) would apply to the death, namely that the deceased died a violent or unnatural death; the cause of death being unknown; or the deceased died in custody or other state detention. If all those circumstances apply to a death the Chief Coroner may direct a coroner in England or Wales to conduct an investigation. Any coroner given such a direction must conduct an investigation into the death, subject to section 3.

Section 14: Post-mortem examinations

134. This section sets out the arrangements for ordering post-mortem examinations, and makes slightly different provision from that contained in sections 19 and 20 of the 1988 Act.

135. *Subsection (1)* gives a senior coroner power to ask a suitable practitioner to make a post-mortem examination of a body if the senior coroner is either responsible for conducting an investigation into the death or a post-mortem examination will enable the senior coroner to decide if he or she has a duty under section 1 to conduct an investigation. This may be relevant where it is not clear whether a death occurred as a result of a notifiable disease or whether a child was stillborn – where, for example, an infant's body is found and it is not clear whether it ever had independent life. Where it is known or established that a child was stillborn, the senior coroner will have no further power to carry out an investigation.

136. The term "post-mortem examination" is not defined but it will include any examination made of the deceased including non-invasive examinations, for example, using Magnetic Resonance Imaging (MRI) scans.

137. The 1988 Act makes a distinction between post-mortem and "special" examinations (the latter are a more specific kind of post-mortem examination and would include toxicology tests to establish whether, for example, alcohol or drugs were in the bloodstream). The Act removes this distinction, enabling the senior coroner to detail

the kind of examination he or she would like the practitioner to make – for example, to ask for a particular examination of a tissue or organ which seems most relevant to the cause of death if a full post-mortem is not considered necessary *(subsection (2)).*

138. *Subsection (3)* defines a suitable practitioner as either a registered medical practitioner 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.

139. *Subsection (4)* ensures that any medical practitioner about whom there are allegations in relation to the death is not able to carry out the examination of the body, although such a person may be represented at an examination.

140. *Subsection (5)* requires the person making the examination to report the result to the senior coroner as soon as is practicable.

Section 15: Power to remove body

141. This section specifies the arrangements for moving a body to a different location, for example to enable a post-mortem examination to be carried out.

142. Under *subsection (1)* a senior coroner who is responsible for conducting an investigation into the death or who needs to request a post-mortem examination in order to decide if he or she has a duty under section 1 to conduct an investigation may order that the body be moved to any suitable place. (The notes to section 14 set out when a senior coroner may need to request a post-mortem examination in order to decide if he or she has a duty under section 1 to conduct an investigation.)

143. This removes the restriction in section 22(1) of the 1988 Act that a body can be moved only within a senior coroner's area or to an immediately adjoining area which has caused practical difficulties in a major incident where there have been several deaths. This power will also allow a senior coroner to make use of specialist equipment or skills available in a different part of the country and may, on occasion, mean that full post-mortems can be avoided.

144. The body can be moved to a place which is outside the senior coroner's area only with the consent of the person providing that place (for example, a mortuary manager) except in the case of local authority premises. The issue of costs will be dealt with in regulations made under section 43.

Section 16: Investigations lasting more than a year

145. *Subsection (1)* places a duty on a senior coroner to notify the Chief Coroner of any investigation that has not been completed within a year of the date on which the coroner was made aware of the death. The coroner must then tell the Chief Coroner when an investigation which has taken more than a year is finally completed or discontinued. *Subsection (3)* gives the Chief Coroner a duty to keep a register of the investigations that take over 12 months to complete. See too section 36(4)(a) as regards reports to the Lord Chancellor relating to investigations lasting more than a year.

Section 17: Monitoring of and training for investigations into deaths of service personnel

146. This section gives the Chief Coroner the duty to monitor investigations into the deaths of service personnel and to ensure that coroners are suitably trained to conduct such investigations.