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.

Chapter 2: Notification, certification and registration of deaths

Section 18: Notification by medical practitioner to senior coroner

147. This section enables regulations to be made by the Lord Chancellor requiring a registered medical practitioner to notify a senior coroner of certain categories of death of which they become aware.

Section 19: Medical examiners

148. This section relates to the appointment of, and functions to be carried out by, medical examiners. It also enables regulations to be made by the Secretary of State for Health (in relation to England) and the relevant Welsh Ministers (in relation to Wales) about the appointment, payment and training of, and functions to be carried out by, medical examiners.

149. *Subsection (1)* requires Primary Care Trusts (PCTs) in England and Local Health Boards (LHBs) in Wales to appoint medical examiners to discharge the functions given to them by this Chapter.

150. *Subsection (2)(a)* specifies that PCTs and LHBs must appoint enough medical examiners and make available enough funds and other resources (including medical examiners' officers) to enable the medical examiners to discharge their functions in the area served by the PCT or LHB.

151. Under *subsection (2)(b)*, medical examiners will be monitored by their PCT or LHB as to whether or not they meet expected standards or levels of performance in carrying out their work as medical examiners. This monitoring needs to be considered alongside the requirement in *subsection (5)* for PCTs and LHBs to take no role in relation to the way that medical examiners exercise their professional judgment as medical practitioners.

152. *Subsection (3)* specifies, subject to regulations under subsection (4)(f), that medical examiners must, at the time of appointment, be fully registered medical practitioners for the previous five years and be practising at the time of appointment or have practiced within the previous five years.

153. Regulations made under *subsection (4)(a)* will specify terms of appointment for medical examiners and allow for the termination of their appointment. Whilst medical examiners will, for the most part, confirm or establish the cause of death for deaths that have occurred in the area served by the PCT or LHB by whom they have been appointed, they may be asked to scrutinise deaths in other areas.

154. Regulations made under *subsection (4)(b)* will specify what payments may be made to medical examiners by way of remuneration, expenses, fees, compensation for termination of appointment, pensions, allowances or gratuities. Such payments would be in line with arrangements applying in the specific area in respect of remuneration and those applying nationally in respect of other similar payments.

155. Regulations made under *subsection (4)(c)* will specify the training that medical examiners must have successfully completed prior to their appointment and the training that they need to undertake during the term of their appointment.

156. Regulations made under *subsection (4)(d)* will make provision about the procedure to be followed by medical examiners in carrying out their functions with a view to ensuring that they are able to carry out independent scrutiny of medical certificates of cause of death (MCCDs) and do so in a way that is robust, proportionate, and consistent. The regulations may also provide that, in order to help ensure their professional independence, medical examiners will not be allowed to confirm or establish the cause of death of any person to whom they are related or with whom they have had any fiduciary relationship; and that they will not be allowed to scrutinise MCCDs prepared

by any doctor with whom they have a close working or professional relationship or with whom they have an established fiduciary relationship (see also section 20).

157. Regulations made under *subsection (4)(e)* may provide for the functions of medical examiners to be extended or changed to support future developments of the service.

158. Regulations made under *subsection (4)(f)* may provide for the functions of medical examiners to be carried out by persons not meeting the criteria in subsection (3) during a period of emergency certified by the Secretary of State in accordance with subsection (7). (See also section 20(4) for a related provision allowing the MCCD to be given during a period of emergency by a registered medical practitioner who has not attended the deceased before his or her death and is therefore not the "attending practitioner".)

159. *Subsection (5)* specifies that PCTs and LHBs must allow medical examiners to exercise their own professional judgement as medical practitioners in deciding, for example, whether to confirm individual causes of death or refer them to a senior coroner. This provision needs to be read together with the obligation on PCTs and LHBs to monitor medical examiners in *subsection (2)* and the procedures to be prescribed by regulations under subsection (4)(d).

160. *Subsections (8)* and *(9)* make provision concerning periods of emergency certified by the Secretary of State under *subsection (7).*

Section 20: Medical certificate of cause of death

161. This section enables the Secretary of State for Health to make regulations about the preparation, scrutiny and confirmation of MCCDs and about the way the confirmed MCCD is notified and given to a registrar or about how the death is referred to a senior coroner. The section also enables regulations to be made about the payment of a fee for the service provided by a medical examiner.

162. The independent scrutiny and confirmation of MCCDs is part of a wider process that starts with the preparation of the certificate by a registered medical practitioner who attended the deceased and ends with the certificate being returned to the medical examiner after it has been used by the registrar to register the death. The new unified process is intended to be simpler and more transparent than the previous one and requires specification of activities, responsibilities and alternative scenarios that are more suited to regulations than to provisions on the face of the Act. *Subsection (1)* provides the power to make the necessary regulations.

163. The new process has been designed with the active engagement of a wide range of stakeholders and is illustrated in an overview booklet published by the Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090533).

164. Regulations made under *subsection (1)(a)* will require a registered medical practitioner who attended the deceased prior to death (the "attending practitioner") to prepare an MCCD (the "attending practitioner's certificate") stating the cause of death to the best of the practitioner's knowledge and belief. This duty has been transferred and adapted from section 22 of the Births and Deaths Registration Act 1953 (the 1953 Act) (see *subsections (1)(m)* and *(3)* for the associated transfer of responsibility for prescribing forms, including the MCCD, and for making them available to medical practitioners).

165. The attending practitioner's certificate will be prepared using first-hand knowledge of the deceased's condition prior to death together with information from medical notes and patient records. PCTs (in England), LHBs (in Wales) and healthcare providers (both in the NHS and the private sector) will also be encouraged to adopt local protocols relating to the verification of the fact of death that are able to provide the attending practitioner with information on circumstances leading to the death. Knowledge of these

circumstances may assist the attending practitioner in establishing the cause of death or in deciding that the death needs to be referred to a senior coroner.

166. Where the attending practitioner needs advice on how to complete an MCCD or wants to discuss the probable cause of death before preparing the certificate, he or she will be able to speak with a medical examiner. This is expected to reduce the number of deaths that are unnecessarily reported to a senior coroner.

167. If the attending practitioner is unable to establish the cause of death, or is unable to do so in a period of time prescribed by regulations made under *subsection (2)(a)*, then the death must be referred to a senior coroner.

168. If the attending practitioner is not contactable within a period of time after death prescribed by regulations that may be made under subsection (2)(a), then the death must be referred to a senior coroner. This is relevant, in particular, to deaths in the community, which, even though they are apparently due to natural causes, occur at a time when the deceased's usual doctor is not contactable.

169. If there is no attending practitioner, for example, where the deceased person was not receiving treatment for the condition that caused the death then the provisions under subsection (1)(a) do not apply and the death must be notified to a senior coroner as prescribed by regulations that may be made under section 18.

170. It is intended that regulations made under subsection (1)(a) will specify that an attending practitioner's certificate will not be required where the death has been notified to a senior coroner in accordance with regulations made under section 18 and is investigated by the senior coroner as specified in section 1. This is a key change from the previous process and addresses a long-standing issue in which a strict interpretation of the 1953 Act requires an attending practitioner to prepare a certificate even if he or she cannot establish the cause of death, and requires the registrar to refer this certificate to a coroner.

171. Section 18 together with regulations under *subsection (1)(a)(ii)* change the practice of medical practitioners to refer deaths to a senior coroner into a statutory duty.

172. It is intended that regulations made under *subsection (1)(b)* will require that where an attending practitioner's certificate has been prepared, the hospital bereavement office or GP surgery (or equivalent) must transmit a copy of it to a medical examiner's office. The original certificate will be held by the hospital bereavement office or GP surgery (or equivalent) until it has been scrutinised and confirmed by a medical examiner. This is a key change to the previous process in which, if there is no local protocol to the contrary, the attending practitioner's certificate is given to the family immediately after it is written. The Government expects that the additional time required to complete the scrutiny will in most cases be no longer than the time taken to complete the forms previously required by the Cremation (England and Wales) Regulations 2008. There is no requirement to complete these forms in the new process.

173. Regulations made under *subsection (1)(c)* will allow registrars to invite a medical examiner to request a fresh attending practitioner's certificate. A fresh certificate may be required if, during registration, the informant provides new information about the death which invalidates the cause of death previously confirmed by the medical examiner. The provisions outlined here allow registrars to retain their duty to provide a last check that a death does not need to be notified to a senior coroner. However, many registrars find it difficult to perform this role – particularly where they have to refer a substantial number of certificates – because they have to rely on knowledge gained through experience and because the delays caused to bereaved families can cause considerable stress. The new process is designed to address this issue and to reduce significantly the number of MCCDs that registrars need to refer to senior coroners.

174. Regulations made under *subsection (1)(d)* will allow arrangements to be established in relation to deaths that senior coroners refer to medical examiners. These will be the

deaths that were originally notified to a senior coroner under section 18 or referred to a senior coroner under subsection (1)(a)(ii) that the senior coroner has decided not to investigate. In these cases, the senior coroner will issue a form stating that he or she has no further interest in the death and will transmit this form to the medical examiner's office together with any relevant information about the death that he or she has used in coming to his or her decision. In some cases, this information may include advice provided by a medical examiner in response to a request from the senior coroner or coroner's officer.

175. Since the senior coroner can refer a death to a medical examiner only where the cause of death is known, the regulations made under subsection (1)(a)(i) will allow the attending practitioner to prepare an attending practitioner's certificate. If there is no attending practitioner or if the attending practitioner is not available within a prescribed period after a senior coroner decides not to investigate, then a medical examiner will establish the cause of death and prepare a "medical examiner's certificate" as specified in regulations made under *subsection (1)(h)(i)*. These changes remove the current situation in which some deaths need to be registered as "uncertified".

176. Regulations may be made under *subsection (1)(e)* requiring a medical examiner to make whatever enquiries appear to be necessary in order to confirm or establish the cause of death. Whilst medical examiners will have full access to medical notes and patient records as a result of the amendment to the Access to Health Records Act 1990 made by paragraph 29 of Schedule 21, they will not be able to require any individual or organisation to respond to their enquiries or provide information. If a medical examiner is not able to obtain information required to confirm or establish the cause of death, then the death will be referred to a senior coroner (as outlined below) and the senior coroner will be able to require the information to be provided.

177. When the copy of an attending practitioner's certificate is received by a medical examiner's office from a hospital bereavement office or GP's surgery (or equivalent) it should be accompanied by relevant medical notes and/or patient records. Where these cannot be transmitted or provided easily, arrangements may be made for a medical examiner to view them in situ. A medical examiner's officer will ensure that the attending practitioner's certificate has been completed and that the associated notes and records have been provided or are available and then, if necessary, contact the deceased person's next of kin, or other appropriate person or people, to obtain any further information required. The medical examiner's officer will talk with the bereaved family, usually by telephone, in a way that does not intrude on their grief or raise concerns that would otherwise not exist. As a further safeguard against unnecessary intrusion, information collected by bereavement officers or, for reported deaths that a senior coroner has decided not to investigate, by coroners' officers, will be made available to the medical examiner's officer.

178. If the attending practitioner's certificate has been completed properly, it will advise that the attending practitioner or another prescribed person has seen, identified and externally examined the deceased person's body after death. The purpose of this examination is to confirm there are no injuries or other suspicious features that might indicate an unnatural death. If, in exceptional circumstances agreed with a medical examiner, the attending practitioner has not been able to see, identify and examine the body, then the medical examiner will need to arrange to do so during scrutiny. A medical examiner will also need to see, identify and examine the body for deaths that are referred to him or her by a senior coroner and which require a medical examiner's certificate as set out in subsection (1)(d).

179. Regulations may be made under *subsection (1)(f)* requiring a medical examiner, after scrutinising the attending practitioner's certificate and other information prepared by the medical examiner's officer, either to confirm the cause of death or to refer the death to the senior coroner.

180. In order to ensure that the scrutiny carried out by the medical examiner is robust, proportionate and consistent, there will be a protocol that recognises different levels of risk depending on the setting, stated cause and circumstances. The protocol will establish the minimum level of scrutiny for specific situations but will allow a medical examiner to use professional judgement to determine the degree to which the scrutiny is pursued.

181. If, during scrutiny, a medical examiner is unable to confirm the cause of death or decides that it meets any of the criteria prescribed in regulations made under section 18, then the death will be referred to a senior coroner as specified in regulations made under *subsection (1)(h)(ii)* or section 18. The medical examiner will give reasons for the referral and, where appropriate, suggest what type of post-mortem may be necessary. If, in exceptional cases, the senior coroner decides not to investigate the death and cannot come to an agreement with the medical examiner about the cause of death then the case would need to be taken through the appeals process as set out in Chapter 6 of Part 1 of the Act. The medical examiner has been included as an "interested person" in section 47 in relation to this appeals process.

182. If, during scrutiny, a medical examiner forms the opinion that the cause of death stated on the attending practitioner's certificate is either insufficient or incorrect, but the death is not reportable to a senior coroner, the medical examiner will discuss the death with the attending practitioner and invite him or her to prepare a fresh certificate. The Government intends that this will be specified in regulations made under subsection (1)(c). If, in exceptional cases, the attending practitioner and medical examiner are unable to agree on the cause of death, the medical examiner will refer the case to a senior coroner.

183. Once any issues raised by the next of kin (or other appropriate person or people) have been resolved, they will be advised that the MCCD can be collected from the hospital bereavement office or GP Surgery (or equivalent) or, for an MCCD prepared by a medical examiner, from the medical examiner's office. At the same time, a medical examiner's authorisation will be transmitted to the attending practitioner (if one exists) and the registrar to notify them that the cause of death has been confirmed and that the MCCD can be issued and used to register the death.

184. A copy of the medical examiner's authorisation will be transmitted to funeral directors to allow them to finish preparing the body for burial or cremation where this involves changing the body in a way that might render it unsuitable for a post-mortem.

185. Regulations may be made under *subsection (1)(g)* about giving the MCCD to a registrar. In practice, the MCCD will be given to an informant or someone collecting it on behalf of the informant and the informant will give the MCCD to a registrar. The regulations may allow the MCCD to be given in other ways: for example, sent by secure post to the informant or sent directly to a registrar. These arrangements are intended to ensure that the new process is as fast and as convenient as possible.

186. The policy intention is that registrars must wait until they have received (or can access) a copy of the medical examiner's authorisation before they can accept (or confirm acceptance of): a request to register a death; a request to defer registration; or a request to authorise disposal before registration.

187. Where a medical examiner has issued a certificate by virtue of regulations under *subsection (1)(h)* after referral of the case to him or her by a senior coroner (see subsection (1)(d)), further provisions, made by regulations under *subsections (1)(i) and (j)*, will apply. These provisions will correspond to those made under subsection (1)(c) and (g) in relation to an attending practitioner's certificate that has been confirmed by the medical examiner in accordance with regulations under subsection (1)(f).

188. Once scrutiny has been completed, a medical examiner or someone acting on behalf of a medical examiner (usually the medical examiner's officer) will speak with the next

of kin of the deceased person (or other appropriate person or people) to advise them of the outcome of the scrutiny. This conversation will be required by regulations made under *subsection (1)(k).*

189. Where the cause of death has been confirmed, the medical examiner or person acting on his or her behalf will explain the cause of death and check that it does not raise any issues that have not yet been considered. If issues are raised and cannot be resolved during the conversation then the medical examiner may decide to re-open the scrutiny or refer the death to the senior coroner.

190. Regulations may be made under *subsection (1)(l)* requiring the person nominated as the informant for the purpose of registration, or another prescribed person, to confirm in writing that a medical examiner or someone acting on his or her behalf (usually the medical examiner's officer) has explained the confirmed cause of death as set out in subsection (1)(k). At present, the Government anticipates that this written confirmation will be provided during registration; however, there are other possible options. The purpose of the written confirmation is to provide evidence that the cause of death has been explained to the informant or other prescribed person, thereby lending transparency to the new process in contrast to that provided by the previous process.

191. Regulations made under *subsection (1)(m)* will enable the Secretary of State for Health, after consultation as set out in subsection (3), to prescribe forms, including the "MCCD" form. The regulations will also require the forms to be made available to medical examiners, registered medical practitioners and others who need to use them.

192. Regulations made under *subsection (1)(n)* will require the Chief Medical Officer of the Department of Health to issue guidance as to how certificates and other forms are to be completed and to do so after consulting the person who holds the office with corresponding functions in relation to Wales, as well as the Registrar General and the Statistics Board.

193. Regulations made under *subsection (1)(o)* will enable all forms, including the MCCD form, to be signed or otherwise authenticated. Authentication in this context will enable the forms to be transmitted or made available electronically.

194. *Subsection (2)(a)* enables any regulation in *subsection (1)* that imposes a requirement to have a prescribed period within which the requirement is to be complied with.

195. *Subsection (2)(b)* enables any regulation in *subsection (1)* that imposes a requirement to have prescribed cases or circumstances in which the requirement does, or does not, apply. This provision may need to be used, in particular, during periods of emergency as defined in section 17(7).

196. *Subsection (3)* requires the Secretary of State for Health to consult with Welsh Ministers, the Registrar General and the Statistics Board before prescribing forms, including the MCCD form, as specified in *subsection (1)(m)*. The Statistics Board will continue to ensure that the MCCD form complies with requirements set by the World Health Organisation.

197. *Subsection (4)* allows regulations under *subsection (1)* to provide that functions otherwise exercisable by attending practitioners to be carried out during a period of emergency by registered medical practitioners who did not attend the deceased prior to death. The primary activities to which this would relate are the preparation of an MCCD and discussion with a medical examiner about any changes that might be required in order for the cause of death to be confirmed (see also section 19(4)(f) on when functions normally carried out by medical examiners may be carried out by others during a period of emergency).

198. *Subsection (5)* enables regulations to be made by the Secretary of State for Health (for England) and Welsh Ministers (for Wales) to provide for a fee to be payable to a PCT or LHB in respect of a medical examiner's scrutiny and confirmation of an attending

practitioner's certificate or the preparation and issue of a medical examiner's certificate. The fee level will be set on the basis of full cost recovery, without any element of profit. The first such regulations, and any subsequent regulations that raise fees by more than the rate of inflation, will be subject to the affirmative resolution procedure: see subsection (4)(a) and (5)(a) of section 176.

199. Funeral arrangers currently pay a total of £160.50 to individual doctors for the preparation and issue of forms required under the Cremation (England and Wales) Regulations 2008. In the new system, the medical examiner will perform the function of all three of these doctors and will, the Government expects, be able to do so at a lower total cost. An analysis of costs and benefits is available in the Department of Health's Impact Assessment (http://www.dh.gov.uk/en/Consultations / Closedconsultations/DH_076971).

200. Under *subsection (6)*, the Secretary of State will not need to make regulations about cremation (under the Cremation Act 1902) if they are unnecessary because of other regulations made under Part 1 of this Act, or provision contained in or made under Part 2 of the the 1953 Act in relation to England and Wales.

Section 21: National Medical Examiner

201. Section 21 allows the Secretary of State to appoint a National Medical Examiner (NME). The NME will issue guidance to medical examiners with a view to securing that they carry out their functions in an effective and proportionate manner. Further functions can be conferred on the NME by regulations. Medical examiners will be required to have regard to that guidance when carrying out their functions.

202. The NME will be appointed by the Secretary of State for Health following consultation with Welsh Ministers who would also be consulted when further functions are conferred on the NME and before the NME issues guidance to medical examiners. The appointment of the NME will be on such terms and conditions as the Secretary of State for Health considers appropriate.

Chapter 3: Coroner areas, appointments etc

Section 22 and Schedule 2: Coroner areas

203. This section gives effect to Schedule 2 which provides for England and Wales to be divided into coroner areas and gives the Lord Chancellor the power to set and alter the boundaries of these areas (by order subject to the negative resolution procedure) after consultation with the relevant local authorities, Welsh Ministers, and any other persons the Lord Chancellor thinks appropriate. Each coroner area will cover either the whole of one local authority area or the whole of two or more local authority areas (although this provision will not apply in relation to coroner areas specified in the transitional order made under paragraph 1(1) of Schedule 22).

204. Where the area includes two or more local authorities (*paragraph 3 of Schedule 2*), one of them will be the lead authority for the area, known as the "relevant authority". If the local authorities cannot agree which of them should be the relevant authority, the Lord Chancellor will decide on their behalf, consulting the Secretary of State for Communities and Local Government in respect of local authorities in England, and Welsh Ministers in respect of local authorities in Wales.

205. The Lord Chancellor may alter, by order subject to the negative resolution procedure, and change the names of, coroner areas using a similar consultation procedure.

206. The Schedule also makes provision in *paragraph 4* in relation to bodies which are situated outside the senior coroner's area. Once a senior coroner is responsible for conducting an investigation into a death, the fact that the body is outside that coroner's area does not change his or her functions in relation to the death or give another senior

coroner any functions in relation to the death. This is broadly equivalent to the provision in section 22(3) of the 1988 Act.

Section 23 and Schedule 3: Appointment etc of senior coroners, area coroners and assistant coroners

207. This section gives effect to Schedule 3 which sets out the procedure for the appointment of coroners, qualifications required and terms of office. It also makes provision for the exercise of a senior coroner's functions by area and assistant coroners.

Part 1 – Appointment of senior, area and assistant coroners

208. The Act will change the titles of the office of coroner. The hierarchy under the 1988 Act consisted (in descending order) of coroners, deputy coroners and assistant deputy coroners. Under the Act, there will be senior coroners, area coroners and assistant coroners.

209. Under the 1988 Act, the relevant local authority appointed coroners (but not deputy and assistant coroners). The Secretary of State approved certain coroners' appointments; and where the coroner's district consisted of two or more such areas, or two or more Welsh principal areas, the relevant local authority consulted the others before making an appointment. The coroner appointed his or her own deputy and any assistant deputy coroners (section 6 of the 1988 Act). This will not continue under the Act.

210. Under Part 1 of Schedule 3 appointments of all coroners are made by the relevant authority for each coroner area. There is a new requirement for the Lord Chancellor and Chief Coroner to consent to the appointment of all senior coroners.

211. Following consultation with the Chief Coroner and the relevant local authorities, the Lord Chancellor can determine whether the coroner area requires one or more area coroners in addition to the senior coroner, and if so how many. He or she can also determine the minimum number of assistant coroners.

Part 2 – Qualifications of senior, area and assistant coroners

212. Under this Act, all coroners must be legally qualified. Previously, under the 1988 Act (section 2(1)(b)), being a legally qualified medical practitioner of five years' standing also sufficed. Transitional arrangements are to be made so that paragraph 3 of Part 2 does not apply in relation to those coroners treated as appointed under the transitional arrangements made in the Act.

213. This Part also disqualifies local councillors from appointment as coroners, if the area in respect of which they were elected falls within the coroner area.

Part 3 – Vacancies, and functions of area and assistant coroners

214. Part 3 of Schedule 3 makes provision for filling vacancies on the resignation, dismissal or retirement of coroners, and the arrangements for filling posts on a temporary basis. This Part also provides that area coroners and assistant coroners can perform any functions of the senior coroner when he or she is absent or unavailable or otherwise with the senior coroner's consent.

Part 4 - Terms of office of senior, area and assistant coroners

215. Part 4 of Schedule 3 introduces a new retirement age of 70 for coroners and sets out the procedure for resignation from office. A coroner is no longer to be regarded as holding a "freehold office".

216. It also gives the Lord Chancellor 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 is guilty of misbehaviour. Before he or she can exercise this power, the Lord Chancellor must have the agreement of the Lord Chief Justice.

217. Part 4 also provides for senior coroners, area coroners and assistant coroners to be subject to the disciplinary provisions of Chapter 3 of Part 4 of the Constitutional Reform Act 2005 (which includes the power for the Lord Chief Justice to issue reprimands).

218. It makes provision for the relevant authority for the area to pay salaries to senior coroners and area coroners and fees to assistant coroners. The amount of these salaries and fees is for the relevant coroner and the relevant authority to agree. If they fail to reach an agreement the matter can be referred to the Lord Chancellor, who can determine the amount.

219. This Part also requires the relevant authority for an area to make provision for pensions for senior and area coroners.

220. Additional terms of office can be agreed between the appropriate authority and the coroner.

Section 24: Provision of staff and accommodation

221. This section requires the relevant authority for a coroner area to provide sufficient administrative staff and coroners' officers. When, locally, the police authority is responsible for providing coroners' officers, then they will be expected to continue to do so. The local authority and local police authority will be expected to work together, with the senior coroner, to secure appropriate staffing levels. (Police authorities currently provide 90% of coroner's officers to support the work of coroners.)

222. The relevant authority is also obliged to provide, or secure the provision of, accommodation to enable senior coroners to carry out their functions. This accommodation must either be maintained by the relevant authority or they must secure that it is maintained. This does not apply if another person has responsibility for maintaining the accommodation. This recognises that not all coroners have a dedicated court to hold inquests and that there will continue to be a need to hire such facilities in the future, including court accommodation where the existing court room is insufficient for the purposes of a particular inquest. Under section 31 of the 1988 Act, the relevant council had power to provide accommodation for inquests.

223. The relevant authority is required to take into account the views of the senior coroner when providing and, where relevant, maintaining accommodation. The Act allows inquests to be held anywhere in England and Wales so that there is new flexibility if particular inquests have requirements for the sort of accommodation which is not available within the coroner's own area. The expectation will be, however, that an inquest is normally held within the area of the coroner who is conducting the investigation.

Chapter 4: Investigations concerning Treasure

Section 25 and Schedule 4: Coroner for Treasure and Assistant Coroners for Treasure

224. This section gives effect to Schedule 4 which sets out the procedure for the appointment of the new Coroner for Treasure, qualifications required and terms of office. It also makes provision for the exercise of the Coroner for Treasure's functions by assistant coroners who are designated as Assistant Coroners for Treasure.

Part 1 – Appointment, qualifications and terms of office of Coroner for Treasure

225. *Paragraph 1* allows the Lord Chancellor to appoint a person as the Coroner for Treasure. This is a new role; the Coroner for Treasure will investigate all finds believed to be treasure or treasure trove from across England and Wales. Although he or she will

have an office in a particular location, the location for any inquest required as part of a treasure investigation will take into account the convenience of interested persons, including the finder and the landowner.

226. The qualification to become the Coroner for Treasure will be the same legal qualification that is used for senior coroners (*paragraph 2*). Senior coroners will therefore be able to apply to become the Coroner for Treasure.

227. *Paragraphs 3 to 6* set out how the Coroner for Treasure may vacate the office and how the Lord Chancellor may, with the Lord Chief Justice's agreement, remove the Coroner for Treasure for incapacity or misbehaviour. They also provide for the Lord Chancellor to remunerate the Coroner for Treasure as appropriate.

Part 2 – Designation and remuneration of Assistant Coroners for Treasure

228. One or more assistant coroners will be designated as Assistant Coroners for Treasure (*paragraph 7*). They will cease to be Assistant Coroners for Treasure if they cease to be assistant coroners (*paragraph 9*).

Part 3 – Miscellaneous

229. Under *paragraph 11*, an Assistant Coroner for Treasure may undertake any of the functions of the Coroner for Treasure, should he or she be absent or unavailable or with the consent of the Coroner for Treasure. The Lord Chancellor will also be able to appoint staff to carry out the administrative functions related to treasure investigations (*paragraph 12*).

Section 26: Investigations concerning treasure

230. The Coroner for Treasure will investigate items which are reported to his or her office under section 8 of the Treasure Act 1996 (1996 Act), and may do so if there is suspicion about an object which has not been reported. This will be to establish whether or not the object is treasure or treasure trove, and if so, who found it, where and when it was found.

231. *Subsection (6)* sets out that senior coroners, area coroners and assistant coroners have no functions in relation to these objects, unless the assistant coroner has been designated as an Assistant Coroner for Treasure. This means that there will be a single reporting point for all treasure finds across England and Wales, and a single point of investigation.

Section 27: Inquests concerning treasure

232. As part of an investigation, the Coroner for Treasure may hold an inquest into an object; many treasure investigations do not however require an inquest. *Subsection (2)* requires the Coroner for Treasure to hold the inquest without a jury unless there is sufficient reason for one. The number of jurors and the way in which the jury will arrive at its determination mirrors the provisions for death investigations in sections 8 and 9.

Section 28: Outcome of investigations concerning treasure

233. This section sets out how the Coroner for Treasure must make treasure determinations, depending on the type of investigation.

Section 29: Exception to duty to investigate

234. This section extends the circumstances in which the Crown or relevant franchisee may disclaim title to an object to allow notice to be given to the Coroner for Treasure disclaiming the title before it is determined that the object is treasure. The finder in these circumstances would not be compensated under the treasure valuation system, but the object would be returned to the finder for them to dispose of as they see fit. Franchisees – where the item will vest in the franchisee rather than the Crown – are

the Duchy of Cornwall, the Duchy of Lancaster, the Corporation of the City of London and the City of Bristol.

Section 30: Duty to notify Coroner for Treasure etc of acquisition of certain objects

235. This section inserts a new section 8A into the 1996 Act, imposing a duty on acquirers of objects which might be treasure to report them to the Coroner for Treasure. The object will be investigated and the usual determinations made about when, where and by whom it was found, and whether it is treasure. The acquirer – who might have bought the object, been given it or had it bequeathed to them – will be able to receive a reward from the Treasure Valuation Committee. Breach of the duty could lead to prosecution, with the penalties, on the commencement of section 280(2) of the 2003 Act, of 51 weeks imprisonment, a level 5 fine, or both.

Section 31: Code of practice under the Treasure Act 1996

236. *Subsection (1)* allows the 1996 Act Code of Practice to be amended to make provision for circumstances where an object is disclaimed under section 29.

237. *Subsection (2)* ensures that the Coroner for Treasure (or an Assistant Coroner for Treasure acting on his or her behalf) will not be liable in the civil courts if he or she acts in accordance with the Code of Practice.

Chapter 5: Further provisions to do with investigations and deaths

Section 32 and Schedule 5: Powers of coroners

238. This section brings Schedule 5 into effect, which sets out the powers of senior coroners and the Coroner for Treasure (who has identical powers save for paragraph 7 which does not apply to the Coroner for Treasure).

Paragraph 1 and 2: Power to require evidence to be given or produced

239. *Paragraph 1* of Schedule 5 gives a senior coroner power to summon witnesses and to compel the production of evidence for the purposes of an investigation.

240. Under *paragraph 1(1)* a senior coroner may issue a notice requiring a person to attend at a given time and place to give evidence at an inquest or to produce any documents they have that are relevant to the inquest or to produce anything else they have that is relevant to the inquest so that it can be inspected, examined or tested.

241. *Paragraph 1(2)* provides that the senior coroner can also notify someone that they must provide the senior coroner with a written statement, or produce any documents or anything else they have that the senior coroner considers is relevant to the investigation.

242. *Paragraph 1(3)* sets out information which must be included in any notice that the senior coroner issues under paragraphs 1(1) or 1(2).

243. *Paragraph 1(4)* gives those to whom the senior coroner has issued a notice under paragraph 1(1) or (2) the right to claim that he or she is unable to comply with the notice or that it is not reasonable for the senior coroner to ask him or her to do so. The senior coroner can cancel or amend the notice on that ground.

244. Under *paragraph 1(5)*, when deciding whether to cancel or amend the notice, the senior coroner has to take into account the public interest of that information being available to the investigation or inquest.

245. Under *paragraph 1(6)*, a document or thing is defined as being under a person's control if it is in that person's possession or if they have a right to possession of it.

246. By *paragraph 1(7)*, the notice is not limited by the coroner's area and can therefore be issued to a person anywhere in England or Wales.

247. *Paragraph 1(8)* extends the powers under paragraph 1 to the Coroner for Treasure when carrying out treasure investigations. This allows the Coroner for Treasure to order a person to produce an object believed to be treasure for examination and testing, for example.

248. *Paragraph 2* of Schedule 5 makes it clear that the senior 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 existing legislation. The senior 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 under Part 1 of the Act.

Paragraphs 3 to 5: Power of entry, search and seizure

249. *Paragraph 3* of Schedule 5 gives senior coroners a new, statutory power to enter and search land and seize items which are relevant to their investigations.

250. By *paragraph 3(1)*, a senior coroner has a power to enter and search particular land if he or she has authorisation from the Chief Coroner or from a senior coroner nominated by the Chief Coroner to give such permission. A record must be made of all authorisations sought and given (*paragraph 4*). (The matters recorded under paragraph 4 have to be included in the Chief Coroner's annual report to the Lord Chancellor: see section 36(4)(c).)

251. By *paragraph 3(2)*, the Chief Coroner, or a senior coroner to whom the power is delegated, may allow a coroner to enter and search premises only if that coroner has reason to suspect that there might be something on the premises relevant to the investigation. One of the conditions in *paragraph 3(3)* must also be met ie that the coroner must be unable to contact the person who could give permission to enter and search the premises; permission has already been refused; there is reason to believe that permission would be refused; or the purpose of the search would be frustrated or significantly prejudiced without immediate entry.

252. Under *paragraph 3(4)* a senior coroner has a power to seize anything on the land, or inspect or take copies of any documents that are relevant to the investigation.

253. *Paragraph 3(6)* extends the new statutory powers of entry, search and seizure to the Coroner for Treasure when investigating objects which may be treasure or treasure trove.

254. Under *paragraph 5(1)*, the power to seize items, inspect and take copies of documents under paragraph 3(4) can only be used if the person exercising it has reasonable grounds to believe that its exercise might assist the investigation and, in relation to seizure, that it is necessary to prevent the items from being hidden, lost, damaged, changed or destroyed.

255. Under *paragraph 5(2)*, the power in paragraph 3(4) to inspect and take copies of documents includes power to require information stored in electronic form on the premises, or accessible from the premises, to be produced in a form which can be taken away and which enables it to be read or easily changed into a readable format. This would include for example printing copies of electronic documents or downloading copies of files from a computer so that they can be printed at a later date.

256. *Paragraph 5(3)* of Schedule 5 makes clear that the person exercising the power under paragraph 3 may not seize items which they believe to be subject to legal privilege.

257. Under *paragraph 5(4) and (5)*, items seized or taken away under paragraph 3 may be kept for as long as they are needed, and reasonable force may be used in the exercising of the power.

Paragraph 6: Exhumation of body for examination

258. *Paragraph 6* of Schedule 5 sets out the powers of a senior coroner to order the exhumation of a body. This paragraph, to a great extent, replicates section 23 of the 1988 Act.

259. *Paragraph 6(2)* enables a senior coroner to order the exhumation of the body of a person buried in England and Wales if the senior coroner thinks it is necessary for a post-mortem examination to be made of the body. Although a senior coroner may order the exhumation of a body buried anywhere in England and Wales, it is likely that a senior coroner will only order the exhumation of a body if it is within that coroner's area. This is because the senior coroner will only have jurisdiction to investigate the death due to the initial presence of the body within his or her area. The exceptions to this are where another senior coroner has been asked to conduct an investigation under section 2; the Chief Coroner has directed another senior coroner to conduct an investigation under section 3 or a fresh investigation is ordered after an appeal. A coroner will in all cases have power to order the exhumation of a body for purposes of a post-mortem examination under section 14 even if the body is not within his or her area.

260. *Paragraph 6(3)* enables a senior coroner to order exhumation of a body buried within his or her coroner area if the senior coroner thinks it necessary for the body to be examined 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.

Paragraph 7: Action to prevent other deaths

261. *Paragraph 7* of Schedule 5 gives the senior coroner the power, at the end of an investigation, to report the matter to authorities or organisations with a view to preventing deaths in the future. This power could, for example, be used by the senior coroner to report to a local authority the fact that several deaths have occurred in similar circumstances on the same stretch of road. The person or organisation to whom the report was made must respond in writing to that report. Further provision may be made in regulations enabling reports and responses to be published.

262. All reports made under this paragraph, and all responses to them, must be copied to the Chief Coroner, and summarised in the Chief Coroner's annual report to the Lord Chancellor (see section 36(4)(d)).

Section 33 and Schedule 6: Offences

263. This section gives effect to Schedule 6 which sets out offences relating to jurors, witnesses and evidence, and the penalties for these offences.

264. Offences relating to jurors 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.

265. The offences relating to witnesses include 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. These offences are new, as the senior coroner is given the power to compel evidence in these provisions.

266. The Act does not remove or alter the powers of a senior coroner under the common law to summon witnesses, require evidence to be given and punish for contempt of court.

Section 34 and Schedule 7: Allowances, fees and expenses

267. This section gives effect to Schedule 7 which gives the Lord Chancellor regulation-making powers regarding fees and allowances that the senior coroner can pay (or are

paid on his or her behalf, for example by the local authority) to jurors and witnesses to cover costs incurred due to their attendance at an inquest or pre-inquest hearing. This Schedule also provides for other payments to be made by senior coroners to practitioners who conduct post-mortem examinations. It allows senior coroners to charge for supplying copies of documents. A relevant authority can issue a schedule of the fees, allowances and other payments that senior coroners can make.

268. The Schedule also provides for coroners, the Chief Coroner, Deputy Chief Coroner, Coroner for Treasure, or a judge, former judge or former coroner, when carrying out an investigation, to be indemnified, or reimbursed any costs, in connection with: costs arising from legal claims made in relation to exercise of the person's powers or functions; disputes of claims as to what they may, or may not have done; damages awarded against them; or in costs ordered to be paid by them in connection with such proceedings. This replicates the effect of Section 27A of the 1988 Act which required a council to indemnify a coroner for expenses reasonably incurred in connection with his or her functions, or in relation to disputing a claim made against him or her.

269. Section 27 of the 1988 Act required senior coroners to produce accounts to the council of their appointing local authority, and made provision as to the funds from which reimbursements should be paid. Provision about such matters will now be contained in secondary legislation.

Chapter 6: Governance etc

Section 35 and Schedule 8: Chief Coroner and Deputy Chief Coroners

270. The Act creates the offices of Chief Coroner and Deputy Chief Coroners, who will be responsible for hearing appeals against decisions of coroners, for establishing and overseeing national performance standards, and for providing leadership to the service in general. They may also conduct investigations. The Government intends to have one full time Chief Coroner and one full time Deputy Chief Coroner, and to appoint others as Deputy Chief Coroners to assist, if required, in particular to hear appeals.

271. Section 35 also gives effect to Schedule 8, which makes provision for the appointment of the Chief Coroner and Deputy Chief Coroners and their respective terms of office, and specifies further functions.

272. Under *paragraph 1* of Schedule 8, a person has to be a High Court or Circuit judge under the age of 70 to be eligible for appointment as Chief Coroner.

273. *Paragraph 2* of Schedule 8 sets out the eligibility criteria and appointment process for Deputy Chief Coroners; it requires appointees to be under the age of 70 and be a High Court or Circuit judge, the Coroner for Treasure or a senior coroner. It also specifies that the Lord Chief Justice will consult the Lord Chancellor as to the number of Deputy Chief Coroners that are needed, and how many of these should be judges, and how many should be senior coroners.

274. *Paragraph 2(4)* of Schedule 8 states that the Lord Chief Justice will (after consulting the Lord Chancellor) appoint Circuit or High Court judges as Deputy Chief Coroners. By *paragraph 2(5)* the term of appointment will be decided by the Lord Chief Justice after consulting the Lord Chancellor. *Paragraph 2(6)* provides that the Lord Chancellor, at the invitation of the Lord Chief Justice, will be responsible for appointing senior coroners as Deputy Chief Coroners. The Lord Chancellor will make appointments following a Judicial Appointments Commission process and will decide the term after consulting the Lord Chief Justice.

275. There is a retirement age of 70 for the Chief and Deputy Chief Coroners. This Schedule also sets out the arrangements for vacation of the office, resignation, removal from office and remuneration. It also provides for the Chief Coroner and Deputy Chief Coroners to be indemnified for costs they incur in connection with legal proceedings

arising from the carrying out of their duties and exercise of their powers, damages awarded against them, and in costs ordered to be paid by them in connection with such proceedings.

276. Schedule 8 also provides for a Deputy Chief Coroner to perform the functions of the Chief Coroner if the latter is absent or unavailable, the office is vacant or otherwise with the Chief Coroner's consent, and allows the Lord Chancellor to appoint staff to assist the Chief and Deputy Chief Coroners.

Section 36: Reports and advice to the Lord Chancellor from the Chief Coroner

277. *Subsection (1)* requires the Chief Coroners to give an annual report to the Lord Chancellor.

278. The Chief Coroner's annual report must cover any matters he or she wishes to bring to the attention of the Lord Chancellor, and any matters the Lord Chancellor has asked the Chief Coroner to cover in the report. The report must also contain an assessment of consistency of standards between coroner areas; information about investigations that have taken over 12 months to complete; authorisations given under Schedule 5 for coroners to enter and search land and seize items; the number, nature and outcomes of appeals made to the Chief Coroner; and a summary of matters reported by coroners under paragraph 7 of Schedule 5 to prevent future deaths, and the responses to those reports under sub-paragraph (2) of that paragraph.

279. The annual report must be published by the Lord Chancellor, and a copy would be laid before each House of Parliament.

280. As well as producing an annual report from the Chief Coroner to the Lord Chancellor, it is also intended that the Chief Coroner will be able to publish occasional summaries of the reports made by coroners to prevent future deaths and the responses to them.

281. If requested to do so by the Lord Chancellor, the Chief Coroner must by virtue of *subsection (7)* give advice to the Lord Chancellor about particular matters relating to the operation of the coroner system.

Section 37: Regulations about training

282. This section provides that the Chief Coroner may, with the agreement of the Lord Chancellor, make regulations about the training of all levels of coroners, coroners' officers and other staff who support coroners. This is designed to ensure that all those working within the coroners' service are aware of and apply best practice, relevant guidelines and standards issued under section 42 (for example) and other developments in legislation.

Section 38 and Schedule 9: Medical Adviser to the Chief Coroner

283. This section and Schedule provide for the appointment of a person as Medical Adviser to the Chief Coroner (MACC), and a person (or persons) to be appointed as Deputy Medical Adviser (or Advisers) to the Chief Coroner (DMACC). These persons will be appointed formally by the Lord Chancellor, following consultation with the Chief Coroner, and Welsh Ministers, as responsibility for health matters is devolved to the Welsh Assembly Government. Terms and conditions will be set by the Lord Chancellor as he or she considers appropriate.

284. The MACC will advise and assist the Chief Coroner in relation to medical matters which are relevant to the coroner system. The DMACC will perform the MACC's functions when the MACC is absent or unavailable or if the post is vacant; or at any other time with the MACC's consent.

285. *Paragraph 3* of the Schedule specifies that, in order to be eligible for the role of MACC or DMACC, a person must be a registered medical practitioner and have been so throughout the previous five years, and have practised within the previous five years.

Section 39: Inspection of coroner system

286. This section sets out that Her Majesty's Inspectorate of Courts Administration will carry out inspections of the operation of the coroner system, and report their findings to the Lord Chancellor. The Chief Coroner and Deputy Chief Coroners (or a person acting as a senior coroner under Schedule 10) will not be inspected in relation to any functions they carry out as such.

287. Under *subsection (2)*, inspectors will not be able to inspect persons making judicial decisions or exercising judicial discretion. This would include decisions taken about whether or not to order a post-mortem examination or matters relating to the scope or conduct of inquests.

288. Under *subsection (3)*, the Chief Inspector must report to the Lord Chancellor on any matter related to the operation of the coroner system that the Lord Chancellor refers to the Chief Inspector. There is also provision (in section 60(5) of the Courts Act 2003) enabling an inspector to carry out the Chief Inspector's functions in the event that he or she is unable to do so.

289. Under *subsection (4)*, the section provides for inspectors to enter coroners' work premises and to take copies of any relevant records. Although they will be entitled to be present at inquests, under *subsection (5)* they will not be able to attend private deliberations, such as jury meetings, or inquests where there has been a direction to exclude persons under Coroners rules (see section 45(3)).

290. Where a report under *subsection (1)* or *(3)* recommends that action is taken by a senior coroner, there is power in *subsection (8)* for the Lord Chancellor to direct the senior coroner to take the action within a specified period.

Section 40: Appeals to the Chief Coroner

291. This section provides a right of appeal to the Chief Coroner against decisions that fall within *subsection (2)*. This right is only open to interested persons (as defined in section 47) although *subsection (5)* enables a person who the senior coroner decides is not classed as an interested person to appeal against the decision that he or she is not an interested person. If such an appeal is upheld by the Chief Coroner, then that person would also be entitled to appeal against the decisions listed in *subsection (2)*.

292. *Subsection (2)* sets out the decisions that can be appealed. Appeals can for example be made against a decision to conduct or not conduct an investigation, a decision to discontinue an investigation and a decision to resume or not resume an investigation, for example, once criminal proceedings or an inquiry under the Inquiries Act 2005 have concluded. It will be possible to appeal a coroner's decision not to request a post-mortem examination. A coroner's decision that a post-mortem examination is needed will not be subject to appeal however, except where a post-mortem of the same type has already been carried out. It will be possible to appeal against a decision as to whether an inquest is held with a jury.

293. A coroner's determination as to who the deceased was, and how, when and where the deceased came by his or her death (and, where relevant, the circumstances of the death) can also be appealed, as can his or her finding of details required for registration of the death.

294. *Subsection (3)* provides for interested persons to appeal decisions of the Coroner for Treasure (or Assistant Coroner for Treasure) in relation to treasure investigations.

295. *Subsection (6)* enables the Lord Chancellor to change the list of decisions in subsection (2) by making an order.

296. Rules under section 45 will set out the procedure for appeals to be made to the Chief Coroner.

297. This route of appeal is new. Under the previous law, there was no appeal as such against a coroner's decisions. An application could be made to the High Court under section 13 of the 1988 Act if a coroner refused to hold an inquest or where a fresh inquest is required. The High Court could compel a coroner to hold an inquest or quash the determination of a previous inquest and order a fresh inquest. Persons with sufficient interest could also apply for judicial review of a coroner's decision. However, there was no simple appeal route for bereaved people and other interested persons. This section provides a route of appeal to the Chief Coroner. It also replaces the statutory procedure of application to the High Court by giving the Chief Coroner power to compel a coroner to hold an inquest, or to amend or quash a determination or finding.

298. *Subsection (7)* allows the Chief Coroner to consider any evidence which he or she thinks is relevant to the substance of the decision, determination or finding against which an appeal has been brought. This can include considering evidence which relates to issues that arose after the decision, determination or finding was made.

299. If the Chief Coroner allows an appeal that is not an appeal against a finding or determination, he or she can substitute his or her own decision or quash the decision and refer it back to the senior coroner for a fresh decision. If the appeal is against a finding or determination, the Chief Coroner can amend it, or quash it and order a fresh investigation. If the appeal is against a failure to make a decision – for example, to conduct an investigation – the Chief Coroner can make the decision that could have been made or, again, refer the matter back to the senior coroner for him or her to make a decision. The Chief Coroner may also make any order he or she sees fit, including an order in relation to costs, although he or she has no authority in relation to the award of legal aid.

300. A decision of the Chief Coroner or a Deputy Chief Coroner may be appealed to the Court of Appeal, on a point of law only. The Court of Appeal can either confirm the decision made by the Chief Coroner, substitute its own decision or quash the decision and ask the Chief Coroner to make a fresh decision.

301. Different appeal arrangements apply when the person acting as coroner is a High Court or Circuit Judge, in which case the appeal is to the Court of Appeal or a High Court judge, respectively (see paragraph 4 of Schedule 10).

Section 41 and Schedule 10: Investigation by Chief Coroner or Coroner for Treasure or by judge, former judge or former coroner

302. This section gives effect to Schedule 10 which provides for the arrangements when an investigation into a death is to be conducted by the Chief Coroner or the Coroner for Treasure, or by a judge, former judge or former coroner, by invitation of the Chief Coroner.

303. The Chief Coroner can by virtue of *paragraph 1* personally conduct investigations. He or she can also arrange, with the permission of the Lord Chief Justice, for a judge (including a retired judge who has not reached the age of 70) to conduct an investigation. This will be appropriate when a case has particularly complex legal or factual characteristics, but it is envisaged that the power will be used sparingly. Arrangements can also be made for a retired or former senior coroner to conduct an investigation and this might be appropriate where backlogs have built up in a particular area or in an emergency situation.

Section 42: Guidance by the Lord Chancellor

304. This section enables the Lord Chancellor to issue guidance about how the coroner system is expected to operate for interested persons. It is intended that the first such guidance will be in relation to bereaved people, in the form of a Charter for the Bereaved, a draft of which was published on 14 January 2009. Further non-statutory guidance may be introduced for other classes of interested persons in the future.

305. *Subsection (4)* specifies that the Lord Chancellor must consult the Chief Coroner before issuing, changing or withdrawing any such guidance.

Chapter 7: Supplementary

Section 43: Coroners regulations

306. This section enables the Lord Chancellor, with the agreement of the Lord Chief Justice, to make regulations for regulating the practice and procedure in connection with investigations (excluding inquests), post-mortem examinations and exhumations.

307. Regulations will include, for example, arrangements for:

- suspending and resuming investigations;
- discharging an investigation and providing for fresh investigations;
- delegation of a senior coroner's functions relating to investigations;
- retention, release and disposal of bodies including reinterment; and
- exercise of the powers of entry, search and seizure.

Section 44: Treasure regulations

308. Treasure regulations may be made on the same basis as those under section 43. The Lord Chancellor will make the regulations with the agreement of the Lord Chief Justice or a judicial nominee. These regulations may also apply provisions of Coroners rules (*subsection (4)*).

309. Regulations will include, for example, arrangements for:

- delegation of the Coroner for Treasure's functions;
- requiring information to be given to the Chief Coroner for an annual report under section 36(1); and
- exercise of the powers of entry, search and seizure in relation to treasure investigations.

Section 45: Coroners rules

310. This section enables Rules to be made by the Lord Chief Justice (or his or her nominee) as to the practice and procedure at or in connection with inquests and appeals to the Chief Coroner, thus separating out the inquest component of the senior coroner's investigation. It replicates the power in section 32 of the 1988 Act.

311. *Subsection (2)* sets out particular matters about which rules can be made. These are as follows:

- Subsection (2)(a) allows for rules regarding evidence including sworn and unsworn evidence;
- Subsection (2)(b) allows for rules regarding discharging a jury and summoning a new jury;

- Subsection (2)(c) concerns discharging inquests and holding fresh inquests;
- Subsection (2)(d) concerns adjourning and resuming inquests;
- Subsection (2)(e) would allow the senior coroner to direct that a person's name should not be disclosed except to persons specified in the direction. It is anticipated that any provision made in rules for this discretion will be used sparingly, for example during inquests into the deaths of UK Special Forces personnel or other investigations where witnesses need to remain anonymous to protect their safety;
- Subsection (2)(f) provides for rules relating to a senior coroner delegating his or her non-judicial functions:
- Subsection (2)(g) permits rules about disclosure of information held by the senior coroner:
- Subsection (2)(h) concerns excusing persons from jury service;
- Subsection (2)(i) allows for rules that would clarify when the Coroner for Treasure should hold an inquest into a possible treasure find; and
- Subsection (2)(j) allows for rules requiring permission to be given to an appeal to the Court of Appeal.

312. *Subsection (3)* sets out particular matters in relation to which rules can confer a power on a senior coroner or the Coroner for Treasure. *Subsection (3)(a)* would enable the coroner to decide that, if in his or her opinion the interests of national security required it, certain persons should be excluded from attending all or part of an inquest.

313. *Subsection (3)(b)* enables a senior coroner or the Coroner for Treasure to exclude persons from an inquest during the giving of evidence by a person aged under 18. A child or young person may find giving evidence at an inquest intimidating or traumatic. These powers would enable the coroner to be flexible about how evidence could be given.

Section 46: Abolition of the office of coroner of the Queen's household

314. This section abolishes the office of coroner of the Queen's household. In future, any investigation which would have been carried out by the coroner of the Queen's household will be carried out by the senior coroner in whose area the body is, or by a coroner directed by the Chief Coroner to carry out the investigation or by a coroner requested to carry out the investigation under section 2.

Section 47: "Interested person"

315. This section lists those who come within the definition of the term "interested person". "Interested persons" have, amongst other things, the right to appeal against certain decisions made during the course of investigations and inquests (section 40). 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. 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.

316. *Subsection (6)* lists those who can be classed as an "interested person" for investigations into treasure finds.

Section 48: Interpretation: general

317. This section explains the meaning of various terms used within this Part of the Act: for example, where the word "body" is used, this includes body parts.

Section 49 and Schedule 11: Amendments to the Coroners Act (Northern Ireland) 1959

318. *Subsection (1)* amends section 13 of the 1959 Act to enable a coroner to hold an inquest if informed that the body of a deceased person is lying within the coroner's district, irrespective of where the death took place. This will enable inquests to take place where a death has occurred abroad and the body is returned to Northern Ireland.

319. *Subsection (2)* introduces Schedule 11, which substitutes for section 17 of the 1959 Act new sections 17A to 17C, which make provision concerning witnesses and evidence and related offences in relation to inquests in Northern Ireland. This brings Northern Ireland into line with the reformed system in England and Wales, as it contains provisions which are broadly equivalent to those contained in Schedule 6.

Section 50: Amendments to the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

320. This section makes amendments to the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (the 1976 Act). *Subsection (2)* inserts a new section 1A into the 1976 Act. If subsection (4) of new section 1A applies, the procurator fiscal for the appropriate district will be required to investigate the circumstances of a death and apply to the sheriff to hold a Fatal Accident Inquiry.

321. Subsection (4) of new section 1A will apply if three conditions are met. First, the Lord Advocate is notified under section 12 (discussed at paragraphs 124 to 130) by the Secretary of State or Chief Coroner that it may be appropriate for a death to be investigated under the 1976 Act. Secondly (in the same way that Fatal Accident Inquiries would be triggered for a death that occurs in Scotland) the person who died was either in legal custody at the time of death or the death was sudden, suspicious or unexplained or the circumstances of the death would give rise to serious public concern. And thirdly, the Lord Advocate decides that it would be appropriate for a Fatal Accident Inquiry to be held into the death and does not reverse this decision.

322. Subsection (5) of new section 1A provides that subsection (4) does not apply to a death if the Lord Advocate is satisfied that criminal proceedings have sufficiently established the circumstances of the death.

323. Subsection (6) of new section 1A outlines the process of an application from the procurator fiscal to the sheriff for a Fatal Accident Inquiry. Subsection (7) gives the Lord Advocate the responsibility for determining the appropriate district and sheriffdom.

324. *Subsections (3) to (5)* make consequential amendments to sections 2, 3 and 6 of the 1976 Act.

Section 51: Public funding for advocacy at certain inquests

325. Section 6(6) of the Access to Justice Act 1999 states that the Legal Services Commission may not fund, as part of the Community Legal Service, any of the services specified in Schedule 2 to that Act. Paragraph 2 of Schedule 2 states that the Legal Services Commission may not fund advocacy, except in the circumstances listed in that paragraph.

326. Section 51 amends the list in paragraph 2 of circumstances where advocacy can be made available by adding (a) inquests into the deaths of British service personnel who die while on active service, and (b) inquests into the deaths of persons who die while in the custody of the State, or those who die in the course of a police action or arrest. The Legal Services Commission will be authorised to fund advocacy for family members to be represented at such inquests, subject to the funding criteria in the Funding Code made under section 8 of the Access to Justice Act 1999 being met. Funding would also be subject to a means test.