



CHIEF CORONER

Deputy Chief Coroner of England & Wales
and
Her Majesty's Senior Coroner
for the City of Sunderland

Derek Winter DL

Role of the Chief Coroner

The Role of the Chief Coroner is to lead the Coroner Service

- Provide support, leadership and guidance for coroners in England and Wales;
- Set national standards for all coroners, including new inquest rules;
- Oversee the implementation of the new provisions of the Coroners and Justice Act 2009;
- Put in place suitable training arrangements for coroners and their staff;
- Approve coroner appointments;
- Keep a register of coroner investigations lasting more than 12 months and take steps to reduce unnecessary delays;
- Monitor investigations into the deaths of service personnel;
- Oversee transfers of cases between coroners and direct coroners to conduct investigations;
- Provide an annual report on the coroner system to the Lord Chancellor, to be laid before Parliament;
- Monitor the system where recommendations from inquests are reported to the appropriate authorities in order to prevent further deaths.

No national service

88 Coroner Areas resourced by Local Authorities/Police

National Statistics 2018

- 541,627 registered deaths in England and Wales
- 220,648 reported to Coroners (41% of all registered deaths)
- 29,094 Inquests
- PM rate 39%
- Average waiting time to Inquests 26 weeks

<https://www.gov.uk/government/statistics/coroners-statistics-2018>

Consistency (1)

Coroners and Justice Act 2009

The Coroners (Inquests) Rules 2013

The Coroners (Investigations) Regulations 2013

The Coroners Allowances, Fees and Expenses Regulations 2013

The Human Tissue Act 2004

Chief Coroner's Guidance (x 33)

Chief Coroner's Law Sheets (x 5)

plus Treasure

<https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/>

- Appointments
- Reports to Prevent Future Deaths
- Caselaw, including Maughan

Chief Coroner's Guidance

<https://www.judiciary.uk/wp-content/uploads/2019/09/Guidance-No.-32-Post-Mortem-Examinations-including-Second-Post-Mortem-Examinations.pdf>



CHIEF CORONER

GUIDANCE No. 32

**POST-MORTEM EXAMINATIONS
INCLUDING SECOND POST-MORTEM EXAMINATIONS¹**

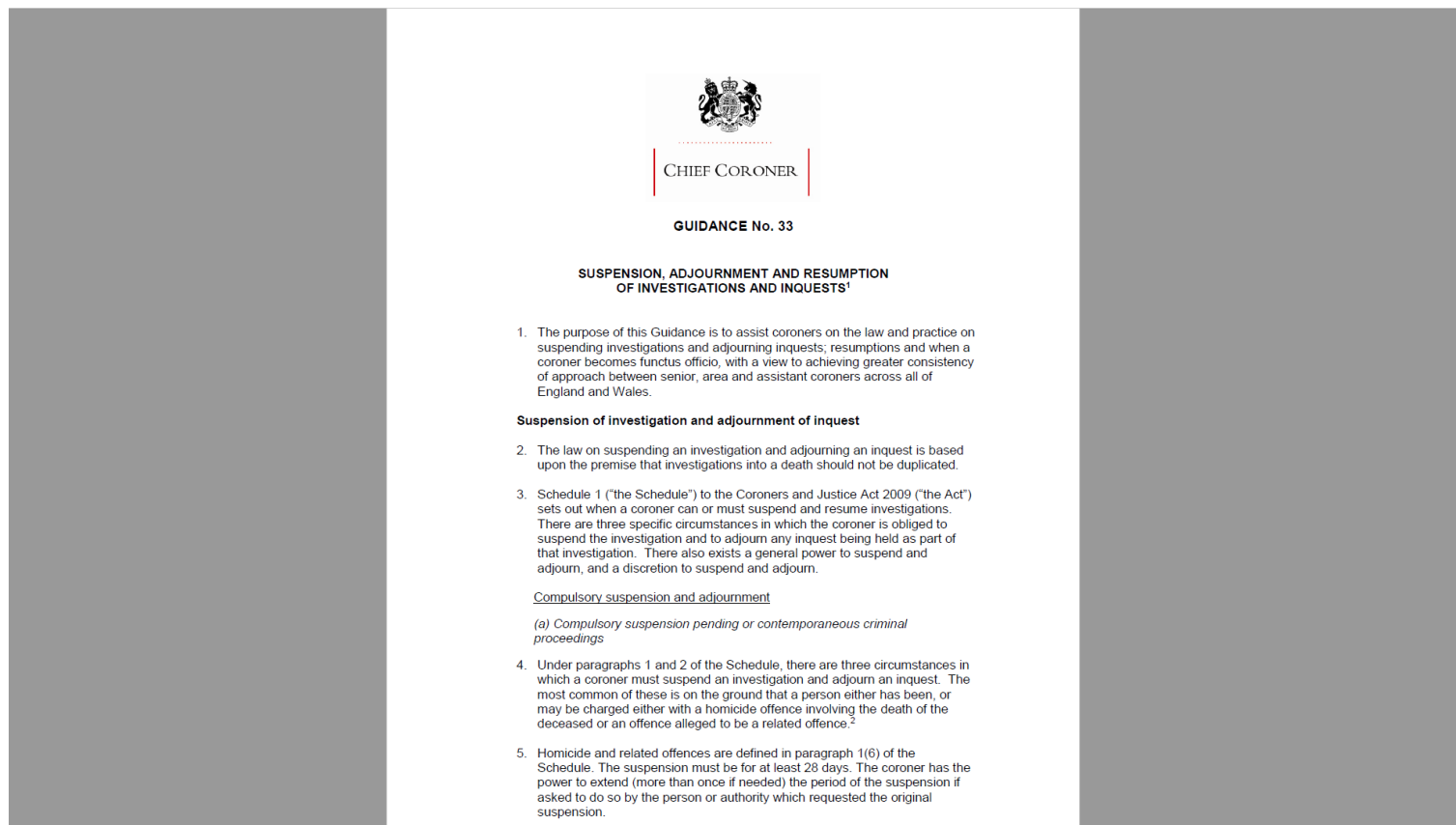
EXECUTIVE SUMMARY

This is the first Guidance in twenty years on the use of post-mortem examinations and second post-mortem examinations. Home Office Circular (No.30/1999) is considered superseded by this Guidance. Whilst there has been a general decrease in the number of post-mortem examinations carried out which the Chief Coroner welcomes, there remains a wide regional variation. This Guidance is intended to promote consistency in coronial practice.

While a coroner has legal control over the body of a deceased person, it is for the coroner to decide whether to commission a first or subsequent post-mortem examination and it is for the coroner to decide whether to permit a second examination of the body on the instruction of an interested party. Despite there being a widespread misconception (particularly in homicide cases), there is no automatic right to a second post-mortem examination and requests should be scrutinised rigorously by the coroner on a case by case basis.

Chief Coroner's Guidance

<https://www.judiciary.uk/wp-content/uploads/2019/10/Guidance-No.-33-Suspension-Adjournment-and-Resumption-of-Investigations-and-Inquests.pdf>



Section 1 of The Coroners and Justice Act 2009

Duty to Investigate

A Coroner must conduct an investigation if there is reason to suspect

- The deceased died a violent or unnatural death
- The cause of death is unknown
- The deceased died while in custody or state detention which no longer includes DoLS

Coroners and Justice Act 2009

Investigations

- ✓ conclude by discontinuing if the death is natural
- ✓ conclude with an Inquest if the death is unnatural / violent / in State Detention

No local reporting criteria

The Notification of Deaths Regulations 2019

<http://www.legislation.gov.uk/uksi/2019/1112/made>

STATUTORY INSTRUMENTS

2019 No. 1112

MEDICAL PROFESSION, ENGLAND AND WALES

CORONERS, ENGLAND AND WALES

The Notification of Deaths Regulations 2019

<i>Made</i>	<i>10th July 2019</i>
<i>Laid before Parliament</i>	<i>15th July 2019</i>
<i>Coming into force</i>	<i>1st October 2019</i>

The Lord Chancellor makes the following Regulations in exercise of the powers conferred by section 18(1) of the Coroners and Justice Act 2009(1).

In accordance with section 18(2) of that Act, the Lord Chancellor has consulted the Secretary of State for Health and Social Care and the Chief Coroner.

Citation, commencement and meaning of "relevant senior coroner"

1.—(1) These Regulations may be cited as the Notification of Deaths Regulations 2019 and come into force on 1st October 2019.

(2) In these Regulations, "relevant senior coroner" means the senior coroner appointed for the coroner area(2) in which the body of the deceased person lies.

Duty to notify a relevant senior coroner of a death

2.—(1) A registered medical practitioner must notify the relevant senior coroner of a person's death if—

- (a) the registered medical practitioner comes to know of the death on or after the coming into force of these Regulations; and
- (b) at least one of the circumstances described in regulation 3(1) applies.

(2) But the duty in paragraph (1) does not apply if the registered medical practitioner reasonably believes that the relevant senior coroner has already been notified of the death under these Regulations.

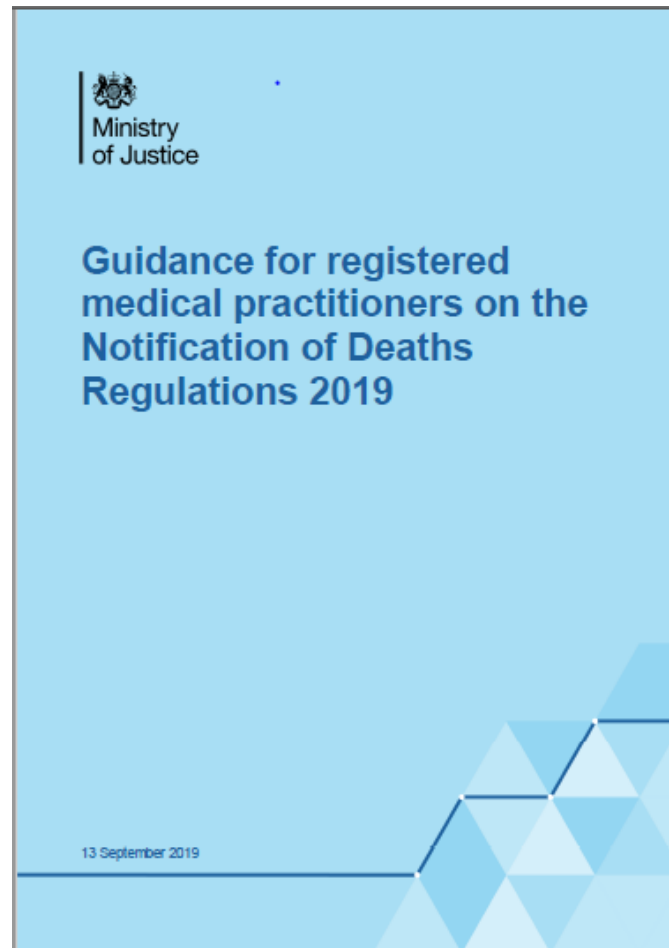
Circumstances in which the duty to notify arises

3.—(1) The circumstances are—

- (a) the registered medical practitioner suspects that that the person's death was due to—

The Ministry of Justice Guidance

<https://www.gov.uk/government/publications/notification-of-deaths-regulations-2019-guidance>



Chief Coroner's Guidance

[https://www.judiciary.uk/wp-](https://www.judiciary.uk/wp-content/uploads/2019/09/Guidance-No.-31-Death-Referrals-and-Medical-Examiners.pdf)

[content/uploads/2019/09/Guidance-No.-31-Death-Referrals-and-Medical-Examiners.pdf](https://www.judiciary.uk/wp-content/uploads/2019/09/Guidance-No.-31-Death-Referrals-and-Medical-Examiners.pdf)



GUIDANCE No. 31

DEATH REFERRALS AND MEDICAL EXAMINERS

1. A key part of the regime set out in the Coroners and Justice Act 2009 is the introduction of a system of medical examiners to cover all deaths within England and Wales. As from April 2019 there is now in place a National Medical Examiner for England & Wales and the roll-out of a non-statutory scheme of medical examiners covering deaths in NHS hospitals. It is envisaged that the non-statutory scheme will cover all hospitals by the end of March 2020 and that there will be a move by the Government towards placing the scheme on a statutory footing and then a further development of the statutory scheme to cover deaths within hospitals and within the community.
2. As part of the process set out above, the Notification of Deaths Regulations 2019 were laid before Parliament on 15th July 2019 and will come into force on 1st October 2019.
3. The Regulations make clear that a registered medical practitioner must notify the relevant senior coroner (the senior coroner appointed for the coroner area in which the body of the deceased person lies) of a person's death if they come to know of the death and in certain types of cases. Hitherto there have been no such regulations and the circumstances of reporting of deaths by medical practitioners to coroners has varied across coroner areas. To address this some senior coroners have issued local guidance to medical practitioners within their area. As with immediate effect any locally issued guidance or direction should be withdrawn and the principles set out in this document used by all coroners to ensure greater consistency over death reporting.

“Good relations/communication channels from Coroner to LA, to ME, to Bereavement Services, to Registrations Services. Making those connections and driving through excellence for bereaved families by acting as one unit. The co-location, dialogue, relationship side of the Service, being pragmatic, getting things done, cutting out unnecessary ‘red tape’ and delivering. Working smart, using technology, improving accessibility and being transparent.”

Karen Lounton

Services Manager – Registration, Coroner and Archives

Northumberland County Council



Tell Us Once

Welsh Version



Dywedwch Wrthym Unwaith - menter y llywodraeth i helpu'r sawl sydd wedi cael profedigaeth

Mae Dywedwch Wrthym Unwaith yn wasanaeth y llywodraeth am ddim sy'n eich galluogi i roi gwybod am farwolaeth pan rydych yn dioddef profedigaeth ac angen dweud wrth llywodraeth ganolog a llywodraeth leol.

Pan fydd rhywun wedi marw, mae llawer o bethau y mae angen eu gwneud, ar adeg pan mae'n debyg na fyddwch yn teimlo fel eu gwneud. Bydd hyn yn cynnwys cysylltu ag adrannau'r Llywodraeth a gwasanaethau cyngor lleol sydd angen eu hysbysu.

"Mae hwn yn wasanaeth da iawn. Y peth olaf sydd ei angen arnoch ar adeg drifast pan rydych wedi colli rhywun amgylch ym 24 oeddi ger y llŷn am oriau'n cansto popeth."

Customer profedigaeth Swydd Rydychen

English Version



Tell Us Once - a government initiative to help those who are bereaved

Tell Us Once is a free government service that allows you to report a death when you suffer a bereavement and need to tell central and local government.

When someone has died, there are lots of things that need to be done, at a time when you probably least feel like doing them. This will include contacting Government departments and local council services that need to be informed.

"This is a very good service. The last thing you need at this sad time when you have lost a loved one is to sit on the phone for hours cancelling everything."

Bereavement customer Oxfordshire

Consistency (2)

Jurisdiction

adversarial v. inquisitorial (not all Court work)

Appointments

open competition

JAC v. Local Authority

IT

eJudiciary

LA systems plus WPC/Civica (electronic reporting and remote working)

Consistency (3)

Judge's Pay

- T & C as employee
- Pay – SSRB

Coroner's Pay

- LA Payroll but not employee
- 24/7
- Pay – JNC (LA and CSEW)

Pensionable (including Assistant Coroners)

Consistency (4)

Common Factors

- Judges – judicial independence
- Retirement age – 70
- Training – Judicial College
- Complaints – JCIO
- Judicial Code of Conduct
- Mentoring
- Appraisals
- Leadership

Consistency (5)

New edition of the Equal Treatment Bench Book

<https://www.judiciary.uk/publications/new-edition-of-the-equal-treatment-bench-book-launched/>



JUDICIAL
COLLEGE

Equal Treatment Bench Book

February 2018 edition

(September 2019 revision)

Consistency (6)

Coroner and Officer training x 2 days (including sensitive use of language and prioritisation)

CC conference for SC and AC

CC conference for LAs on 20.03.20 (reply by 15.11.19)

Appointments and Interviews

Coroner Engagement

Faith Groups

GP

Hospitals

Ambulance Service

Funeral Directors

Registrars

Pathologists

Other Coroners

Police

HTA

CCSS

Organ Donation

Emergency planners

Mental Health

Alcohol and drug teams

Safeguarding-Children (and now adults)

FAMILY

<https://www.sunderlandcoroner.co.uk/feedback/>

The screenshot shows the homepage of the Sunderland Coroner's Office. At the top left is the Royal Coat of Arms and the text "SUNDERLAND CORONER'S OFFICE". A navigation menu includes "Home", "Bereavement Support", "Useful Information", "Links", "Inquests", and "Contact Us". The "Home" link is highlighted in a purple box. Below the navigation is a large banner image featuring a purple puzzle piece. A secondary navigation bar contains icons for "Bereavement Support", "Feedback", "Useful Links", and "FAQ's".

Welcome to Sunderland Coroner's Office

The law states that certain types of deaths must be reported to the Coroner and some cases may result in an investigation with or without an Inquest. HM Senior Coroner for the City of Sunderland deals with deaths when the body is within Sunderland including Washington and Houghton le Spring.

This website contains information that will help you know what to expect if you come into contact with the Coroner's Service if someone close to you has died or you are a witness in the fact finding process.

As well as a summary of the role of the Senior Coroner and an overview of the Inquest process you will find a list of upcoming Inquests and signposts to external agencies for further information or support.

If you require further advice or information then please contact the office.

[View Inquests](#)

[Report a Death](#)

The map at the bottom shows the location of the Office of HM Coroner at Sunderland Civic Centre, Burnton Road. Other landmarks visible include the University, Sunderland Museum, and various residential areas like Ford Estate and Sunnyside.

Ministry of Justice

Stakeholders Forum

Conference for Lawyers - making Inquests less adversarial

Updated MoJ Guide to Coroner Service

Chief Coroner's Report to the Lord Chancellor

Delays

Salaries

Model Coroner Area

Schedule of Resources (premises and staff)

Draft Annual Report template

Mergers

- 88 Areas and reducing (83?)

- economies of scale

- consistency

Welfare and wellbeing – day job and major incident



Court 1

HM Coroner's Office
Manchester City Area
Royal Exchange
Building



Court 1

HM Coroner's Office
Manchester City Area
Royal Exchange
Building



Court 2

HM Coroner's Office
Manchester City Area
Royal Exchange
Building



Exchange Conference Room

HM Coroner's Office
Manchester City Area
Royal Exchange
Building



Coroner's Officers Main Office

HM Coroner's Office
Manchester City Area
Royal Exchange
Building



Staff Kitchenette

HM Coroner's Office
Manchester City Area
Royal Exchange
Building



Shower Room

HM Coroner's Office
Manchester City Area
Royal Exchange
Building

Useful Contacts

Office of the Chief Coroner

11th Floor - Thomas More Building

Royal Courts of Justice

London

WC2A 2LL

<https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/>

The Coroners' Society of England and Wales

www.coronersociety.org.uk

Coroners' Officers and Staff Association (COASA)

<http://www.coasa.org.uk/>

