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BRIEFING PAPER

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Coroners' investigations and inquests

By Catherine Fairbairn and Terry McGuinness

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Summary

This briefing paper deals with the law in England and Wales. It includes information about:

- when a coroner's investigation and inquest is held;
- the impact of human rights legislation;
- the procedure at an inquest and when the coroner must sit with a jury;
- the standard of proof at an inquest;
- who is entitled to ask for information relating to an investigation; and
- reports to prevent future deaths.

Duty to investigate death

A coroner must investigate a death where (s)he is made aware that the body is within that coroner's area and (s)he has reason to suspect that:

- the deceased died a violent or unnatural death;
- the cause of the death is unknown; or
- the deceased died while in custody or state detention.

Purpose of investigation

The purpose of an investigation is to establish:

- who the deceased was;
- how, when and where the deceased came by his or her death; and
- the particulars (if any) required to register the death.

The scope of the coroner's investigation must 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 Article 2 of the European Convention on Human Rights (right to life).

Ministry of Justice guide

The Ministry of Justice has published A Guide to Coroner Services for Bereaved People (updated January 2020) to provide bereaved people with an explanation of the coroner investigation and inquest process and links to organisations that may provide help and advice.

Other Commons Library briefings

Other Commons Library briefing papers provide further information about coroners and inquests:

Challenging coroners' decisions, (number 00525);

Legal aid for representation at an inquest (number 04358);

The Office of the Chief Coroner (number 05721).

1. Coroner's investigation of a death

Part 1 of the *Coroners and Justice Act 2009* (the 2009 Act), which was largely implemented in July 2013, introduced the concept of the coroner's 'investigation' into a death. An inquest may form part of the investigation.

Online information and guidance about the role of the coroner and the investigation and inquest procedure

The Chief Coroner has published:

- The Chief Coroner's Guide to the Coroners and Justice Act 2009;[1]
- a range of guidance and law sheets on specific matters.

The Ministry of Justice has published:

- A Guide to Coroner Services for Bereaved People.[2]

1.1 Duty to investigate

In many cases there is no need for a coroner's investigation following a death. Instead, the doctor who provided care during the last illness of the deceased person completes a certificate of the medical cause of death. This, in turn, is presented to the local registrar who issues an authority for the disposal of the body.

However, some deaths require further investigation and must be reported to the coroner who decides whether to carry out further inquiries.

Section 1 of the 2009 Act imposes a duty on a coroner to investigate a death where (s)he is made aware that the body is within that coroner's area and (s)he has reason to suspect that:

- the deceased died a violent or unnatural death,
- the cause of the death is unknown, or
- the deceased died while in custody or state detention.

Gov.UK provides information about reporting a death to the coroner.[3]

At the request of the coroner, or at the direction of the Chief Coroner, the investigation may be carried out by a different coroner than one in whose area the body is lying.[4]

1.2 What happens when a death is reported to the coroner?

When a death is reported to the coroner, (s)he may make preliminary inquiries and, if satisfied as to the nature of the death, the coroner may

1 1 September 2013 [all links in this briefing paper accessed 19 February 2021 unless otherwise stated]
2 Updated 28 January 2020
3 Gov.UK, 'When a death is reported to a coroner'
4 Coroners and Justice Act 2009 sections 2 and 3

decide that there is no need to carry out a post-mortem examination or to hold an investigation.

Alternatively, the coroner may decide to carry out a post-mortem examination and, on the basis of the results, decide to discontinue any investigation (in which case there would not be an inquest). If the coroner considers that the circumstances of the death do require a post-mortem examination, in relevant circumstances (s)he may proceed with the examination, regardless of any objections.

Finally, the coroner may decide that further investigation is required, and an inquest will be conducted as part of that investigation.

The coroner may not discontinue the investigation if they suspect that the deceased died a violent or unnatural death or died whilst in custody or state detention.[5]

1.3 How quickly will the coroner begin to consider a death?

A funeral cannot take place until the coroner releases the body. The time taken for a coroner to release a body for burial or cremation can depend on a number of factors, including the time of death and whether this is outside of usual office hours (for example, over a weekend or bank holiday).

Sometimes, bereaved families request the coroner to treat a particular death as a matter of urgency. This might be, for example, because the family has a religious or cultural belief that the body should be buried on the day of death or as soon as possible thereafter. Jewish and Muslim families, or their representatives, sometimes make such requests.

In May 2018, the Chief Coroner of England and Wales issued new guidance on expedited decision making.[6] This followed the High Court's April 2018 decision (in "the AYBS Case") that it was unlawful for a coroner to adopt a policy ruling out the possibility of prioritising consideration of a death on religious grounds.[7]

The Chief Coroner's guidance states that coroners should pay appropriate respect to religious and cultural wishes about the treatment of a body and burial following a death, "within the framework of their legal duties and in the context of their other responsibilities".[8]

The guidance also states that any policy or practices adopted by coroners must be sufficiently flexible to allow them to give due consideration to expediting decisions where there is good reason to do so:

> The judgment in the AYBS Case reflects two important legal considerations: (i) that a coroner should be open to representations

5 Coroners and Justice Act 2009 section 4

6 Chief Coroner Guidance No. 28, Report of death to the coroner: decision making and expedited decisions, 17 May 2018

7 Judiciary of England and Wales, Summary of the Judgment in the case of: The Queen (on the application of Adath Yisroel Burial Society & another) -v- HM Senior Coroner for Inner North London, 27 April 2018

8 Chief Coroner Guidance No. 28, Report of death to the coroner: decision making and expedited decisions, 17 May 2018, paragraph 4

> that a particular case should be treated as a matter of urgency (whether for religious or other reasons); and (ii) that proper respect should be given to representations based on religious belief.
>
> However, the decision of the Court does not require a coroner to give automatic priority to deaths from particular religious communities, nor does it require coroners to drop other important work to deal with such deaths. The Court also recognised that other deaths may require urgent handling for non-religious reasons.
>
> There is no obligation for coroners to adopt formal written policies for dealing with requests for expedition or for dealing with deaths from faith communities. Practices may differ between coronial areas because of the characteristics of the areas. However, any policy or practices adopted by coroners must be sufficiently flexible to allow them to give due consideration to expediting decisions where there is good reason to do so. They should seek to strike a fair balance between the interests of those with a well-founded request for expedition (including on religious grounds) and other families who may be affected.[9]

1.4 What is the purpose of an investigation?

The purpose of an investigation is to ascertain:

- who the deceased was;
- how, when and where the deceased came by his or her death;
- the particulars (if any) required to register the death.[10]

An inquest is not a trial: the purpose of the inquest is to find facts, and not to attribute blame or liability.

1.5 Who carries out the investigation?

An investigation may be carried out by:

- a senior coroner;
- an area coroner;
- an assistant coroner;
- the Chief Coroner;
- a nominated judge;
- a former judge; or
- a former coroner.[11]

1.6 Suspension of investigation

A coroner must suspend an investigation, and adjourn the inquest if it has been opened, in the following circumstances:

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9 Ibid, paragraphs 14 to 16
10 Coroners and Justice Act 2009 section 5
11 Coroners and Justice Act 2009 Schedule 3, section 41, Schedule 10

- if asked to do so by a prosecuting authority because someone may be charged with a homicide or related offence involving the death of the deceased;[12]
- when criminal proceedings have been brought in connection with the death;[13] or
- where there is an inquiry under the *Inquiries Act 2005.*[14]

A coroner may also suspend an investigation if it appears to them that it would be appropriate to do so.[15]

Information about when a suspended investigation might be resumed is available at:

- Chief Coroner's Guide to the Coroners and Justice Act 2009, paragraphs 96-100; and
- Ministry of Justice, A Guide to Coroner Services for Bereaved People.[16]

1.7 Timescale for inquest

An inquest should be opened as soon as reasonably practicable after the date on which the coroner considers there is a duty to hold an inquest.[17] The inquest must generally be completed within six months from the date on which the coroner is made aware of the death, or as soon as is reasonably practicable after that date.[18]

1.8 When might a public inquiry be held rather than an inquest?

In some circumstances it will not be possible to hold an inquest and a public inquiry will be more appropriate. This might be where there is relevant intelligence material which the coroner is not allowed to see.

Opinions are divided on whether, where either route of investigation might be chosen, it is better to have an inquest or a public inquiry.

In 2014, the House of Lords Select Committee on the *Inquiries Act 2005* concluded that, where public concern extends significantly beyond a death itself to wider related issues, an inquiry may be preferable to an inquest.[19]

A coroner's investigation of a death may be resumed after a public inquiry has concluded, but only if the coroner thinks there is sufficient reason for doing so. If the investigation is resumed, an inquest might be held as part of that investigation.

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12 Coroners and Justice Act 2009 Schedule 1, paragraph 1
13 Coroners and Justice Act 2009 Schedule 1, paragraph 2
14 Coroners and Justice Act 2009 Schedule 1, paragraph 3
15 Coroners and Justice Act 2009 Schedule 1, paragraph 5. As summarised in the Chief Coroner's Guide to the Coroners And Justice Act 2009, 2013, p30
16 Section 7.3
17 Coroners (Inquests) Rules 2013, SI 2013/1616, Rule 5
18 Coroners (Inquests) Rules 2013, SI 2013/1616, Rule 8
19 House of Lords Select Committee on the Inquiries Act 2005, The Inquiries Act 2005: post-legislative scrutiny , 11 March 2014, HL 143 2013-2014, paragraph 92

Another Library briefing paper provides further information: Inquests and public inquiries.[20]

[20] Number 08012

2. Impact of human rights legislation

Article 2 of the European Convention on Human Rights (ECHR) enshrines the right to life and imposes on the state both negative obligations not to take life intentionally, and positive obligations to protect life. The positive duty to protect life implies a duty to investigate unnatural deaths, including, but not confined to, deaths in which state agents may be implicated.[21]

In 2003, the European Court of Human Rights established that, in order to satisfy the requirements of Article 2, any investigation had to satisfy the following five criteria to be effective:

- the inquiry must be on the initiative of the State, and it must be independent;
- it must be capable of leading to a determination of whether any force used was justified, and to the identification and punishment of those responsible for the death;
- it must be prompt and proceed with reasonable expedition;
- it must be open to public scrutiny to a degree sufficient to ensure accountability; and
- the next-of-kin of the deceased must be involved in the inquiry to the extent necessary to safeguard their legitimate interests.[22]

Section 5(2) of the 2009 Act requires the scope of the coroner's 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 ECHR, in particular Article 2.[23]

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21 McCann v UK (1996) 21 EHRR 97; Ergi v Turkey (2001) 32 EHRR 18; Yasa v Turkey (1999) 28 EHRR 408, Joint Committee on Human Rights, Scrutiny: First Progress Report, 24 January 2005, HL Paper 26 HC 224 2004-05, p48

22 Jordan v UK (2003) 37 EHRR 2 as set out in the Lord Chancellor's Exceptional Funding Guidance (Inquests), 15 June 2018

23 Chief Coroner's Guide to the Coroners and Justice Act 2009, 2013, p37

3. Legal aid

Legal aid is available for advice and assistance in the run-up to an inquest involving a member of the individual's family, for those who qualify financially.

However, legal aid for representation at an inquest is only available through the "exceptional funding" criteria of the *Legal Aid, Sentencing and Punishment of Offenders Act 2012*. The exceptional funding criteria allow funding for representation at an inquest to be provided on two grounds:

- where it is necessary to carry out an effective investigation into a death, as required by Article 2 of the European Convention on Human Rights; or
- where the Director of Legal Aid Casework has made a wider public interest determination that the provision of advocacy for the bereaved family at the inquest is likely to produce significant benefits for a wider class of people.

Caseworkers in the Legal Aid Agency's exceptional case funding team follow guidance issued by the Lord Chancellor when deciding whether or not an application for funding will be granted.[24]

Financial eligibility (means) criteria also apply, but they can be waived.

Another Library briefing paper, Legal aid for representation at an inquest, provides further information, including about calls for change to the current position.[25]

[24] Ministry of Justice, Lord Chancellor's Exceptional Funding Guidance (Inquests), 15 June 2018

[25] Number 04358, 9 April 2019

4. Procedure at an inquest

4.1 Hearing in public

An inquest is a court proceeding and must be held in public, unless the coroner directs that the public be excluded in the interests of national security. A coroner may also direct that the public be excluded from a pre-inquest review hearing if the coroner considers it would be in the interests of justice or national security to do so.[26]

Unless issues of national security are involved, the media may generally attend and report details of the inquest.

4.2 What information can a coroner call for?

The coroner decides which documents should be produced, which evidence will be heard at the inquest, and the order in which witnesses give evidence.

4.3 Interested persons

"Interested person" is defined in section 47 of the 2009 Act and includes a spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half-brother or half-sister and a personal representative of the deceased.

Interested persons are not parties to the inquest as such. However, they have rights to be notified of certain matters including, for example, aspects of the post-mortem and information about the date, time and place of the inquest. They also have rights to be involved in the inquest procedure, including, for example, by questioning witnesses and seeing written evidence.

The Ministry of Justice's Guide to Coroner Services for Bereaved People includes a protocol of key principles which applies when a Government department has interested person status in an inquest. The Guide introduces the protocol as follows:

> This Protocol applies when a Government department has interested person status in an inquest and will guide the behaviour of that department in recognising the need for the bereaved to be properly involved throughout the inquest process.
>
> This protocol has been developed in response to Dame Elish Angiolini's report of her review of deaths and serious incidents in police custody; and Bishop James Jones' report of his review of the experiences of the Hillsborough families and the Government's Final Report of the review of legal aid at inquests.
>
> The principles in this protocol do not affect or replace the provisions in the Coroners and Justice Act 2009.[27]

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26 Coroners (Inquests) Rules 2013, SI 2013/1616, Rule 11

27 Ministry of Justice, Guide to Coroner Services for Bereaved People, January 2020, Annex A

The protocol states that, where a Government department has interested person status at an inquest, the Government and the lawyers it instructs at inquests will adopt the following principles:

> 1. Remain committed to supporting the inquisitorial approach and assisting the coroner to find the facts of what happened and learn lessons for the future.
>
> 2. Approach the inquest with openness and honesty, including supporting the disclosure of all relevant and disclosable information to the coroner.
>
> 3. Communicate with the bereaved in a sensitive and empathetic way which acknowledges and respects their loss.
>
> 4. Keep in mind that the bereaved should:
>
> > (1) Be at the heart of the inquest process;
> >
> > (2) Feel confident that the inquest will get to the facts of what happened;
> >
> > (3) Feel properly involved throughout and listened to.
>
> 5. Challenge the evidence of other interested persons or witnesses sensitively, where it is necessary to do so.
>
> 6. Consider a formal acknowledgement to the bereaved to recognise when the death of their loved one happened whilst in the care of the state.
>
> 7. Consider the number of lawyers instructed bearing in mind the commitment to support an inquisitorial approach.

The protocol applies to all Government departments represented at inquests and states that "it is designed to make sure that the consideration of families and loved ones are fully taken into account".

4.4 Questioning of witnesses

The coroner questions witnesses first and then additional relevant questions may be asked by any interested person or their legal representative. The coroner decides whether a question is relevant to the purpose of the inquest.

Where appropriate, the coroner may warn a witness that (s)he is not obliged to answer any question which might incriminate him or herself.[28]

[28] Ministry of Justice, Guide to Coroner Services, January 2020, section 5.13

5. Juries

Section 7 of the 2009 Act requires the coroner to sit with a jury if the coroner has reason to suspect:

- that the deceased died while in custody or otherwise in state detention, and that either:
  - the death was a violent or unnatural one, or
  - the cause of death is unknown,
- that the death resulted from an act or omission of:
  - a police officer, or
  - a member of a service police force,

  in the purported execution of the officer's or member's duty as such, or
- that the death was caused by an accident, poisoning or disease which must be reported to a Government department or inspector.

An inquest may also be held with a jury if the coroner thinks that there is sufficient reason for doing so.

In all other cases the inquest must be held without a jury.

Section 30 of the *Coronavirus Act 2020* removed the requirement for an inquest to be held with a jury if the coroner has reason to suspect the death was caused by COVID-19.

In 2019, jury inquests represented just 2% of all inquests. The Ministry of Justice has stated that the proportion of inquests held with juries has remained stable between 1% and 2% over the last decade. [29]

[29] Ministry of Justice Statistics Bulletin, Coroners statistics 2019: England and Wales, 29 May 2020, section 6

6. The outcome of the inquest

6.1 Conclusions

The 2009 Act and associated rules and regulations no longer use the word 'verdict'. Verdicts have become "conclusions". Conclusions may be short-form or narrative.[30] It is also permissible to combine the two types of conclusion.

The outcome of an inquest is recorded in the Record of Inquest (Form 2) which is set out in the Schedule to the *Coroners (Inquests) Rules 2013*. The notes to Form 2 list the short form conclusions as:

- accident or misadventure;
- alcohol/drug related;
- industrial disease;
- lawful/unlawful killing;
- natural causes;
- open;
- road traffic collision;
- stillbirth;
- suicide.

It is for the coroner to decide whether a short-form or a narrative conclusion is more appropriate to the case in question.

The first Chief Coroner published guidance, Conclusions: short-form and narrative.[31] This advises that, wherever possible, coroners should conclude with a short-form conclusion:

> This has the advantage of being simple, accessible for bereaved families and public alike, and also clear for statistical purposes.[32]

However, a narrative conclusion may be more appropriate at inquests where there is an investigative duty under Article 2 of the European Convention on Human Rights:[33]

> Frequently a narrative conclusion will be required in order to satisfy the procedural requirement of Article 2, including, for example, a conclusion on the events leading up to the death or on relevant procedures connected with the death…[34]

6.2 Standard of proof

The standard of proof for all inquest conclusions is the civil standard of proof – i.e. the balance of probabilities.

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30 Coroners (Inquests) Rules 2013, SI 2013/1616, Schedule, Form 2
31 30 January 2015, revised 14 January 2016
32 At paragraph 26
33 See section 2 of this briefing paper above
34 Chief Coroner, Guidance No 17, Conclusions: short-form and narrative, paragraph 47

This is a lower threshold than the standard of proof applied in the criminal courts – i.e. being sure, or "beyond all reasonable doubt". Until the 2018 case of R (Maughan) v HM Senior Coroner for Oxfordshire and others,[35] both case law and the leading practitioners' texts considered that the higher standard of proof was necessary for a coroner's conclusion of suicide. This meant that, in order to return a conclusion of suicide, the coroner (or jury) had to be sure that the deceased intentionally took their own life.

This position is still reflected in Note (iii) to Form 2, which deals with the standard of proof at inquests generally. It distinguishes conclusions of suicide and unlawful killing from all other conclusions:

> The standard of proof required for the short form conclusions of "unlawful killing" and "suicide" is the criminal standard of proof. For all other short-form conclusions and a narrative statement the standard of proof is the civil standard of proof.

In Maughan, the High Court held that previously decided cases did not correctly state the law, and that the lower civil standard of proof applies to a conclusion of suicide. In November 2020 the Supreme Court confirmed that the civil standard applies to all inquest conclusions, including unlawful killing.[36]

35 [2018] EWHC 1955 (Admin)
36 R (Maughan) v HM Senior Coroner Oxfordshire and others [2020] UKSC 46

7. Disclosure of information relating to an investigation

Part 3 of the *Coroners (Inquests) Rules 2013* sets out arrangements for the disclosure of information to "interested persons".[37] The rules require the coroner to disclose copies of relevant documents to an interested person, on request, at any stage of the investigation process (unless one of the restrictions set out in Rule 15 applies).

7.1 What information should be disclosed?

Rule 13 lists the documents that should be disclosed:

- any post-mortem examination report;
- any other report that has been provided to the coroner during the course of the investigation;
- where available, the recording of any inquest hearing held in public, but not in relation to any part of the hearing from which the public was excluded;
- any other document which the coroner considers relevant to the inquest.

7.2 Recordings

Rule 26 of the *Coroners (Inquests) Rules 2013* requires a coroner to keep a recording of every inquest hearing, including any pre-inquest review hearing. There is no longer any legal requirement for the coroner to take notes of evidence or to provide them after the inquest.

When providing a recording of an inquest to an interested person, a coroner should place limitations on its use.[38] The Chief Coroner has issued guidance to coroners that each recording must be supplied with a written notice warning that misuse may be a contempt of court.[39]

7.3 Restrictions on disclosure

Rule 15 sets out restrictions on disclosure. A coroner may refuse to provide a document, or a copy of a document, requested under rule 13 where:

- there is a statutory or legal prohibition on disclosure (eg police reports);
- the consent of any author or copyright owner cannot reasonably be obtained;
- the request is unreasonable;
- the document relates to contemplated or commenced criminal proceedings; or

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37 See section 4.3 of this paper above for information about "interested persons"

38 Chief Coroner's Guide to the Coroners and Justice Act 2009, 2013, paragraph 147

39 See the Chief Coroner's Guidance No.4 Recordings, 16 July 2013

- the coroner considers the document irrelevant to the investigation.

7.4 Fees

A coroner may not charge a fee for any document disclosed to an interested person before or during an inquest; but a fee may sometimes be charged for disclosure after an inquest.[40]

[40] Coroners (Inquests) Rules 2013, SI 2013/1616, rule 16 and Coroners Allowances, Fees and Expenses Regulations 2013, SI 2013/1615, regulation 12

8. Reports to prevent future deaths

8.1 Statutory duty

The 2009 Act requires the coroner to make a report (known as a report to prevent future deaths, or a PFD report, or a regulation 28 report) in the following circumstances:

- a coroner has been conducting an investigation into a person's death,
- anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
- in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances.

The report must be made to the person the coroner believes may have power to take such action. [41] Previously coroners had a discretion as to whether to make a report.[42]

It is for the coroner to decide, on a case by case basis, whether or not the statutory duty to make a report arises in a particular investigation.

Regulations set out details of the procedures. [43]

The coroner must send a copy of the report to the Chief Coroner; every interested person who, in the coroner's opinion, should receive it; and, where the deceased was under the age of 18, the Local Safeguarding Children Board. The coroner may also send a copy of the report to anyone who the coroner believes may find it useful or of interest.

PFD reports are published on the Courts and Tribunals Judiciary website.

8.2 Chief Coroner guidance

The Chief Coroner's Guidance No. 5, Reports to prevent future deaths provides detailed information, including about the circumstances in which the coroner's duty arises:

> (1) The coroner has been conducting an investigation into a person's death. Normally the investigation will be complete, with the inquest concluded, but not necessarily (see below).
>
> (2) Something revealed by the investigation (including evidence at the inquest) gives rise to a concern. The coroner is not restricted to matters revealed in evidence at the inquest (as was the case with rule 43 reports). The matter giving rise to concern will usually be revealed by evidence at the inquest, but it may be something revealed at any stage of a coroner's investigation. Giving rise to a concern is a relatively low threshold…

41 Coroners and Justice Act 2009, Sch.5 para 7 (1)
42 Under Coroners Rules 1984, Rule 43 (as amended)
43 Coroners (Investigations) Regulations 2013, SI 2013/1629, regulations 28 and 29

> (3) The concern is that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future. It is concern of a risk to life caused by present or future circumstances…
>
> (4) In the coroner's opinion, action should be taken to prevent those circumstances happening again or to reduce the risk of death created by them.
>
> (5) If (1) – (4) apply, the coroner has a duty to report ('must report') the matter to a person or organisation who the coroner believes may have power to take such action.[44]

The Guidance states that it is not for the coroner to express precisely what action should be taken:

> **A prevention of future deaths report raises issues and is a recommendation that action should be taken, but not what that action should be.** The latter is a matter for the person or organisation to whom the PFD report is directed.[45]

8.3 Responses

A person or organisation must respond within 56 days (or longer if the coroner grants an extension).[46] The response must detail the action taken or to be taken, whether in response to the report or otherwise, and the timetable for it, or it must explain why no action is proposed.[47]

The coroner must forward a copy of the response to the Chief Coroner's Office and to any interested persons the coroner thinks should receive it and may send a copy to anyone the coroner believes may find it useful or of interest.[48]

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44 Chief Coroner, Guidance No. 5, Reports to prevent future deaths, 16 July 2013, revised 4 November 2020, paragraph 11

45 Ibid paragraph 27

46 Coroners (Investigations) Regulations 2013, SI 2013/1629, regulation 29

47 Ibid regulation 29(3)

48 The Coroners (Investigations) Regulations 2013, Reg.29 (6)

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