



# Coroner and inquest information sheet

## Updated June 2025

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### Why is a coroner involved?

A coroner is likely to become involved when a death is sudden, violent, suspicious, unnatural, or the cause is unknown. A death must also be reported to the coroner if:

- No doctor saw the person during their last illness.
- The death occurred during surgery or before recovering from the effects of anaesthetic.

A coroner is usually a lawyer, though in some cases they may be a doctor. The coroner’s role is to determine whether a formal investigation is necessary. Initial enquiries (for example, with the deceased’s GP) may show that the death was due to a known and natural cause, and that there are no unusual circumstances. In such cases, the coroner may decide no further investigation is needed.

If more information is required, the coroner may request a post-mortem examination to help establish the cause of death. The pathologist will send a report to the coroner, which may include toxicology results such as drug or alcohol levels. This report can take several weeks.

If the post-mortem determines the cause of death, the coroner may close the investigation. If further enquiries are required, the body may still be released for the funeral. However, in some cases, the funeral may need to be delayed. The coroner’s office can clarify arrangements.



## Pre-inquest reviews and inquest

An inquest is required if the post-mortem does not establish a clear cause of death. In more complex cases, the coroner may hold one or more preliminary hearings known as **pre-inquest reviews** or **directions hearings**. **Staff may be invited to attend**, and there will be an opportunity to raise relevant issues.

An inquest is a public court hearing to determine how someone died. It is not about assigning blame, and there are no prosecution or defence teams. However, if evidence suggests that someone may be responsible for the death, the coroner can pass the information to the police or the Crown Prosecution Service.

In most cases, **the inquest should be held within six months of the death; however, there can be delays**. The coroner's office should inform you of the date, time, and location of the inquest within a week of confirming the hearing.

An inquest may be held with or without a jury. **You may be called to give evidence as a witness**, for example, to provide information about the deceased or the circumstances of the death. Other witnesses could include medical staff, police officers, or members of the public.

**Note:** *If a criminal investigation is ongoing, there may be two post-mortems. If someone is charged with a crime such as murder, the coroner's investigation will be paused until the criminal trial concludes. If the facts around the death are clarified during the trial, the coroner may not need to continue their investigation.*

## What to expect when a coroner is involved

You will need to cooperate fully with the coroner's office, provide all relevant information, and raise any concerns you have about the death. You may be asked to submit a report outlining your organisation's involvement with the deceased. Please bear in mind that any written report may enter the public domain and could be referenced in national media. It is advisable to seek guidance from your organisation on how to draft this report.

**A single person should be nominated as the point of contact ('next of kin') for communication with the coroner's office. If contact details change, it is important to update them.**

A staff member may be required to attend the inquest and give evidence.

Coroner investigations can take several months. You should receive an update at least every three months regarding the progress of the case and any delays. If you have not received an update, you can contact the coroner's office directly or check in with the Westminster HHCP, who routinely liaise with coroners to obtain cause of death updates for Westminster's quarterly death review meetings.

If the cause of death is still under investigation, or if an inquest is pending, you should ask the coroner for an **interim death certificate** (also known as a "certificate of the fact of death" or "coroner's interim certificate"). **This interim certificate allows for administrative tasks, such as arranging funerals, managing the estate, and using the [Tell Us Once service](#), even before the final certificate.** Once the inquest concludes, the coroner notifies the Registrar, who then issues the **final death certificate**



## City of Westminster

### Preparation for an inquest

Inquests are formal public hearings that can be emotionally intense. Family members, the coroner, and sometimes the press may attend. If possible, attend an inquest in advance to familiarise yourself with the setting.

#### When preparing:

- Always use the deceased's full name in reports (not initials).
- Keep documents from when the person was alive separate from those created after death.
- Do **not** amend existing records.
- If there are any gaps in service provision, it is better to highlight these than have them identified during the inquest.

#### On the Day

- Arrive in good time; allow at least 15 minutes for security checks and to locate the courtroom.
- Dress formally, e.g., suit and formal shoes.
- Organise all relevant papers in a ring file or folder with dividers.
- Bring a notebook and pen.
- Switch off your mobile phone.
- Witnesses will usually read their statements under oath from the witness box.
- Address the judge or coroner as Sir or Ma'am.
- Speak clearly and audibly; proceedings are recorded.
- Take your time when responding. Be calm, honest, professional, and courteous.
- If a question is unclear, ask for clarification.
- If questioned in a confrontational way, remain composed and respond simply and clearly.
- Acknowledge that the inquest may be distressing for the family; show empathy in your conduct.
- If your evidence is complex, consider using diagrams or visual aids.
- If the media is present, **do not** speak to journalists. Refer all press enquiries to your organisation's Communications Team.

### When the inquest concludes

Once the inquest concludes and findings are issued:

- Inform your commissioner of the outcome.
- Record the cause of death on **CHAIN** and your organisation's internal database.



## Contacts

Organisation	Contact details
<b>Westminster Coroner’s Court</b>	65 Horseferry Rd, Westminster, London SW1P 2ED <b>Phone:</b> 020 7641 1212 <b>Email:</b> <a href="mailto:innerwestlondoncoronerscourt@westminster.gov.uk">innerwestlondoncoronerscourt@westminster.gov.uk</a>
<b>Southwark Coroner’s Court</b>	<b>Email:</b> <a href="mailto:islcoronerinquest@coroners.southwark.gov.uk">islcoronerinquest@coroners.southwark.gov.uk</a>
<b>Coroners Court Support Service (CCSS)</b>	CCSS is a voluntary organisation whose trained volunteers offer support to people attending an Inquest at a Coroner’s Court. <b>Phone:</b> 0300 111 2141 (Mon-Fri 9:00-19:00 and Saturday 09:00-14:00) or email <a href="mailto:helpline@ccss.org.uk">helpline@ccss.org.uk</a>

## Further resources

1. [HHCP’s Supporting staff when a client dies toolkit](#)
2. [HHCP’s Grief information sheet for clients](#) (this is a foldable handout)
3. [HHCP’s Grief information sheet for staff](#)
4. [Government’s information sheet ‘When a death is reported to a coroner’](#)
5. [Government’s Short Guide to Coroner services and coroner Investigations](#)
6. [Government’s Long Guide to Coroner Services](#)

