National Suicide Prevention Alliance

Public Health England

Information Sheet: Working with Coroners

Thank you to Louise Hunt, Senior Coroner at Birmingham and Solihull Coroner Service for providing this information.

What is a coroner?

A coroner is an independent judicial office holder who has the statutory responsibility to investigate all violent, or unnatural deaths, or deaths where a person has died in custody or in state detention, or where the cause of death is unknown. All coroners have to be legally qualified.

What is an inquest?

The purpose of a coroner inquest is to answer four statutory questions:

- Who the deceased was
- Where the death took place
- When the death took place
- How the person came by their death

The 'How?' is interpreted as determining by what means the death occurred at that time. It is not a mechanism for apportioning any blame and no coroner's conclusion can be framed in any way as to appear to determine any question of civil or criminal liability on the part of a named person. It is important to recognise that the coroner is not there to determine 'Why?'

Why do deaths by suicide involve an inquest?

The 2009 Coroners and Justice Act introduced the concept of the coroner's 'investigation', of which the inquest only forms a part, recognising that much of the coroner's work takes place before the formal inquest hearing.

There are some cases where the coroner is allowed time to consider whether the duty to hold an inquest applies. In these cases, an 'investigation' would initially be opened, rather than an inquest. This can allow time for example, for an autopsy and toxicology report to be requested.

If someone has taken their own life then almost inevitably it is going to fulfil the requirement for an inquest as the mechanism for death is likely to be either, or both, violent (e.g. hanging) or unnatural (e.g. medical overdose).

How quickly do inquests happen and how long do they take?

The 2009 Act requires Coroners to open an inquest as soon as practically possible once there is reason to suggest a violent or unnatural death. They are usually concluded within four months.

What conclusions can inquests result in that could relate to suicide?

To reach a conclusion of suicide the coroner has to be sure to a criminal standard of proof that the deceased undertook a deliberate act that resulted in their death, and that they intended their death, and any other reasonable explanations are ruled out. In many cases the coroner may not have evidence of intent and it may not be possible to be sure if the deceased was under the influence of drink or drugs which could have impeded decision making.

A coroner may alternatively determine:

- An open conclusion, where there remain unknowns and therefore there is not enough evidence for the coroner to return an alternative.
- A narrative conclusion, which provides a short, neutral and factual statement that explains what happened. For example, the deceased died from a deliberate act but their intention is unknown.

Within the narrative conclusion coroners are encouraged to confirm intention if there is evidence to suggest it was a deliberate act. This is in order that these deaths can be more accurately recorded in local and national statistics.

When a probable rather than confirmed conclusion of suicide is reached, some coroners are completing a further form to provide Public Health England with information regarding possible risk factors and emerging methods.

Coroners have a statutory function to provide a Report to Prevent Future Deaths (formerly known as Rule 43 report) where there is evidence at an inquest that indicates that something could be done to prevent similar fatalities. These reports must be sent to the Chief Coroner and are published on the Courts and Tribunals Judiciary website (www.judiciary.gov.uk/subject/suicide).

What records do coroners keep and who can they be accessed by?

The main document is the Record of Inquest (Form 2), which is prepared at the end of every case and states the deceased name, the cause of death, the circumstances of death (a brief narrative) and the coroner's conclusion. It also includes the statutory requirements for the death registration: age, place of birth, gender and marital status.

Any properly interested person, including family, medical professionals or the local public health team, may apply to inspect the notes of evidence, any document put in evidence, or a copy of the post-mortem examination report. Copies can be obtained with payment of a fee to the Coroner. It is also possible to write to the coroner and request an audio copy of the inquest proceedings.

Coroners records are held for 15 years.

What can suicide prevention multi-agency groups learn from coroners' records?

Coroners records can help to determine the scale of the problem of suicide. In addition – although it is not a requirement of the inquest to determine 'Why?' – there are often details around the personal circumstances of the worst moments in people's lives and may suggest potential risk and/or contributory factors. This information may enable more targeted suicide prevention activity including the provision of better resources and support networks before people reach crisis point.

What are the barriers?

Coroners are under-resourced so try to make it as easy as possible for them to comply with your request to review the records. It's crucial to provide reassurance that the data will be anonymised. Coroners also want to feel confident that the people doing the analysis are credible and understand how to use the data accurately and sensitively. Having an initial meeting is a helpful way to get to know each other and understand the roles, responsibilities and experience of the people involved, how the data will be collated and stored, and what the programme is aiming to achieve. Multiple individuals and agencies sometimes make approaches for information. It is helpful to take a joined-up approach locally and have a single point of contact.

The data has to be reviewed in the coroners' offices because it can't be taken off site. It usually works best if the files are audited once a year, and it's likely to take a minimum of a couple of days.

The Chief Coroner is very supportive of using coroners' records and may be able to provide assistance if there are any difficulties in getting access.

Where is there more information available?

Further information about coroners and investigations is available at www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide.

Coroners' offices are also keen to make further relevant information available and to be able to signpost people on, although there isn't always the time or space to do this effectively. Leaflets can sometimes be made available in the reception area, and it's often helpful to have a list of sources of support that can be shared electronically.