
Medical Examiner & Coroner Guide

What the Medical Examiner system means for your family, the process step by step, and what happens if a coroner is involved — England & Wales.

B-10 · BEREAVEMENT

"A death certificate starts many conversations. It ends very few."

POST-EVENT · FREE INSTITUTIONAL GUIDE

PREPARED FOR

Andrew Pemberton · Executor

Estate of David Pemberton · died 22 May 2026 · Leeds ·
11 June 2026

The Medical Examiner system is new, systematic, and — for most families — straightforward. It was introduced to ensure every death in England and Wales is independently scrutinised before a death certificate is issued. For David's death, the process completed without complication in under 48 hours. This guide explains what happened, what might have happened if the circumstances had been different, and what the process means for your estate administration timeline.

DAVID'S PATHWAY — SUMMARY

Death type: Expected death from cancer — Leeds community. **Medical Examiner:** Dr Susan Halloran, Leeds Teaching Hospitals NHS Trust Medical Examiner service. **Family call:** 23 May 2026 (the day after death). **Outcome form:** ME-3 issued 24 May 2026. **Funeral:** Unimpeded — death certificate released and funeral director instructed.

No coroner referral was required. This is the expected pathway for a death from a known, confirmed terminal illness attended by the treating GP or specialist team. Andrew, as executor, may proceed with the estate administration from the death certificate issued on 24 May 2026.

How to use this guide.

Section 1 explains the Medical Examiner system and why it was introduced. Section 2 walks through the ME process step by step. Section 3 covers the family call specifically. Section 4 explains when deaths are referred to the coroner. Section 5 covers post-mortems. Section 6 covers the inquest process. Section 7 explains the impact on probate and estate administration. Section 8 sets out David's specific pathway in detail. Section 9 summarises the family's rights. Section 10 provides reference contacts and a checklist for Andrew as executor.

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The Medical Examiner — what changed in April 2023

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MANDATORY ME SYSTEM • POST-SHIPMAN • QUALITY ASSURANCE NOT ADVERSARIAL

Every death in England and Wales is now independently scrutinised by a Medical Examiner before a death certificate is issued. This was not always the case. Understanding why the system was introduced helps explain what it is — and, importantly, what it is not.

The Harold Shipman inquiry changed death certification permanently

Harold Shipman, a GP in Greater Manchester, murdered at least 215 of his patients between 1975 and 1998. He was able to do so in part because the system of death certification relied entirely on the certifying doctor — with no independent scrutiny unless a cremation was planned. The Shipman Inquiry (Dame Janet Smith, 2002–2005) identified the death certification process as a core systemic failure and recommended fundamental reform. The Medical Examiner system is the result of that reform.

What changed and when

Medical Examiner offices were piloted on a non-statutory basis from 2019, initially covering hospital deaths. The Health and Care Act 2022 placed the system on a statutory footing. From **9 September 2024**, the ME system became mandatory for all deaths in England: hospital deaths, community deaths, care-home deaths, and deaths at home. This means David's death in May 2026 fell fully within the mandatory system. Wales introduced equivalent requirements under Welsh Government regulations on the same timeline.

Quality assurance, not investigation

The ME's role is **quality assurance** — not accusation, not investigation. The ME reviews the medical records, checks that the cause of death as certified by the treating doctor is consistent with the clinical history, and gives the bereaved family an opportunity to raise any concerns. In the vast majority of cases (over 95%), the ME confirms the certifying doctor's cause of death and the process is complete. Referral to the coroner is the exception, not the norm.

Who Medical Examiners are

Medical Examiners are senior medical practitioners — typically senior clinicians or retired consultants — appointed by NHS Trusts and, for non-hospital deaths, by local NHS authorities. They are independent of the certifying doctor. They hold statutory powers under the Health and Care Act 2022 and are regulated by NHS England's National Medical Examiner. Leeds Teaching Hospitals NHS Trust runs its own ME service, led by MEs including Dr Susan Halloran who reviewed David's case.

What the ME is not

The ME is not a coroner. The ME does not order post-mortems. The ME does not hold inquests. The ME does not investigate deaths — the coroner does that, if referred. The ME's role is to confirm the cause of death is medically supported, to give the family a voice, and to act as the gateway between death certification and the coroner if anything requires scrutiny. For most families, the ME process is the entire process — the coroner never becomes involved.

The ME process step by step

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DEATH → GP CERTIFIES → ME NOTIFIED →
ME REVIEWS → FAMILY CALL → OUTCOME •
24-72 HOURS TYPICAL

The process from death to the ME issuing an outcome typically takes between 24 and 72 hours for an expected death in the community. For hospital deaths, it is often faster. For complex or unexpected deaths, it may take longer if the coroner becomes involved.

1

Death occurs and is confirmed by an attending healthcare professional — the treating GP, a specialist, a palliative care nurse, or an out-of-hours GP. For expected deaths at home or in a care home, the family contacts the GP surgery or 111 for a clinical review. A doctor confirms death and issues a Medical Certificate of Cause of Death (**MCCD**) — the green form. This was David's pathway on 22 May 2026.

2

The certifying doctor notifies the Medical Examiner office. Under the mandatory system, the certifying doctor is required to notify the relevant ME office. For community deaths in Leeds, this is the Leeds Teaching Hospitals NHS Trust ME service. The ME receives the **MCCD** and the relevant clinical records.

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The Medical Examiner reviews the medical records. The ME examines the patient's clinical history, the cause of death as stated on the **MCCD**, any hospital admissions, any recent prescribing, and any factors that might indicate the cause of death is uncertain or that the death ought to be referred to the coroner. This review is desk-based — the ME does not physically examine the deceased unless a post-mortem is ordered.

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The Medical Examiner or Medical Examiner Officer contacts the family. A call is made to a close family member or the named next of kin to explain the process, to ask if the family has any concerns they wish to raise, and to confirm the proposed cause of death. This call is a right, not optional — the family is entitled to this conversation. Dr Halloran's office contacted the Pemberton family on **23 May 2026**.

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The ME issues the outcome. If the ME is satisfied that the cause of death is correctly certified and there are no matters requiring coroner referral, the ME issues the **ME-3 form** — a scrutiny outcome that allows the death to be formally registered at the Register Office. The **MCCD** (green form) and the ME-3 travel together. Dr Halloran issued the ME-3 for David's case on **24 May 2026**.

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The family registers the death at the Register Office. The next of kin or executor attends the Register Office (in Leeds, the Leeds Register Office) with the **MCCD** and ME-3. The Registrar issues the Death Certificate (form BD8 and the standard death certificate). The death certificate is the document needed for probate, for bank accounts, for life insurance claims, and for the funeral director.

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Funeral arrangements proceed. With the death certificate issued, the funeral director can proceed. If the deceased is to be cremated, the funeral director submits the cremation forms (including Cremation 4 and Cremation 5) for separate authority — but this is administrative and does not delay the funeral once the death certificate is in hand. For burial, the death certificate alone suffices.

The family call

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WHAT THE ME ASKS • RIGHT TO RAISE CONCERNS • NOT AN ACCUSATION

The family call with the Medical Examiner or Medical Examiner Officer is a statutory right introduced by the Health and Care Act 2022. It is designed to give bereaved families a formal opportunity to be heard — and to raise any concerns about the care their relative received or about the circumstances of the death. It is not a routine notification call; it is a structured conversation.

Who makes the call and when

The call is made by the Medical Examiner or, more commonly, by a **Medical Examiner Officer** — a specially trained administrative professional who works alongside the ME. The call is typically made within 24–48 hours of the death being notified to the ME office. For David's case, the call came from Dr Halloran's team at Leeds Teaching Hospitals on the morning of **23 May 2026**, the day after his death.

What questions to expect

The Medical Examiner Officer will introduce themselves and explain their role. They will then ask: whether you have any concerns about the care your relative received; whether you have any questions about the cause of death as proposed on the certificate; whether the death was expected; and whether there is anything you feel should be drawn to the ME's attention. The conversation is not a formal interview — there is no transcript, no legal consequences for what you say, and you are not under any obligation to answer questions you are not comfortable with. The purpose is to listen.

Your right to raise concerns — and what happens if you do

If the family raises a concern during the ME call — about the care, the cause of death, or the circumstances — the ME takes this into account. The ME may: amend the cause of death on the **MCCD**; refer the case to the coroner for further investigation; or note the concern without action if it is outside the ME's scope (e.g. a complaint about treatment, which is handled separately via NHS PALS or the Parliamentary and Health Service Ombudsman). Raising a concern does not automatically trigger a coroner's inquest — the ME will explain what the concern means in practice.

The call is not an accusation

Families are sometimes anxious before the ME call, fearing it implies something went wrong or that the death is under suspicion. In the great majority of cases it does not — the call is simply the completion of a quality assurance step. The ME system was designed precisely to separate independent scrutiny (ME) from investigation (coroner), so that routine independent review does not carry the weight of a formal investigation. Dr Halloran's call to the Pemberton family was cordial and confirmatory — the cause of death as certified was consistent with David's known cancer diagnosis and treatment history.

Practical note: who should be on the call

The ME call is typically to the next of kin. As executor, Andrew is an appropriate person to take the call — particularly if the next of kin is distressed or if there are administrative questions about the estate. It is entirely appropriate to say: "I am the executor and I am also a close relative — may I be the contact for the ME process?" The ME office will be receptive to this.

When the coroner is involved 4

CIRCUMSTANCES REQUIRING REFERRAL • WHAT THE CORONER DOES

The Medical Examiner refers a death to the coroner when the circumstances fall into defined categories where independent investigation is required. This is a legal obligation, not a discretionary step. The following circumstances require coroner referral.

- ▶ **Unexpected death** — the death was not anticipated, was sudden, or occurred without a known terminal illness or prior deterioration that would explain it.
- ▶ **Unnatural cause** — the death resulted from an accident, an injury, violence, poisoning, or any cause other than natural illness. This includes deaths from falls, road traffic collisions, drowning, and similar events.
- ▶ **Unknown cause** — the certifying doctor cannot state a cause of death that is supported by the clinical history, or there is no doctor who can certify the death (e.g. no attending physician saw the deceased within the required period before death).

- ▶ **Death within 24 hours of admission to hospital** — or before the patient had been seen and assessed by a senior treating clinician who would be able to certify cause of death with confidence.
- ▶ **Death during or after surgery or an invasive procedure** — including deaths that occur post-operatively where the procedure may have contributed to or failed to prevent death.
- ▶ **Industrial disease** — where the death may have been caused or contributed to by an occupational disease (asbestosis, mesothelioma, silicosis, noise-induced hearing loss, or similar) arising from the deceased's working life.
- ▶ **Suicide or suspected suicide** — or any death where self-harm may have been a contributing factor.
- ▶ **Custody or state detention** — any death of a person who was in prison, police custody, immigration detention, or under a compulsory psychiatric order. These deaths are automatically referred and often require an inquest regardless of cause.
- ▶ **Death of a child (under 18)** — most child deaths are automatically referred. Sudden Unexplained Death in Infancy (SUDI) triggers a specific multi-agency investigation protocol.
- ▶ **Any death the ME considers should be referred** — the ME has a discretionary power to refer any death where, in their professional judgment, independent coroner scrutiny is appropriate, even if it does not fall neatly into the categories above.

David's case did not require referral.

David died from cancer — a known, confirmed, expected terminal illness. He was attended by his treating GP and specialist team throughout his illness. The cause of death was clearly supported by the clinical record. Dr Halloran confirmed on the family call of 23 May 2026 that there was no basis for coroner referral. This is the typical outcome for deaths from terminal illness.

If a post-mortem is ordered

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WHAT IT INVOLVES • NO CONSENT REQUIRED •
SECOND PM RIGHT • FUNERAL TIMELINE

A post-mortem examination is ordered by the coroner when the cause of death cannot be established from the clinical record alone. It is the most common initial step when a death is referred to the coroner. Understanding what it involves — and what your rights are — reduces the anxiety that accompanies an unexpected referral.

The coroner's post-mortem does not require family consent

Unlike a hospital post-mortem (which is conducted for clinical or research purposes and requires consent), a **coronial post-mortem** is ordered by the coroner under statutory powers and does not require the family's consent. The family must be informed that a post-mortem is to take place, and they have the right to be represented by a medical professional at the examination, but they cannot prevent it. This is frequently distressing for families — the absence of consent is a deliberate feature of the coroner system, designed to prevent evidence from being withheld.

What a post-mortem examination involves

The post-mortem is conducted by a pathologist — typically a Home Office-registered forensic pathologist for deaths involving possible crime or violence, or a hospital pathologist for other coronial cases. The examination involves a thorough internal and external examination of the body. Samples of tissue, blood, and fluid may be retained for laboratory analysis. The pathologist issues a report to the coroner, identifying the cause of death and any contributing factors. The report is not automatically provided to the family — families must specifically request it via the coroner's officer.

Families have the right to request a second post-mortem

If the family is not satisfied with the findings of the first post-mortem — or simply wishes independent verification — they have the legal right to request a second examination. The second PM must be conducted at the family's expense and must be arranged before the body is released for burial or cremation. The coroner must be notified of the intention to commission a second examination before the first examination destroys or removes samples needed for the second. Solicitors acting for the family can request this formally.

Release of the body and impact on the funeral

The coroner retains authority over the body until the post-mortem is complete and, if an inquest is to be held, until the inquest is concluded or the coroner formally releases the body. In practice, coroners release bodies for funeral as soon as the post-mortem is complete and the cause of death is no longer in question — even if an inquest is pending. The funeral director must obtain the **Coroner's Order for Burial** (form 101) or the appropriate cremation authority before proceeding. These are issued by the coroner's office, not the Register Office. A typical post-mortem result is available within 48–96 hours; complex toxicology may take up to four weeks.

Religious and cultural considerations

Some religious traditions require burial within a specific period after death. If a post-mortem would delay burial in conflict with religious requirements, the family (or their solicitor) should notify the coroner's office as early as possible. Coroners have discretion to expedite post-mortems where there are documented religious or cultural reasons for urgency. This is not guaranteed, but coroners routinely accommodate such requests where it is operationally possible.

The inquest process

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WHEN • NOT A CRIMINAL TRIAL • STANDARD OF
PROOF • VERDICTS • TIMELINES

An inquest is a public hearing held by the coroner to establish the facts of a death. It is held when the cause of death is unnatural, unknown, or where a duty to hold a full inquest arises by law (e.g. deaths in custody).

Understanding what an inquest is — and is not — removes a significant source of family anxiety.

When an inquest is required

An inquest is required when: the post-mortem does not establish a natural cause of death; the death was violent or unnatural; the deceased was in state custody or detention; or the coroner considers that a public hearing is in the public interest. Not every referral to the coroner leads to an inquest — most deaths that are referred are resolved by post-mortem without proceeding to hearing. An inquest is opened formally (often within days of death, for administrative purposes) and may then be adjourned for months while investigation continues.

An inquest is not a criminal trial

An inquest is an inquisitorial, not adversarial, proceeding. It does not assign blame, does not determine civil liability, and does not return a verdict of criminal guilt. The standard of proof is different: verdicts at inquest are reached on the **balance of probabilities** (for most conclusions) or — where the conclusion is unlawful killing or suicide — on the higher standard of **beyond reasonable doubt**. The coroner's conclusions ("conclusions" replaced the word "verdicts" in the Coroners and Justice Act 2009) are findings of fact: how, when, and where the deceased came to their death. They are not criminal findings.

Who can participate in an inquest

The family is an **interested person** at the inquest and has the right to ask questions of witnesses, to be represented by a solicitor or barrister, and to make submissions on the conclusions the coroner should reach. Other interested persons may include the NHS Trust responsible for care (if a hospital death), an employer (if an industrial accident), or the police. Legal representation at inquest is not legally aided in most cases — but specialist inquests solicitors often accept cases on a conditional or charity-funded basis, particularly for deaths in custody or systematic failures.

Standard conclusions at inquest

Common short-form conclusions include: **Natural causes**; **Accident or misadventure**; **Suicide** (balance of probabilities since 2018 reform); **Industrial disease**; **Unlawful killing**; **Narrative conclusion** (where the facts are complex and a short-form conclusion would not fully reflect them). Where the inquest involves a jury (required for deaths in custody and some industrial deaths), the jury reaches the conclusion.

Timeline expectations

A straightforward inquest (single accident death, cause clear) typically concludes within **3–6 months** of death, depending on the coroner's office caseload. Complex cases — deaths in hospital, systemic failures, deaths in custody — may take **6–24 months**. Particularly complex cases with public interest dimensions can take longer. During the inquest, the body is typically released for funeral long before the hearing takes place. The inquest date is set by the coroner and notified to all interested persons.

Impact on probate and estate administration

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INTERIM DEATH CERTIFICATE • LIFE INSURANCE • WHAT THE EXECUTOR CAN AND CANNOT DO

The death certification and coroner process has a direct bearing on probate and estate administration.

Understanding the rules avoids delays and — in coroner cases — prevents the executor from inadvertently acting without authority.

The death certificate is the starting document for probate

The Grant of Probate (or Letters of Administration if there is no will) requires a death certificate. The full death certificate from the Register Office is the standard form. Andrew should obtain **multiple certified copies** from the Register Office at the time of registration — each financial institution, the Probate Registry, and HMRC will require an original certified copy. In 2026, copies cost **£12.50** each from the Leeds Register Office at the time of registration. Online certified copies (from the General Register Office) cost the same and can be ordered after registration.

Interim certificate of the fact of death — when the coroner is involved

Where a death has been referred to the coroner and an inquest is to be held, the Register Office cannot issue a full death certificate until the inquest concludes. However, the coroner can issue an **Interim Certificate of the Fact of Death** (ICFD) immediately after the inquest is opened. This interim certificate can be used to begin probate proceedings and, critically, to make life insurance claims. Banks and financial institutions must accept the ICFD as sufficient for account access in most cases. The executor should request the ICFD from the coroner's office immediately after the inquest is opened if a full death certificate is not available.

Life insurance claims during a pending inquest

Life insurance policies do not contain a blanket suspension of claims pending a coroner's inquest. Insurers assess claims on the evidence available. Where the cause of death is not disputed (e.g. a fatal road traffic collision) the insurer may pay the claim on the ICFD and other evidence before the inquest concludes. Where the cause of death is the subject of the inquest, most insurers suspend settlement until the conclusion is reached. Andrew should notify each life insurer immediately of the death (using the ICFD or death certificate), even if settlement will be deferred.

What the executor can do before probate is granted

Before the Grant of Probate is issued, an executor has authority to: protect and preserve the estate assets (change locks, maintain insurance, pay urgent estate bills); notify financial institutions of the death and request account freezing; instruct a funeral director and arrange the funeral (costs are recoverable from the estate before any distribution). The executor cannot: transfer or sell assets (including property); access bank accounts for distribution purposes; or deal with registered land. The ICFD enables the probate application to begin, but assets cannot be transferred until the Grant is in hand.

HMRC IHT timeline — not delayed by the coroner

The inheritance tax return (IHT400, where the estate is not an excepted estate or tax is payable) and any tax payment are due within **6 months** of the end of the month of death — regardless of whether probate has been granted or a coroner's inquest is pending. Interest runs from that date. Where the estate is an excepted estate there is no separate inheritance tax return at all: the estate information is reported directly on the probate application itself — PA1P where there is a valid will, PA1A where there is not — which the online probate service presents as the Estate Information Summary. If the estate is large and IHT may be due, Andrew should take advice on meeting the HMRC deadline even if the inquest has not yet concluded.

David's specific pathway

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EXPECTED CANCER DEATH • ME PROCESS ONLY • ME-3
ISSUED 24 MAY 2026

The information below sets out David's pathway through the Medical Examiner system in detail. It is included here so that Andrew, as executor, and the wider family have a clear factual record of what happened and when, and why no coroner involvement was required.

DAVID PEMBERTON – ME PROCESS RECORD

Date of death: 22 May 2026, at home in Leeds. Time of death confirmed by the out-of-hours GP service (111 response) who attended at the family's call.

Cause of death: Metastatic cancer (primary: lung, with hepatic secondaries). David had been under the care of the Leeds Teaching Hospitals oncology department and received palliative community care in the final weeks. His death was expected and had been discussed with the family and his GP.

Certifying doctor: David's registered GP, who had attended David within the 28-day period immediately before death required to certify cause of death without coroner referral. The Medical Certificate of Cause of Death (**MCCD**) was completed and delivered to the ME service on 22 May 2026.

Medical Examiner: Dr Susan Halloran, Leeds Teaching Hospitals NHS Trust Medical Examiner service.

Family call: Made by a Medical Examiner Officer from Dr Halloran's team on **23 May 2026**. Andrew Pemberton was present on the call. The family confirmed they had no concerns about David's care or the proposed cause of death.

ME-3 outcome form issued: 24 May 2026 —
Dr Halloran confirmed the cause of death as stated on the **MCCD** was fully supported by the clinical record and the family call. No referral to the coroner was required or made.

Death registered: Andrew attended Leeds Register Office with the **MCCD** and ME-3 on 25 May 2026. Multiple certified copies of the death certificate were obtained.

Funeral: Proceeded without impediment. No Coroner's Order required. Cremation forms submitted by the funeral director (Cremation 4 and Cremation 5 completed by the attending GP and a second doctor) — cremation authority granted.

What this means for probate.

David's estate proceeds in the standard way. The death certificate issued on 25 May 2026 is a full death certificate — not an interim. Andrew may proceed directly with the probate application. There is no pending inquest, no coroner authority over the estate, and no circumstance that would prevent normal estate administration. The IHT400 must be filed (unless the estate is an excepted estate, which reports its figures on the probate application itself) and any IHT paid by **30 November 2026** (six months from the end of May 2026). The Grant of Probate application should be submitted as soon as the IHT position is established.

The family's rights

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RIGHT TO CONCERNS • TO INFORMATION • TO LEGAL REPRESENTATION • AT INQUEST

The Medical Examiner system and the coroner's inquest process both recognise the bereaved family as having statutory rights. These rights were significantly strengthened by the Coroners and Justice Act 2009 and the Health and Care Act 2022. The following is a summary of the rights most relevant to families in Andrew's position.

Right to raise concerns with the Medical Examiner

Every family has the statutory right to a conversation with the Medical Examiner or Medical Examiner Officer and to raise any concerns about the care the deceased received or about the cause of death as certified. This is not a discretionary offer — it is a legal right under the Health and Care Act 2022. If you were not contacted by the ME office within 48 hours of the death, or if the call was cursory and you were not given a proper opportunity to speak, you should contact the ME office directly or ask the NHS Trust Patient Experience team to arrange a conversation.

Right to be treated as an interested person at inquest

If a coroner's inquest is held, the family of the deceased is automatically an "interested person" under the Coroners and Justice Act 2009. As an interested person, the family has the right to: attend all hearings; examine witnesses (either personally or through legal representatives); make submissions to the coroner on the conclusions to be reached; and receive copies of the post-mortem report and other expert evidence. These rights apply to pre-inquest review hearings as well as the final hearing.

Right to legal representation

The family has the right to be legally represented at any stage of the coroner's process. At pre-inquest review hearings and at the inquest itself, a solicitor or barrister can attend on the family's behalf, examine witnesses, and make submissions. The Right to legal representation at inquest is not usually legally aided — but specialist organisations including **INQUEST** (inquest.org.uk) provide free advice and support to bereaved families navigating the inquest process, particularly in cases involving deaths in custody or systemic failure.

Right to a second post-mortem

If a post-mortem has been ordered by the coroner, the family has the right to instruct a pathologist of their choice to conduct a second post-mortem examination, provided they notify the coroner before the first examination is complete and the second examination is conducted before the body is released for funeral. This right must be exercised promptly — delays mean samples may no longer be available. Specialist medical solicitors can arrange this at short notice.

Right to information throughout the process

The family has the right to receive: a copy of the post-mortem report (on request); copies of witness statements disclosed to other interested persons; advance notice of the inquest hearing date; and reasons for the coroner's conclusion in writing. The coroner's officer — a specially trained professional employed by the coroner's service — is the key contact for information. Every coroner's jurisdiction in England and Wales has at least one officer; they can be contacted directly and will usually answer queries promptly.

Right to request a Prevention of Future Deaths report

Where the evidence at an inquest reveals matters that give rise to a risk of future deaths, the coroner has a duty to send a **Regulation 28 Prevention of Future Deaths (PFD) report** to the person or body able to take action. Families can also formally request that the coroner considers making a PFD report. These reports are public documents — published on the Chief Coroner's website — and require a formal response from the recipient body. For families where a systemic failure may have contributed to the death, the PFD process is a meaningful outcome mechanism.

Reference contacts and executor checklist

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KEY CONTACTS • ANDREW'S IMMEDIATE ACTION LIST

The table below provides the key institutions and contacts relevant to the Medical Examiner and coroner process. The checklist below is Andrew's immediate action list as executor, now that the ME process is complete.

ORGANISATION	ROLE / RELEVANCE	CONTACT
Leeds Teaching Hospitals NHS Trust — Medical Examiner Service	ME service that scrutinised David's death. Dr Susan Halloran. ME-3 issued 24 May 2026.	Leeds Teaching Hospitals NHS Trust, Great George Street, Leeds LS1 3EX. Contact via main trust switchboard: 0113 243 3144.

ORGANISATION	ROLE / RELEVANCE	CONTACT
Leeds Register Office	Death registered 25 May 2026. For additional certified copies of death certificate.	Leeds Register Office, Merrion House, Merrion Way, Leeds LS2 8BB. 0113 222 4408. Online copies via gro.gov.uk .
HM Courts & Tribunals Service – Probate Registry	Issues the Grant of Probate. Apply online at apply-for-probate.service.gov.uk or via a solicitor.	Leeds District Probate Registry, York House, 31 York Place, Leeds LS1 2BA. 0300 303 0648.
HMRC Inheritance Tax	IHT400 must be filed (an excepted estate reports its figures on the probate application instead). Tax due within 6 months of end of month of death.	HMRC Inheritance Tax, Ferrers House, PO Box 38, Castle Meadow Road, Nottingham NG2 1BB. 0300 123 1072.

ORGANISATION	ROLE / RELEVANCE	CONTACT
INQUEST (charity)	Free support and legal advice for bereaved families navigating coroner inquests — particularly custody and hospital deaths.	inquest.org.uk · 0207 263 1111 (helpline)
Chief Coroner's Office	Oversight of coroner system in England & Wales. Guidance, guidance on coroner powers, and PFD report register.	www.judiciary.uk/ courts-and-tribunals/ coroners-courts/ office-chief-coroner

ANDREW PEMBERTON – EXECUTOR ACTION CHECKLIST

☐ **Multiple certified death certificates obtained** from Leeds Register Office on 25 May 2026. Recommend minimum of 8 copies for bank accounts, probate, insurers, and pension providers.

☐ **All financial institutions notified** of death — Lloyds, HSBC, NS&I, pension providers. Use Tell Us Once service (gov.uk/tell-us-once) to notify multiple government departments simultaneously.

☐ **Life insurance claims submitted** to each insurer with certified death certificate. Quote policy numbers. Request interim settlement information if inquest were pending (not applicable in this case).

☐ **Probate application prepared** — IHT position established; IHT400 drafted (or excepted-estate figures ready for the PA1P); Probate Registry application initiated online. Deadline: IHT due by 30 November 2026.

☐ **Property protected** — buildings insurance maintained in the deceased's estate name (notify NFU Mutual or relevant insurer that the policyholder has died; coverage may need amendment).

☐ **ME process confirmed complete** — ME-3 issued and retained. No coroner involvement. No pending inquest. Estate administration proceeds on normal timeline.

☐ **Grant of Probate applied for** once HMRC's letter with the unique code has arrived (sent up to 20 working days after the IHT400 is submitted; not needed for an excepted estate). Target: within **3 months** of death.

☐ **Final estate accounts drafted** and distributed to beneficiaries once Grant issued and assets collected.

Where Valoren can help Andrew next

The Medical Examiner process is complete. The death certificate is in hand. The next steps — probate application, IHT400, bank account access, property transfer, and beneficiary distribution — are the process that typically takes **6–12 months** for a straightforward estate (**12–18 months** with a house to sell or inheritance tax to agree) and consumes hundreds of hours of an executor's time, often without any professional support.

Valoren's free executor guide sets out every duty in the order it matters. For the first days, the Executor's First Hour pack prepares four documents for this estate: the First Hour Brief, a Funeral Director Brief, a Family Meeting Agenda and a Tell Us Once Companion.

valoren.uk/executor · Ref: MEG-AP-001-11062026

POWERED BY VALOREN

Medical Examiner & Coroner Guide — Valoren free reference.

Medical Examiner system established under the Health and Care

Act 2022 (mandatory from 9 September 2024). Coroner rules:

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