CHIEF CORONER

Report of the Chief Coroner to the Lord Chancellor

Second Annual Report: 2014-2015

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Introduction

1. This is the Chief Coroner's second annual report to the Lord Chancellor. Section 36 of the Coroners and Justice Act 2009 (the 2009 Act) provides that the Chief Coroner must give the Lord Chancellor a report for each year.

2. Section 36 contains a number of statutory requirements for the contents of the report. Each will be addressed below.

Contents of report

3. As required by section 36(2)(a) of the 2009 Act the Chief Coroner wishes to bring a number of matters to the attention of the Lord Chancellor. These include the development of the statutory reforms which came into force in July 2013, the additional package of reforms which the Chief Coroner devised and continues to develop, and actions taken by the Chief Coroner under his powers and duties in the 2009 Act.

Appointment of Chief Coroner

4. The post of Chief Coroner of England and Wales was created by section 35 and Schedule 8 to the 2009 Act which came into force on 1 February 2010.

5. The first post holder, His Honour Judge Peter Thornton QC, a senior circuit judge, was appointed by the then Lord Chief Justice after consultation with the then Lord Chancellor on 6 May 2010 but was asked by the then Government not to take up his post at that time. He was however requested in May 2012 to take up his post with effect from September 2012 for a three year term.

6. In April 2015, the Lord Chief Justice, after consultation with the then Lord Chancellor, extended the term of office of Judge Thornton as Chief Coroner of England and Wales until 1 October 2016.

7. The Chief Coroner's jurisdiction is England and Wales.

8. The Chief Coroner also sits in the Divisional Court of the High Court on coroner cases, either applications for judicial review or applications for a fresh inquest (brought with permission of the Attorney General) under section 13, Coroners Act 1988 (as amended). He also sits from time to time as a judge at the Central Criminal Court (the Old Bailey) and in the Court of Appeal (Criminal Division). and Wales until 1 October 2016.

The Chief Coroner's role

9. Judge Thornton was appointed as the first Chief Coroner in order to lead the coroner service of England and Wales, to set new national standards in the coroner system, to develop a national framework in which coroners will operate, and to implement and develop statutory and other coroner reforms. At the time of his appointment the then Lord Chancellor, Kenneth Clarke MP, said:

> *"Everyone is agreed that the priority is to ensure coroners provide a high standard of service at what can be a difficult time for bereaved families. I am therefore giving the Chief Coroner the full range of powers to drive up standards, including thorough coroner training, and to tackle delays within the system."*

10. The Chief Coroner has since his appointment been working to achieve those goals. As he said on his appointment:

> *"I will aim to provide quality and uniformity in the coroner system, with a national consistency of approach and standards between coroner areas. Openness, inclusiveness, thoroughness and fairness must be at the heart of the process if it is to be effective and serve the needs of the public."*

11. To achieve those aims the Chief Coroner devised and continues to develop a package of reforms (see below). They were designed to create across England and Wales a more modern, open, consistent and just coroner service, and to reduce unnecessary delays. In all of these reforms, statutory and otherwise, the Chief Coroner maintains as central to his thinking the essential concept that bereaved families must at all times be at the heart of the coroner process.

The coroner service

12. The coroner service of England and Wales remains essentially a local service. There have in the past been calls, as in the Luce Review, *Death Certification and Investigation in England, Wales and Northern Ireland, The Report of a Fundamental Review 2003* (Cm 5831), for a national service, with coroners to be appointed and the service funded and run centrally, like other judicial services. But that has not happened. Coroners continue to be appointed locally, paid locally, the service is funded locally including the provision of courts and other accommodation, and coroners' officers and support staff are employed locally.

13. This localness has in the past produced an inevitable level of inconsistency between coroners and coroner areas. Coroners have to an extent worked in isolation, unsupported by a sound framework and network of coroner resilience. The Chief Coroner is therefore working towards a greater consistency in all areas of the coroner domain, through guidance, training and discussion with coroners and all stakeholders.

14. This localness has also produced inconsistency in the provision of services. For example, the number of coroners' officers provided by the police (and sometimes by the local authority) to support coroners in death investigation varies widely. In coroner areas where there are approximately 2,500-3,000 deaths reported to the coroner each year, the number of officers ranges from 2-11, while a ratio of one coroner's officer for every 500 deaths would suggest a figure of five or six officers as a minimum. On this basis several police authorities and local authorities are not supplying sufficient resources. This in turn may cause stress and lead to long-term sickness, reducing even further the number of available officers and causing unwanted delays for families in the completion of investigations.

15. The Chief Coroner strives to increase the support for coroners in under-resourced areas. Whilst recognising the restraints of public austerity, many coroner areas have been sadly neglected for many years, often decades.

16. Localness also provides challenges for the coroner service in employment and deployment. Coroners are appointed and paid by local authorities but not employed by them. They are independent judicial office holders and can only be removed by the Lord Chancellor with the agreement of the Lord Chief Justice for incapacity or misbehaviour. Coroners do not employ coroners' officers or support staff. Coroners' officers are usually employed by the police, sometimes by local authorities. They are line-managed by the police and subject to police disciplinary procedures. Support staff (administration staff) are employed by the local authority and are line-managed by the local authority.

17. All of this must work together: coroners, coroners' officers and support staff. But it is not an easy managerial mix. Where problems arise, for example over discipline, the coroner may be powerless to take effective action or any action at all. The Chief Coroner describes this tri-partite arrangement - coroners, officers and support staff - as the triangle of responsibility. The senior coroner is at the head of the process but the triangle will only succeed if there is good will and good collaborative working.

18. In the past some local authorities have left coroners to get on with their work, content merely to pay the bills at the end of the month. This approach is no longer appropriate. The Chief Coroner expects local authorities to work more closely with senior coroners, making sense of the triangle of responsibility, discussing the work of the coroner and its cost. By way of example the Chief Coroner invites local authorities to discuss with coroners tendering for the provision of body removal and toxicology services on a regular basis.

19. With this broad objective in mind, and with a view to creating a more effective and resilient coroner service at a local level, the Chief Coroner has encouraged bringing coroner services together under one roof. Too often coroners' officers are spread in ones and twos across the county, distant from the coroner and support staff. Working together in one place has been shown to work and to work better. The senior coroner is in a better position to manage the caseload and work closely with coroners' officers and officers can provide more support for each other, with the more experienced helping and encouraging the less experienced. This is often difficult and stressful work, dealing as the front-line staff with families at their most vulnerable period of grief. Working together provides resilience for all.

20. For a better understanding of what each coroner service needs locally, the Chief Coroner held a one-day conference in December 2014 with all relevant local authorities, explaining the work of coroners and the triangle of responsibility, looking at the coroner service from all perspectives while recognising the needs and restraints upon local authorities.

21. In the end the Chief Coroner believes that there is now a greater understanding of the work of coroners, their statutory duties and the nature of this important public service.

The work of coroners

22. Under the law coroners have two main functions. First, in relation to each death reported to them they explain the unexplained. If the death is not from natural causes, if it is unnatural, violent, in custody or of unknown cause, coroners will investigate so that answers are found, both for bereaved families in the first place but also for the wider public. Secondly, where appropriate, coroners report to prevent future deaths. This is an important part of their work and one which has been repeatedly emphasised by the Chief Coroner in training and discussion.

23. There are some 500,000 deaths in England and Wales every year, a figure which is relatively constant. Each death is registered with the local registrar of births and deaths to create a complete record of how people die. Most of these deaths are from natural causes, certified as such by a general practitioner or hospital doctor. But in every case where it is not clear that the death is from natural causes it must be reported to the coroner.

24. Some 223,000 deaths are reported to coroners across England and Wales each year but only a small proportion will require full investigation with an inquest. The vast majority of cases reported to the coroner are signed off by the coroner after preliminary inquiries, with or without a post-mortem examination, as being deaths from natural causes. They do not require a formal investigation under the 2009 Act and therefore there is no inquest.

25. There is therefore a relatively small number of cases which require investigation (and inquest), some 25,000 cases a year. This figure is down 15% this year from 30,000 cases last year. This is a welcome reduction. It means that with the Chief Coroner's encouragement the greater use of preliminary inquiries under section 1(7) of the 2009 Act, 'whatever enquiries seem necessary in order to decide' whether the duty to investigate (and hold an inquest) under section 1 arises, has meant that coroners are looking more closely at information available in the early stages in order to find that there is no statutory requirement for an investigation.

26. In the last year there have been only 397 jury inquests, also a slight reduction from the previous year. Many of these will have concerned deaths in prison or police custody under section 7 of the 2009 Act. In this context it must be noted that official statistics show that levels of self-inflicted deaths in custody are particularly high, especially amongst those recently admitted to prison. Coroners investigate all of these cases thoroughly and often make reports to prevent future deaths. The Chief Coroner held a one-day training conference for coroners in May 2015 on deaths in prison.

27. One of the unanticipated implications for coroner work this year has arisen from the authorisation by local authorities of Deprivation of Liberty Safeguards (DoLS), restricting the liberty of many residents of care homes or in hospitals, usually the elderly suffering from dementia. These authorisations under the Mental Capacity Act 2005 (as amended by the Mental Health Act 2007) have caused extensive extra work for coroners in some areas. The Chief Coroner reviewed in detail the legal provisions relating to these authorisations and concluded (with some reluctance) in his Guidance No.16 that those who die subject to a DoLS authorisation have died 'in state detention' for the purposes of the 2009 Act and therefore each death must be investigated (with an inquest) under section 1(2)(c) of the 2009 Act.

28. Accordingly, DoLS have produced a considerable volume of extra work. Although the numbers have not been clearly identified, the fact that the number of DoLS applications has increased from 11,300 for the whole of the year 2013-2014 to some 83,100 for the first three quarters of 2014-2015 alone is itself an indication of the increase in numbers. The Law Commission is considering the impact of these provisions on the coroner service (amongst other matters) and will be consulting shortly on proposed law changes. The Chief Coroner and no doubt many individual senior coroners will participate in the consultation process. The Chief Coroner has given talks on this difficult subject to local authorities and other stakeholders.

29. In the meantime coroners are content to deal with this work. Most senior coroners have put in place sound arrangements with their local authorities so that there is automatic referral to the coroner of the death of a person subject to a DoL. For their part coroners inquire of the families if there is any concern about the circumstances of the death, either at the care home or hospital, and if there are none proceed to a quick and paper-based inquest. Some families have expressed dismay that an obviously natural causes death requires an inquest. Coroners have nevertheless had to proceed under the law, but with sensitivity and compassion in all the circumstances.

30. When at a recent training session the Chief Coroner asked coroners if they would prefer deaths subject to DoLS to be investigated, at least in the first place, by another organisation such as the Care Quality Commission, the response was an emphatic No. Death investigation, they said, is the business of the coroner. If it means more work, so be it, but we will do it, and without complaint.

31. This response reflects the attitude of coroners across England and Wales that this service is an important public service which they will conduct carefully, thoroughly, sensitively and independently. It is the Chief Coroner's opinion that greater consistency is being achieved in this regard. There is much in the coroner service that is excellent. There are many coroners who investigate fully, act with compassion and understanding, and at the same time provide a timely and efficient process. They are hard-working judicial office holders, proud of their independence, acting for the public good.

Reduction in backlogs

32. The Chief Coroner is particularly pleased to report to the Lord Chancellor that backlogs of older cases have been very significantly reduced.

33. The wording of the 2009 Act and the Coroners (Inquests) Rules 2013 reflected the concern of the public and Parliament that cases were not being completed by coroners in a timely fashion. Rule 8 requires coroners to complete inquests within six months of the date on which the coroner is made aware of the death 'or as soon as reasonably practicable after that date'.

34. What is 'reasonably practicable' will of course depend on the facts and circumstances of a particular case. There are often good reasons for older cases being outstanding. For example, there may be ongoing police inquiries, criminal prosecutions, investigations in countries overseas, and Health and Safety Executive or Prisons and Probation Ombudsman inquiries, all of which take time.

35. But in order to keep a check on older cases, section 16 of the 2009 Act requires all coroners in England and Wales to notify the Chief Coroner of any investigation which has not been completed (or discontinued) within a year. Hence the Chief Coroner now requires senior coroners to produce an annual return of all cases outstanding after 12 months, setting out the number of days beyond twelve months, the reason for the delay and, where there are a number of such cases outstanding, what remedial steps are being taken to reduce the backlog.

36. The Chief Coroner is very pleased to report that there has been a substantial reduction in such cases. The number of inquest cases which have not been completed within the 12 months' period has fallen by a dramatic 45%. In 2013-2014 the number of cases over 12 months and not then completed (or discontinued) was 2,673. The figure for 2014-2015 has fallen to 1,467, which is less than 1% of all deaths referred to coroners in England and Wales.

37. 70% of all coroner areas in England and Wales have recorded a decrease in the number of outstanding cases over 12 months from the previous year. Some areas, such as Teesside, Manchester North, West London and Birmingham and Solihull, have reduced their respective backlogs remarkably and should be congratulated.

38. The Chief Coroner welcomes this reduction of delays in coroner cases. He is grateful to senior coroners who have responded well to requests to review and complete older cases. Huge efforts have been made in some coroner areas. Backlogs in many coroner areas have been dramatically reduced. This is good news for bereaved families. Each case should be given special care and attention so that it is completed within a fair timescale. This requires robust case management and the effective deployment of local resources. With further hard work on the part of senior coroners the Chief Coroner believes this trend will continue next year as well.

The statutory reforms

39. The relevant provisions of the 2009 Act came into force on 25 July 2013 along with the Coroners (Investigations) Regulations 2013, the Coroners (Inquests) Rules 2013 and the Coroners Allowances, Fees and Expenses Regulations 2013.

40. The principal statutory reforms have worked well. Coroners have embraced the introduction of the distinction between preliminary inquiries and formal investigation. Coroners now focus more readily on early inquiries in order to see whether an investigation (and inquest) is necessary at all. As a consequence many cases reported to the coroner have been signed off early, with the appreciation of bereaved families, as being shown to be (on a balance of probabilities) a death from natural causes, not requiring a formal investigation. This has reduced the number of inquests across England and Wales, by some 15%, and allowed coroners to concentrate more on the deaths which really require to be explained.

41. Discontinuance of an investigation where the cause of death has been revealed by a post-mortem examination has also been a useful provision for coroners (see recommended law change below).

42. The new provisions also provide for earlier release of the body, where appropriate, for burial or cremation. It is no longer necessary to open an inquest before the body may be released. This, too, is welcome news for bereaved families.

43. The provisions for jury inquests are now more flexible. For example, under the previous law, the Coroners Act 1988, all deaths within a prison required an inquest with a jury. This included the deaths of staff and visitors as well as detainees who died of natural causes. Now, under the 2009 Act, the former category may not need a coroner investigation at all, and while an inquest is still required in the latter category, it is not mandatory to hold it with a jury. In all deaths of prisoners, however, coroners will continue to take extra care to investigate where there may be concerns about the death. As the Chief Coroner reiterated in the High Court case of *Chambers* [2015] EWHC 31 (Admin), 'All prison deaths, especially self harm cases, must be given the most careful public scrutiny.' Overall, jury inquests are down in number from 456 to 397, representing about 1% of all inquests.

44. Mergers of coroner areas by the Lord Chancellor are progressing gradually and effectively (see below).

45. Other statutory provisions such as reports to the Chief Coroner seeking a direction to conduct an investigation in the absence of a body have worked well. For the exercise of all the Chief Coroner's statutory powers and duties in the last year, see below.

Developing the Chief Coroner's reforms

46. There were six main strands in the Chief Coroner's original package of reforms. Each was designed to provide a better, more effective and prompt process for bereaved families and to achieve greater consistency of standards in coroner areas across England and Wales. These reforms are developing well.

(1) The role of Chief Coroner

47. In the absence of a national coroner service the Chief Coroner remains the central national focus for reform. It is his role to continue to establish national standards in what remains an essentially local service.

48. The Chief Coroner has a statutory duty to make an assessment in this report of the consistency of standards between coroner areas (section 36(3)). He believes that much has been achieved already and good progress continues to be made as a result of the measures being taken, although inevitably this is a gradual, ongoing process.

49. The Chief Coroner continues to work towards greater consistency in a number of ways, not least by extensive training and written guidance on the central areas of coroner work.

Training

50. Training continues to be an essential part of coroner reform. The Chief Coroner has devised, developed and implemented compulsory training for all coroners. Training is conducted by the Chief Coroner either under the auspices of the Judicial College (which trains all judicial office holders) or, separately, by the Chief Coroner and his office. The Chief Coroner is involved in all aspects of training and attends all courses.

51. As reported in last year's annual report there was regional training for all coroners on the statutory provisions of the 2009 Act and the 2013 Rules and Regulations. New residential courses were also designed and implemented: induction courses for newly appointed coroners and continuation courses for all existing coroners.

52. This year there have been further induction courses and a newly created continuation course for all 380 coroners on conclusions of inquests and Deprivation of Liberty Safeguards. These are compulsory residential courses which are devised, created and delivered by the Chief Coroner with coroner course directors and coroner syndicate leaders under the auspices of the Judicial College. Next year's continuation course will focus on mental health issues.

53. Also this year and for the first time there have been compulsory residential training courses held regionally for all 450 coroners' officers in England and Wales. These courses have been devised by the Chief Coroner, coroner course directors, coroners' officer course directors and with assistance in delivery of syndicate leaders who are experienced coroners' officers. They focus on a mixture of law, medicine and good practice. There are talks, syndicate discussions on working examples, preparation and overnight homework. Despite the hard work required from the attendees, these courses have been warmly and enthusiastically embraced. On the first day of the first course held in Leeds, with 100% attendance, the Chief Coroner was impressed to observe that all coroners' officers were in place ready for the start 15 minutes early.

54. It is clear that there is an appetite for training and learning amongst coroners' officers. They play a hugely important role in the coroner service, a role which the Chief Coroner is pleased to recognise and support. They are the front line, the first point of contact; receiving death reports, investigating and collecting evidence; making arrangements; liaising with emergency services, doctors and hospitals, mortuary staff and pathologists, funeral directors, toxicologists (and many more); arranging hearing dates; preparing cases for the coroner; managing a case load; recording actions; giving notifications; providing disclosure. As the Chief Coroner says to them at their training: 'That is quite a job. And on top of that you are expected to respond promptly and politely and with sensitivity and compassion. That is even more of a job.'

55. It is for these reasons that the Chief Coroner encourages police authorities (and where appropriate local authorities) to provide the necessary numbers of coroners' officers. Without sufficient numbers the coroners will not be able to provide a timely and compassionate service to the public. In some areas the inadequacy of local resources has produced poor telephone services, with families, doctors and others unable to get through to a person. The Chief Coroner encourages local authorities to do better on this front. Following consultation he has identified the functions and duties of coroners' officers. He now wishes their role to be fully recognised and resourced.

56. In addition to induction, continuation and coroners' officer training, the Chief Coroner has devised and presented a number of one-day events. In May 2015 110 coroners attended a one-day training event on deaths in prison. These are important, often complex cases. As stated above they require very careful investigation including the thorough collection and disclosure of evidence, well organised pre-inquest hearings and full and fair inquests. The training day went through every stage of the process from report of the death to inquest and reports afterwards. There will be a one-day course next year on child deaths and other medical training days are in preparation.

57. In 2014 the Chief Coroner also held events for very different audiences. He held a one-day event for bereavement organisations. This involved in-depth explanation of the workings of the coroner service and candid discussion of the good and in need of improvement elements of the coroner service from their perspective. Top of their wish list, and rightly so in the view of the Chief Coroner, was good communication from the coroner service, good explanation of the process and better opportunities for participation, particularly where they wished to raise concerns. They also wanted to see a national coroner service for the purpose of greater consistency.

58. In December 2014 the Chief Coroner invited all local authorities to a one-day event on the coroner service. As with the bereavement organisations event this was a day to explain the coroner service, to encourage local authority participation and to understand their concerns. They expressed concerns about the spending of public money and budgetary restraint, the need for better lines of communication with the senior coroner and clearer contracts for services such as toxicology and body removal. Some areas were concerned about the shortage of pathologists locally.

59. After both of these positive events the Chief Coroner collated his notes and observations, making them available for those who attended and for those who were unable to attend.

60. The Chief Coroner continues to hold an annual training day with the 91 senior coroners of England and Wales. This year the day focused on the meaning of the statutory term of 'unnatural death' (section 1(2)(a) of the 2009 Act) and on practical procedures for investigating deaths subject to DoLS. Senior coroners also discussed the Australian model for some inquests to be completed without a hearing, the duty to investigate deaths abroad, the shortage of pathology services and out of hours services, among a number of topics.

Advice and guidance

61. The Chief Coroner also works towards national consistency of good practice by providing written advice and guidance to coroners. Formal guidance is circulated to all coroners and published on the judiciary website for all to see.

62. There are now 18 pieces of separate guidance and five law sheets to assist coroners. This year the Chief Coroner has provided guidance on Deprivation of Liberty Safeguards, on section 1(4) reports (investigation without a body) and on dealing with the possibility of apparent bias. He has also provided a major piece of work on conclusions of inquests (short-form and narrative). This guidance on conclusions has been coupled with this year's continuation training for all coroners, learning how best to complete the Record of Inquest, whether sitting alone as coroner or with a jury. The process of identifying the medical cause of death, the answers to the four statutory questions who died, when where and how did they come by their death, and the final conclusion is not always an easy task. The training and the guidance are therefore directed to a thorough and consistent approach to this work, so that the outcome of all inquests will be clear to the bereaved family, to the wider public and for the purposes of statistical recording. Death investigation requires clear answers.

63. Recent law sheets have included the topics of hearsay evidence and the discretion of the coroner.

64. The Chief Coroner also gives guidance, when appropriate, in High Court cases when he sits on applications for judicial review and applications for orders for a fresh inquest under section 13 of the Coroners Act 1988 (as amended). In the last year there have been four judicial reviews and five statutory applications under section 13.

65. Overall the Chief Coroner believes that it is his role to bring consistency, good practice and good justice to the coroner service. Guidance and training are central to this objective. In addition the Chief Coroner, with two experienced coroners, has commenced production of a new Coroner Bench Book. Targeted in particular at newly appointed coroners, but hopefully of assistance to all, the first section on Jury Inquests was published in June 2015.

(2) Mergers

66. In England and Wales there are currently 97 coroner areas, with 91 senior coroners. It makes good sense to reduce coroner areas to about 75 in number so that each coroner area is an appropriate size in terms of numbers of deaths reported, geographically and in terms of special work involving prisons, major hospitals, mental health institutions and airports, all of which affect the workload of the local coroner service.

67. In the view of the Chief Coroner each coroner area should receive reports of approximately 3,000-5,000 deaths each year, with a full-time senior coroner in post. Whereas at present some 60% of coroner areas have fewer than 2,000 reported deaths, many with a part-time senior coroner.

68. The Chief Coroner has been pleased to work closely with the Lord Chancellor and the Ministry of Justice on encouraging mergers. The Lord Chancellor has exercised his power to combine, or merge, coroner areas after consultation under paragraph 2, Schedule 2 of the 2009 Act in two cases this last year. Several more are being considered.

69. The Chief Coroner has discussed succession planning for the future with a number of local authorities in line with his written Guidance No.14 *Mergers of Coroner Areas*. But progress on mergers is unlikely to be quick because mergers are generally dependent on one or more coroners deciding to retire.

(3) Appointments

70. Coroners are now categorised by the 2009 Act in descending order of importance as senior coroners, area coroners, and assistant coroners.

71. Before the 2009 Act came into force in July 2013, senior coroners (then known as coroners) were appointed by the local authority and all other coroners were appointed by the coroner. On occasions that caused difficulties.

72. Now under the 2009 Act all coroners are appointed by the local authority. Previously coroners were appointed with freehold tenure for life. Now newly appointed coroners must retire at the age of 70. The Chief Coroner has encouraged older coroners to consider retiring at about 75 and to give way to younger, and hopefully more diverse, post-holders. Some have answered the call.

73. This year the appointments process has worked well. Following the Chief Coroner's Guidance No.6 *The Appointment of Coroners*, appointments have all been open, fair and transparent. Positions are advertised widely and there have been large numbers of applicants for most positions.

74. This year the Chief Coroner has encouraged local authorities to consider applicants for assistant coroner appointments both with and without coroner experience, so that fresh blood is brought into the coroner service. Local authorities have heeded that call and the Chief Coroner is pleased with the variety of backgrounds and experience from which new appointees are drawn. This year, for example, legal executives, first-tier tribunal judges, magistrates' courts legal advisers, managers within HM Courts and Tribunals Service and others from diverse backgrounds have been appointed as area and assistant coroners. A Judge Advocate has been appointed as assistant coroner in one area in order to conduct a complex military death investigation and two circuit judges have been nominated by the Lord Chief Justice under Schedule 10 of the 2009 Act to deal with complex inquests.

75. As always the Chief Coroner has maintained close involvement with each appointment process in order that his consent to an appointment may be fully and fairly informed. He is involved through his office with the advertisement stage, assisting local authorities where necessary. He himself is involved at the sift stage to see that the criteria are correctly and appropriately applied and he is involved in looking at the interview process, questions, marking and outcome. With senior coroner and area coroner appointments he or one of his nominees will be present at the final interviewing stage for the purpose of the exercise of his consent, not voting but making sure that the process is complete and fair, and in order to report to the Lord Chancellor for the purpose of exercising his consent.

76. This process has worked well this year now that the details of Guidance No.6 are regularly followed by local authorities. In any event local authorities are experienced in the process of recruitment. They take each appointment and the process extremely seriously, which the Chief Coroner welcomes.

77. Appointments of senior coroners and area coroners are announced by the relevant local authority and on the judiciary website.

78. This year there have been two senior coroner appointments, six area appointments and 51 assistant coroner appointments. The majority of persons joining the coroner service as first-time appointees have been women.

Salaries and fees

79. The Chief Coroner has no statutory responsibility for the payment or level of payment to coroners but considers that there should be a fresh approach to promote greater consistency and transparency. Remuneration is expressed rather generally in Schedule 3 to the 2009 Act. Senior coroners and area coroners are 'entitled to a salary' and assistant coroners are 'entitled to fees'. Coroners hold office on 'whatever terms are from time to time agreed by that coroner and the local authority'. These terms include pay.

80. In effect this means that each coroner and each relevant local authority may agree any level of remuneration as they choose without reference to any national scale or standard and without comparison with any other coroner area.

81. Inevitably this has produced inconsistency. This year the Chief Coroner, with the assistance of the Ministry of Justice, conducted a survey of all coroners' salaries and fees. This showed a wide variation in payment, both of salaries paid to senior coroners and fees paid to assistant coroners. Not only were the figures highly variable, the method and arrangements of payment were highly diverse. By way of illustration salaries of full-time senior coroners were shown to vary by up to £70,000 pa; and the highest paid senior coroner in England and Wales is part-time with a jurisdiction of less than 2,000 reported deaths.

82. Up until now payment by local authorities to coroners has usually been made in accordance with the sliding scale based on population band in the 'Joint Negotiating Committee agreement' set out in Coroners' Circular No.51. This agreement was reached between the Local Government Association (LGA) and the Coroners' Society of England and Wales. The latest version of this agreement is dated 14 April 2011. It is certainly arguable that it has lapsed. It refers to terminology which pre-dates the Coroners and Justice Act 2009 and in any event does not include payment for area and assistant coroners. The agreement also contains modern-day anomalies such as the so-called long inquest payment and the payment for a deputy by way of 80% of 11.5% of the annual caseload.

83. In the absence of a statutory scheme and with a voluntary scheme (above) that may have lapsed, local authorities may agree with a coroner any salary or fee as they see fit. That is the LGA's approved position. There is, however, no up-to-date guidance and there is an obvious lack of consistency in the current position.

84. In the view of the Chief Coroner this is not satisfactory. This is public money. It should be spent appropriately and in a way which demonstrates accountability to the public. Whereas the salaries and fees of judges are set nationally and published annually, the salaries and fees of coroners continue to be agreed individually (on a local basis) and not published.

85. For the purpose of achieving greater consistency across England and Wales, the Chief Coroner has suggested that the Senior Salaries Review Body (SSRB), which makes recommendations independently of Government in relation to the pay of all judges and tribunal members, should make a similar assessment for coroners.

86. Even if this proposal were adopted, however, it would be some considerable time before implementation. In the meantime, therefore, the Chief Coroner is considering recommending to local authorities a scale of salaries and fees for (newly appointed) coroners as an interim measure. The scale would not be intended to be binding on the SSRB, were a referral to be made to them, nor upon local authorities, but would be recommended with a view to promoting a greater degree of consistency and transparency pending a full assessment by the SSRB. These proposals are being discussed with and considered by relevant stakeholders.

(4) Senior coroners

87. The post of senior coroner (formerly coroner) has changed considerably in the last two years. 50 years ago a coroner would have been male, part-time, usually from a local firm of solicitors, and assisted by a part-time secretary, perhaps one from his solicitors' office. The work of the coroner would have been to consider reports of deaths, investigate where appropriate and usually hold an inquest. The local authority would sign the cheque for coroner services, salaries and pathology bills at the end of each month.

88. All of that has changed. The senior coroner now has greatly enhanced responsibilities. Not only has the coroner case-load increased, for example with Deprivation of Liberty Safeguards, and would be likely to increase further were the Medical Examiner scheme to be brought into effect, but a senior coroner (supported by the area coroner where there is one) is now expected to do much more than just investigate deaths with or without an inquest. A senior coroner stands at the head of the coroner service locally, has to lead on coroner work, managing the caseload, organising and supporting the coroner team locally, working closely with the local authority and the police, managing the expectations of the public and bereaved people, on call all the time for urgent cases and for making those all-important life-saving decisions about organ and tissue donation, and being ready for a mass fatality disaster.

89. That is quite a different job. And with training and guidance and discussion and support the Chief Coroner is helping senior coroners to cope with those additional functions of their role. He held a one-day conference in 2014 for all senior coroners on leadership, management and organisation. He has distributed the notes of the conference discussions to senior coroners. He visits many coroner areas to talk about the new reforms, with coroners as well as coroners' officers, local authority representatives and the police, so that the modern role of the senior coroner is fully understood.

(5) Investigations and inquests

90. In last year's report the Chief Coroner referred to additional written advice which he had provided to coroners on a number of practical topics in the context of investigations (including inquests). This year he has provided advice on aspects of jury cases, such as the new oath for jurors, swearing in jurors individually not all together, requiring jury questions to be in writing and not made orally, the use in some cases of questionnaires to achieve a narrative conclusion, and the new juror misconduct offences under Schedule 6 to the Coroners and Justice Act 2009 as amended by the Criminal Justice and Courts Act 2015.

91. The Chief Coroner has also given advice to individual coroners this year on a wide range of topics. These have included for example applications for reporting restrictions in coroners' courts and recent changes to such restrictions; dealing with media inquiries and disclosure requirements; meeting the eligibility requirement for coroner appointment; powers of the coroner to resume an inquest previously suspended or adjourned; and an issue concerning jurisdiction where a body entered the country solely for the purpose of a post-mortem examination.

92. Whenever providing advice to coroners the Chief Coroner reminds coroners that any decision of a judicial nature is a matter for the exercise of their independent judicial judgment, and not a matter for the Chief Coroner. The Chief Coroner's advice is designed to do no more than give coroners the necessary tools for making their own decisions.

93. The Chief Coroner has reaffirmed with coroners the duty to set dates for inquests or pre-inquest reviews at the opening of an inquest with a view to holding timely hearings and providing bereaved families and other interested persons with a clear timetable for each case. This continues to be of considerable importance.

94. In more complex cases coroners have been reminded to draft an agenda for pre-inquest review hearings and give clear rulings with reasons in writing shortly afterwards.

Post-mortem examinations

95. Death investigation in England and Wales has traditionally relied heavily upon invasive post-mortem examinations by pathologists (autopsies) for ascertaining the medical cause of death. Although there has been some reduction in the number of autopsies, and the trend over the last 10 years has been a steady reduction from 61% to 40% of post-mortems in all reported cases, the reduction this year has not been substantial and numbers continue to be much higher in England and Wales than in other common law countries.

96. The increased use of post-mortem imaging for adults, usually by way of CT scanning, has been encouraged as an alternative, but it has limitations. It will provide a medical cause of death in many cases but not all. Where it does not, an autopsy may still be required. It is also of limited availability. In many areas of the country no scanning is available, and where it is available it is only available at a cost to the bereaved family with a range of £300 to £1,000 in each case. Autopsies on the other hand are funded by the state as part of the coroner service. As a result post-mortem imaging is not available to all. It is particularly favoured by Muslim and Jewish communities who wish for the least possible invasion of the body after death. Post-mortem imaging is not entirely non-invasive but it is considerably less invasive than the autopsy.

97. It is desirable that more post-mortem imaging should be available. It is provided at present on a rather ad hoc basis by the private sector in certain parts of the country. Ideally, in the view of the Chief Coroner, mortuary and pathology services would be organised on a regional basis with medical centres of excellence. Each centre would house a sufficiently sized mortuary with employed forensic pathologists and histopathologists with a structured employment career. As is the current practice at the medical centre at the Coroner's Court of Victoria in Melbourne, each body would be examined externally and CT scanned by the duty pathologist (who would be skilled in radiology as well as pathology). At that point the duty coroner would discuss with the pathologist and the coroner's officer, who would have collated early information about the death, whether an autopsy were to be required and what the next steps in the investigation should be. But this requires money, organisation and commitment.

98. Faith groups are also keen to ensure early burial for their loved ones. By necessity this means providing out of hours services. In a few areas, but only a few, resources are provided for a limited out of hours service. In some others coroners are on call on a voluntary basis. The law does not provide for an out of hours service, except on a limited basis, and there is little will to provide resources. An out of hours on-call service at weekends and on public holidays, would require a rota of coroners, coroners' officers to make early investigation of the death, liaise with the family and report to the coroner, access to a mortuary and the availability of pathologists, and the registrar's office to be open, at least for part of the weekend. In most parts of the country that list remains unfunded and therefore unavailable.

99. Sir Simon Hughes, Minister of Justice in the last Government, had begun to involve the Metropolitan and City of London Police and local authorities in considering a pan-London scheme, actively supported by the Chief Coroner. The Chief Coroner is hopeful that renewed progress may be made under the new Government.

Treasure

100. The provisions in the 2009 Act which relate to investigations concerning treasure have not been brought into force. The provisions of the Coroners Act 1988 therefore remain in force as before. In order to assist coroners the Chief Coroner is working to produce a step-by-step guide to treasure finds with a new simplified set of forms.

(6) Reports to prevent future deaths

101. As was stated in last year's report it is an essential part of coroner work that coroners write reports with a view to preventing future deaths. This traditional role of the coroner now has added statutory emphasis and the template designed by the Chief Coroner for providing these reports has proved an effective means of providing more consistent reports.

102. Coroners do not have the luxury as in some parts of the common law world of researchers to assist them in this task. Hence the law requires coroners to make recommendations of a general nature, such as 'I recommend that you review this procedure' or 'that policy' but not 'I recommend that your policy should be altered from X to Y'. Nevertheless coroner reports are a valuable tool to prevent future deaths and the regular publication of reports on the public judiciary website is a purposeful reminder of the importance of this public work. The Chief Coroner selects certain reports to pursue. Examples in the last year include ambulance attendance times, deaths in custody and child deaths.

103. Since the publication of last year's Chief Coroner's report 504 Prevention of Future Death reports (paragraph 7(1) Schedule 5 to the 2009 Act) have been issued.

Promoting coroner reforms

104. For the promotion of these reforms, the spreading of good practice and the development of greater consistency across England and Wales, the Chief Coroner has given talks about his reforms to a wide range of stakeholders in the coroner service. Both this year and before he has spoken to coroners, the Coroners' Society of England and Wales (both national and regional societies), regional local authority coroner service managers, registrars, police, lawyers, bereavement organisations, pathologists, toxicologists, parliamentarians and many others.

105. The Chief Coroner attends the Ministerial Board on Deaths in Custody and the National Suicide Prevention Strategy Advisory Group. He also speaks at the annual volunteers' conference of the Coroners' Courts Support Service, whose work providing independent support and advice to bereaved families is welcomed and encouraged by him. He speaks annually to the Coroners' Officers and Staff Association.that renewed progress may be made under the new Government.

106. He spoke about coroner reforms to family law judges of the High Court and discussed the mutual arrangements for implementing his Guidance No.13 *Family Court Proceedings - Findings of Fact*.

107. He is pleased to have met and discussed coroner work with many individuals including those who have been bereaved, as well as organisations and government agencies. The Chief Coroner is grateful to all those who have expressed views and ideas.

108. The Chief Coroner also wishes to express a debt of gratitude for the work and support of his team in the Chief Coroner's office led by James Parker and Brenda Jones, and Elena Morecroft his legal adviser, for regular working cooperation from both the team in the Ministry of Justice Coroners, Burials, Cremation and Inquiries Policy Team led by Judith Bernstein and the team at the Judicial College led by Judith Lennard and Julia Peters, the valued collaboration of the Coroners' Society of England and Wales, and for the work of many coroners who have been consulted or visited or who have assisted with training and many other aspects of the developing reforms. The Chief Coroner thanks them all.

International

109. Special arrangements were made by the Chief Coroner following the Malaysian Airlines Flight MH17 disaster in Ukraine in July 2014. Coroners have a duty to investigate violent or unnatural deaths which occur overseas where the body is returned to England and Wales. In this case, with the consent of all families concerned, all repatriated bodies were received first in one central coroner area where one senior coroner co-ordinated all arrangements with the assistance of the Foreign and Commonwealth Office and the police. The coroner's co-ordinated investigations will be subject to the outcome of the extensive Dutch inquiries. The Chief Coroner is grateful to the senior coroner for her excellent and careful work.

110. A slightly different approach was adopted by the Chief Coroner in respect of nationals from England and Wales who died in the Lufthansa Germanwings flight 4U9525 disaster in the French Alps in March 2015. But in the case of both flights the Chief Coroner was able to produce a co-ordinated approach with which the respective bereaved families were content.

111. In all such disaster cases the Chief Coroner will effect a co-ordinated strategy, working with the cadre of DVI coroners, the FCO and the police, having in the forefront of any arrangements the wishes of the families who have lost loved ones. The Chief Coroner requests that senior coroners should notify him immediately of all such cases. Senior coroners also have a duty to notify the Chief Coroner in military death cases, cases of viral haemorrhagic fevers such as the Ebola virus disease, cases which may involve consideration of the provisions of the Regulation of Investigatory Powers Act 2000 or other very sensitive intelligence material and other exceptional cases, so that details and arrangements can be discussed with the Chief Coroner at an early stage. The Chief Coroner has issued advice to senior coroners on the Chief Coroner's role in the event of a major incident involving mass fatalities in England and Wales.

112. The Chief Coroner addressed the Asia Pacific Coroners' Society Conference in Melbourne, Australia, in November 2014 talking about his strategy for reform. He also took the opportunity to visit coroners (and Chief Justices) in Melbourne and Sydney to see and discuss at first hand different working practices and procedures. As a result of his meetings with the New South Wales state coroner the Chief Coroner was able to assist the state coroner over Christmas 2014 by providing access to a team of experienced UK siege officers who could be used to make an independent assessment of police tactics and actions at the Sydney coffee house siege.

113. In May 2016 the Chief Coroner will be hosting an international conference of chief coroners and other death investigators of similar rank. The conference will be held at the Ministry of Justice in London. They will discuss issues of mutual interest including

the strengths and weaknesses of different systems of death investigation, comparative structures of different coroner and medical examiner systems, the qualifications, appointment and training of coroners, the scope of investigations, different forms of inquest hearings, inquests without hearings, the outcome and aftermath of hearings, and the best ways in death investigation of working for the public good.

114. The Chief Coroner also discussed issues of mutual interest with the Spanish Liaison Magistrate in April 2015.

Northern Ireland

115. Northern Ireland has a separate coroner service which is outside the Chief Coroner's jurisdiction. The Chief Coroner was therefore grateful to the authorities in Northern Ireland for the opportunity to visit the coroner service in Belfast in May 2015 and discuss topics of interest including differences in coroner legislation and practice, legacy cases, disclosure and still births. The Chief Coroner noted that the employment of an in-house medical adviser had reduced the post-mortem examination rate by over 10% to about 25% of all reported deaths.

Recommended law changes

116. The Chief Coroner recommends that consideration should be given to the following law changes.

117. (1) The Chief Coroner has recommended, and the previous Government agreed in principle, that there needs to be a change in the law by way of amendment to section 13 of the Coroners Act 1988 (as amended). Section 13 allows the High Court, on an application brought with the permission of the Attorney General, to quash an inquest and order a fresh one where it is necessary or desirable in the interests of justice to do so, for example by reason of irregularity of proceedings, insufficiency of inquiry or the submission of fresh evidence.

118. At present the High Court's powers are limited to quashing the inquest and ordering a fresh inquest, as for example in the deaths at Hillsborough (the Chief Coroner sat on the Hillsborough cases with the then Lord Chief Justice and Mr Justice Burnett, as he then was). But some section 13 cases require only a change to the record of the inquest, and do not need a fresh inquest which may involve extra time and expense, and above all extra distress for families. For example in the case of *Roberts v Coroner for North and West Cumbria* [2013] EWHC 925 (Admin), the outcome of the inquest recorded the deceased as a person unknown. Ten years later DNA testing identified the deceased. A simple alteration of the record by the High Court from person unknown to the named person would have been sufficient, but under the law as it stands a fresh inquest had to be ordered.

119. (2) The Chief Coroner also recommends that consideration be given so that deaths at sea may be investigated by the coroner in the absence of a body even if the death may not have occurred 'in or near the coroner's area'. At present the death has to be 'in or near the coroner's area' for the coroner to request the Chief Coroner to direct the coroner to investigate: section 1(4)(a). This means that if the death is beyond the reach of the coastal coroner's jurisdiction because it was not 'near' to the land, there can be no investigation (and inquest). example by reason of irregularity of proceedings, insufficiency of inquiry or the submission of fresh evidence.

120. A better and more flexible approach would be to adopt the law as codified in section 6 of the Coroners Act 2009 No.41 of New South Wales whereby the coroner may investigate if the death or suspected death occurred outside the State but had 'a sufficient connection with the State'.

121. Applying this kind of test to deaths at sea which are not 'near' the land of the coroner's area but are further out to sea, the coroner would be permitted to investigate the death if the deceased (or presumed deceased) had sufficient connection to the land. Taking an actual example, the deceased regularly set out to sea to fish alone on his boat. The boat was found with the engine on, drifting several miles out, with no sign of the deceased. His death was presumed after an extensive maritime investigation. It occurred too far out from the land to be 'near' the coroner's area, but he had a 'sufficient connection' with the land because he was resident there and/or he set out to sea from his usual mooring on the land.

122. Section 1(4)(a) could be amended by adding to the words 'in or near the coroner's area' words such as 'or with a close connection to the coroner's area'.

123. (3) The Chief Coroner recommends that consideration be given to amending the discontinuance provisions of the Coroners and Justice Act 2009. At present section 4 of the 2009 Act limits discontinuance of a coroner investigation to cases where the cause of death has been revealed by a post-mortem examination. This provision should be extended to material which reveals the cause of death without a post-mortem examination and there is no other good reason to continue the investigation.

124. This would give the coroner more flexibility to discontinue an investigation which has been commenced. Material other than from a post-mortem examination may come to light and persuade the coroner of the cause of death. Medical records not previously available or not known about, for example, could lead a coroner to discontinue an investigation.

125. This change could be effected by adding the words 'or other relevant material' after 'an examination under section 14' in section 4(1)(a) and amending the heading.

126. (4) The Chief Coroner recommends that consideration be given to a new legal approach to second post-mortem examinations in homicide cases. In too many cases bereaved families are further distressed by defence requests for a second (or even third) post-mortem examination without good justification. The Chief Coroner has drafted a proposal which involves the involvement of a Crown Court judge where a charge is brought early with an alternative approach involving the coroner where there is no early charge. This proposal is being considered by stakeholders.

127. (5) The Chief Coroner recommends that consideration be given to amending the provisions in Schedule 2 to the Coroners and Justice Act 2009 so as to permit two or more coroner areas to merge (combine) into a coroner area which consists of the area of part of a local authority.

128. At present a coroner area must consist of the whole area of a local authority or the combined areas of two or more local authorities (paragraph 1(2)). This means that where a local authority wishes to merge all of its coroner areas into one large coroner area, coterminous with the area of the local authority, it cannot do so piecemeal or gradually, one area at a time, as each senior coroner retires, but must wait for all senior coroners to retire bar one who will be the senior coroner who inherits the merged area.

Statutory powers and duties

129. The following is a summary of the Chief Coroner's powers and duties under the Coroners and Justice Act 2009 and the 2013 Coroners Rules and Regulations and the action taken by the Chief Coroner during the last year.

130. Where a senior coroner exercises his discretion to report to the Chief Coroner under section 1(4) of the 2009 Act that he has reason to believe that a death has occurred in or near the coroner's area, that the circumstances of the death are such that there should be an investigation into it, and the duty to conduct an investigation does not arise because of the destruction, loss or absence of the body, the Chief Coroner may direct a senior coroner to conduct an investigation into the death (section 1(5)). Since July 2014 there have been 58 applications and the Chief Coroner has granted 49 of them.

131. The Chief Coroner must be given notice in writing of any request made by a senior coroner for an investigation to be carried out by another coroner including the outcome of the request (section 2(5)). In the last year the Chief Coroner has received 829 notifications.

132. The Chief Coroner also has a discretionary power to direct a coroner other than the coroner who apart from this direction would be under a duty to conduct it to investigate a person's death (section 3). By this power the Chief Coroner may direct transfers of investigations from one coroner area to another. The Chief Coroner has exercised this power once in the last year, with the transfer effected with the consent of the coroners concerned.

133. The Chief Coroner may notify the Lord Advocate that it may be appropriate for the circumstances of certain deaths of service personnel abroad to be investigated in Scotland under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (section 12 of the 2009 Act). A protocol facilitating the notification process has been agreed between the Chief Coroner, the Crown Office and Procurator Fiscal Service, the Scottish Government, the Ministry of Defence and the Ministry of Justice. The Chief Coroner has not yet made any notifications to the Lord Advocate.

134. The Chief Coroner also has a power in certain circumstances to direct a senior coroner to conduct an investigation into such a death despite the body being in Scotland (section 13). The Chief Coroner has also not yet used this power.

135. The Chief Coroner may designate suitable practitioners to make post-mortem examinations (section 14). The Chief Coroner has not exercised this power.

136. The Chief Coroner must keep a register of notifications by senior coroners of investigations lasting more than a year (section 16). That register was opened on 25 July 2014, one year after the statutory provisions came into force. A summary of the reduced number of cases this year is set out at paragraph 36 above.

137. The Chief Coroner must monitor and train for investigations into deaths of service personnel (section 17). The Chief Coroner requires senior coroners to notify him of all such investigations and update him upon their progress and outcome. He also created in 2013 a special cadre of coroners to conduct such investigations if and when necessary and he has held special training for them. The Chief Coroner has given guidance on the use and function of the cadre, Guidance No.7 *A Cadre of Coroners for Service Deaths*. The Chief Coroner has discussed the cadre and its operation with Ministers in the Cabinet Office and Ministry of Defence and consults regularly with the Royal British Legion to discuss such cases. Fortunately, since the withdrawal of many armed forces from Afghanistan there have been few military deaths.

138. No appointment of a coroner may be made by a local authority without the consent of the Chief Coroner (and Lord Chancellor) (section 23, Schedule 3). The Chief Coroner has given his consent to the appointment in the last year of 2 senior coroners, six area coroners and 51 assistant coroners: see paragraphs 70-78 above.

139. The Chief Coroner has responsibility to train coroners and coroners' officers (section 37): see paragraphs 50-60 above.

140. The Chief Coroner may carry out an investigation into a person's death (section 41, Schedule 10). In October 2014 he completed the investigation into the death of Dr Abbas Khan who died in custody in Syria in December 2013.

141. The Chief Coroner may also request the Lord Chief Justice to nominate a judge, former judge or former coroner to conduct an investigation (section 41, Schedule 10). He has done so twice this year.

142. Senior coroners who report to prevent future deaths under paragraph 7 of Schedule 5 to the 2009 Act and Regulation 28 of the Investigations Regulations must send a copy of the report and any response to the Chief Coroner (Regulations 28(4) and 29(6)). The Chief Coroner may publish these documents (Regulations 28(5) and 29(7)). In practice they are published, with redactions where necessary, on the judiciary website. The Chief Coroner's office is working to create subject alerts for those who wish to subscribe.

143. Under regulation 19 of the Investigations Regulations the Chief Coroner has power to direct the receiving local authority to bear the costs of an investigation transferred by direction under section 3 of the 2009 Act. He has not exercised this power.

144. In addition under regulation 25 the Chief Coroner has power to require information in relation to a particular investigation or investigations. The Chief Coroner frequently requests details from coroners which are always complied with and as such has not needed to make a formal request under this section.

145. The Chief Coroner also has the power under regulation 27 to direct a coroner to retain documents for a period other than 15 years. He has used this power this year on two occasions.

Conclusion

146. This is the second annual report to the Lord Chancellor and the second year of the statutory reforms and the Chief Coroner's reforms. In the opinion of the Chief Coroner much progress has been made across England and Wales. The changes have been positive and the Chief Coroner remains confident that coroners are embracing these changes. The Chief Coroner believes that in the interests of the public the reforms are taking good effect.

147. The Chief Coroner will continue to develop and encourage reform, through training, guidance, advice, encouragement and support. He will further develop the reforms so that with increased confidence he will be able to report to the Lord Chancellor about further consistency of standards between coroner areas next year.

HH Judge Peter Thornton QC
Chief Coroner
June 2015

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