



CHIEF CORONER

Report of the Chief Coroner to the Lord Chancellor

Third Annual Report:
2015-2016

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to the Lord Chancellor

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Introduction

1. This is the Chief Coroner's annual report to the Lord Chancellor. It is the third and final report from the first Chief Coroner of England and Wales, HH Judge Peter Thornton QC. In this report he will assess the state of the coroner service during his term of office from 2012-2016 and make recommendations for the future.
2. 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.

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.

The 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 for appointment purposes on 1 February 2010.
5. The first post holder, HH Judge Peter Thornton QC, a senior circuit judge, was appointed by the then Lord Chief Justice, Lord Judge, after consultation with the then Lord Chancellor, the Rt. Hon. Jack Straw MP, on 6 May 2010, but was asked by the following 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, Lord Thomas, after consultation with the then Lord Chancellor, The Rt. Hon. Chris Grayling MP, extended the term of office of Judge Thornton as Chief Coroner of England and Wales until 1 October 2016, when a successor will take over the role.
7. The extent of 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).

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, the Rt. Hon. 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.”

Reforms and planning for the future

11. To achieve those aims the Chief Coroner devised and continues to develop a package of reforms. They are 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.
12. In April 2015 the Chief Coroner formulated a 77 point Development Plan for 2015-2016. The Plan charts objectives and progress under the following headings: structures, investigation, inquests, reports to prevent future deaths, High Court, changes in the law, treasure, training, guidance, speeches, meetings, visits and complaints. Many points have been completed or are subject to continuing assessment: see attached copy at Annexe 1.
13. The Chief Coroner has also drafted a blueprint for now and the future entitled A

Model Coroner Area (June 2016), an aspirational document for the coroner service in its present local area structure: see Annexe 2 and paragraphs 28-33 below.

The Coroner Service

14. The coroner service of England and Wales remains essentially a local service. There is no national structure. Coroners are appointed and paid locally, the service is funded locally including the provision of courts and other accommodation, and coroners' officers and support staff are employed locally by police and local authorities.
15. There have in the past been calls, as in the report of Tom Luce's Fundamental Review, *Death Certification and Investigation in England, Wales and Northern Ireland*¹, 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.
16. The Chief Coroner supports these calls for a national service. Much would be gained, in terms of standardisation, consistency and the implementation of reform, by a national structure.
17. In the meantime, the localness of the present service has produced an inevitable measure of inconsistency between coroners and between coroner areas. Coroners have to an extent worked in isolation, unsupported by a sound framework and network of coroner resilience. The Chief Coroner has therefore been working in his term of office towards a greater consistency in all areas of the coroner domain, through guidance, training and discussion with coroners and all stakeholders.
18. The localness of the system also produces inconsistency in the provision of services. This is inevitable. For example, the number of coroners' officers provided (usually by the police but sometimes by the local authority) to support coroners in death investigation varies widely. In coroner areas in different parts of the country, where there are approximately 2,500-3,000 deaths reported to the coroner each year, the number of officers ranges from 2 to 11.
19. On this basis it would seem clear that several police authorities and local authorities have not been supplying sufficient resources. Some have not done so for a long time. This in turn has caused stress for staff in some areas and led to long-term sickness, reducing even further the number of available officers and causing unwanted

¹ Cm 5831 (2003) <http://webarchive.nationalarchives.gov.uk/20131205100653/http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf>

delays for families in the completion of investigations. Coroners' work is stressful work. It is particularly stressful for coroners' officers who are constantly dealing with death and grieving families. This year coroners' officers have reported significant levels of stress when giving feedback to the Judicial College at training courses.

20. Nevertheless, there have been some signs of improvement in officer numbers. In Avon and Somerset, for example, two new officers have been provided. In London the Metropolitan Police have committed to raising the number of coroners' officers to the full complement. In another area the Chief Constable has agreed to provide temporary cover when officers are off sick or suspended. Progress of this kind makes a huge difference to the morale and resilience of coroners' officers in their daily investigative work for the coroner.
21. There are very positive signs too in the contribution of local authorities. 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. Now the approach has changed. More local authorities wish to play a positive role in supporting the work of the coroner to provide an excellent public service. There may be little public money to spare, but thinking about the wise use of resources - merging smaller areas together, tendering for contracts for toxicologists and funeral directors, bringing the coroner and all staff together in one building, sharing resources with local authorities responsible for other coroner areas - all helps to reduce costs and generate greater resilience.

Positive developments

22. While a local as opposed to a national coroner system continues to cause some problems, there are a significant number of positive developments to report.

Statutory framework

23. The legal structure set out in the 2009 Act for investigation and inquest, implemented from July 2013 with statutory rules and regulations, has in the main worked well. The structure is simple and effective.
24. The Government's promised review of the coroner service is awaited. The Ministry of Justice has consulted widely and many stakeholders have responded to its Post-Implementation Review of the Coroner Reforms in the Coroners and Justice Act 2009. The review should display the views of stakeholders on a work in progress.

Mergers: reduction in number of coroner areas

25. There has been considerable benefit from the reduction of coroner areas across England and Wales. Since the implementation of the 2009 Act in July 2013, the number of areas has reduced from 110 to 92, with more planned for the future. This has been achieved by sensible business planning and discussion with the Ministry of Justice. Although the Lord Chancellor has the power to require areas to merge, so far all mergers have been effected by agreement. All have produced areas with full-time senior coroners.
26. The clear advantages of bringing smaller areas together (or with a larger area) are efficiency of scale, the opportunity to bring the working team of coroners, officers and support staff together in one building, often with a dedicated court, and a full-time senior coroner in charge.
27. Successful mergers over the last year have included the creation of a new area in Wales named South Wales Central from the merger of Powys, Bridgend and Glamorgan Valleys with Cardiff and the Vale of Glamorgan, the creation of a single coroner area in Somerset following the merger of Somerset (Eastern) and Somerset (Western), the creation of a single coroner area in Cambridgeshire and Peterborough and the merger of the Isles of Scilly with the Cornwall coroner area.

A blueprint for the future: A Model Coroner Area

28. As a result of extensive discussions and meetings with coroners and all stakeholders for the coroner service, particularly local authorities and police, the Chief Coroner has developed a draft blueprint for now and the future, an aspirational document entitled *A Model Coroner Area*².
29. In this document the Chief Coroner lays out his recommendations for the ideal coroner area, bearing in mind that the coroner service is likely to remain a local, not national, service for the foreseeable future. He describes his recommended size for coroner areas, the need for smaller jurisdictions to merge, the role of the senior coroner and the team of coroners, assisted by coroners' officers and administrative support staff. He outlines the work of coroners in investigations and inquests, and in reports to prevent future deaths. He suggests timescales for referrals of deaths to the coroner, release of the body by the coroner, opening and completing inquests and holding pre-inquest review hearings. He also deals with pathology services, out of hours services, tendering for contracts, training and discipline.

² Latest draft, 17 June 2016.

30. The Chief Coroner believes that there is now a greater awareness of the role of the coroner in death investigation. Under the law coroners have two main functions. 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 obtained, both for bereaved families in the first place but also for the wider public.
31. In addition, 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. For example, following a recent inquest the coroner drew attention in a written report to the Secretary of State of the risk of self-harm for prisoners previously sentenced to indeterminate sentences under the Indeterminate Sentences for Public Protection sentencing regime. Although the regime has now been repealed, prisoners sentenced to it in the past continue to remain in prison without release dates.
32. The Chief Coroner hopes that *A Model Coroner Area* will generate further thinking and discussion about how a coroner area should function and how it can best serve the public. This document also explains the basic features of a local coroner service and how they can best work.
33. Already much progress has been made to achieve the aspirations of this document. In particular the Chief Coroner would like to draw attention to his call for coroners and staff to work together in one building, preferably with a court on site, and the registrar and local authority nearby. 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. Officers can provide more support for each other, with the more experienced helping and encouraging the less experienced. Working together provides resilience for all.

Statistics

34. The Chief Coroner is pleased to report to the Lord Chancellor that there are positive trends in a number of this year's statistics.

Cases over 12 months

35. The Chief Coroner is particularly pleased to report that the number of cases not completed or discontinued within 12 months has greatly reduced. The Chief Coroner has a statutory duty³ to report to the Lord Chancellor on these cases. In effect,

³ Sections 16 and 36, Coroners and Justice Act 2009.

backlogs of cases have substantially decreased.

36. Since the introduction by the Chief Coroner in 2014 of a standard procedure for reporting to the Chief Coroner on cases over 12 months, there has been a decrease by 52% of cases outstanding. This is a reduction from 2,673 cases to 1,285 cases, a figure which is now little more than 0.5% of all deaths referred to coroners in England and Wales.
37. Two years ago seven coroner areas had over 100 cases over 12 months old (two of them had over 200 cases); now there are none. 96% of coroner areas now have 40 or fewer cases outstanding. And 43 areas have less than 10 cases outstanding.
38. The wording of the 2009 Act and the Coroners (Inquests) Rules 2013 reflects the concern of the public and Parliament that cases had not in the past been 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'.
39. 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, or Health and Safety Executive or Prisons and Probation Ombudsman inquiries, all of which take time.
40. In some areas there have been difficulties with resources. In Derby and Derbyshire, for example, cases have been ready to be heard but there has been a shortage of coroners to hear them. The Chief Coroner is pleased to note that the local authority has now appointed an additional assistant coroner to resolve this problem.
41. The Chief Coroner welcomes this decrease in the number of older cases. He is grateful to senior coroners (and local authorities) who have responded well to requests to review and complete older cases. This year some coroner areas have done remarkably well in reducing backlogs, for example West Yorkshire East, Inner London South and East London.
42. More work needs to be done - in some areas with additional resources - in order to reduce cases over 12 months to just a handful of cases, as the Chief Coroner recommends.⁴ But progress to date has been excellent. This is, of course, good news for bereaved families who should not suffer the distress of undue delay. Each case should be given special care and attention so that it is completed within a fair timescale. This requires both robust case management and the effective deployment of local resources. With further hard work on the part of senior coroners the Chief

⁴ See Chief Coroner's *A Model Coroner Area*.

Coroner believes this positive trend will continue.

Average time to inquest; post-mortem rates

43. From the annual Ministry of Justice statistics⁵, there are two further positive trends. The average time of all cases from death to inquest completed has fallen considerably by 28.6% from 28 weeks to 20 weeks. Also the percentage of deaths in which coroners have required a post-mortem examination has fallen by 2% from 38% of all cases to 36%.
44. Both figures are to be welcomed, although with a note of caution. The figures will to some extent have been affected by cases involving Deprivation of Liberty Safeguards (DoLS). There were 7,183 reported DoLS cases last year. The Chief Coroner will say more about these cases in paragraphs 146-151 and 173 below. But in view of the fact that a post-mortem will rarely be required and the inquests should normally be completed within a week, the number of DoLS cases will undoubtedly have affected the national picture.

Overall figures

45. There are usually about 500,000 registered deaths in England and Wales every year. This figure is relatively constant, although higher in 2015 with 529,613 deaths following an exceptional (and not entirely explained) increase over the winter months. All deaths are registered with the local registrar of births and deaths in order 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.
46. 45% of all registered deaths are reported to coroners. This amounts to some 220,000 or so deaths in England and Wales each year, higher than usual in 2015 with 236,406 referrals. 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. A formal investigation under the 2009 Act is not required and therefore there is no inquest.
47. Only a relatively small number of cases, therefore, require investigation and inquest. This figure is rightly reducing over the years, although the figure this year has increased from 29,153 inquests to 35,473 as a result of DoLS cases (see paragraph 44 above) which accounted for over 7,000 inquests in 2015. This total number of inquests

⁵ Coroners Statistics Annual 2015, England and Wales (12 May 2016).

is still only 15% of all deaths reported to the coroner. Nevertheless, the number of hearings is very much higher than any other comparable jurisdiction, and as the Chief Coroner recommends at paragraphs 182-188 below, they could be substantially reduced by a special procedure for non-contentious cases

48. In the last year there have been only 457 jury inquests, many of which 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 continue to rise, 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. He continues to sit on the Ministerial Board on Deaths in Custody and he sits on the majority of High Court cases arising from inquests into the deaths of prisoners. The issue is of continuing concern.

Appointments

49. Further good news is provided by the ongoing reform of the appointments' system
50. Coroners are now categorised by the 2009 Act in descending order of importance as senior coroners, area coroners, or assistant coroners. And local authorities now make all coroner appointments, subject to the consent of the Chief Coroner and the Lord Chancellor.
51. Local authorities have in the main embraced this role with enthusiasm, following the Chief Coroner's Guidance No.6 The Appointment of Coroners. The process is now more open, transparent and fair. Positions are advertised widely and there have been large numbers of applicants for most positions.
52. This year the appointments process has worked well. Appointees have come from a variety of backgrounds and experience. For example, legal executives, first-tier tribunal judges, magistrates' courts legal advisers, managers within HM Courts and Tribunals Service and others from diverse legal backgrounds have all been appointed in the role of assistant coroner. A Judge Advocate completed a complex military death investigation and two circuit judges are in place to deal with complex inquests, including the inquests into the deaths of those killed at the holiday resort in Sousse, Tunisia, in June 2015. Both judges have been nominated for this role by the Lord Chief Justice under Schedule 10 of the 2009 Act.

53. The Chief Coroner continues to maintain close involvement with each appointment process in order that his consent to an appointment may be fully and fairly informed. The Chief Coroner's office provides assistance where required, for example with the job description, advertisement, sift process, membership of appointments' panel and with the presentation and questions at final interview.
54. The Chief Coroner continues to be involved at the sift stage to see that the criteria are correctly and appropriately applied. He looks 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 exercising the Chief Coroner's 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 the exercise of his consent.
55. Appointments of senior coroners and area coroners are announced by the relevant local authority and published on the judiciary website.
56. This year there have been four senior coroner appointments, five area coroner appointments and 57 assistant coroner appointments. The majority of those appointed as assistant coroners, which is the entry point to judicial appointment in the coroner service, are women.

Training

57. The Chief Coroner now trains nearly 1,000 people in coroner work every year: 380 coroners and 595 coroners' officers. This training, under the auspices of the Judicial College (which trains all judges and tribunal members), has been highly successful. It now involves a number of two-day residential courses, which are all compulsory, including an induction course for newly appointed assistant coroners, continuation courses for all coroners and continuation courses for all coroners' officers.
58. Last year the coroners' continuation courses concentrated on developing good practice in inquests, looking especially at conclusions, short-form, narrative and using questionnaires. This year the annual continuation courses for coroners will focus on mental health issues in investigations and inquests.
59. The positive feedback from all courses demonstrates that they have been exceptionally well received, with high levels of achievement in learning outcomes, aims and usefulness. In particular, the new course for coroners' officers has been markedly acclaimed. It brings together coroners' officers from across the country for learning and discussion on good practice. It is a great tool for developing consistency.

60. The Chief Coroner devises and delivers (in part) all training with the assistance of nine course directors all of whom are coroners. The Chief Coroner and course directors meet quarterly at the Chief Coroner's Training Committee. They are supported by two experienced coroners' officers.
61. The Chief Coroner has been singularly impressed by the commitment of the course directors and the quality of their course designs and training delivery. Course directors are appointed following an open selection process at the Judicial College. This year two coroners have retired as course directors; their contribution has been very much appreciated by the Chief Coroner. Five new course directors have been appointed, including senior coroners, an area coroner and an assistant coroner.
62. In addition to the regular annual courses, there have been a number of one-day training events this year. They include the Chief Coroner's annual conference for senior coroners and the first course in a series of one-day training on medical issues, starting with the head and the brain. The Chief Coroner has attended a number of training events in preparation for mass fatality events including a table-top exercise about the football Euros, and this year he has held a one-day training course on the subject for urban coroners. He has also produced the Mass Fatality Checklist for senior coroners' use. The Chief Coroner will also hold a one-day training event for local authorities in July 2016 and a course for coroners in September 2016 on deaths of children.
63. These courses and events are instructive and developmental for coroners and coroners' officers. They are intended to and do lead to greater consistency in coroner work across England and Wales. With some exceptions in some areas, the changes effected by these reforms in raising standards have been tangible and visible.
64. In May 2016 the Chief Coroner held the first international training event for Chief Coroners from around the world (see paragraphs 111-112 below).

Guidance and Advice

65. To support and add to the training, and with a view to increased consistency and enhanced national standards, the Chief Coroner has continued to produce written guidance for coroners (and others), all of which is published on the judiciary website⁶. There are now 22 separate pieces of written guidance
66. In the past 12 months the Chief Coroner has issued guidance on mentors for coroners (a new scheme is now in place), core competencies for newly appointed assistant coroners, the use of translators and interpreters and the handling of pre-inquest review hearings. Updated versions of earlier guidance and of the existing five

⁶ <https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/>

law sheets have also been issued and published.

67. In addition to formal written and published guidance, the Chief Coroner has given advice to coroners on a number of topics. They include transfers of cases, data protection and loss of data, copyright issues, witness summonses, deaths overseas following execution, and in respect of funeral directors advice on contracts for coroner's removals of bodies.
68. The Chief Coroner continues to promote effective case management, through guidance, advice and training, on dates to be set for hearings, directions for timely production of reports and witness statements, reviews of case files, holding pre-inquest reviews in more complex cases, and well-structured inquests. This is an essential part of a modern coroner service which aims to serve the public. Coroners are reminded too that from the very start families must be given good information and good explanation about the investigation and inquest process. And families must always be given the opportunity to express any concerns that they may have about the circumstances of the death.⁷
69. This year the Chief Coroner has also written to coroners to inform them that he had secured, through the good offices of the Judicial Office, a new personal support service for all coroners, namely access if needed to the dedicated and confidential helpline (which is available to all judges). The Chief Coroner would like to give special thanks to Joanne Peel, former head of HR for the Judiciary, for her help in securing this support.

Medical examiners

70. The investigation of deaths in England and Wales will be greatly enhanced by the proposed implementation of the Medical Examiner (ME) system.⁸ The Chief Coroner welcomes it. The scheme should supplement and complement the work of the coroner service. It should provide, with the coroner service, a more complete and independent system of death investigation in England and Wales. It should achieve more accurate medical certificates of the cause of death (MCCDs). It should ensure more appropriate referrals (reports) of deaths to the coroner. It should also produce more accurate data about the causes of death, particularly in hospitals. These are admirable objectives.

71. The Government consultation entitled *Consultation on the introduction of*

⁷ See Chief Coroner's A Model Coroner Area, paragraph 53.

⁸ See Part 1 Chapter 2 of the 2009 Act.

medical examiners and reforms to death certification in England and Wales closed on 15 June 2016. The Chief Coroner's response to the consultation exercise is published on the judiciary website.⁹ The Chief Coroner welcomed the scheme, currently scheduled for implementation in 2018, although he also expressed some reservations (see paragraphs 152-166 below).

72. The introduction of an ME system should benefit the work of coroners. In general, it should provide greater scrutiny of all deaths, particularly at an early stage. Deaths from natural causes should be more readily identified and registered more quickly. Cases which should be reported to the coroner, and which in the past may have gone unreported and not investigated, will also be more readily identified. This should provide a more complete death investigation service, combining good medical knowledge with good investigative skills. It should benefit both bereaved families, who will have the opportunity to raise concerns at an earlier stage, and the wider public, who will have greater confidence in death investigation.
73. The coroner service should benefit specifically in three ways, all of which are to be welcomed.
74. First, there should be fewer inappropriate referrals to coroners from medical practitioners, both GPs and hospital doctors. The reduction in referrals to coroners should be achieved by MEs giving advice to doctors on the medical cause of death. This should reduce the number of cases referred to coroners which in due course are signed off by coroners to the registrar of births and deaths as deaths from natural causes, requiring no formal investigation.
75. In 2015, of the 236,406 of deaths referred (reported) to coroners by doctors, only 32,857 cases proceeded to inquest. This figure suggests that too many deaths are reported to coroners unnecessarily. The vast majority of the referrals, more than 85%, were therefore sent by coroners (with or without a post-mortem examination) for registration as deaths from natural causes without a formal coroner investigation and inquest.
76. It is therefore believed that the availability of MEs to advise doctors on the cause of death should reduce the number of cases which are referred to coroners unnecessarily.
77. Secondly, the ME scheme is likely to bring with it for the first time statutory criteria for referrals (see paragraphs 120-128 below).
78. Thirdly, the presence of a local ME should make medical advice more freely

⁹ <https://www.judiciary.gov.uk/wp-content/uploads/2016/06/chief-coroner-cp-resonse-medical-examiners.pdf>

available to the coroner. Most coroners have no medical qualifications. Since 2013, coroners are required only to have the judicial eligibility appointment of five years' legal qualification and practice. No medical qualification or experience is necessary. Some coroners will have medical knowledge. They may for example have been solicitors practising in medical negligence cases. But some coroners will not have that experience. They have to learn the medical side of things through training and on the job.

79. In Northern Ireland the coroner's office has the benefit of a medical practitioner employed in-house. This person has advised coroners on medical issues. As a result, it is believed, the post-mortem rate has reduced substantially. Any significant reduction in the post-mortem rate in England and Wales would be welcome. It would represent a considerable saving of distress for families as well as a saving of money.
80. Coroners in England and Wales do not have the luxury of in-house medical practitioners, although some senior coroners use the services of assistant coroners who are doctors (appointed before 2013). As a result, the post-mortem rate across England and Wales is very variable. It ranges from 20% to 62%. That level of inconsistency is unacceptable
81. Accordingly, the benefit of a local ME to advise the coroner should help. It should reduce the number of post-mortem examinations.
82. The Francis Report made a number of recommendations about coroners and inquests.¹⁰ The majority of them concern the benefits of the introduction and application of MEs. The other coroner recommendations have been followed and implemented.
83. Despite these positive advantages, the Chief Coroner has also expressed some concerns about the impact the introduction of the ME system will have on the coroner service unless addressed before implementation. These concerns are set out at paragraphs 152-166 below.

Service deaths

84. The Chief Coroner has statutory responsibility¹¹ for the monitoring of and training for investigations into deaths of service personnel on active service or in preparation for active service. The Chief Coroner requires senior coroners to notify him

¹⁰ Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Recommendations 273-285 <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffpublicinquiry.com/report>

¹¹ Section 17, 2009 Act.

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*.

85. Fortunately, since the withdrawal of many armed forces from Afghanistan there have been few military deaths. 456 military personnel have died in Afghanistan since 2011, 400 from hostile action. In 2009 and 2010 those numbers were over 100. By contrast, in 2015 there were three deaths in Afghanistan, two of which were in a helicopter crash.
86. Since July 2013 there have been 20 relevant service death inquests. Most recently they have concerned training and related activities, including the three Brecon Beacon training deaths and the so-called 'beasting' case in Salisbury. The latter was conducted by a Judge Advocate as coroner. In addition the second inquest into the death of Private Cheryl James at Deepcut Barracks was concluded on 3 June 2016, with a retired senior judge as coroner.
87. In all such cases the local senior coroner is under a duty to report the case and its progress to the Chief Coroner.¹² In his evidence to the Parliamentary Defence Sub-Committee on 1 February 2016 the Chief Coroner outlined the details of the cadre, training for the cadre, monitoring of all service deaths, his good relations with the Defence Inquests Unit at the Ministry of Defence and with the Royal British Legion, his ongoing contact with Ministers, the thorough, public nature of these inquests, and the necessary close involvement of bereaved families throughout the process.
88. In this way the Chief Coroner seeks to ensure that he maintains close oversight of every such case, that the right coroner, sufficiently trained, conducts the investigation and inquest, that a full, fair and independent investigation takes place, that families are at the heart of the process, and that where appropriate reports to prevent future deaths are written and published.

Reports to prevent future deaths

89. Coroners continue to write reports to prevent future deaths (PFD reports). These are important statements by coroners who have a concern arising from the inquest and report that action should be taken to prevent future deaths.¹³
90. These PFD reports - 571 in number in 2015 - are hugely important. They draw

¹² As per advice given by the Chief Coroner, December 2014.

¹³ Paragraph 7, Schedule 5 to the 2009 Act.

attention of government agencies, individuals and organisations to the fact that something has gone wrong and action should be taken. Learning lessons from a tragic death can be a positive outcome and one often welcomed by the family of the deceased.

91. Because of their importance the Chief Coroner decided to publish all PFD reports on the judiciary website (sometimes with redaction). They are therefore made public and accessible to all who may have an interest in them. Email alerts are now available. For example, NHS England (London Region) has used this resource to identify learning from the deaths of vulnerable adults and children in healthcare settings across London.
92. The Chief Coroner will continue to encourage coroners to write PFD reports where appropriate.

Faith communities

93. The Chief Coroner continues to work with faith communities, particularly Muslim and Jewish, so as to try and comply with two main religious requirements: avoidance where possible of so-called invasive post-mortem examinations; and early burial.

Post-mortem imaging

94. The developing use of post-mortem imaging by way of CT scanning as an alternative to the so-called invasive post-mortem examination (autopsy) in appropriate cases is progressing, albeit slowly. Under the law at present, an autopsy is free of charge, paid for by the state. CT scanning is more expensive. There is no state funding for it at present, so where it is available families have to pay for it. It is not available in all parts of the country, but is becoming more so gradually, and the Chief Coroner encourages its availability and use.

Out of hours services

95. Early burial is not always easily achieved, especially when the death occurs out of workday hours. There are some formalised out of hours services in some parts of the country. In others there are informal schemes. In others there are no schemes at all. It is not just a question of the coroner being on duty (paid or unpaid) at weekends and over bank holidays. It requires resources from police and local authorities for a rota of coroners' officers to take the front-line calls and investigate on the coroner's behalf. It also requires the local registrar's office to be open for part of the weekend and bank holidays. The local public mortuary (if there is one) may also have to be open. In

addition the senior coroner should be paid for being on rota call along with other local coroners.

96. All of this is not easily achieved. In the absence of a national coroner service, different local authorities and police authorities have different views about funding out of hours services. Some are happy for a service to be provided by coroners and others volunteering their services for free. Others would like to provide a service but say they have no money.
97. Nevertheless, there are some positive signs. The Metropolitan Police Service (MPS), which employs all coroners' officers in Greater London, has recently agreed to raise the number of officers to full complement. This in itself will have a substantial impact on the quantity and quality of work for coroners in London. In respect of out of hours services, newly employed MPS coroners' officers will have out of hours rota work included in their terms and conditions of employment. This will lead gradually to an out of hours service across London, something the Chief Coroner has been advocating vigorously.
98. Elsewhere across England and Wales the picture is variable. But there is certainly a growing awareness amongst all involved that out of hours services should become more available. They will not just benefit the faith communities; they will benefit the public as a whole. It is in everybody's interest that bodies can be released for burial or cremation as early as possible.

Second post-mortem examinations

99. The Chief Coroner continues to work towards a new scheme to regulate the number of second post-mortem examinations in the case of suspicious deaths. Requests for second (or even third) post-mortem examinations are sometimes made when defendants in homicide cases (murder, manslaughter and infanticide) are charged and brought before the courts. Sometimes the issue arises when no person has been charged.
100. Second post-mortem examinations invariably cause additional distress to families who have suffered the loss of a loved one, usually in violent circumstances. The Chief Coroner's proposal seeks to restrict additional post-mortem examinations to cases where there is a good and reasonable justification for them. There is no automatic right vested in a defendant charged in relation to a death to be granted a second post-mortem examination. But fairness dictates that some requests should be granted in the interests of justice.
101. In the past, however, many requests by defendants for a second post-mortem

examination have been routine and not objectively justified. Pathologists often advise that a second post-mortem is in any event of little or no value. Where there is no good reason for a second examination, the Article 6 rights of the defence to a fair trial may be outweighed by the Article 8 rights of the deceased's family to respect for private and family life including respect for the body (European Convention on Human Rights).

102. The essence of the scheme would be to hand control of decisions on second autopsies to a Crown Court judge in the event that criminal charges are brought. The key points of the proposal are:

- Comprehensive first post-mortem examination by forensic pathologist; fully recorded and documented
- Right of defendant to a desktop review of pathologist's findings and conclusions
- Requests for further post-mortem examination to be decided by judge in Crown Court proceedings; guidance to be given to judges in Crown Court
- Where there are no criminal proceedings, coroner to review options with pathologist and police
- Release of the body by the coroner as soon as possible
- Bereaved families to be informed of the process at all stages

103. The Chief Coroner's proposal is at the consultation and discussion stage.¹⁴

Treasure

104. The Chief Coroner has taken steps to modernise and simplify the arrangements for treasure investigations and inquests. Chapter 4 of Part 1 of the Coroners and Justice Act 2009, which provides for the appointment of a Coroner for Treasure and other provisions on treasure investigations, has not been brought into force. The provisions on treasure finds in the Coroners Act 1988 therefore remain in force.

105. An earlier proposal by the Chief Coroner to reduce some aspects of coroner work on treasure finds by transferring administrative responsibility to the Department of Culture, Media and Sport was not approved by the Government. Therefore the Chief Coroner, with the invaluable assistance of Andrew Haig, senior coroner for Staffordshire

¹⁴ *Second Post-Mortems* (2 March 2016).

South, has produced *Treasure: A Practical Guide for Coroners* with a set of standard letters for each stage of the process.¹⁵

International

International cases

106. The Chief Coroner continues to have oversight of the arrangements for major cases involving deaths overseas. Following major incidents the Chief Coroner liaises with coroners, the Foreign and Commonwealth Office (FCO), the Cabinet Office, the police and local authorities in order to ensure that the arrangements for repatriation of bodies to England and Wales and subsequent investigations are sound.
107. Following the deaths of 30 British holidaymakers in Sousse, Tunisia, in a terrorist incident on 27 June 2015, the Chief Coroner worked with agencies to ensure that the most appropriate process could be developed. This included repatriation through RAF Brize Norton and then on to West London where the coroner assumed jurisdiction, carrying out early investigations including forensic post-mortem examinations. The families were consulted throughout.
108. Thereafter, the Chief Coroner requested that the Lord Chief Justice nominate a judge for the inquests and a judge was appointed. The families of four deceased from Scotland (where there are no coroners because of the different legal system) agreed that their loved ones should also be repatriated in the same way so that they, too, could take part in the inquests to be held in England. This was all agreed through the good offices of the Lord Advocate in Scotland and David Green, Head of the Scottish Fatalities Investigation Unit in the Crown Office and Procurator Fiscal Service.
109. In the same way the Chief Coroner continues to have oversight of the arrangements made in the Leicester City and South Leicestershire coroner area following the Malaysian Airlines Flight MH17 disaster over Ukraine in July 2014, and the arrangements in Hull and East Riding following the Lufthansa Germanwings Flight 4U9525 in the French Alps in March 2015.
110. In all such disaster cases the Chief Coroner executes a co-ordinated strategy, working with the cadre of disaster victim identification coroners, the FCO and the police, whilst having in the forefront of any arrangements the wishes of the families who have lost loved ones. In all of these cases the Chief Coroner has provided the families with written advice about the details of the coroner process to come. In all

¹⁵ The Guide (12 November 2015) and letters have been published on the judiciary website <https://www.judiciary.gov.uk/publications/treasure-a-practical-guide-for-coroners-advice-from-the-chief-coroner/>

three cases the foreign investigations are ongoing.

International conference

111. In May 2016 the Chief Coroner hosted and conducted the first global conference for Chief Coroners and other death investigators of similar rank (but with different titles, such as the Chief Medical Examiner of Manitoba). In a three-day event, issues of mutual interest on comparative systems of death investigation were discussed and debated. Amongst many topics delegates considered competing structures of death investigation, pathology and post-mortem imaging in the modern era, investigation procedures, hearings and appeals, mass fatality events, more complex inquests, lessons to be learned and the benefits of international cooperation.

112. In the final session of the conference delegates agreed on a number of conclusions. In order of favoured priority they agreed that it was necessary to strike the right balance in investigations between the medical and the legal, while maintaining the independence of coroners. They agreed on the need for good and repeated planning for mass fatality events. They agreed on early and informed communications and explanations for bereaved families. They agreed that there should be clearer guidance and education of clinicians on reporting deaths. They agreed on working to reduce the number of autopsies. They agreed on a tighter control of long inquest hearings with clear timetabling. They agreed that there should be quality assurance and peer review of coroners.

Northern Ireland and Scotland

113. Northern Ireland has a separate coroner service which is outside the Chief Coroner's jurisdiction. Scotland has no coroner service.

114. Nevertheless, the Chief Coroner and his office maintain good contact with both the Coroners Service for Northern Ireland and the Lord Advocate and Crown Office and Procurator Fiscal Service in Scotland in order to discuss subjects of mutual interest. In respect of Northern Ireland there has, for example, been discussion about legacy cases. In respect of Scotland there has been discussion about deaths abroad and the arrangements for Scottish families involved in the Sousse killings. The Chief Coroner is grateful to the Lord Advocate for continuing relations.

Stakeholders

115. The Chief Coroner continues to meet regularly with a wide range of relevant

stakeholders. They include coroners of all ranks, Ministers (at the Ministry of Justice, Department of Health and Ministry of Defence), senior judges, local authorities, senior police officers, registrars of births and deaths, pathologists, toxicologists, funeral directors through the national associations, coroner trainers and course directors, lawyers, the Director of Public Prosecutions, bereaved family members, bereavement organisations and charities.

116. This year, amongst many meetings, he has met with senior members of the Coroners' Society on a wide range of topics, with Professor Louis Appleby and officials from Public Health England on suicide issues, with the Chair of the Youth Justice Board, Lord McNally, and, separately, the Chief Inspector of Prisons Nick Hardwick, and his successor Peter Clarke on deaths in prison and detention, with Dame Elish Angiolini, Chair of The Independent Review into Deaths and Serious Incidents in Police Custody, on deaths in police custody, with the Air Accident Investigation Branch on air accidents, with the Law Commission on DoLS, with the London Strategic Registration Board on registration issues, with the Defence Inquests Unit on military service deaths, with the Royal College of Pathologists and others on the deaths of children including SIDS (sudden infant death syndrome) and SUDI (sudden unexpected deaths in infancy), with the Tunisian judge investigating the Sousse killings, with Government departments about intelligence and intercept material, with the FCO about deaths overseas, the Home Office and others about forensic pathologists and coroners' pathologists, with Professor Mary Sheppard on a visit to the CRY (Cardiac Risk in the Young) sponsored cardiovascular pathology unit at St George's Medical School, with a number of hospital trust representatives about working with coroners, and with charities such as RoadPeace, Co-Gas Safety and the Lullaby Trust.

117. This year the Chief Coroner has continued to complete an extensive schedule of speaking engagements with a view to promulgating knowledge about the work of coroners and understanding of the Chief Coroner's reforms and modernisation programme. This year the Chief Coroner has spoken at the annual conference of the Coroners' Society of England and Wales and other regional Society meetings, at the annual conference of the Coroners' Officers and Staff Association, at the Senior Investigating Officers' Annual Conference, at the Local Registration Services Association annual meeting, at the annual conference of the National Association of Funeral Directors, at the Royal College of General Practitioners' Secure Environments Group 3rd Annual Health and Justice Summit, at meetings organised by solicitors and barristers, at the UK Power Networks training day, at various regional meetings of coroner service manager groups, at the *Criminal Law Review* annual conference, and at 13 multi-day training events arranged by the Chief Coroner under the auspices of the Judicial College. The Chief Coroner also gave evidence to the Sub-Committee of the Parliamentary Defence Select Committee.

118. The Chief Coroner 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, with Elena Borisova 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 Glenn Palmer and the team at the Judicial College led by Sheridan Greenland, Judith Lennard and Julia Peters, as well as 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 Chief Coroner's work. The Chief Coroner thanks them all.

Issues of concern

119. Certain issues affecting the coroner service remain unresolved. Some of them may require statutory change.

Reporting deaths to the coroner

120. The Chief Coroner is concerned that there are no statutory or other clear criteria for medical practitioners reporting deaths to coroners. This has created uncertainty and inconsistency. When should a doctor report a death to the coroner? The answer to this question is not definite.
121. More than 236,400 deaths were reported to coroners in England and Wales in 2015. The vast majority of them were reported (referred) to coroners by GPs and hospital doctors. And yet there are no statutory criteria for doctors on when to report a case to the coroner
122. The notes for doctors attached to the Medical Certificate of Cause of Death state, under the heading *When to Refer to the Coroner*: 'There is no statutory duty to report any death to a coroner.' The notes, therefore, do no more than encourage doctors to adopt the criteria for registrars and report any death which should be referred to the coroner by the registrar of births and deaths.
123. But this is no requirement or instruction. Doctors are not bound by it. There is, therefore, a lacuna in the law. Doctors need clear statutory guidance for reporting deaths to the coroner.¹⁶ It would provide a clear framework for referrals to coroners and it would form the basis for better education and training of doctors and regular discussion with the local coroners about when a death should be reported. Doctors would develop greater confidence and accuracy about death certification, registration and referrals.

¹⁶ Francis Report, Recommendation 277.

124. At the same time statutory criteria would also guide local coroners. It would preclude them from promoting their own policies for reporting deaths locally. At present there is inconsistency of practice amongst senior coroners.¹⁷ Some, for example, request doctors to report all still births and all child deaths. There is no legal basis for this approach and a neighbouring coroner area may have no such policy. This is confusing for doctors who travel and work in different parts of the country.
125. It is therefore a matter for Parliament in regulations to decide what types of death should be referred. Some other countries provide detailed criteria for reporting, for example in the New Zealand Coroners Act 2006 and the State of Victoria Coroners Act 2008 in Australia.
126. In England and Wales Parliament has envisaged that the Lord Chancellor could make regulations 'requiring a registered medical practitioner, in prescribed cases or circumstances, to notify a senior coroner of a death of which the practitioner is aware'.¹⁸ This task should be completed as a matter of urgency.
127. There are two possible routes for this. If the ME scheme is implemented, draft Death Certification Regulations are ready to be brought into force. Alternatively, free-standing regulations should provide the necessary criteria.
128. Once implemented, doctors should make referrals to coroners electronically, not orally as is often done at present, by email or other means, such as a web-based solution. The Chief Coroner is devising and consulting on a recommended standard reporting form.

Pathology Services

129. There is considerable concern amongst coroners about the dwindling availability of pathologists to carry out post-mortem examinations at the request of coroners.
130. Section 14 of the 2009 Act permits a coroner to request a post-mortem examination (autopsy), either before or during an investigation into a death which has been reported to the coroner. Each request is a judicial decision made at the discretion of the coroner.
131. The vast majority of these autopsies are carried out by histopathologists (coroners' pathologists).¹⁹ Most of them are employed by health trusts or boards to carry out other pathology work (often on the living). The work for coroners is not

¹⁷ There are 86 senior coroners in England and Wales.

¹⁸ Section 18 (not yet in force), 2009 Act.

¹⁹ In a smaller number of cases, autopsies are carried out by forensic pathologists who are accredited by the Home Office and employed in private practice.

usually conducted under their formal contracts or job plans, but independently. Their work for coroners often takes place outside their normal working hours. Arrangements vary widely.

132. In a relatively small number of cases, mostly suspected homicide cases, autopsies are carried out by forensic pathologists who are accredited by the Home Office and employed in private practice. Their fee is paid for by the police but they also act at the request of the coroner.

133. 87,000 autopsies were ordered and conducted in this way in 2015. Unfortunately, despite that significant number of autopsies, the number of histopathologists available to carry out this work for coroners is decreasing. As a result, local pathology services are stretched and coroners are forced to delay releasing the body to the family for burial or cremation. Coroners and medical examiners around the world release bodies within a timescale of approximately 24 hours. In England and Wales many coroners struggle to achieve a three day timescale. Longer than three days is not acceptable.

134. The provision of pathology services to coroners has recently been described by a senior pathologist as 'an already hard-pressed service on the edge of a complete meltdown'. In his Review of forensic pathology in England and Wales (March 2015)²⁰, Professor Peter Hutton described the immediate future of forensic and non-forensic pathology services as 'fragile, and corrective action needs to be taken now'. A recent survey of 463 consultant pathologists who conduct autopsies revealed that 26% intend to give up coroner autopsy work in the near future. Most of them cited 'poor remuneration' as the reason for doing so. The standard statutory fee for an autopsy, set by central Government but paid by local government, has remained static for about ten years at the modest level of £96.80 per body.

135. For these reasons many coroners in different parts of the country are struggling to obtain the regular services of pathologists, which in turn causes delay.

136. This problem arises because there is a complete lack of control and oversight over the provision of this service. Most pathologists who do this work have to make themselves available out of hours of their day jobs. This is not part of their hospital trust contracts or job plans but extra work carried on outside normal working hours. Anecdotally the Chief Coroner is told that in some cases NHS trusts actively discourage their pathologists from undertaking this outside work despite it being essential to the delivery of a vital public service. As a result local authority mortuaries may be open early in the morning for autopsies, but are empty in the afternoon (except for storage of bodies), expensively unused.

137. No government department wishes to take responsibility for this service. The

²⁰ <https://www.gov.uk/government/publications/review-of-forensic-pathology-in-england-and-wales>

Department of Health (DH) does not consider that it has responsibility for pathologists in this work. The Home Office will, at present, only take responsibility for forensic pathologists.

138. The Chief Coroner therefore believes that action is required in both the short term and the longer term. In the longer term he proposes that pathology services for coroners should be organised regionally. Some 12 to 15 regional centres of excellence should be created, providing mortuary, post-mortem examination and post-mortem imaging (CT scanning) facilities.
139. The Chief Coroner's proposal is that each centre would be funded through local authorities and the NHS both in England and Wales. Forensic pathologists and other pathologists would be employed by the NHS at these centres. A forensic pathologist would lead the team.²¹ The employment of pathologists by the NHS to carry out coroner work would recognise that death investigation, for the benefit of the living, should be part of the NHS's core business. In the short term this would cost money. In the longer term substantial savings would be made, including from the closure of small out of date local authority mortuaries which are expensive to maintain and even more expensive to replace.
140. Ideally, and in order to proceed swiftly, a regional centre would have an on-duty pathologist at all times. The centre would operate a triage system. The centre would receive the body into the mortuary and (i) the pathologist would make an external examination of the body followed by imaging. (ii) The coroners' officer would receive the report of the death from the GP or hospital doctor and carry out any relevant initial inquiries including speaking to the family, especially asking if they have any concerns about the circumstances of the death. (iii) The coroner would receive information from stages (i) and (ii), discuss the pathologist's preliminary findings with the pathologist and decide whether a post-mortem examination was necessary and what further action should be taken, if any, before releasing the body to the family.
141. Under this or a similar scheme pathologists would be expected to provide a report, either preliminary or full, to the coroner within three days of the examination or earlier where possible. Training for all pathologists could be re-ordered and rationalised. The autopsy module provided by the Royal College of Pathologists would no longer be optional. It should become mandatory for all trainee pathologists, as it was before. Under the Chief Coroner's proposal further training for all pathologists should be provided by NHS England and Wales with additional skills training from the Home Office. All pathologists would have to be on a specialist register of pathologists (with level of expertise identified).

142. The Chief Coroner suggests that regional centres could in the first instance be

²¹ See Chief Coroner's *A Proposal for Coroner Pathology Services* (22 February 2016).

a mixture of units developed by local authorities (and independent of NHS trusts) or units based on premises of NHS England or Wales. Ideally they would be a combined NHS and local authority resource, funded by both. Small local authority mortuaries which are out-dated would in time be closed. At present there are too many smaller mortuaries.

143. Short-term solutions are more difficult. In the absence of Government action, the Chief Coroner encourages coroners and their local authorities to nurture and support existing arrangements as best they can. But that will not be enough. In the short to medium-term at least, imaging facilities are likely to develop through the private sector, and, as is current practice, although not desirable, at a cost to the families (within the range of £400-£1,000). In due course the NHS should provide post-mortem imaging for all cases. In many cases imaging will be able to replace more invasive post-mortems.
144. In the short term the NHS could make autopsy work by pathologists part of the working contract (job plan) and not, as at present, allow pathologists to work out of contract hours for separate fees. Learning lessons from death should once more become an integrated part of learning about life.
145. As a result of the shortage of coroners' pathologists many coroners are facing delays in releasing bodies and in taking cases to inquests. Although pathologists' reports should sensibly be provided to the coroner within three to four weeks, the dwindling number of pathologists prevents that happening. Delays are now built into the system. There needs to be change.

Deprivation of Liberty Safeguards

146. As the Chief Coroner has reported previously²², one of the unanticipated and unwanted consequences of statute and case law combined²³ is that anybody who dies while subject to a Deprivation of Liberty Safeguards (DoLS) authorisation, with their liberty restricted in a care home or hospital, dies 'in custody or otherwise in state detention' for the purposes of the 2009 Act and therefore an inquest must be held even though the death is clearly from natural causes.²⁴
147. As a consequence the caseload of all coroners has substantially increased for no good purpose. There were 7,183 DoLS cases in 2015. They have all had to be processed and taken to inquest. Bereaved families have been caused considerable distress. Why,

²² Chief Coroner's response to the Law Commission Consultation on Mental Capacity and Deprivation of Liberty

²³ Mental Capacity Act 2005 as amended by the Mental Health Act 2007; and *HL v UK* (2004) 40 EHRR 761; *P v Cheshire West and Cheshire Council*; *P and Q v Surrey County Council* [2014] UKSC 19

²⁴ See Chief Coroner's Guidance No.16 *Deprivation of Liberty Safeguards* (DoLS).

they ask, should their elderly relative, who suffered from dementia and has died a natural death, suffer the indignity of the coroner process? There has been unnecessary work for coroners and additional cost for local authorities.

148. Coroners have nevertheless had to proceed under the law, but with sensitivity and compassion in all the circumstances. To their credit coroners have risen to the challenge. They accept that if the need for investigation is the consequence of the law they are the right persons to carry out that task. They have adopted procedures to match the need for speedy resolution. At the Chief Coroner's suggestion coroners have in the main complied with a five point initiative: they have checked with the local authority that a DoLS authorisation is in place, obtained a medical report from the doctor that the death is from natural causes, obtained a brief report from the care home or hospital about the circumstances of death, checked with the family that they have no concerns about the circumstances of the death, and proceeded to a paper inquest within a week.
149. The Chief Coroner has therefore proposed that section 1 of the 2009 Act should be amended to remove such cases from the category of 'in state detention'. For the draft amendment see paragraph 173 below.
150. The Law Commission's provisional recommendation in its interim statement²⁵ is that those who die while subject to a DoLS authorisation should be scrutinised by Medical Examiners and not subject to coroner investigation per se unless there is a specific reason for referral to the coroner. While the Chief Coroner recognises that this is a valid approach and would be an undoubted improvement upon the present position, the Chief Coroner believes that action is required immediately. Hence his proposal.
151. The Chief Coroner is especially grateful to the Law Commissioner, Nicholas Paines QC, for visiting coroner training events on several occasions, in order to explain the Law Commission's thinking and engage in stimulating discussion with coroners.

Medical Examiners

152. Despite the undoubted benefits of the introduction of the Medical Examiner (ME) system, which are to be welcomed (see paragraphs 70-83 above), the Chief Coroner has some concerns about the consequences to the coroner service of implementation. He expressed these concerns in his response of 15 June 2016 to the Department of Health consultation exercise.

153. Primarily, the Chief Coroner is concerned about the likely increase in the
- 25 Law Commission, *Mental Capacity and Deprivation of Liberty Interim Statement* 25 May 2016.

workload of coroners without additional resources. It is generally believed that the involvement of MEs will produce a significant increase in the number of cases referred to the coroner. These are cases which will proceed to inquest and are likely to be the more difficult and complex medical cases.

154. How great the increase in inquests will be is undoubtedly uncertain. None of the pilot schemes have been complete. The Sheffield pilot, for example, which has been the most developed scheme, has not dealt with community deaths.
155. Nevertheless, the figures from Sheffield are troubling. Since its pilot began, Sheffield has faced an increase in inquest work of some 35%. This is a very significant increase in caseload. Some coroner areas in England and Wales could not readily bear the burden of an increase of that magnitude. Even a smaller increase of 25% in inquests would impose an intolerable burden for many areas²⁶.
156. Many coroner areas have been neglected for years if not decades in the provision of resources. They have a very modest number of coroners' officers to investigate and prepare cases for the coroner and very few administrative staff to support them. Local authorities are currently seeking to reduce their spending substantially, as too are police authorities who employ most coroners' officers.
157. An increase in inquest work of this proportion would not be funded by central Government and there could be insufficient funding from local Government.
158. From the Chief Coroner's point of view, coroners and their staff must be protected from extra and intolerable burdens of work. The Department of Health (DH) does not appear to recognise the existence of these impending burdens and how they will be resourced. It would be wrong to ignore this. There is no point in developing one part of a death investigation service to the detriment of another part. That will not achieve success.
159. In addition there will be other costs which may impact upon the coroner service. MEs or their officers may have to find accommodation in coroners' offices, some of which are extremely limited in terms of space.
160. These concerns are in addition to some basic concerns about payment for the ME scheme. Who will pay for the service? How much will they pay? Who will collect payment? What will happen in the event of default of payment?

²⁶ The Francis Inquiry found that an audit of practice in the Mid-Staffordshire NHS Trust concluded that 27% of deaths that were certified as due to natural causes should have been referred to the coroner but were not. <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffpublicinquiry.com/report>

161. It seems clear that bereaved families will be burdened with this payment even if they have not obviously benefited from the scheme. The suggested DH figure of £80-£100 is not considered to be sufficient. Local authorities who have spoken to the Chief Coroner have struggled to arrive at a projected minimum figure of £150. Funeral directors seem reluctant to collect payment off bereaved families in mourning. In default of payment local authorities will probably have to foot the bill.
162. Other concerns centre around the independence and quality of MEs. Will they be, and be seen to be, sufficiently independent of those they are scrutinising?²⁷ If they are (or were) hospital doctors, will they be sufficiently independent of their present and former colleagues and of the hospital trusts in England and health boards in Wales? It is fundamental to the essence of the ME scheme that they must be independent in their appointment and in the execution of their functions.
163. Will they be of sufficient quality? Are there enough doctors or recently retired doctors at consultant level to provide this service?²⁸ Will they be sufficiently accredited in this specialist field?
164. Finally, the Chief Coroner raises the issue of possible delays. Increased coroner workloads without extra resources may lead to delays, both in releasing bodies and in concluding inquests. The ME service could also add delay by introducing an extra layer of investigation. And if MEs are part-time appointments will they be sufficiently available for early release of the body for burial or cremation? This issue is particularly acute for faith communities who seek very early burial. Will MEs be available to make relevant decisions out of hours, at weekends and on bank holidays?
165. These are not trivial issues. A public service of death investigation which is not understood and valued by the public, particularly those required to pay, and where a lack of planned resources could lead to delays in releasing bodies and completing inquests, will not flourish. If local authorities have to face increased costs, coroners' services may well suffer as a result. The Chief Coroner suggests that there must be clear resolution of these issues before full implementation of the ME scheme.
166. The Chief Coroner has therefore proposed in his response to the consultation exercise one possible way forward for the time being: to introduce in advance of full implementation further pilot schemes which are fully operational. At present none of the pilot schemes covers all deaths in the community. None of the pilots operates on a payment and collection of fee basis. The financial side has simply not been tested. One possible way forward, it is therefore suggested, would be to develop three fully-fledged pilots in three different types of area: urban, rural and mixed.

²⁷ Francis Report, Recommendation 275

²⁸ Francis Report, Recommendation 276

Salaries and fees of coroners

167. The Chief Coroner has no statutory responsibility for the payment or level of payment to coroners. But he considers that in order to promote greater consistency and transparency there should be a fresh approach to the payment of salaries and fees to coroners. 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.
168. In effect this means that each coroner and each relevant local authority may agree between them any level of remuneration as they choose without reference to any national scale or standard and without comparison with any other coroner in the past. This has generated wide variations, both of salaries paid to senior coroners and fees paid to assistant coroners, and in the method and arrangements for payment.
169. In the absence of a national statutory or voluntary scheme, local authorities may agree with a coroner any salary or fee as they see fit. That is the Local Government Association's stated position. There is, however, no up-to-date guidance and an obvious lack of consistency in the current position. 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.
170. In last year's report the Chief Coroner referred to these anomalies in some detail. As a result, he proposed to the Lord Chancellor in July 2015 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. Unfortunately the Chief Coroner has received no formal final reply to this proposal. The Lord Chancellor has requested the Chief Coroner in the interim not to publish a recommended scale of salaries and fees. Neither an SSRB (or similar) recommended scale nor, in the alternative, a scale from the Chief Coroner would be binding on local authorities. But one or the other would be recommended with a view to promoting consistency and transparency.
171. This issue needs urgent attention. The absence of any national guidance continues to cause local authorities a degree of frustration when making new appointments.

Recommended law changes

172. The Chief Coroner recommends that consideration should be given to the following changes in the law. The following recommendations were also proposed in last year's annual report: items (2), (3), (6) and (7).

(1) Deprivation of Liberty Safeguards cases (DoLS)

173. DoLS cases should be removed from coroner jurisdiction (see paragraphs 146-151 above). This requires an insertion amendment to section 1 of the 2009 Act:

1...

(2A) For the purposes of this Act a person who dies while subject to an authorisation granted under Schedule A1 to the Mental Capacity Act 2005 depriving that person of his or her liberty and detaining him or her in a hospital or care home does not die while in custody or otherwise in state detention

(2) Mergers of coroner areas

174. Under the law at present, two coroner areas may not be merged into one area if that area will consist in total of less than the area of a local authority: paragraph 1(2) of Schedule 2 to the 2009 Act.

175. This has caused difficulties. For example, Kent consists of four separate coroner areas. Kent County Council, with the approval of the Chief Coroner, wants all four areas to be combined into one coroner area, coterminous with the area of Kent County Council and the Kent Police authority. Kent would have liked to achieve this piecemeal, merging one area with another as and when a senior coroner from one of the coroner areas retires. But that is not possible under Schedule 2 of the 2009 Act in its present form. Hampshire County Council is in a similar position.

176. This provision therefore needs revision in order to provide greater flexibility. Whether the present position was intentional or not is not clear. It may have been an oversight in the statutory drafting.

177. It is therefore proposed that Schedule 2 be amended to permit two coroner areas to combine, by order of the Lord Chancellor, into one coroner area which consists of the area of a local authority or part of the area of the local authority, with

the following proposed amendment to paragraph 1(2) of Schedule 2 to the Coroners and Justice Act 2009:

1 ...

(2) Each coroner area is to consist of the area or part of the area of a local authority or the combined areas or parts of the area of two or more local authorities.

(3) Discontinuance without a post-mortem examination

178. Section 4 of the 2009 Act provides for discontinuance of a coroner investigation, but only where the cause of death is revealed by a post-mortem examination. This is a new provision, not previously available to coroners.

179. In practice it permits a coroner who has commenced an investigation into a death²⁹ to bring the investigation to an end without having to hold an inquest. But the coroner may do so only if the cause of death has been revealed by a post-mortem examination. In all other circumstances, once an investigation has been commenced, the coroner has no power to discontinue the investigation; there must be an inquest.³⁰

180. This means that even if the coroner discovers the cause of death by any means other than by a post-mortem examination, for example from medical records not previously available, the coroner must proceed to inquest even though the outcome will be a foregone conclusion. This is an unnecessarily time consuming and costly exercise, and one which may cause unnecessary distress to the bereaved family from the investigation not being brought to an end earlier.

181. The simple remedy is to amend section 4 of the 2009 Act so as not to limit discontinuance to circumstances where a post-mortem examination has been carried out and reveals the cause of death, namely by an amendment to section 4 of the 2009 Act as follows:

4 Discontinuance where cause of death revealed by post-mortem examination or other inquiry

(1) A senior coroner who is responsible for conducting an investigation under this Part into a person's death must discontinue the investigation if -

²⁹ Under section 1 of the 2009 Act

³⁰ Section 6, 2009 Act.

(a) an examination under section 14 or other inquiry reveals the cause of death before the coroner has begun holding an inquest into the death, and

(b) the coroner thinks that it is not necessary to continue the investigation.

(2) ...

(3) ...

(4) ...

(4) Inquests without a hearing

182. There is no need for all inquests to be concluded with a hearing. In a case where the facts are not contentious, no witnesses are required to attend, the outcome is clear (at least on a balance of probabilities), the family do not want an inquest and there is no other public interest for conducting an inquest in a public hearing, the case could be concluded by a decision 'on the papers' with a written ruling.

183. A written ruling would have the advantage of a clear (and brief) decision with reasons, based upon the circumstances of the death, with findings of fact and a conclusion (short-form or narrative). This ruling could be handed down in open court and provided to the family for them to keep.

184. The ruling would be more focused than an *ex tempore* decision and more permanent. In some cases it need be no more than the completed Record of Inquest. In others, one or two pages will usually suffice. There would be no need for an inquest, thereby saving court time, coroner time and the time of others. Families would not need to attend court.

185. Rulings of this kind are common in Australia (and other countries) and work well. Families appreciate the process and welcome receiving a copy of the ruling. Across the courts estate in England and Wales, electronic developments are leading to fewer hearings in court. It is inevitable that in due course, in straightforward cases, inquests will be concluded without the need for a hearing.

186. In cases where the inquest must be held with a hearing or where there is a clear public interest in holding an inquest with a hearing, a hearing will be held.

187. In most cases where there is no hearing, the public nature of the coroner's investigation and conclusion can be recognised by publication of the ruling, sometimes

in a redacted form, or publication of the Record of Inquest (which is a public document³¹).

188. The Chief Coroner therefore proposes the following amendment to the 2009 Act by addition of new section 6A:

6A Inquest without a hearing

(1) An inquest into a death must be conducted with a hearing, unless subsection (2) applies.

(2) An inquest into a death shall be held without a hearing, if the senior coroner is of the opinion that -

(a) the details required for the Record of Inquest are complete and not disputed,

(b) no interested person reasonably requires a hearing, and

(c) there is no public interest which requires a hearing.

(5) RIPA and IPA

189. The Chief Coroner had proposed amendments to the Investigatory Powers Bill (IPB), so as to permit a small group of senior coroners and retired judges under 75 who are nominated to conduct an inquest under paragraph 3 of Schedule 10 to the 2009 Act to see intercept material. Under the present law only sitting judges of the rank of Circuit judge or above may view such material.

190. Part of this objective has now been achieved. Following consultation with the Home Office and others, the IPB, which is currently before Parliament with a view to replacing the Regulation of Investigatory Powers Act 2000, has been amended to permit retired judges (although not the group of coroners) so nominated to view intercept material.³²

(6) Fresh inquests

191. The Chief Coroner has previously recommended, and the previous Government agreed in principle³³, that there should be a change in the law by way of amendment

³¹ See Chief Coroner's Guidance No.17 *Conclusions: Short-Form and Narrative*, at paragraph 12.

³² Paragraph 24(1), Schedule 3 to the Investigatory Powers Bill.

³³ By the then Lord Chancellor, the Rt. Hon. Chris Grayling MP, in December 2013.

to section 13 of the Coroners Act 1988 (as amended) in order to give the High Court greater flexibility when it quashes an inquest.

192. 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.

193. At present the High Court's powers are limited to quashing the inquest and ordering a fresh inquest, as for example in the Hillsborough inquests (the Chief Coroner sat on the Hillsborough cases with the then Lord Chief Justice, Lord Judge, and Mr Justice Burnett, as he then was). But some section 13 cases would be sufficiently concluded without ordering a fresh inquest. For example, in some cases it would be necessary only to amend the record of the inquest. 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 advances in 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. That involves extra time and expense, and above all may cause extra distress to the family.

194. Section 13 applications are still relatively common. Despite the recent repeal of many sections of the 1988 Act, Parliament decided to retain the section 13 provision, a power which has been in existence since 1887. In the Chief Coroner's view it continues to be a useful provision. However, in the Chief Coroner's experience of such cases, sitting in the Divisional Court on applications, the powers of the High Court seem to be unduly restricted in the way described.

195. In many cases there will undoubtedly need to be a fresh inquest and the final decision will rightly be left to be made at that inquest and not by the High Court, as for example in the Hillsborough case. But in other cases there will be no such need.

196. Under the proposed amendment to section 13, the High Court would not automatically be required to order a fresh inquest. The proposed amendment is as follows:

13A Where by virtue of the discovery of new facts or evidence or otherwise the High Court is satisfied that it is neither necessary nor desirable in the interests of justice that a fresh investigation or inquest should be held into the death, the High Court may direct that the particulars of the Record of the Inquest (Form 2, Schedule, Coroners (Inquests) Rules 2013) be amended as appropriate.

(7) Deaths at sea (body not recovered)

197. The Chief Coroner also recommends 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) of the 2009 Act. 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 therefore no inquest).
198. 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'.
199. 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, a retired man regularly set out to sea to fish alone on his boat. One day the boat was found with the engine on, drifting several miles out, with no sign of the man. 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.
200. Section 1(4)(a) could therefore 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', as follows:

1 ...

(4) A senior coroner who has reason to believe that—

(a) a death has occurred in or near the coroner's area or with a close connection to the coroner's area,

(8) Representation for families

201. In a small number of inquests the family of the deceased is unable to obtain legal aid funding for representation at the inquest, despite individuals or agencies of

the state being funded for legal representation as 'interested persons'.³⁴ In some cases one or more agencies of the state such as the police, the prison service and ambulance service, may be separately represented. Individual agents of the state such as police officers or prison officers may also be separately represented in the same case. While all of these individuals and agencies may be legally represented with funding from the state, the state may provide no funding for representation for the family.

202. Many less complex or contentious inquests are conducted entirely satisfactorily in the absence of legal representation for interested persons, including some cases involving the state. But in some cases the inequality of arms may be unfair or may appear to be unfair to the family. It may also mean that the coroner has to give special assistance to the family which may itself give the appearance of being unfair to others.

203. The Chief Coroner therefore recommends that the Lord Chancellor gives consideration to amending his Exceptional Funding Guidance (Inquests)³⁵ so as to provide exceptional funding for legal representation for the family where the state has agreed to provide separate representation for one or more interested persons.

Statutory powers and duties

204. The following is a summary of the Chief Coroner's powers and duties under the 2009 Act and the 2013 Coroners Rules and Regulations and the action taken by the Chief Coroner since 1 July 2015.

205. 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 1 July 2015 there have been 66 applications and the Chief Coroner has granted 63 of them.

206. 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 1,533 notifications.

³⁴ For meaning of interested person, see section 47 of the 2009 Act.

³⁵ Published August 2015.

207. The Chief Coroner also has a discretionary power to direct a coroner to conduct an investigation into a person's death even though, apart from the direction, a different coroner would be under a duty to conduct it (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 three times in the last year.
208. 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.
209. 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.
210. The Chief Coroner may designate suitable practitioners to make post-mortem examinations (section 14). The Chief Coroner has not exercised this power.
211. The Chief Coroner must keep a register of notifications by senior coroners of investigations lasting more than a year (section 16). That register was first 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.
212. The Chief Coroner must monitor and train coroners for investigations into deaths of service personnel (section 17). For details see paragraphs 84-88 above.
213. No appointment of a coroner may be made by a local authority without the consent of the Chief Coroner (and the Lord Chancellor) (section 23, Schedule 3). The Chief Coroner has given his consent to the appointment in the last year of 4 senior coroners, 5 area coroners and 57 assistant coroners: see paragraphs 49-56 above.
214. The Chief Coroner has responsibility to train coroners and coroners' officers (section 37): see paragraphs 57-64 above.
215. The Chief Coroner may carry out an investigation into a person's death (section 41, Schedule 10). No investigation has been conducted by the Chief Coroner this year.
216. The Chief Coroner may request the Lord Chief Justice to nominate a judge or a former judge to conduct an investigation (section 41, Schedule 10). The Chief Coroner

may also request a former coroner to conduct an investigation (section 41, Schedule 10). He has made one request to the Lord Chief Justice this year which was granted.

217. Senior coroners who report to prevent future deaths under paragraph 7 of Schedule 5 to the 2009 Act and Regulation 28 of the Coroners (Investigations) Regulations 2013 (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 all published, with redactions where necessary, on the judiciary website. Subject alerts have now been created for those who wish to subscribe.
218. 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. The Chief Coroner has exercised this power twice in the last year.
219. 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.
220. 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

221. This is the third annual report of the Chief Coroner to the Lord Chancellor. In the opinion of the Chief Coroner significant progress has been made across England and Wales in this period. The statutory reforms and the first Chief Coroner's reforms have been effective and positive and in the public interest. The Chief Coroner is confident that coroners will continue to embrace these changes. He believes that new national standards are now in place with a greater consistency of approach.
222. While there is still much to be done, the Chief Coroner is confident that the landscape of the coroner service has changed for the better, both for the benefit of bereaved families and for the wider public. In the words of one senior judge: 'The coroner service has been transformed.'
223. Judge Thornton steps down as Chief Coroner at the end of September 2016.

He is grateful to have had the opportunity to lead the coroner service. It has been an honour. Working with coroners has been a pleasure and a privilege. He has no doubt that his successor, who will be appointed to commence in post from 1 October 2016, will continue to develop and promote reform, through training, guidance, advice, encouragement and support. Judge Thornton wishes his successor and the coroner service well.

HH Judge Peter Thornton QC
Chief Coroner
June 2016



CHIEF CORONER'S DEVELOPMENT PLAN 2015-2016

This Business Plan for 2015-2016 reflects the work of the Chief Coroner in implementing and developing the statutory reforms of the Coroners and Justice Act 2009 and the 2013 Coroners Rules and Regulations. Much of the work has been commenced and is ongoing; some of it will continue after 2016. But the purpose of this Plan is to identify the differing and evolving aspects of coroner reform and the advancement of a modern coroner system which serves the public efficiently, effectively and compassionately.

No.	TOPIC	ACTION	TIMESCALE	COMMENTS
1	MERGERS	With Lord Chancellor (LC) reduce 99 coroner areas to approximately 75	Reduced to 92 (as of June 2016); ongoing	Purpose: to produce more effective, efficient size of coroner area with full-time senior coroner; regular discussion with Ministry of Justice (MoJ) and local authorities (LAs)
2	APPOINTMENTS	New procedures for appointments of all coroners (open competition, consent by Chief Coroner and LC).	Completed; Guidance No.6 amended Jan 2016	Senior appeal Judge swears in new senior coroners at RCJ with Chief Coroner; medical coroners assisted with General Medical Council revalidation (March 2015)

A. STRUCTURES

3	CORONER TEAMS	Advice to senior coroners	First delivered Feb 2014, ongoing	Needs organisation at local level
4	TRIANGLE OF RESPONSIBILITY	Advice to senior coroners, local authorities and police	Completed 2014, ongoing	
5	ROLE OF SENIOR CORONERS	Identified by Chief Coroner with advice to senior coroners	Completed Feb 2014, ongoing	
6	SALARIES AND FEES	Survey levels of salaries/fees of coroners; consider national scheme	Survey completed Feb 2015; proposal to LC July 2015 (awaiting final reply); scheme under discussion	Future scheme including reference to Senior Salaries Review Body is being considered by LC; ongoing discussion with Coroners' Society (CSEW), MoJ, Local Government Association
7	CORONERS' OFFICERS (1)	Identify functions and duties	Drafted 2014, in consultation	In discussion with CC's draft <i>Model Coroner Area</i>
8	CORONERS' OFFICERS (2)	Survey of numbers for coroner areas	Completed Feb 2015: CC makes requests	Purpose: to increase numbers in under-staffed areas
9	MEDICAL EXAMINERS	Discuss consequences of implementation with coroners, acting National Medical Examiner, pilot schemes, Government, LAs	Ongoing discussion since 2013; implementation by Government scheduled for 2018	CC's response to DH consultation paper: 15 June 2016; further observations in 3 rd Annual Report

B. INVESTIGATION

10	REPORTING DEATHS	Review criteria for which kind of deaths, and in what circumstances, deaths should be reported to the coroner.	Considered, discussed	Statutory list of criteria proposed in CC's 3 rd Annual Report
11	TRANSFERS	Receive notice of transfers; to consider exceptional use of section 3 powers	Ongoing	For details see Annual Reports
12	'NATURAL CAUSES'	Definition: review law and practice	Discussion commenced at Chief Coroner's Conference for Senior	

			Coroners Feb 2015; ongoing	
13	PRELIMINARY INVESTIGATIONS	Section 1(7) of Coroners and Justice Act 2009 in force; monitor use by coroners	Ongoing	Awaiting Government review of coroner service following 2015 consultation
14	STILLBIRTHS	To consider whether stillbirths/near term deaths should be reportable cases	Discussion commenced	Likely to require Parliament to legislate eg in statutory criteria for reporting deaths (see above)
15	CHILD DEATHS	One-day training for coroners	14 Sept 2016	Chief Coroner attended Child Death Overview Panels' Conference; discussion with Local Safeguarding Children Boards; meets with charities; involved in revision of Kennedy Guidelines
16	DEATHS IN PRISON	One-day training for coroners	13 May 2015	Chief Coroner attends Ministerial Board on Deaths in Custody and meetings with PPO, Chief Inspector of Prisons etc
17	POST-MORTEM EXAMINATIONS (P-Ms) (1)	Encourage coroners to avoid invasive P-Ms by reference to wider information; develop use of alternatives such as post-mortem imaging	Commenced; continuing	See Chief Coroner's Guidance No. 1 on Post-Mortem Imaging (Adults); reducing P-M rates (see MoJ statistics)
18	POST-MORTEM EXAMINATIONS (2)	Advice on P-Ms for deaths in prison; monitor	Advice produced 2014; ongoing monitoring	
19	POST-MORTEM EXAMINATIONS (3)	2 nd P-Ms in homicide cases	Proposal drafted April 2015, in consultation; round table discussion July 2016	Purpose: to reduce numbers of 2 nd P-Ms in cases of suspected homicide
20	PATHOLOGISTS	Draft standard instructions for pathologists	By March 2016	Draft CC Guidance on coroners and hospital trusts in discussion
21	TOXICOLOGY	Draft scheme for standardised coroner/provider arrangements	Drafted March 2015, continuing consultation	
22	DISPOSAL OF ORGANS, TISSUE	Advice to coroners; monitor and	Advice provided 2013;	

	ETC	discuss	continuing monitoring and discussion with HTA	
23	FUNERAL DIRECTORS	Draft scheme for standardised coroner/funeral director arrangements	By Nov 2015; issued 8 Dec 2015	
24	OUT OF HOURS SERVICES	Consider extending scope of service	Discussion commenced; pan-London scheme proposed 2014; police and LAS agree in principle at meeting convened by Minister of Justice to London service Dec 2014, detail being considered 2015	Law and resources limited; developing interest across E & W; 'light touch approach requires on call coroners' officers and open registrar's office
25	SECTION 1(4) REPORTS: INVESTIGATIONS WITHOUT A BODY	Guidance for senior coroners; draft template for use; monitor	Completed April 2015; updated Jan 2016; monitor ongoing (working well)	167 reports received, 148 directions made by Chief Coroner (July 2013-June 2016); law change on bodies lost at sea proposed (see below)
26	DISCONTINUANCE	Monitor use; consider amendment to section 4 of Coroners and Justice Act 2009 where no P-M	Continuing	Amendment proposed: see 3 rd Annual Report
27	SPECIAL CASES	Advice: Duty to Notify Chief Coroner in special cases, including mass fatality, military deaths, viral haemorrhagic fevers (eg Ebola), Regulation of Investigatory Powers Act 2000 etc	Issued Dec 2014, monitoring (working well)	Now used widely eg for MH17 (Ukraine) and Germanwings (France) air disasters and Sousse, Tunisia, killings, with special arrangements devised by Chief Coroner with coroners, police and Foreign and Commonwealth Office (FCO)
28	DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)	Guidance; discussion with coroners, Law Commission, LAS	Guidance No. 16 Dec 2014, updated Jan 2016; ongoing discussion	Substantial additional workload for coroners; special difficulties discussed, Chief Coroner advises; CC response to Law

				Commission June 2016 and 3 rd Annual Report both propose removal from coroner jurisdiction
29	DEATHS ABROAD	Review procedures, draft scheme and guidance	By April 2016; not yet finalised, except CC advice on executions abroad July 2015	Chief Coroner has discussed with FCO, coroners and charities
30	MASS FATALITIES	Scheme for coroners and role of Chief Coroner; regular discussion with Government	Scheme completed July 2014; training conference 10 May 2016; discussion, training ongoing	CC's <i>Mass Fatality Checklist</i> June 2016; CC attends police training events
31	ASPHYXIA RESTRAINT DEATHS	Monitor deaths in police/prison/other custody; provide advice where necessary	Ongoing	Evidence by CC to Dame Elish Angiolini's inquiry into deaths in police custody
32	TASER DEATHS	Monitor and provide coroners with information	Assistance provided; ongoing	
33	APPOINTMENT OF JUDGE CORONERS	Draft scheme for nomination process	By August 2015; completed Sept 2015	Chief Coroner also provides advice to judge coroners on process and arrangements with LAS
34	LEGAL AID	Encourage Government to provide through Legal Aid Agency for families in appropriate cases	Completed: generally and on some individual cases; letter to Minister sent	LC reconsidered his guidance in light of High Court decision in <i>Letts</i>
35	BEREAVED FAMILIES	Meet with families, organisations; discuss issues, concerns	Ongoing	NB Chief Coroner cannot overturn judicial decisions of coroners

C. INQUESTS

36	SETTING DATES	Encouragement to set dates for all hearings as early as possible	Completed; ongoing monitoring and encouragement	
37	DISCLOSURE	To produce Guidance	By August 2016; incomplete	

38	ARTICLE 2 INQUESTS	To produce Guidance	By August 2015; still in draft form (awaiting decision in <i>Tyrell</i>)	
39	EXPERT EVIDENCE	Review; devise scheme for use of, instructions for, and receipt of expert evidence	12-18 months; delegated to coroners for first draft (awaiting)	
40	PRE-INQUEST REVIEW HEARINGS	To produce Guidance	By end of 2015; completed Jan 2016	
41	INQUESTS WITHOUT HEARINGS	To consider whether (i) appropriate and (ii) law change required	By June 2016; proposal in 3 rd Annual Report July 2016	Written judgment without a hearing where (a) facts are uncontroversial, (b) there is no special public interest, and (c) family agree
42	TIMELINESS	Monitor cases of over 12 months; reduce backlogs	Annual figures from coroners commenced 2014, second return due May 2015; continuing with advice and training	In 3 years, number of cases over 12 months has reduced by 52%; nearly half of areas have less than 10 cases outstanding
43	USE OF FINDINGS IN FAMILY COURT PROCEEDINGS	Guidance; monitoring	Guidance No.13 April 2014 (working well); discussion with senior family law judges April 2015	
44	CONCLUSIONS	Guidance; training for all coroners	Guidance No.17 Jan 2015, updated Jan 2016; continuation training for all coroners 2015-2016	
45	RECORD OF INQUEST	Guidance on completion of Form 2 and public nature of document	Completed in Guidance No. 17 above; part of training 2015-2016	Considering proposal to publish Records of Inquest
46	JURY INQUESTS	Draft directions for coroners	Completed April 2015	In new Bench Book (see below)
47	MEDIA	Guidance	2016; not yet finalised	
48	RETENTION OF RECORDS	Direction to retain longer than 15 years	2 cases 2015-2016	

D. REPORTS TO PREVENT FUTURE DEATHS

49	CORONERS' REPORTS	(1) Encourage more reports (2) monitor reports (3) publish reports on judiciary website (4) Chief Coroner to follow-up certain reports (5) set up alerts for monitoring agencies	All completed 2014-2016	All PFD reports are published on the judiciary website (subject to occasional redaction), with email alerts
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E. HIGH COURT

50	APPLICATIONS FOR FRESH INQUEST (1)	Chief Coroner sits in High Court on most section 13 Coroners Act 1988 cases		
51	APPLICATIONS FOR FRESH INQUEST (2)	Further amend section 13 of Coroners Act 1988 so that High Court has discretion in uncontentious cases to amend Record of Inquest and not require further inquest	Proposal for amendment made: 2 nd and 3 rd Annual reports	MoJ has agreed in principle to change Dec 2013 but 'no Parliamentary time yet available'
52	JUDICIAL REVIEW	Chief Coroner is notified of all JR applications and sits in High Court on many hearings		

F. CHANGES IN THE LAW

53	POSSIBLE CHANGES	<p>Consider and recommend changes, including</p> <ul style="list-style-type: none"> merger of coroner areas into part of LA area section 4 discontinuance without P-M section 13 applications 	Discussion and consideration ongoing – dependent on Parliamentary time	Proposals of some changes in 2 nd and 3 rd Annual Reports
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		<ul style="list-style-type: none"> • stillbirths • bodies lost at sea • suicide standard of proof • revocation of assistant coroner appointments • registration of deaths of British nationals who die abroad. 		
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G. TREASURE

54	TREASURE	Rationalise treasure work, create step by step process and standard forms	Complete by October 2015; completed November 2015	Without implementation of Chapter 4 of Coroners and Justice Act 2009 existing procedures continue: new <i>Practical Guide for Coroners</i> with standard letters
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H. TRAINING

55	CHIEF CORONER'S TRAINING COMMITTEE	Regular meetings with Judicial College (JC) and course directors. Chief Coroner is lead course director for all coroner training	CC held committee 3 meetings between July 2015 and June 2016; ongoing	Chief Coroner also attends JC Courts Committee
56	COURSE DIRECTORS	Appoint through JC	Completed; ongoing for fresh appointments	2 retirements April 2016; 5 new appointments April 2016
57	SYNDICATE LEADERS	Appoint through JC	Completed; ongoing for fresh appointments	1 new appointment April 2016
58	INDUCTION TRAINING	Devise, produce, deliver (with JC) for newly appointed coroners	New course completed, delivered; two courses pa continuing	Last course March 2016; next course Sept 2016
59	CONTINUATION TRAINING	Devise, produce, deliver (with	First year's course	New course each year

		JC) for all coroners	completed; second year course on conclusions and DoLS ready for delivery from June 2015; 2016-2017 course will focus on mental health	
60	CORONERS' OFFICERS TRAINING	Devise, produce, deliver regionally (with JC) for all coroners' officers	Created 2014-2015; delivery commenced April 2015	New course each year
61	SPECIAL ONE-DAY TRAINING	Devise, produce, deliver	Military cadre 2013; Deaths in prison May 2015; Child deaths Sept 2016; plus one day medical courses, mass fatality training May 2016	Other courses being discussed with course directors and JC
62	CHIEF CORONERS' CONFERENCES FOR SENIOR CORONERS	Devise, produce, deliver	Leadership, management and organisation Feb 2014; natural causes, DoLS etc Feb 2015; media issues Feb 2016	Continuing on annual basis; opportunity for senior coroners to meet and discuss coroner issues; area coroners to attend from Feb 2016
63	CHIEF CORONER'S SPECIAL TRAINING DAYS	Devise, produce, deliver	Bereavement organisations June 2014; LAs Dec 2014, July 2016	Further days to be considered
64	CHIEF CORONER'S INTERNATIONAL CONFERENCE	Devise, produce, deliver conference for overseas Chief Coroners (or equivalent)	3 day event in London May 2016	Follow-up email group
I. GUIDANCE ETC				
65	CHIEF CORONER'S GUIDANCE	Produce, circulate to all coroners, publish on judicial intranet and judiciary website	Guidance Nos.1-22 completed and published, with updates in Jan 2016	Further possible Guidance to include an introduction to Article 2, dealing with the media, deaths overseas, hospital trusts and coroners, disclosure etc

						Email alert scheme to be implemented
66	CHIEF CORONER'S LAW SHEETS	Produce, circulate to all coroners, publish on judicial intranet and judiciary website	Law Sheets Nos. 1-5 completed and published, updated Jan 2016	Further Law Sheets to be considered		
67	CHIEF CORONER'S ADVICE	Produce, circulate to all coroners, publish on judicial intranet	Various completed; ongoing			
68	WELFARE ADVICE	Access to judges helpline	By July 2015; completed 29 July 2015			
69	JOINT GUIDANCE	Produce, circulate to all coroners, publish on judicial intranet and judiciary website	Joint Guidance with British Heart Foundation etc completed	Further Joint Guidance with Health and Safety Executive in development		
70	NEW CORONER'S BENCH BOOK	Produce in sections, publish on judicial intranet	Section on jury inquests completed April 2015; further sections to follow	Written and produced by Chief Coroner with two coroners		
71	CHIEF CORONER'S NEWSLETTER	Occasional publication for coroners, with news, events, dates, announcements, discussion	First edition published on judicial intranet February 2015	Further editions in due course		

J. SPEECHES, MEETINGS, VISITS

72	SPEECHES, TALKS, MEETINGS, VISITS	To coroners, coroners' officers, organisations, agencies, police, LAs, charities, faith groups, judges, lawyers etc	Ongoing	To explain coroner service, role of Chief Coroner and reforms; to discuss issues, concerns, reorganisation, progress etc
73	MINISTRY OF JUSTICE	Regular contact with LC, relevant Ministers and Head of Coroners, Burials, Cremation and Inquiries Policy Team	Ongoing	
74	JUDICIAL EXECUTIVE BOARD (JEB)	Regular updates to senior judges at JEB	Ongoing	
75	CORONERS' SOCIETY OF	Regular meetings to discuss	Ongoing	Chief Coroner also speaks at

ENGLAND AND WALES (CSEW)	coroner issues		local CSEW meetings
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K. COMPLAINTS

76	JCIO COMPLAINTS	Chief Coroner has no role in investigation and adjudication of complaints, but occasionally provides pastoral advice	Ongoing	
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L. ANNUAL REPORT

77	ANNUAL REPORT TO LORD CHANCELLOR	Chief Coroner reports annually to LC	2 nd annual report due July 2015, completed	3 rd Annual Report June 2016
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HH JUDGE PETER THORNTON QC
CHIEF CORONER

22 April 2015
29 June 2016



CHIEF CORONER

Draft

A MODEL CORONER AREA

THE CHIEF CORONER'S RECOMMENDED MODEL

This document is intended to assist senior coroners, local authorities and police authorities as to the nature, scope and organisation of a model coroner area. All should work together to try and achieve, wherever possible, the aspirations of this model.

Size of coroner area; mergers

1. Approximately 220,000 deaths are reported to coroners in England and Wales each year.
2. The size of a coroner area should be such that the senior coroner receives approximately 3,000 to 6,000 reports of deaths each year. Areas which receive less than 2,500 reported deaths should consider merging with another area. Smaller, part-time jurisdictions may sometimes be less efficient and effective.
3. Applications to merge two or more coroner areas are considered by the Lord Chancellor. If two or more local authorities wish to merge their coroner areas into one combined area, they should apply to the Lord Chancellor through the Ministry of Justice (MoJ). The MoJ will ask the authorities to complete a business case for the merger in standard form before the Lord Chancellor formally consults relevant stakeholders.¹ The Chief Coroner is always available to discuss mergers.

Coroners

4. Each coroner area should have a senior coroner supported by assistant coroners. In some larger areas there will also be an area coroner.
5. Where there is an area coroner, the senior coroner's administrative workload should be shared with the area coroner by agreement.
6. The senior coroner, with the agreement of the local authority, must allocate the area coroner (if there is one) or an assistant coroner as the senior coroner's

¹ See Chief Coroner's Guidance No.14 *Mergers of Coroner Areas*.

deputy. This is not a formal statutory post; the deputy should deputise for the senior coroner in their absence for leave or sickness.

7. New coroners should be appointed by the local authority following an open and transparent competition.²
8. The role of the senior coroner, a post which came into force for the first time with the implementation in 2013 of the Coroners and Justice Act 2009, embraces the following. The senior coroner:
 - stands at the head of the local coroner service
 - provides collaborative leadership
 - leads on coroner work and manages the caseload
 - organises and supports the coroner team locally
 - works closely with the local authority and the police
 - manages the expectations of the public and bereaved people
 - is on call all the time (or on a rota basis) for urgent matters and for making decisions about organ and tissue donation, and
 - is prepared for a mass fatality disaster.
9. Senior coroners and area coroners are entitled to a salary. Assistant coroners are entitled to fees. Fees for assistant coroners should be paid at a daily (or half daily) rate for preparation and court casework as well as office work. The basis of all payments should be clearly agreed in advance.
10. Salaries and fees (and other terms and conditions) should be agreed from time to time between coroner and local authority. It is the Chief Coroner's view that an independent assessor (such as the Senior Salaries Review Body) should recommend levels of salaries and fees.
11. In the Chief Coroner's view the JNC Agreement on coroners' pay as set out in Circular No.51 (latest version 14 April 2011) lapsed in July 2013. The Coroners' Society of England and Wales and the Local Government Association, who entered into the JNC Agreement, both accept that it has lapsed. The agreement referred to terminology in an Act of Parliament which was been repealed. Accordingly, new agreements between coroners and local authorities should not include terms such as long inquest payments, county loading and assessment of 11.5% of annual caseload for payment of a deputy. Senior coroners should not be required to pay for any other coroner or pay for any expenses out of their salary.
12. Senior coroners should be expected to have and take an annual leave entitlement of 30 days.
13. Assistant coroners should be given a minimum of 15 days work a year (either sitting and/or office coroner work). They must first be assessed as competent and ready to work on their own.³
14. There is a mentoring scheme for assistant coroners (and other coroners) who require additional assistance or advice.⁴

² See Chief Coroner's Guidance No.6 *The Appointment of Coroners*.

³ In accordance with the Chief Coroner's Guidance No.20 *Core Competencies for Assistant Coroners*.

⁴ See Chief Coroner's Guidance No.19 *Mentors for Coroners*.

15. Where possible, senior coroners should provide 'shadowing' opportunities for aspiring assistant coroners.
16. Area coroners and assistant coroners should be appraised annually by the senior coroner. An appraisal scheme needs to be developed.
17. The senior coroner should hold regular (possibly monthly) meetings with the coroner team to discuss relevant coroner issues and work. There should also be regular meetings with the relevant local authority and the police, as well as local registrars. The senior coroner should also hold meetings with hospitals and GPs, and with community and faith groups.
18. Meetings of senior coroners within a region are encouraged.
19. The senior coroner should present a brief annual report to the local authority. The report, which should be published on the local authority website, should include relevant statistics on current and concluded cases (with comparison figures for previous years), an update on coroner work and relevant issues, a summary of the coroner team and staffing arrangements, and any plans for the future.
20. Coroners (including senior coroners) should be computer competent and therefore able to deal with correspondence and other necessary documentation themselves, if required. That is not to say that coroners should not be provided with necessary administrative support whether by a personal assistant or other staff (see below).

Coroners' officers

21. Coroners' officers are employed by the police authority or local authority. For their functions and duties as coroners' officers see the Chief Coroner's note on *The Functions and Duties of Coroners' Officers*.
22. In order that coroners can carry out their functions, there should be a minimum of one coroner's officer for every 350-450 reported deaths. In complex jurisdictions, particularly those with prisons, more should be provided.
23. Those employing coroners' officers, whether police or local authority, should maintain a full complement of officers at all times. Arrangements should be in place so that proficient temporary cover is available whenever officers are absent through long-term sickness or suspension.
24. Employers of coroners' officers and councillors are encouraged to visit the coroner's office (by appointment) to discuss the work of coroners' officers and the issues raised by them.

Administrative support staff; the telephone system

25. Coroners and coroners' officers should be supported by administrative support staff employed by the local authority. The minimum ratio of coroners' officers to administrative staff should be approximately 3:1.
26. The work of administrative support staff employed by the local authority should be of a purely administrative nature. Administrative staff should not usually be carrying out the work of coroners' officers; their role is to support coroners and coroners' officers.

27. Administrative support staff should carry out the following functions: answer the telephone; copy documents (which cannot be scanned); distribute disclosure; deal with jurors and juries; manage invoices in connection with post-mortem examinations, toxicology and body removal/storage, as well as witnesses and jurors etc; collate management data; manage the computer system (ALS or another system); and deal with insurance companies and others.
28. Administrative staff, through a telephonist receptionist or other system, should answer all incoming telephone calls in the first instance. In doing so they should provide basic general information and information on specific cases, taken from a centralised computer system. In this way calls to coroners' officers should be greatly reduced.
29. The telephone system should be operated during working hours, ordinarily from 9am - 5pm (or 8am - 4.30pm), Monday to Friday, including the lunch hour. Calls should be answered promptly, ideally within 30 seconds. Where necessary, staff working hours should be staggered in order to permit good access to the coroner service. It is vital that all stakeholders, including doctors, pathologists, toxicologists, registrars, funeral directors and insurance companies, as well as members of the public, should have prompt access to the coroner service. Appropriate answering messages should be given for calls out of normal hours with appropriate emergency numbers. Telephone systems should not have complex 'menus'.

Accommodation

30. The local authority should provide office accommodation for all coroners, coroners' officers and administrative support staff. Ideally, all personnel should be close together in one building. The coroner's court should be in the same premises where possible. Where the local court is not large enough for jury inquests, courts should be made available to the coroner for jury inquests on a regular basis. Coroner areas should actively work towards these arrangements.
31. Where the police employ coroners' officers, the police authority may share some of the necessary cost of accommodation. Coroners' officers should not be in different parts of the county or in police stations, but working together in one place with the coroner and administrative staff. This produces greater resilience, efficiency and effectiveness of working. It serves the public better.
32. The coroner's premises should, where possible, be close to the registration services and other relevant local authority staff (and Medical Examiner service when implemented).
33. In a busy jurisdiction there should be more than one coroner's courtroom in the premises: a larger court capable of holding jury inquests, and a smaller court for everyday work.
34. Senior coroners should not routinely use their home as an office. The local authority should provide them with an office.
35. The use of private email addresses for judicial work should be discouraged. The local authority should provide coroners with a secure email address. There should also be secure storage for documents.

Investigations and inquests

36. Coroners must act independently in making judicial decisions, including (but not exclusively) on the following issues:
- deciding whether to commence an investigation or to complete Forms 100A and 100B
 - requesting a post-mortem examination
 - releasing a body for burial or cremation
 - issuing interim death certificates
 - discontinuing an investigation
 - conducting hearings
 - completing inquests
 - making Out of England orders, and
 - writing reports to prevent future deaths
37. Coroners are expected in most cases to follow the Chief Coroners Guidance on practice and procedure. Coroners may depart from guidance, however, where there are good reasons to do so, but they should provide their reasons either in open court or in correspondence. As independent judicial office holders, coroners must make their own judicial decisions. The Chief Coroner may not interfere with those decisions, nor amend or reverse them, except when he sits in the High Court.
38. Doctors should have a statutory duty to report deaths to coroners in specified circumstances. In the current absence of statutory regulation, doctors should comply with the recommended reporting requirements set out in the notes for doctors on the Medical Certificate of Cause of Death.⁵ Coroners should not require doctors to make reports (referrals) in any other circumstances.
39. Deaths should be reported (referred) to the coroner immediately (at the latest within 24 hours) and electronically, by email or other means, such as a web-based solution, in standard form. Doctors should not be paid by the coroner for referral reports.
40. All bodies should be released for burial or cremation within three days of the report of the death to the coroner, or where possible earlier.
41. Most inquests should be completed within six months of the death being reported. Coroners should aim to complete 40% (or more) of all inquests within one month and a further 20-25% (or more) within one to three months.
42. In some cases, such as deaths overseas, deaths in custody, or where the police or other agency have ongoing investigations, this timescale may not be possible. But coroners should keep a close watch on such cases to ensure that they are completed within a reasonable time.
43. In cases where the death occurs overseas the coroner should take a realistic view when no useful purpose would be served in deferring further the inquest. Similarly, where the body has been lost at sea or in a river and may never be recovered, the coroner should not delay unreasonably in making a section 1(4) request to the Chief Coroner to hold an inquest in the absence of the body. Some

⁵ Paragraph 5.3.

such cases in the past have been deferred almost indefinitely. Earlier inquests may be needed, even though information may be limited.

44. A coroner area should avoid a backlog of cases. There should be no more than a handful of cases which are not completed or discontinued within 12 months of the report of the death. Coroners must report annually to the Chief Coroner with details of all cases not concluded within 12 months.
45. All inquests should be opened in open court, in a local courtroom. Open court means a court arranged in a building in such a way that any member of the public can drop in to observe the hearing (any hearing) unannounced.
46. At the opening hearing a date should be fixed either for the inquest itself or, in more complex cases, for a pre-inquest review hearing. Normally, the name of the coroner who will be hearing the case should be announced. The coroner should not as a matter of course fix review hearing dates instead of inquest dates at the opening hearing.
47. Reports, including, post-mortem reports should be required from pathologists within three to four weeks, except where further reports from toxicologists or other experts are required. Timescales should be announced at the opening hearing.⁶
48. All hearings should be recorded. Coroners should usually avoid obtaining a transcript of a hearing.
49. Interim hearings and final hearings should be notified to the public by notice on the coroner's or local authority website.⁷
50. In non-contentious cases, where no witness is required, the family have no concerns and there is no particular public interest, inquests should be concluded with brief paper rulings. This proposal will require a change in the law.
51. In more complex cases, coroners should hold pre-inquest review hearings (PIRs). The coroner should set an agenda in advance and give rulings either at the hearing or shortly afterwards. All rulings should be reduced to writing (in brief) and distributed to Interested Persons. Topics for a PIR agenda may include:
 - identity of Interested Persons
 - representation
 - scope of inquest
 - whether Article 2 is engaged
 - whether jury is required
 - venue
 - timescale
 - list of witnesses
 - disclosure
 - jury bundle
 - other outstanding issues
52. Where a person dies in a care home or hospital subject to a Deprivation of Liberty Safeguard authorisation (DoLS), the coroner may proceed to a brief paper

⁶ See Chief Coroner's draft Guidance *Coroners and Healthcare Providers*.

⁷ See Chief Coroner's Guidance No.9 *Opening Inquests*.

inquest, preferably within two weeks of the death, in the following circumstances: the coroner obtains (i) a copy of the authorisation and (ii) a medical report indicating that the death was from natural causes, and (iii) the coroner checks with the family that they have no particular concerns about the death.

53. Coroners, through their officers, should check with all families in all cases to see whether they have any particular concerns about the death.
54. Coroners, through their officers, should provide families with early information and early explanation about the forthcoming coroner process. Officers should keep families and other interested persons informed of the progress of the investigation including the reason for any delay.
55. Coroners' officers should not normally be required to remain at court during an inquest.
56. In due course, Records of Inquests should be published (subject to any necessary redaction) on the coroner's or local authority's website. Similarly, where inquests are permitted to take place without a hearing (see paragraph 50 above), the final rulings should also be published.

Reports to prevent future deaths

57. All coroners are encouraged to write reports to prevent future deaths in appropriate cases. They are of value to the family concerned and the wider public.
58. Reports should be completed using the standard template. A copy of the report and any response must be forwarded to the Chief Coroner's office by email.⁸ The report and any response will usually be published on the judiciary website (sometimes with redactions).

Out of hours services

59. The senior coroner, in collaboration with the police and the local authority, should provide an out of hours coroner service.
60. In view of current financial limitations, an out of hours service (overnight, weekends and bank holidays) should be arranged on a 'light touch' basis. This should require as a minimum the availability of one or more coroners' officers on a rota system, in the first instance answering calls and having access to case records on a centralised local computer system. It should also require an on call rota of coroners, special opening hours for registrar's offices and occasional access to local authority mortuaries.
61. A local coroner should always be available for emergencies such as homicide cases, mass fatalities and decisions on organ and tissue donation. In some areas an out of hours service will require more, particularly in order to assist families who seek early burial for their loved ones or Out of England orders.
62. The registrar's office should be open for a limited period at the weekend and on bank holidays for the registration of deaths and the provision of death certificates.

⁸ See Chief Coroner's Guidance Nos.5 and 5A *Reports to Prevent Future Deaths and Practical Guidance: PFD Reports*.

This will complement out of hours arrangements in the coroner service and provide a more coordinated system for death investigation and registration.

63. Since the coroner service continues to be funded locally, the cost of providing an out of hours service will fall on the local authority and local police authority.

Mortuary and pathology services

64. Mortuary and pathology services should be arranged on a regional basis. Local authorities and NHS England and NHS Wales should combine to provide regional medical centres of excellence. These should include mortuary services, a hierarchy of pathologists (with forensic pathologists at the highest level), CT scanning and ideally other facilities such as toxicology and other forensic testing.
65. The Chief Coroner will be working actively with NHS England, NHS Wales, the Department of Health, as well as coroners, local authorities and others, to encourage developments in this direction.
66. Until regional centres are available, coroners should have access to CT scanning facilities (although this may be a facility which requires payment of a fee by families).
67. Coroners should aim towards a post-mortem examination (autopsy) rate of 30% of reported deaths or below. (Current post-mortem rates in coroner areas across England and Wales vary from 22% to 62%.) Coroners are encouraged, as in other jurisdictions, to judicially manage resources proportionately, allocating to any one case an appropriate share of resources, while taking into account the need to allot resources to other cases.

Tendering

68. Tendering for services from external providers should be undertaken every three or four years. Relevant providers include toxicology and funeral directors.
69. The precise process of tendering is a matter for each relevant authority in discussion with the senior coroner.
70. Tendering criteria should always focus on more than just cost. Quality and delivery of service are essential.
71. Funeral directors who have a contract with the coroner and local authority for 'coroner's removals' (removal of a deceased person on the authority of the coroner from the place of death to the coroner's mortuary) should not solicit bereaved families for business at the time of removal. They may, however, leave behind with the family a Notice of Transfer (or similar document) in the terms suggested by the Chief Coroner.⁹

Local authorities

72. The relevant local authority should discuss issues including financial issues with the senior coroner and staff on a regular basis. Good, frequent and collaborative contact is essential.

⁹ See Chief Coroner's Advice *Contracts for Coroners' Removals*.

73. Local authorities should understand that coroners are independent judicial officers and that the local authority may not interfere in matters within the exclusive jurisdiction of the coroner. This does not, however, mean that coroners have exclusive rights over all things coronial. Much needs to be the subject of sensible discussion and agreement. Senior coroners are not chief officers of the local authority, although in some cases there may be useful analogies from the way chief officers and other council departments operate.
74. When the senior coroner is approaching retirement (ideally at least a year in advance), local authorities should consider succession planning and, if a small jurisdiction, possible future merger with another coroner area or areas.
75. Local authorities should provide the senior coroner with a dedicated website or a page of the local authority website, so that information about the coroner service and details of forthcoming inquests (and, in due course, outcomes) may be posted.

Training

76. Compulsory training is provided for all coroners (380) and coroners' officers (590), from basic learning to continuing development, as part of the modern requirement for a professional public service. Training is devised, arranged and delivered by the Chief Coroner together with the Chief Coroner's course directors (selected by competition). Training is provided under the auspices of the Judicial College which trains all judges, magistrates and tribunal members. The College funds and administers the training.
77. Newly appointed assistant coroners receive compulsory residential induction training.
78. Newly appointed assistant coroners should also receive local in-house training at the coroner's premises. They must satisfy the core competencies for assistant coroners (see paragraph 13 above).
79. In order to ensure that assistant coroners are sufficiently skilled in coroner work for the benefit of local people, local authorities should remunerate assistant coroners for attendance at training (by way of daily rate for lost working time) and pay their reasonable expenses. Where assistant coroners hold posts in more than one jurisdiction, these costs should be shared between relevant local authorities. The training, accommodation and meals are provided by the Judicial College free of charge.
80. All coroners receive compulsory residential training each year (which is similarly arranged by the Chief Coroner).
81. In addition, the Chief Coroner provides one-day courses on specific topics such as deaths in prison, deaths of children, mass fatality events, medical topics, as well as special training for his cadre of coroners for military deaths.
82. Coroners' officers also receive (as of 2015) compulsory residential training from the Chief Coroner (as above) each year. They should also receive extensive in-house training while learning in post, both from the coroner and coroners' officer manager. Local registrars should also be invited in to help train coroners' officers.

83. Where possible, senior coroners (or a member of the local coroner team) should make themselves available to instruct GPs and hospital doctors about the coroner service and requirements for reporting deaths and contents of MCCDs.

Discipline

84. Coroners' officers and administrative support staff are line-managed and disciplined where necessary by their employers (police or local authority) and not by the senior coroner. Police and local authorities should, however, discuss with the senior coroner the implications of enforcing discipline.

85. Coroners are appointed (but not employed) by local authorities. As independent judicial office holders, they cannot be dismissed or removed from office by local authorities. By statute, a coroner (like other judges) may only be removed from office by the Lord Chancellor, with the agreement of the Lord Chief Justice, for 'incapacity or misbehaviour'.

86. In practice complaints against coroners over personal conduct should be made to the Judicial Conduct Investigations Office which investigates and makes recommendations to the Lord Chancellor. Complaints about judicial decisions by coroners should be made through the High Court.

87. The Chief Coroner has no role, statutory or otherwise, in the disciplinary process of coroners.

**HH JUDGE PETER THORNTON QC
CHIEF CORONER**

15 July 2016

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