



Ministry  
of Justice



# **Coroners Statistics Annual 2016 England and Wales**

Ministry of Justice  
Statistics bulletin

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## Introduction

This annual bulletin presents statistics of deaths reported to coroners in England and Wales in 2016. Information is provided on the number of deaths reported to coroners, post-mortem examinations and inquests held, and conclusions recorded at inquests. The data are collected via statistical returns completed by coroners. For previous editions of this report, please see:

[www.gov.uk/government/collections/coroners-and-burials-statistics](http://www.gov.uk/government/collections/coroners-and-burials-statistics)

This publication should be read alongside the statistical tables which accompany it, also found via the link above. There is also a supporting comma-separated values (CSV) file to allow users to carry out their own analysis.

In addition to the bulletin and tables, we have published a coroners' statistical tool (also available at the link above). The tool provides easier access to local level data and allows the user to compare up to four areas of interest, for example, it is possible to compare a coroner area with a geographical region, England or Wales.

The accompanying guide to coroner statistics provides a more detailed overview of coroners; including the functions of coroners and the chief coroner, policy background and changes, statistical revision policies, and data sources and quality. The guide also includes a glossary providing brief definitions for some of the terms used in this bulletin.

The Explanatory Notes section at the end of this bulletin provides information about statistical revisions, and the symbols and conventions used.

If you have any feedback, questions or requests for further information about the bulletin, please direct them to the appropriate contact given at the end of this report.

### **The legislation**

Coroner services in England and Wales are governed by Part 1 of the Coroners and Justice Act 2009 (the 2009 Act), as well as the rules and regulations made under it. The 2009 Act came into force in July 2013, largely replacing the Coroners Act 1988<sup>1</sup> (the 1988 Act).

The 2009 Act and its rules and regulations can be accessed via the links below:

[www.legislation.gov.uk/ukpga/2009/25/contents](http://www.legislation.gov.uk/ukpga/2009/25/contents)

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<sup>1</sup> The Coroners Act 1988 was repealed in July 2013 with the exceptions of section 13 (application for a fresh coroner investigation or inquest) and 4A (8) (a coroner in Wales being regarded as a coroner for the whole of Wales).

[www.legislation.gov.uk/2013?title=coroners](http://www.legislation.gov.uk/2013?title=coroners)

### **Related statistics**

All deaths in England and Wales must be registered with the Registrar of Births and Deaths. For those deaths where a coroner conducts an inquest, the death will be registered at the conclusion of the inquest, and the cause of death classified according to the conclusion recorded by the coroner.

Statistics on registered deaths in England and Wales are published by the Office for National Statistics (ONS) in their series on mortality statistics. These can be accessed from the ONS website at:

[www.ons.gov.uk/ons/taxonomy/index.html?nscl=Mortality+Rates](http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Mortality+Rates)

The Ministry of Justice's coroner statistics differ from ONS figures because they count two different, albeit related, events. The Ministry of Justice's coroner statistics provide the number of deaths which are reported to coroners in England and Wales. These include deaths reported to coroners which occurred outside England and Wales. The ONS mortality statistics, based on death registrations, report the number of deaths registered in England and Wales in a particular year irrespective of whether a coroner has investigated the death. These do not include deaths that occurred outside England and Wales.

The proportion of deaths which are reported to coroners has been estimated using death registration figures published by ONS. Estimates for 2016 have been calculated using ONS' monthly provisional figures on death registrations, while percentages for 2015 and earlier years have been calculated using final annual death registration figures for the relevant year. Additionally, ONS counts deaths when they have been registered whilst coroners count deaths when they are reported. There can be considerable delay between the date when the death occurred and when the death is registered. Deaths reported to a coroner would not be added to the deaths register until the coroner has concluded their investigation. Therefore it is advised that caution is used when using these figures.

This publication includes figures for deaths reported to coroners which occurred in state custody. Statistics on deaths in prison custody are also published by Her Majesty's Prison and Probation Service (HMPPS), previously the National Offender Management Service (NOMS), accessible via the following link:

<https://www.gov.uk/government/collections/safety-in-custody-statistics>

Differences between the two sets of figures are in part due to a time lag in reporting processes. The figures for deaths in custody in this publication relate to those deaths when they have been reported to a coroner in the given year and then reported to MoJ, whereas for the HMPPS publication, deaths are recorded directly after they have occurred. HMPPS figures includes all deaths which have occurred in prison custody and those which occurred whilst the offender was released on temporary licence for medical reasons.

This publication also includes figures on deaths reported to coroners of individuals detained under the Mental Health Act (MHA) – similar statistics are published by the Care Quality Commission (CQC)<sup>2</sup>. Differences between the two sets of figures are likely to be due to a time lag in reporting processes: coroners are required to conduct an investigation within six months of the death being reported to them whilst the CQC receives reports of all deaths of individuals detained under the MHA in a particular year. In addition, not all deaths reported to the CQC are reported to a coroner. The CQC also publishes information on the number of deprivation of liberty safeguards applications in their ‘State of Care’ annual report<sup>3</sup>.

This publication includes the number of deaths with a conclusion of suicide recorded at inquest - statistics on suicide deaths are also published by the ONS<sup>4</sup>. The ‘ONS Suicide Statistics UK’ series uses the national statistics’ definition of suicide: deaths given an underlying cause of intentional self-harm or an injury/poisoning of undetermined intent. In 2016, this definition has been modified to include deaths from intentional self-harm in 10- to 14-year-old children in addition to deaths from intentional self-harm and events of undetermined intent in people aged 15 and over.

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<sup>2</sup> The Care Quality Commission (CQC) annual report on Monitoring the Mental Health Act can be found here: [www.cqc.org.uk/content/monitoring-mental-health-act-report](http://www.cqc.org.uk/content/monitoring-mental-health-act-report)

<sup>3</sup> The annual CQC State of Care report can be found here: [www.cqc.org.uk/content/state-of-care](http://www.cqc.org.uk/content/state-of-care).

<sup>4</sup> For more on ONS Suicide please visit: [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/previousReleases](http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/previousReleases)

### **Date of next publication**

The next edition of the annual Coroners Statistics is scheduled to be published in May 2018, covering statistics for calendar year 2017.

### **Users of the statistics**

The main users of these statistics are coroners and Ministers and officials in central government to assist in developing coroners' policy and its subsequent monitoring. Other users include the Chief Coroner, local authorities (who are responsible for appointing and paying coroners as well as funding their services), other central government departments, and those non-governmental bodies, including various voluntary organisations, with an interest in coroners and inquests. The statistics are used to monitor the volume and types of cases dealt with by coroners in England and Wales each year.

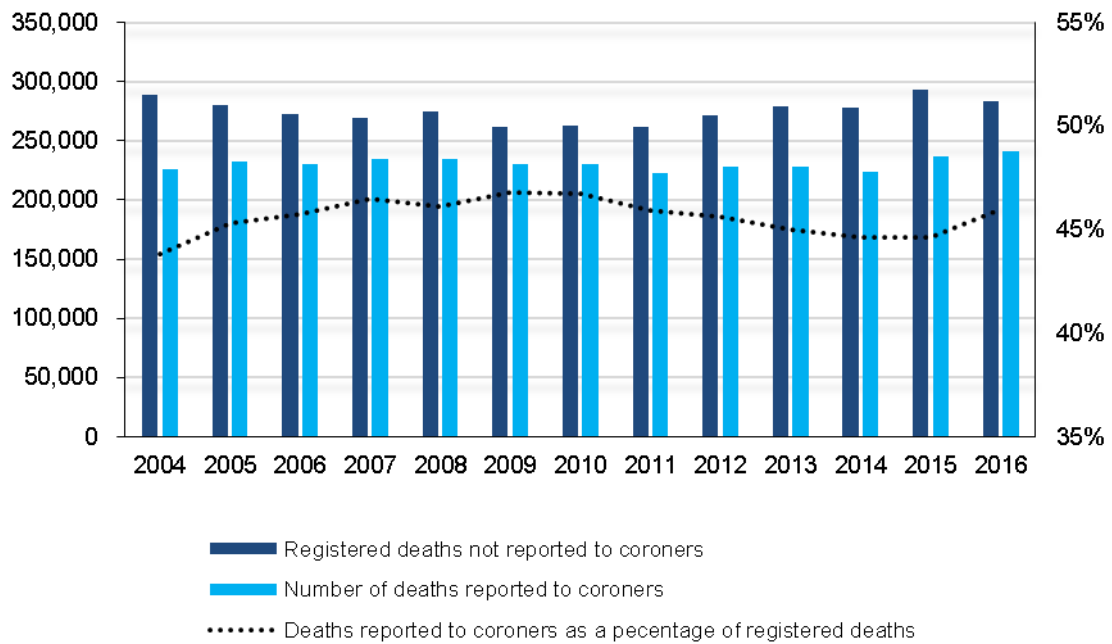
## Key Findings

- 241,211 deaths were reported to coroners in 2016, the highest to date. This shows an increase of 4,805 (2%) from 2015, reflecting the increase in the number of deaths under Deprivation of Liberty Safeguard (DoLS) authorisations reported to coroners.
- Just under half (46%) of all registered deaths<sup>6</sup> were reported to coroners in 2016, up one percentage point on 2015. Over the last ten years, this proportion has been generally stable, within the range of 45% to 47%.
- In 2016, there were 11,376 deaths of individuals subject to DoLS authorisations, 4,193 more than in 2015 (up 58%) reflecting the increase in the number of active DoLS over the same period.
- Deaths in state detention (excluding DoLS) increased by 19%, to 574 deaths being reported to coroners in 2016, with the largest increase seen in deaths while detained under the Mental Health Act (252 in 2016, up 34%) and deaths in prison custody (298, up 14%).
- The number of inquests opened in 2016 increased by 5,769 (up 18%) to 38,626, driven by the increase in deaths while subject to DoLS. All such cases require an inquest.
- There were 86,545 post-mortem examinations ordered by coroners in 2016, 36% of all cases reported to them. This is down two percentage points since 2015, consistent with the long-term downward trend.
- In 2016, 40,504 total inquest conclusions were recorded, up 14% on 2015, reflecting in part the rise in the number of inquests opened.
- Three of the inquest short form conclusions account for almost 68% of all conclusions recorded. These are natural causes (39%) accident and misadventure (19%) and suicide (9%). A further 12% were in the 'unclassified' inquest conclusion category.
- Inquest conclusions of natural causes were up 45% on 2015 to 15,962, driven by the majority of DoLS cases having an inquest conclusion of natural causes.
- The two inquest conclusions introduced in 2013, 'Drugs/Alcohol Related' and 'Road Traffic Collision', have both increased on 2015, up 10% to 2,503 and 16% to 900, respectively.
- In 2016, post-mortem examinations were conducted in 47% of inquest cases, down 9 percentage points on 2015, driven by the increase in deaths of individuals subject to DoLS authorisation.

## 1: Deaths reported

The number of deaths reported to coroners in 2016 rose by 4,805 (2%) to 241,211, the highest to date. In comparison, ONS registered deaths fell by 4,932 from 2015 to 2016 (down 1%)<sup>5</sup>. The proportion of registered deaths in 2016 that were reported to coroners was 46%, up one percentage point from 2015.

**Figure 1: Registered deaths and deaths reported to coroners, England and Wales, 2004-2016**



Over the last decade, the number of registered deaths in England and Wales initially dropped from 502,599 in 2006 to a low of 484,367 in 2014. It increased to 529,655 in 2015 with the 2016 provisional figures standing at 524,723. The number of deaths reported to coroners followed a similar trend, with 230,007 deaths reported in 2006, falling to a low of 222,371 in 2011 and then rising to a high of 241,211 in 2016.

<sup>5</sup> Provisional figure based on ONS monthly death registration figures for 2016



## 2: Post-mortem examinations held and inquests opened

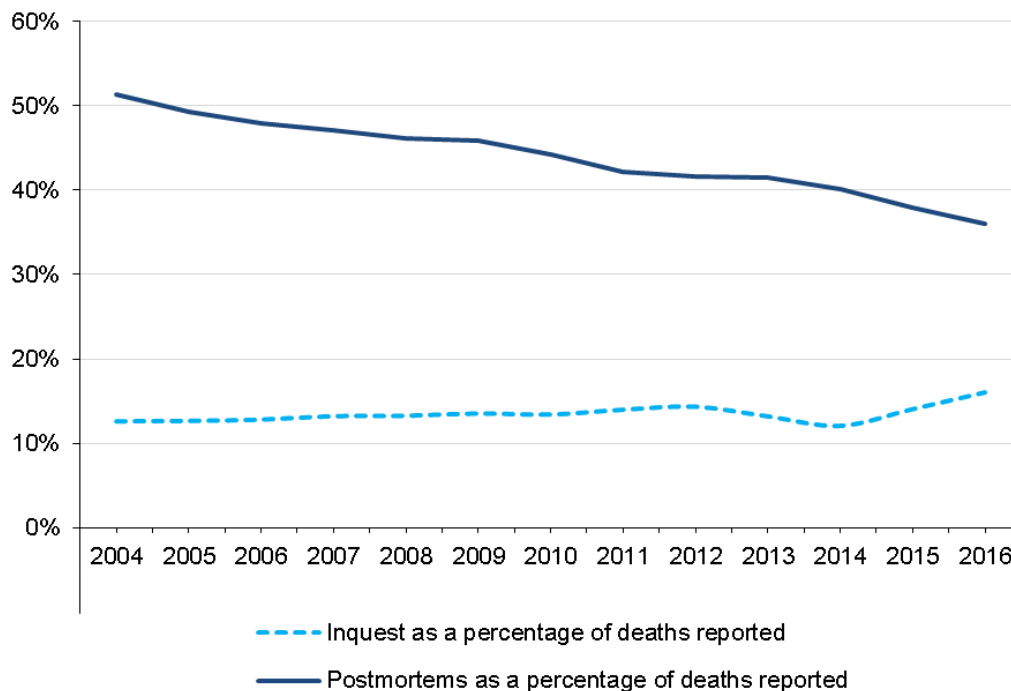
Post-mortem examinations were held for 86,545 deaths reported to coroners in 2016, down 2,661 (3%) from 2015.

Post-mortem examinations were ordered by coroners in 36% of all deaths reported to them in 2016, down two percentage points on 2015, and consistent with the existing long-term downward trend. Since 1995, the proportion of post-mortem examinations ordered has decreased by 25 percentage points, from 61% to 36% (see Table 3).

There were 38,626 inquests opened in 2016, an increase of 18% on 2015, driven by the increase in deaths of individuals subject to DoLS authorisations, as all such cases require an inquest<sup>6</sup>.

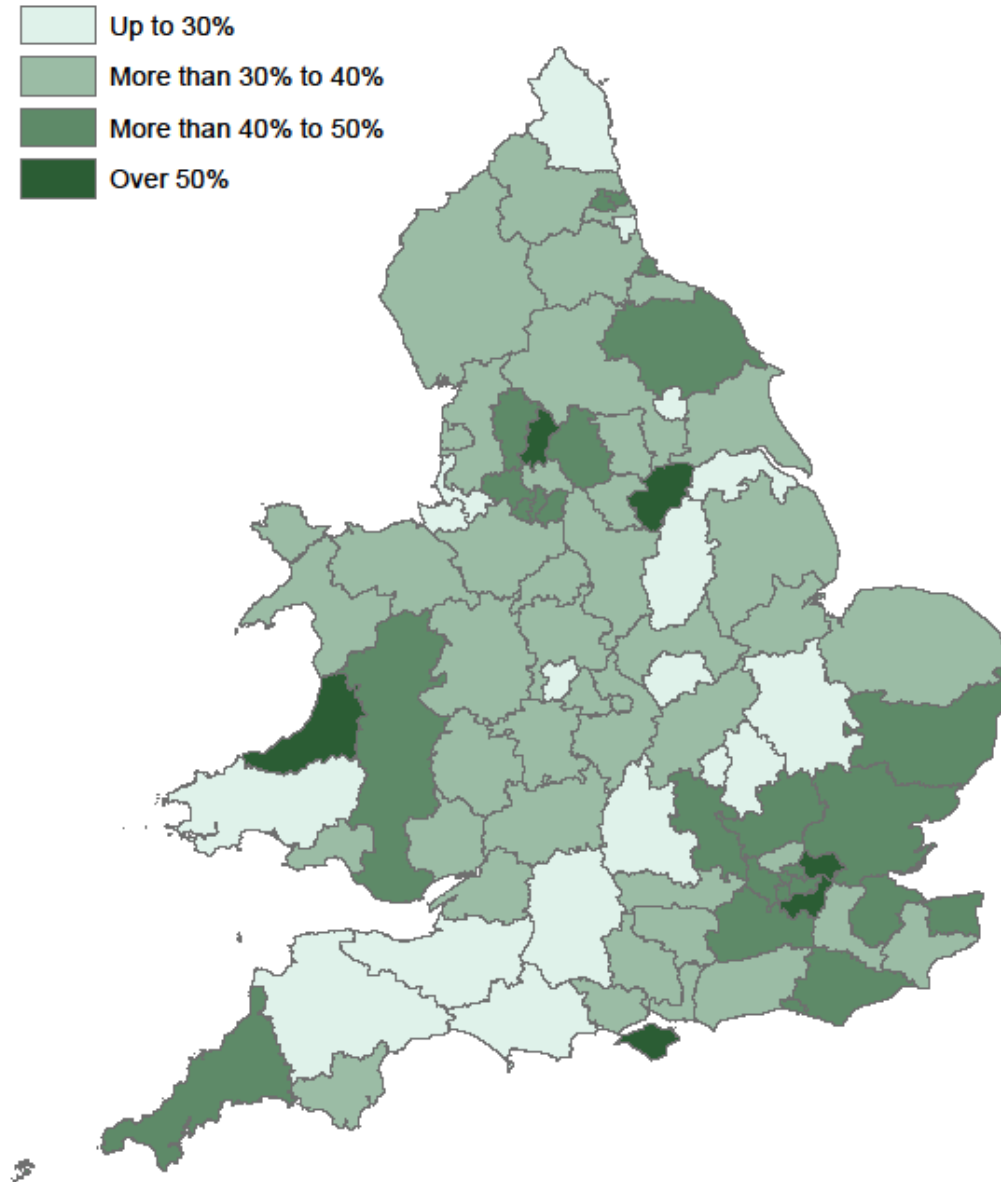
Inquest cases represented 16% of all the deaths reported to coroners in 2016, an increase of two percentage points on 2015.

**Figure 2: Post-mortems and inquests as a percentage of deaths reported to coroners, England and Wales, 2004-2016**



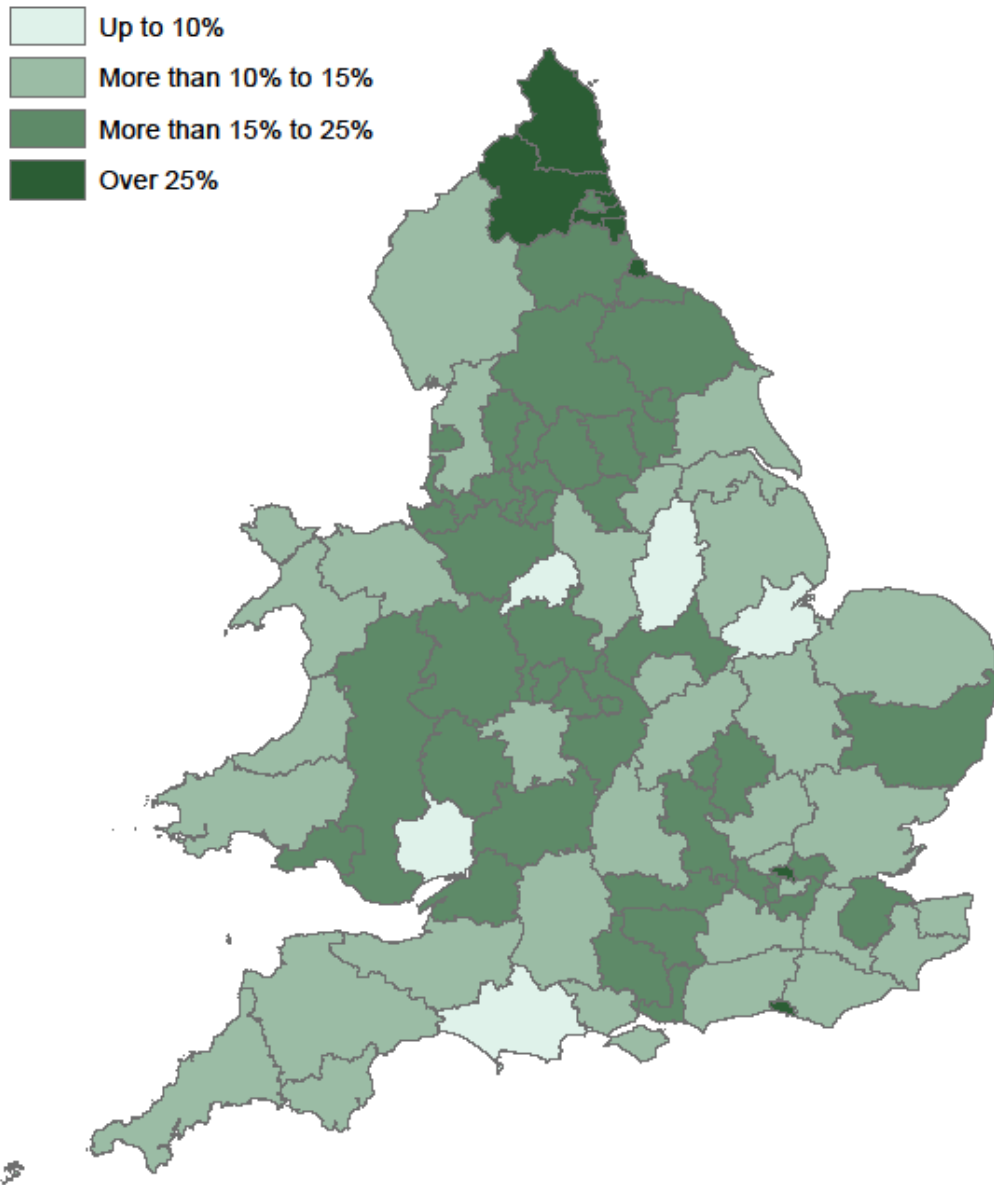
<sup>6</sup> More information on DoLS can be found in the section of the Guide to Coroners Statistics published alongside this bulletin.

**Map 1: Post-mortems held as a proportion of deaths reported to coroners, England and Wales, 2016**



The proportion of post-mortems carried out varies from 21% in North Lincolnshire and Grimsby to 62% in Isle of Wight.

**Map 2: Inquests opened as a proportion of deaths reported to coroners, England and Wales, 2016**



The proportion of inquests carried out varies from 8% in Stoke-on-Trent and North Staffordshire to 40% in North Tyneside.

### **Post-mortem examinations in inquest cases**

When an inquest is opened, a post-mortem examination will usually be conducted. In 2016, just under half (47%) of inquest cases involved a post-mortem, down 9 percentage points on 2015, driven by the increase in deaths of individuals subject to DoLS authorisation. – all such cases require an inquest, with the majority recording an inquest conclusion of natural causes; a post-mortem examination is therefore unlikely to be required to determine the cause of death and the inquest may well be a ‘paper’ inquest.

Historically, it was quite rare for an inquest to be opened without a post-mortem; however, since 1999 this proportion had been gradually increasing, with sharp increases seen in the last two years. In 2016, 53% of all inquests had no post-mortem, compared with 44% in 2015 and 24% in 2014. This may be attributed to the provisions in the Coroners Act 2009 which came into effect in July 2013, allowing a coroner to conduct a brief investigation prior to making a decision on whether to hold a formal inquest. These are captured in the potential inquest cases below.

### **Post-mortems in non-inquest cases**

In the majority (81%) of cases referred to coroners, there is no inquest. In 2016, there were 62,828 non-inquest cases where a post-mortem was held. The percentage of non-inquest cases that required a post-mortem has fallen from 34% in 2015 to 32% in 2016, continuing the steady downward trend seen since the beginning of the time series (56% in 1995).

### **Post-mortems in potential inquest cases**

Prior to July 2013, cases were either categorised as ‘inquest’ or ‘non-inquest’ cases. Changes in the way coroners are able to conduct an investigation mean that there is now a third category of ‘potential inquest’ cases. This means that the coroner is investigating the death, but has not yet decided whether it is necessary to hold an inquest. Depending on whether or not the coroner deems it necessary to hold an inquest, these cases will all eventually end up in either the ‘inquest’ or ‘non-inquest’ category.

In 2016, there were 6,417 potential inquest cases being dealt with by coroners in England and Wales, with 85% requiring a post-mortem.

### **Cases requiring neither an inquest nor a post-mortem**

There were 133,101 cases reported to coroners where there was neither an inquest nor a post-mortem. This type of case has generally been increasing in number over the years, from 81,701 in 1995 to 132,029 in 2015, with a 1% increase from 2015 to 2016. The proportion of cases where there was neither an inquest nor a post-mortem examination has increased from 66% in 2015 to 68% in 2016, after remaining at 66% since 2012. This continues the upward trend seen prior to 2012, from 44% in 1995 when the time series began.

## **Post-mortem rates, histology<sup>7</sup> and toxicology<sup>8</sup>**

Post-mortem examinations can be classed as either standard or non-standard, depending on the cost of the examination. A non-standard post-mortem is charged at a higher rate than a standard post-mortem and is defined as a post-mortem which requires special skills. A non-standard post-mortem could, for example, require a paediatric or specialist pathologist. In 2016, almost all (95%) of post-mortems were ordered at a standard rate - this has remained at the same level since 2011.

In 2016, 23% (19,558) of all post-mortems included histology, an increase from 21% (18,659) in 2015. Post-mortems including toxicology also increased over the same period to 16,091 (up 9%), with 19% of all post-mortems held in 2016 including toxicology. This follows the steady rising trend seen since 2011.

## **Out of England and Wales Orders**

To remove a body of a deceased person out of England and Wales, notice must be given to the coroner within whose area the body is lying. When the coroner gives permission for the removal of a body, an Out of England and Wales order is issued.

Coroners issued 5,738 Out of England and Wales orders in 2016, compared with 5,339 issued in 2015. In both years, the number of orders issued represented 2% of the total number of deaths reported to coroners – this proportion has been stable at this level since 2011 (see Table 5).

## **Deaths abroad**

Of the 241,211 deaths reported to coroners in 2016, around 1% (1,849) were reports of deaths that had occurred outside England and Wales. This percentage has remained stable since 2011.

## **Deaths in State Detention**

In 2016, a total of 11,950 deaths which occurred in state detention were reported to coroners<sup>9</sup>, an increase of 4,283 deaths (56%) on the previous year and representing 5% of all deaths reported to coroners.

In 2016, there were 11,376 deaths of individuals subject to DoLS<sup>10</sup> authorisations, up from 7,183 in 2015. Deaths of individuals subject to DoLS authorisations accounted for 95% of all deaths in state in detention in 2016.

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<sup>7</sup> Histology in the context of post-mortems is the examination of tissues under a microscope.

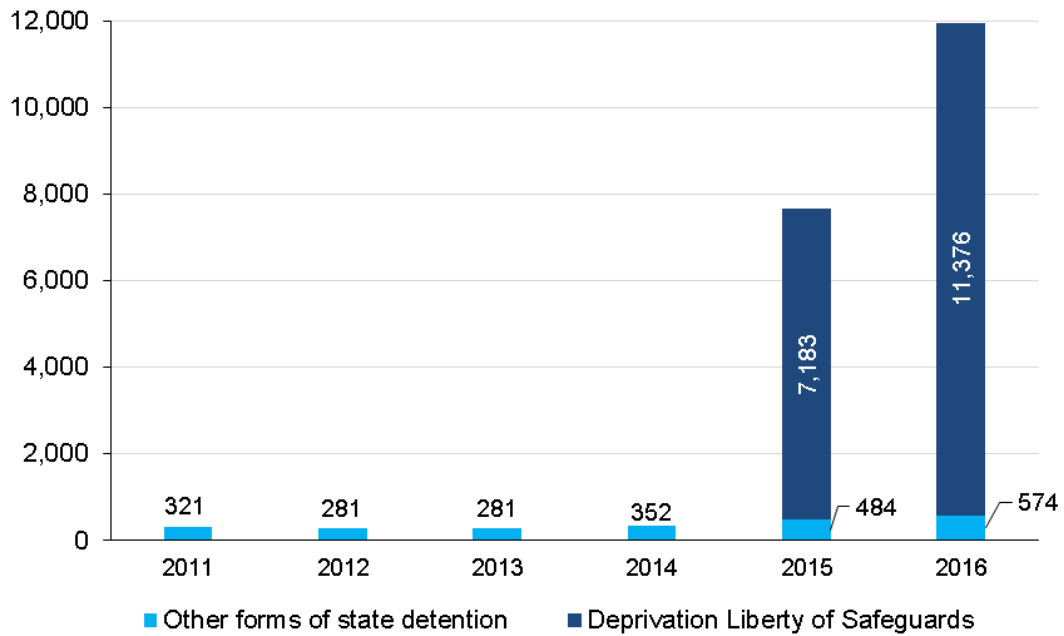
<sup>8</sup> Toxicology in the context of post-mortems is the study of body fluids and tissues for the detection of drugs.

<sup>9</sup> This data only represents deaths in custody which were referred to a coroner and subsequently reported to MoJ in the coroner's annual return.

<sup>10</sup> See the Guide to Coroners Statistics published alongside this bulletin for more information on DoLS.

Figure A below shows that the inclusion of deaths of individuals subject to DoLS authorisations within the number of deaths in state detention has distorted the long-term trend. However, the trend in deaths in state detention excluding DoLS is in line with that seen previously and within the Safety in Custody statistics quarterly bulletin (see 'Related statistics' section above).

**Figure 3: Number of deaths in state detention, by type of detention, 2011-2015**

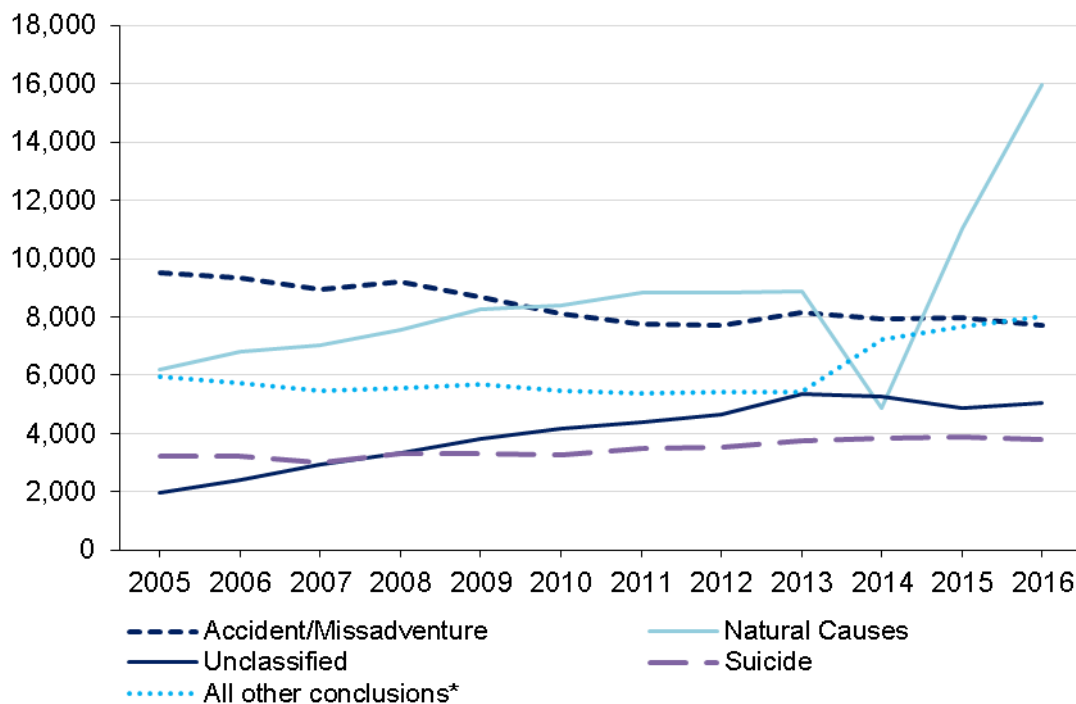


### 3: Inquests Completed

There were 40,504 inquest conclusions recorded in 2016, up by 5,031 (14%) from 2015, in part reflecting the increase in the number of inquests opened. This is the highest number of inquest conclusions recorded since the series began in 1995.

As in previous years, in 2016 the most common short form conclusions (by order of frequency) were death from natural causes (15,962 or 39%) and death by accident or misadventure (7,692 or 19%) and suicide (3,789 or 9%). Unclassified conclusions (which include narrative verdicts) made up 12% (5,030) of all inquest conclusions in 2016.

**Figure 4: Number of conclusions recorded at inquests, England and Wales, 2004-2016**



\*Killed unlawfully, Killed lawfully, Attempted or self-induced abortion, Cause of death aggravated by lack of care, or self-neglect, Want of attention at birth, Stillborn, Disasters, Open, Industrial Diseases, Drugs/Alcohol Related<sup>11</sup>, Road traffic collision

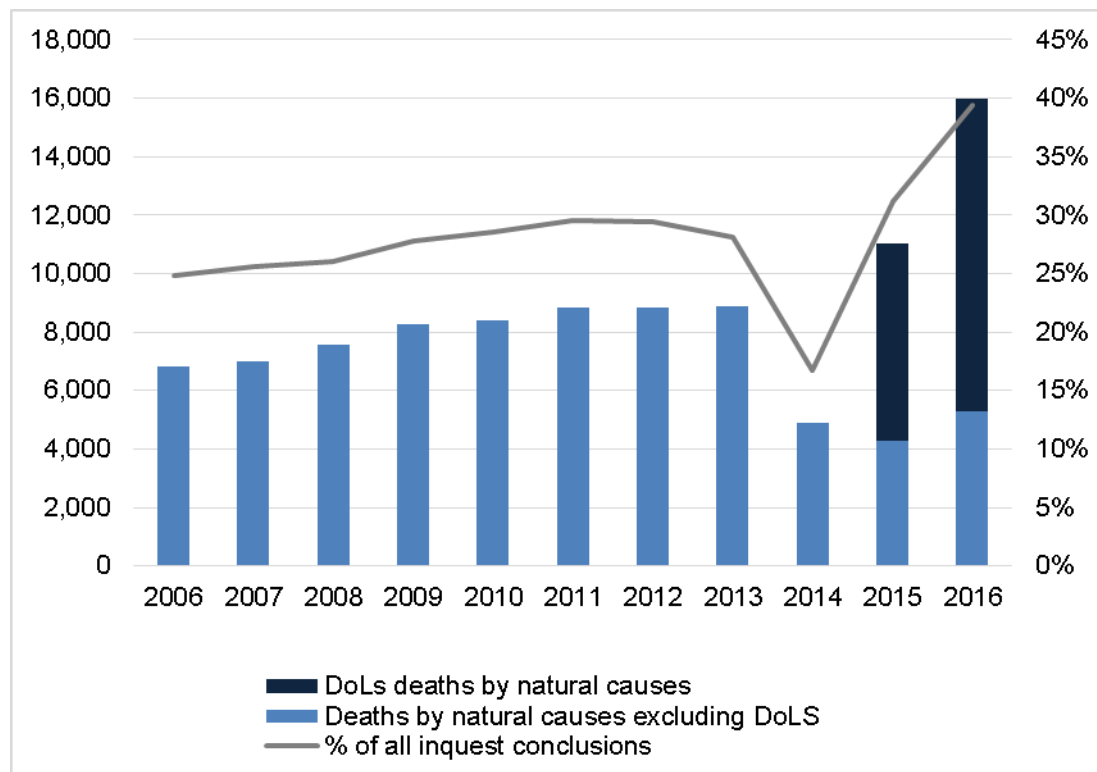
The recent (2015 and 2016) increases seen in natural causes, are driven by deaths of individuals subject to DoLS authorisations, where the majority (94%) had an inquest conclusion of natural causes. Historically, natural cause conclusions had been gradually increasing to a peak of 8,881 in 2013, and as

<sup>11</sup> For years 2004-2013, this includes the previously used conclusions “Dependence on Drugs” and “Non-dependence on Drugs”

a proportion, accounted for 25-30% of all inquest conclusions (between 2006 and 2013). In 2014 it almost halved (down 45%), to 4,873 (17% of all inquest conclusions). This was driven by the Coroners Act 2009 coming into force in July 2013 which meant coroners could issue death certificate without an inquest if the death was from natural causes.

Figure 5 below shows the time series of natural cause inquest conclusions when including or excluding DoLs. In total, natural conclusions made up 31% and 39% of all inquest conclusions in 2015 and 2016. However, when excluding the DoLs cases, natural causes only made up 12% and 13% of all inquest conclusions respectively, suggesting the continued impact of the Coroner Act 2009 reforms.

**Figure 5: Number of conclusions recorded at inquests, England and Wales, 2004-2016**



In 2016, the number of unclassified conclusions increased by 160 cases (up 3%) to 5,030, continuing the long term increasing trend seen from 2000 to 2013 and showing a reversal of the decreases seen in 2014 and 2015 in this category.

The rise in unclassified conclusions seen until 2014 is partly due to the increasing use of what are known as 'narrative conclusions' by some coroners. In these cases, the conclusion is recorded as unclassified. As well as narrative conclusions, this category includes short non-standard



conclusions which a coroner or jury might return when the circumstances do not easily fit any of the standard conclusions<sup>12</sup>.

For the remaining conclusion types, drugs and alcohol related cases increased by 236 cases (up 10%) to 2,503 and road traffic collisions by 121 cases (up 16%) to 900. These two categories were added as short form conclusions in Coroner Statistics 2014, resulting in the large increase seen in figure 4, for the 'all other conclusion' group.

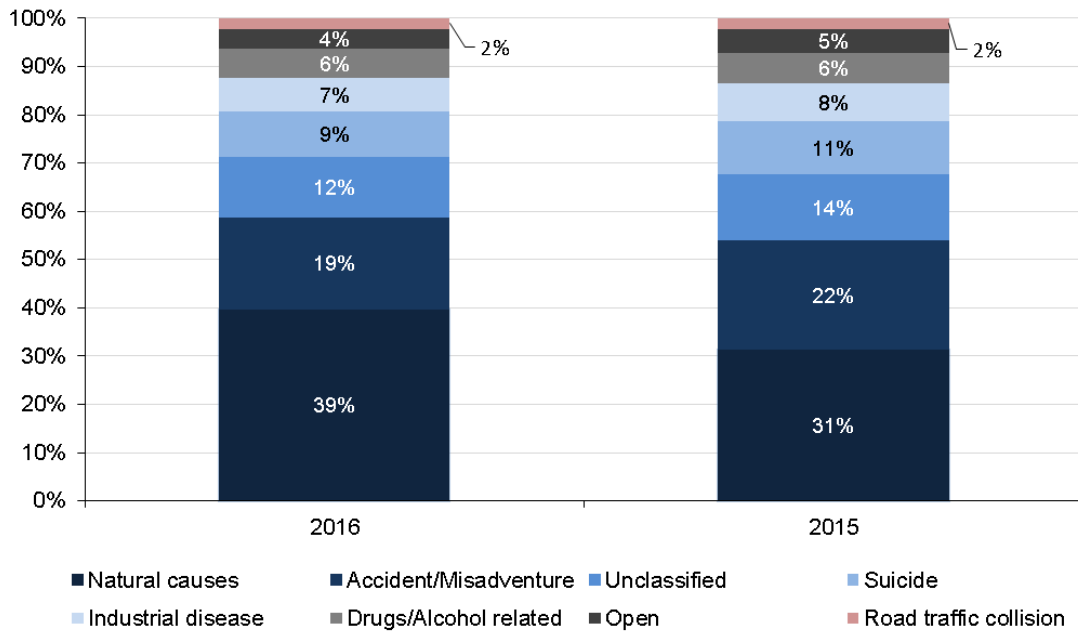
Open conclusions have been decreasing over the same period, particularly over the last few years - they accounted for 4% in 2016 compared with 9% in 2006.

Figure 6 shows the proportion changes in inquest conclusions between 2015 and 2016. The natural cause inquest conclusion has had the largest shift, increasing its share by 8 percentage points compared to 2015. Both suicide and accident and misadventure inquest conclusions showed slight decreases when compared to 2015, down 2 and 3 percentage points respectively.

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<sup>12</sup> An analysis on unclassified conclusions can be found in the Coroners Statistics 2012 publication (Annex A), available at: [www.gov.uk/government/publications/coroners-statistics](http://www.gov.uk/government/publications/coroners-statistics)

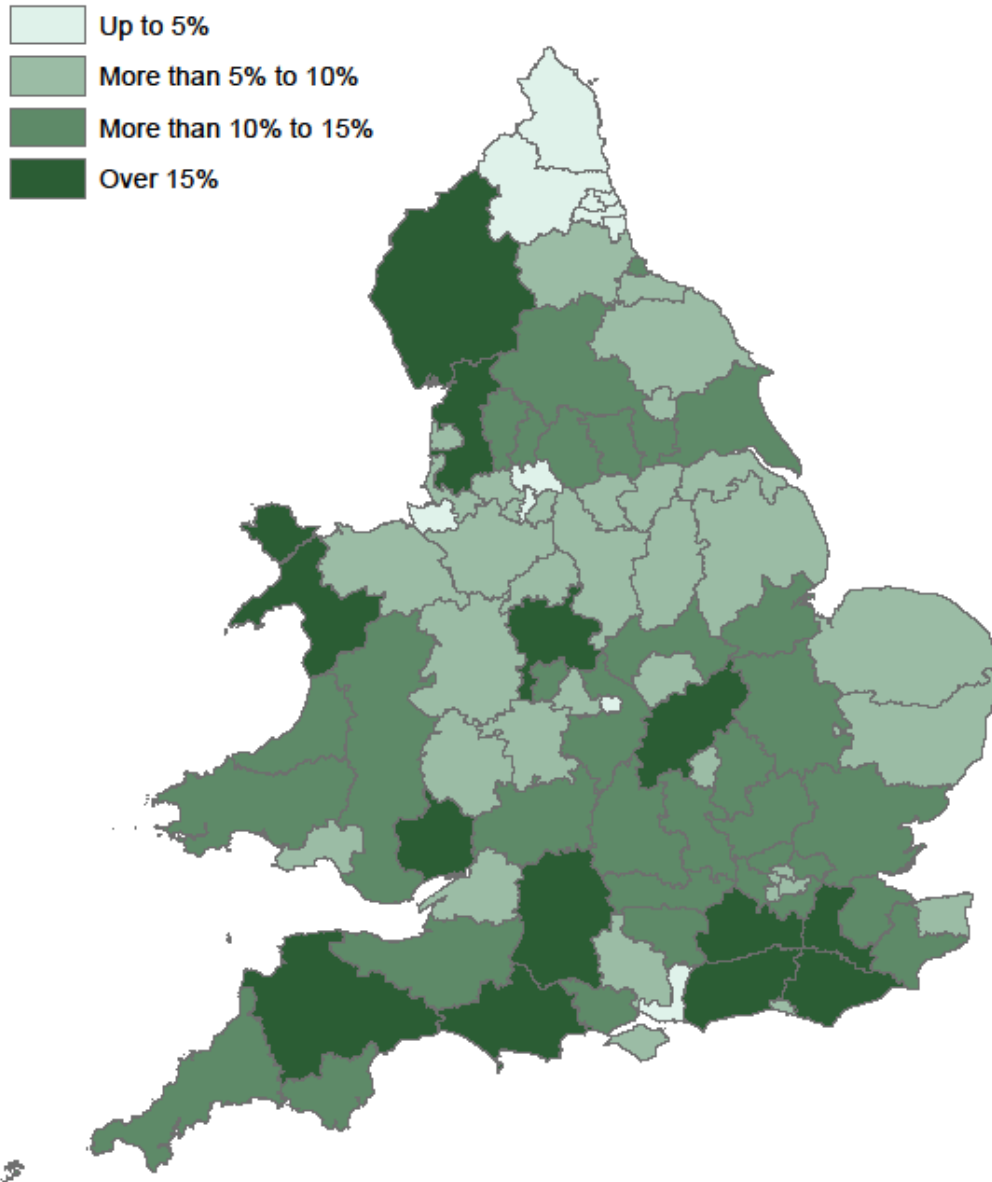
**Figure 6: Conclusions recorded at inquest, by category and as a proportion of all conclusions, England and Wales, 2015 and 2016<sup>13 14</sup>**



<sup>13</sup> Figures may not equal 100% due to rounding.

<sup>14</sup> All other conclusions (including Killed unlawfully, Killed lawfully, Attempted or self-induced abortion, Cause of death aggravated by lack of care, or self-neglect, Stillborn) were not included in the chart as they represented less than 1% of the short-form conclusions

**Map 3: Suicide conclusions as a proportion of all inquest conclusions, England and Wales, 2016**



The proportion of conclusions recorded as suicide varies from 1% in Portsmouth and South East Hampshire and Gateshead and South Tyneside to 25% in East Sussex.

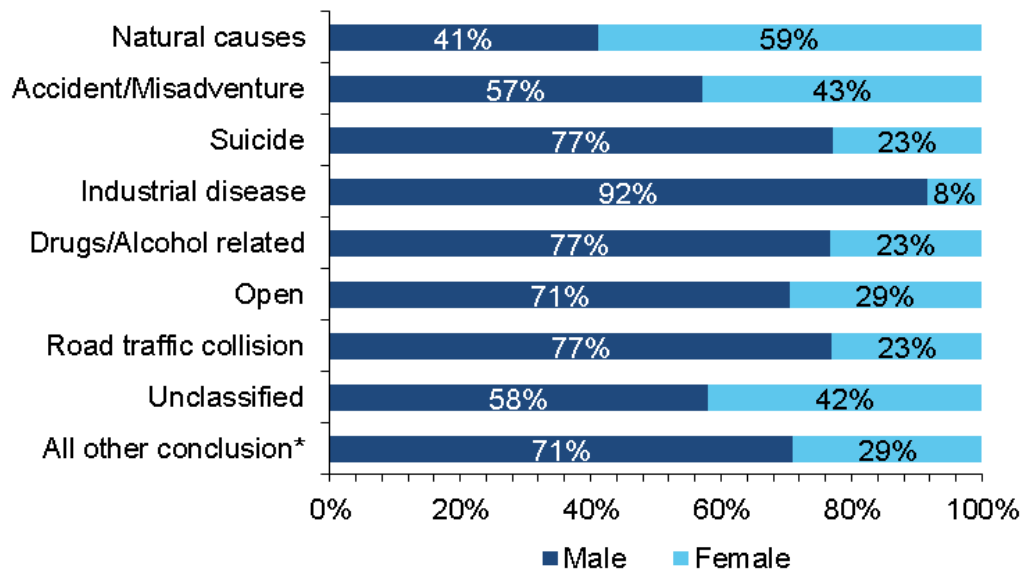
#### **Differences in conclusions recorded by gender**

The pattern of conclusions recorded differs between males and females. Male deaths accounted for 57% of all conclusions recorded in 2016, however they

accounted for 54% of deaths reported; this suggests that males are more likely to die in circumstances that lead to an inquest. Female deaths accounted for 43% of all conclusions recorded in 2016 (and 46% of all deaths reported).

Figure 6 shows the variation in the gender proportions, depending on the type on inquest conclusion. Industrial disease had the highest proportion of males, at 92% and natural causes had the highest proportion of females, with 59%.

**Figure 7: Conclusions recorded at inquests by gender, England and Wales, 2016**



\*Killed unlawfully, Killed lawfully, Attempted or self-induced abortion, Stillborn, Neglect, Want of Attention at Birth, and Disaster

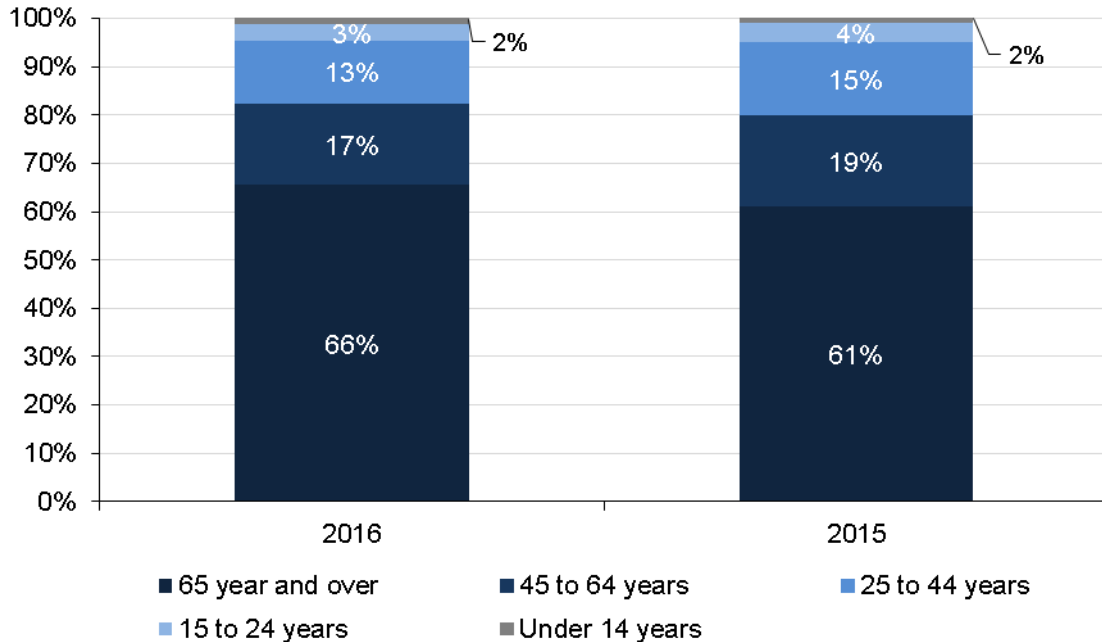
**Age of deceased in inquests where a conclusion was recorded**

Since 2008, coroners have been asked to provide information (in summary form) on the ages of persons in inquest cases where a conclusion was recorded. Of the inquests completed in 2016, 66% related to persons who were aged 65 years or over at time of death compared with 5% related to persons under 25 years of age (see Table 8). Although an age breakdown of registered deaths in England and Wales in 2016 is not yet available, ONS figures for 2015 show that 85% of registered deaths in England and Wales were persons aged 65 or over, with only 1% aged under 25 years old.

The profile of the age of deceased at inquests has changed slightly from 2015 to 2016. The percentage of inquests completed relating to persons aged 65 or over has increased from 61% to 66%, while the percentage of those between 25 and 65 years has fallen from 34% to 30%. This may be due to the increase in the number of deaths of individuals subject to DoLS authorisations, all of

which require an inquest and may predominantly relate to the older population.

**Figure 8: Age of deceased in inquests where a conclusion was recorded, England and Wales, 2016<sup>15</sup>**



**Inquests with juries and adjourned inquests**

There were 576 inquests held with juries in 2016 (representing 1% of all inquests), an increase of 119 compared to 2015.

The number of inquests held with juries showed a downward trend until 2013, but it has increased year on year since 2014 to the highest level since 2003. This mirrors the upward trend in the number of inquests held and the more recent upward trend in deaths in state detention. The proportion of inquests held with juries has however remained stable at between 1% and 2% over the last eleven years (see Table 9).

In 2016, 753 inquests were adjourned (and not resumed) by the coroner under Schedule 1<sup>16</sup> of the Coroners and Justice Act 2009 because criminal proceedings took place. This represents 2% of all inquests concluded, the same proportion as 2013 to 2015, and slightly less than in earlier years - around 3% since 2006.

<sup>15</sup> The 'age not known' category has been excluded from the chart due to small numbers (less than 0.5%). Totals may not add up to 100% due to rounding.

<sup>16</sup> Schedule 1 of the Coroners and Justice Act 2009 states that the coroner should adjourn an inquest in the event that criminal proceedings may or will take place.

### **Time taken to process an inquest**

The estimated<sup>17</sup> average time taken to process an inquest in 2016 (defined as being from the date the death was reported until the conclusion of the inquest) was 18 weeks (see Table 13)<sup>18</sup>, a reduction of two week compared to 2015. This can largely be attributed to DoLS where, in accordance with the Chief Coroner's guidance, in uncontroversial cases, an inquest can be a 'paper inquest', i.e. decided in open court but on papers without the needs for witnesses or a post-mortem.

The time taken to process an inquest varies by coroner area - the maximum average time taken to process an inquest in 2016 was 40 weeks, and the minimum average time was 5 weeks. The large range of average time (35 weeks – based on 5 and 40 weeks) could be due to the fact that coroners' caseloads can vary greatly and a direct comparison between coroner areas is therefore not advised.

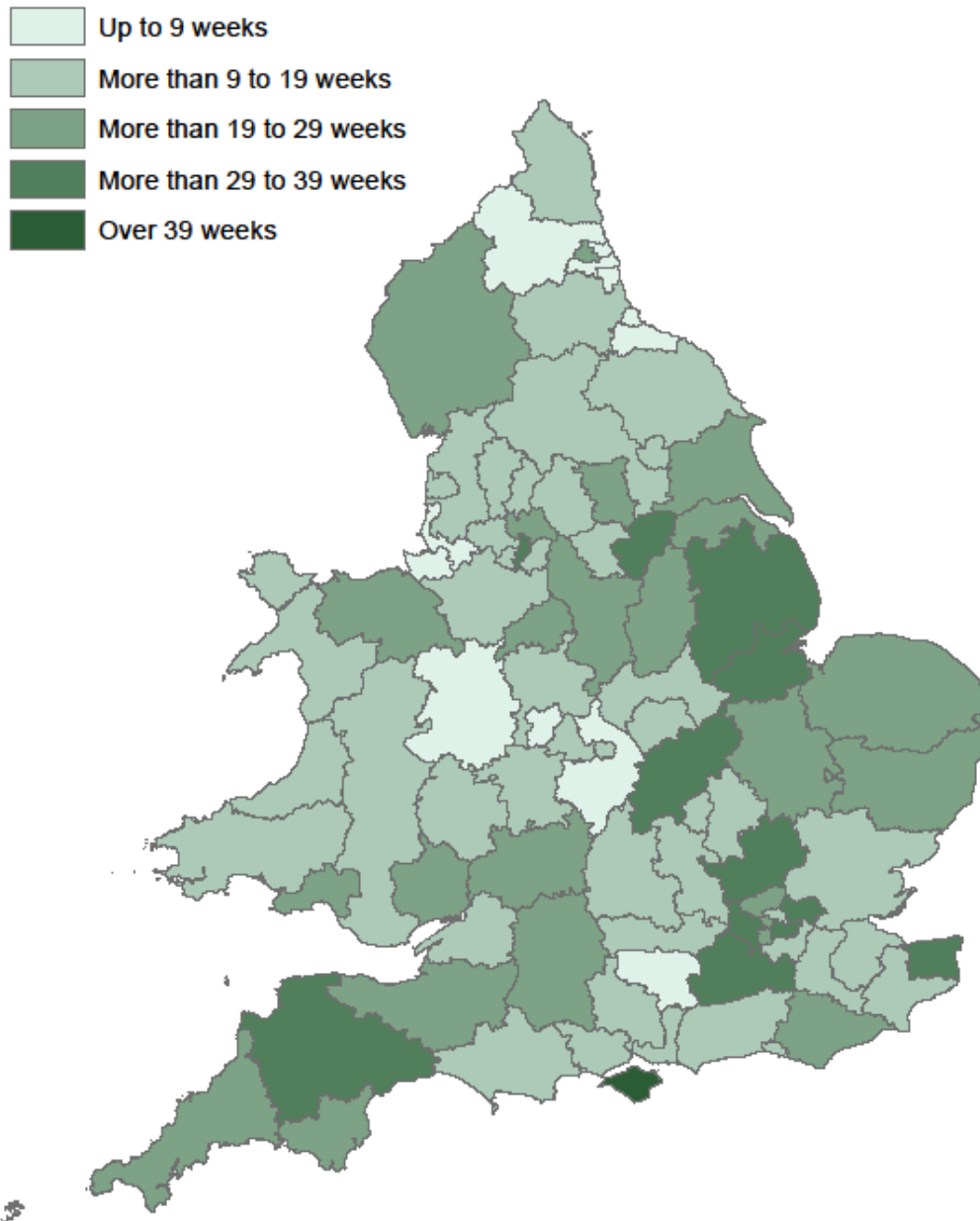
More information about how the average time taken has been estimated can be found in the [explanatory notes](#) section of this report.

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<sup>17</sup> A direct average of the time taken to process an inquest cannot be calculated from the summary data collected; an estimate has been made instead. Please see the [explanatory notes section](#) of this report for more information.

<sup>18</sup> Only deaths occurring within England and Wales are included in this estimation.

**Map 4: Estimated average time taken to process inquests, England and Wales, 2016**



The average time taken to process an inquest varies from 5 weeks in Hartlepool to 40 weeks in Isle of Wight.

## 4: Treasure and Treasure Trove

On 24 September 1997, the Treasure Act 1996 came into force and replaced the common law of Treasure Trove in England and Wales. The 1996 Act introduced new requirements for reporting and dealing with finds. Not all finds need be the subject of an inquest. For more information please see:

[www.legislation.gov.uk/ukpga/1996/24/contents](http://www.legislation.gov.uk/ukpga/1996/24/contents)

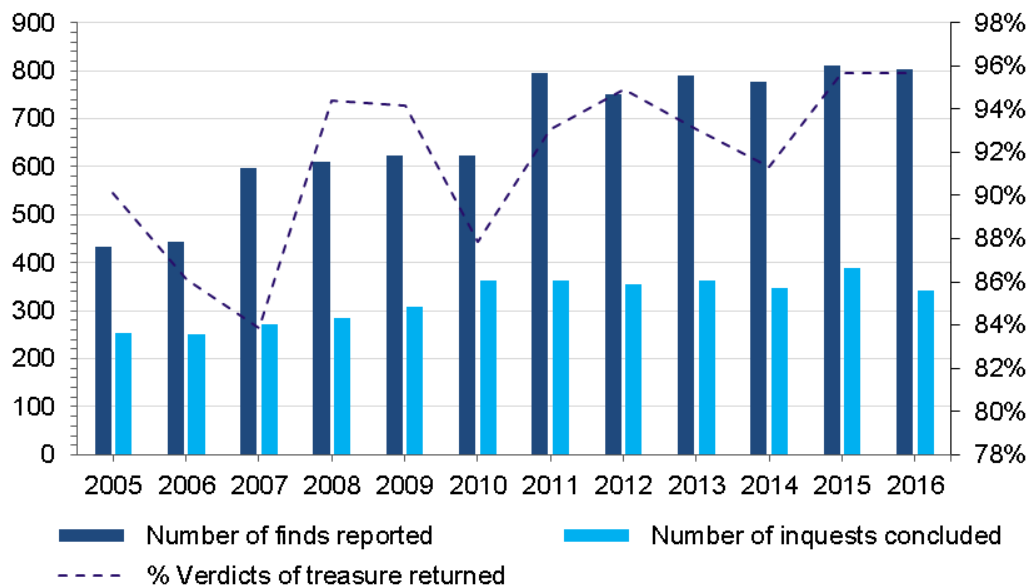
In 2016, 804 finds were reported and 341 inquests were concluded. In addition, there were two inquests held into Treasure Trove in 2016 (relating to finds made before the current Act came into force), and it is likely that a few such inquests will continue to be held from time to time.

The number of finds reported was steadily increasing over the last ten years but decreased slightly to 804 in 2016 from the peak of 810 in 2015 (down 1%). Of those 341 inquests concluded in 2016, 96% (326) returned a verdict of treasure, the same proportion as in 2015.

An annual report on the operation of the Treasure Act 1996 is published by the Department for Culture, Media and Sport. For more information please see:

[www.gov.uk/government/organisations/department-for-culture-media-sport/series/treasure-and-portable-antiquities-statistics](http://www.gov.uk/government/organisations/department-for-culture-media-sport/series/treasure-and-portable-antiquities-statistics)

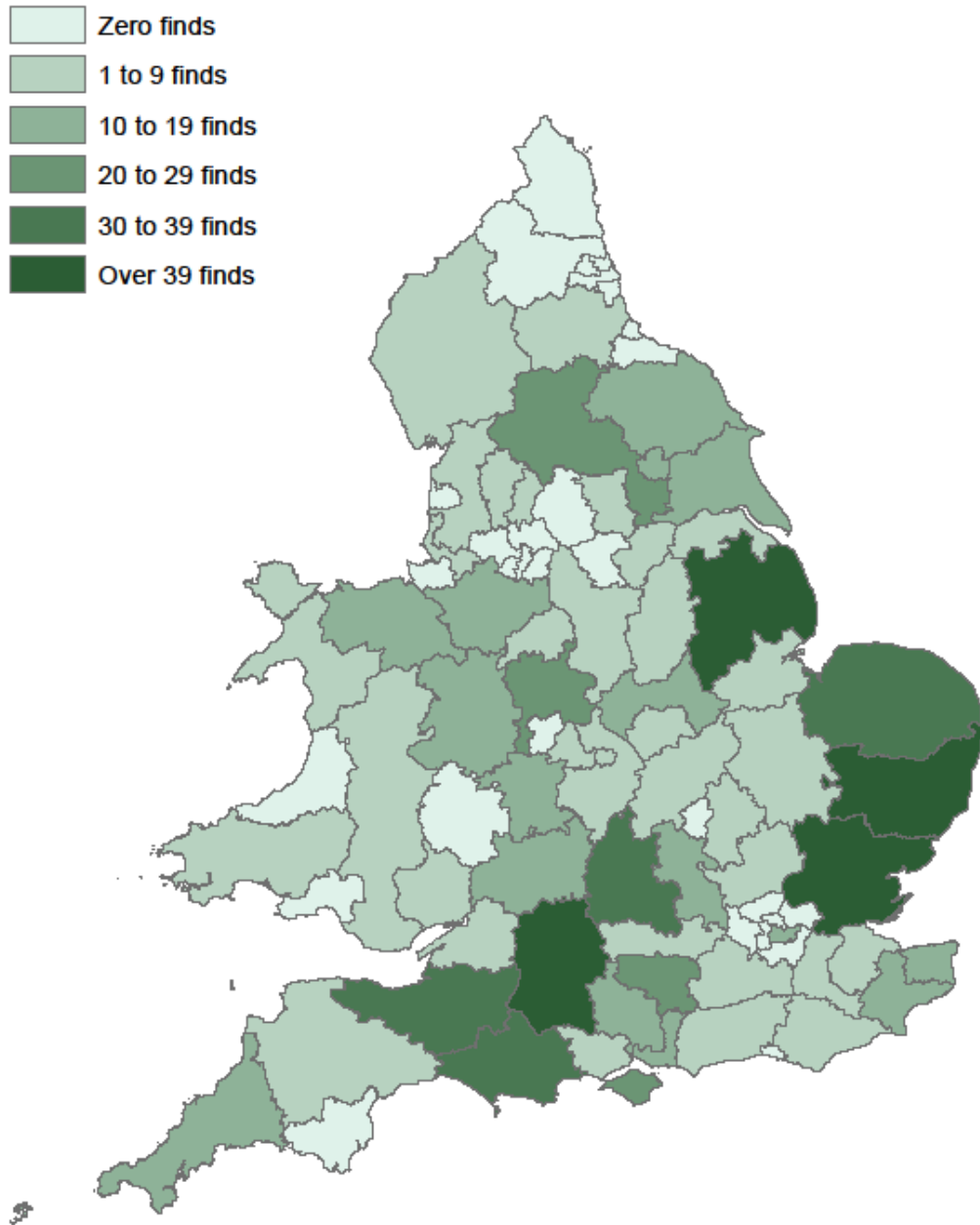
**Figure 9: Finds reported to coroners, treasure inquests held under the Treasure Act, and proportion of treasure verdicts returned, 2004-2016<sup>19</sup>**



<sup>19</sup> This chart does not include reported findings under “Treasure Trove”



**Map 5: Number of treasure finds reported to coroners, England and Wales, 2016**



Thirty coroner areas had no treasure finds reported to them. Suffolk had the highest number of treasure finds at 77.

# Annex A: Map of coroner areas in England and Wales, 2016



## Key to coroner areas

### North East

- 101 – County Durham and Darlington
- 103 – Hartlepool
- 104 – North Northumberland
- 105 – South Northumberland
- 106 – Teesside
- 107 – Gateshead and South Tyneside
- 108 – Newcastle upon Tyne
- 109 – North Tyneside
- 110 – Sunderland

### North West

- 201 – Cheshire
- 203 – Cumbria
- 205 – Manchester (city)
- 206 – Manchester North
- 207 – Manchester South
- 208 – Manchester West
- 209 – Blackburn, Hyndburn and Ribble Valley
- 210 – Blackpool and Fylde
- 211 – East Lancashire
- 212 – Preston and West Lancashire
- 213 – Sefton, Knowsley and St Helens
- 214 – Liverpool and the Wirral

### Yorkshire and the Humber

- 301 – East Riding and Hull
- 302 – North Lincolnshire and Grimsby
- 303 – York City
- 304 – North Yorkshire - East
- 305 – North Yorkshire - West
- 306 – South Yorkshire - East
- 307 – South Yorkshire - West
- 308 – West Yorkshire - East
- 309 – West Yorkshire - West

### East Midlands

- 401 – Derby and Derbyshire
- 403 – Leicester and South Leicestershire
- 404 – North Leicestershire and Rutland
- 406 – Central Lincolnshire
- 408 – South Lincolnshire
- 409 – Northamptonshire
- 410 – Nottinghamshire

### West Midlands

- 501 – Herefordshire
- 502 – Shropshire, Telford and Wrekin
- 504 – Staffordshire South
- 505 – Stoke-on-Trent and North Staffordshire
- 507 – Warwickshire
- 508 – Birmingham and Solihull
- 509 – Black Country
- 510 – Coventry
- 512 – Worcestershire

### East of England

- 601 – Bedfordshire and Luton
- 602 – Cambridgeshire and Peterborough
- 604 – Essex
- 605 – Hertfordshire
- 607 – Norfolk
- 611 – Suffolk

### London

- 701 – City of London [not visible]
- 702 – East London
- 703 – Inner London North
- 704 – Inner London South
- 705 – Inner London West
- 706 – North London
- 707 – South London
- 708 – West London

### South East

- 801 – Berkshire
- 802 – Brighton and Hove
- 803 – Buckinghamshire
- 804 – East Sussex
- 805 – Central Hampshire
- 806 – North East Hampshire
- 807 – Portsmouth and South East Hampshire
- 808 – Southampton and New Forest
- 809 – Isle of Wight
- 810 – Central and South East Kent
- 811 – Mid Kent and Medway
- 812 – North East Kent
- 813 – North West Kent
- 814 – Milton Keynes
- 815 – Oxfordshire
- 816 – Surrey
- 817 – West Sussex

### South West

- 901 – Avon
- 902 – Cornwall and Isles of Scilly
- 903 – Exeter and Greater Devon
- 904 – Plymouth, Torbay and South Devon
- 906 – Dorset
- 908 – Gloucestershire
- 910 – Somerset
- 912 – Wiltshire and Swindon

### Wales

- 1001 – South Central Wales
- 1003 – Carmarthenshire and Pembrokeshire
- 1004 – North Wales (East and Central)
- 1005 – Ceredigion
- 1006 – Gwent
- 1007 – Swansea and Neath Port Talbot
- 1009 – North West Wales

## Annex B: Details of recent coroner area amalgamations

The following table summarises the coroner area amalgamations that have occurred since the 2014. Coroner areas formed during 2016 are reported on by their new areas within this bulletin.

<b>Date effective</b>	<b>Previous coroner area</b>	<b>New coroner area</b>	<b>Nature of merge</b>
01-Jan-15	North and West Cumbria; South and East Cumbria	Cumbria	2 into 1
02-Apr-15	Liverpool; the Wirral	Liverpool and the Wirral	2 into 1
01-Aug-15	North and East Cambridgeshire; South and West Cambridgeshire; Peterborough	Cambridgeshire and Peterborough	3 into 1
01-Apr-16	East Somerset; West Somerset	Somerset <sup>20</sup>	2 into 1
01-Apr-16	Cornwall; the Isles of Scilly	Cornwall and the Isles of Scilly	2 into 1
01-Apr-16	Cardiff and Vale of Glamorgan; Powys, Bridgend & Glamorgan Valleys;	South Wales Central	2 into 1

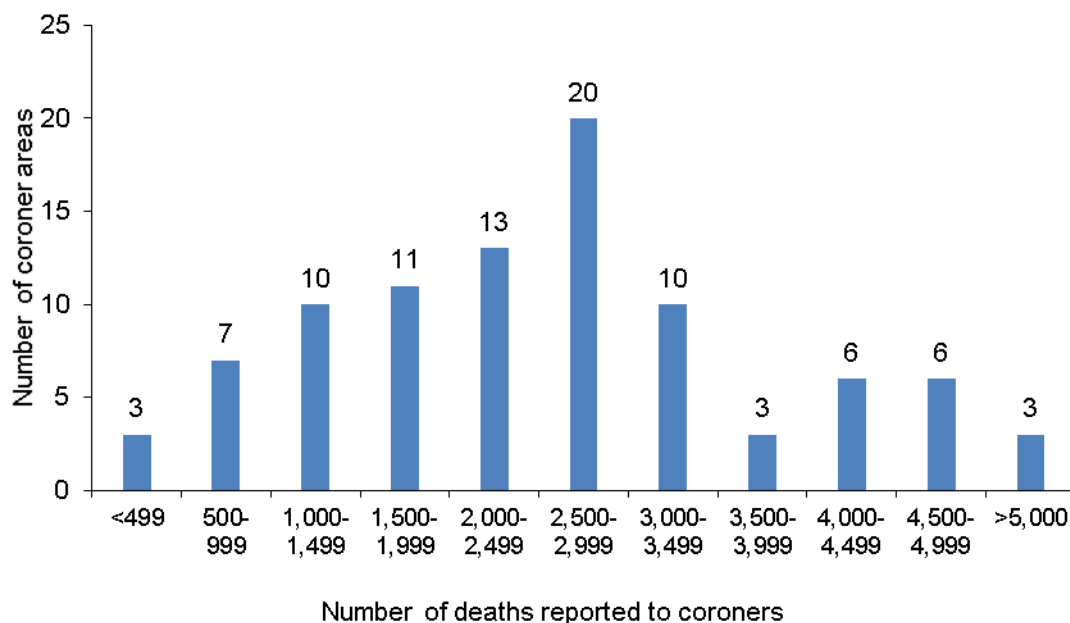
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<sup>20</sup> In 2015 a coroner data return was received from Somerset coroner area, even though this area did not officially come into force until 1st April 2016. Therefore it was not possible to report on East Somerset and West Somerset coroner areas individually in 2015, even though they were officially separate Coroners Areas during this year.

## Annex C: Further analysis of deaths reported to coroners

The number of deaths reported to coroners in 2016 varied by coroner area – from 218 in City of London to 7,100 in Essex. The number of deaths reported in each area will be affected by its size, population and demographic breakdown so comparisons of deaths reported to the coroner across coroner areas should be treated with caution.

**Figure C1: Number of deaths reported to coroners, 2016**

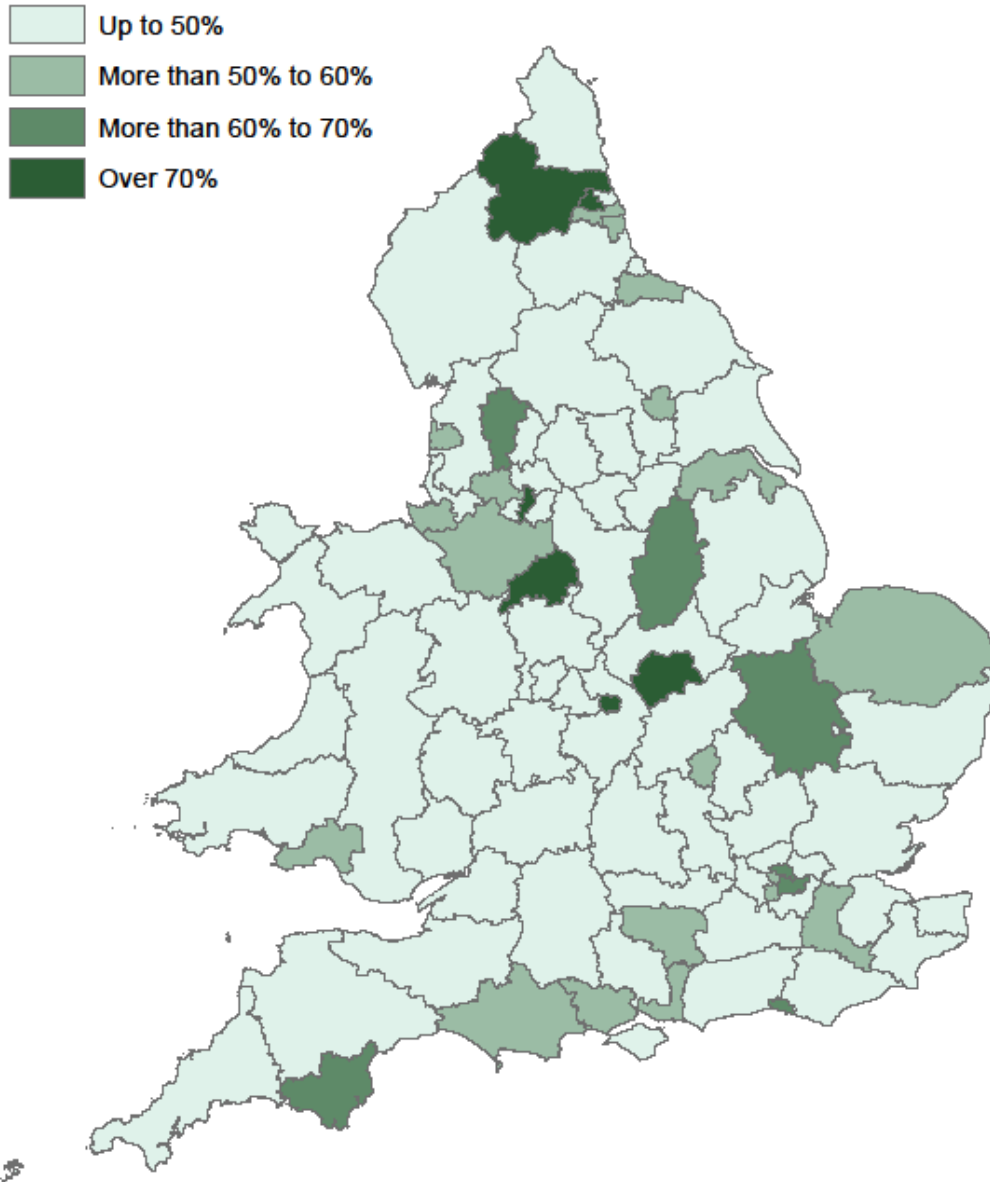


When looking at the number of deaths reported to coroners in 2016 as a proportion of registered deaths<sup>21</sup>, which allow for some differences in population characteristics, there is still a wide variation across coroner areas e.g. 28% in East Lancashire compared to 96% in Stoke-on-Trent and North Staffordshire. However, caution should be taken when using these figures as local area factors can influence these proportions. For example large hospitals near boundary lines can impact the proportion, due to the difference between the coroners figures being based on the place of death and the ONS figures being based on the place of residence.

<sup>21</sup> As the ONS death registration figures are based on area of usual residence whereas the coroners' figures are based on the area where a person died, these figures should be used with caution. For example, the coroner office for the City of London shows a distorted figure of 532% due to the low levels of residence and high level of commuters.

Map C below shows deaths reported in each coroner area in 2016 as a percentage of the total registered deaths in each area<sup>22</sup>.

**Map C: Deaths reported to coroners as a percentage of total registered deaths in each area<sup>23</sup>, England and Wales, 2016**



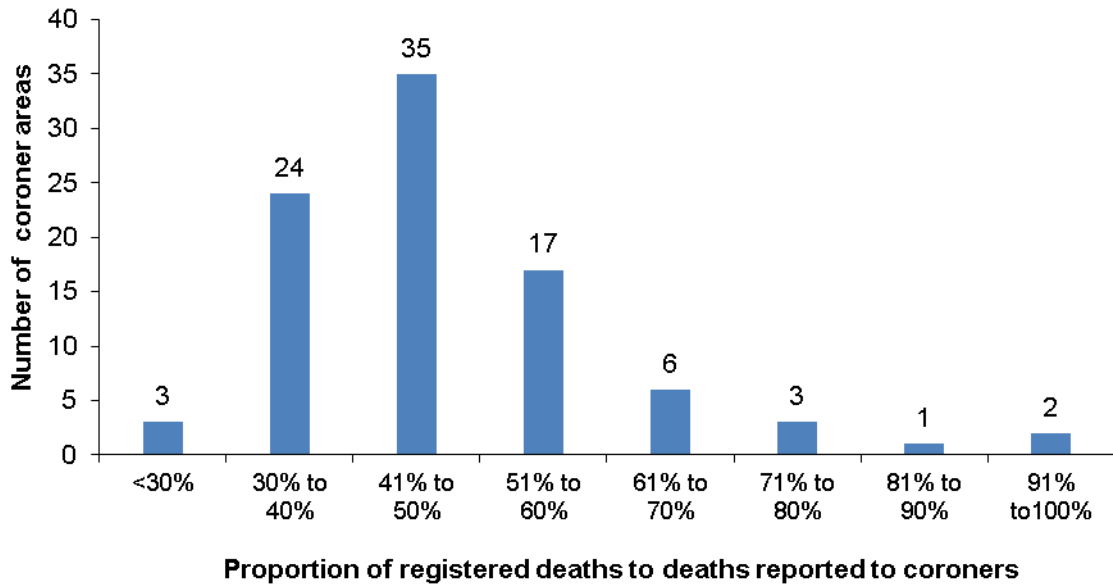
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<sup>22</sup> The registered deaths figure for 2016 is provisional, based on ONS monthly death registration figures

<sup>23</sup> The ONS death registration figures are based on area of usual residence whereas the coroners' figures are based on the area where a person died. Therefore the coroner office for the City of London shows a distorted figure of 532% due to the low levels of residence and high level of commuters.

The proportion of deaths reported to the coroner varies from 28% in East Lancashire to 96% in Stoke-on-Trent and North Staffordshire compared to the national average of 46%.

**Figure C2: Deaths reported to coroners in 2016 as a proportion of registered deaths<sup>24,25</sup>**



<sup>24</sup> Provisional figure based on ONS monthly death registration figures for 2016

<sup>25</sup> Data for the City of London has been excluded from this analysis due to the small size of this coroner area. The total number of coroner areas shown in Figure C2 is therefore 91.

## Explanatory notes

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods, and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

The data analysed in this publication are based on annual returns from coroners. Thanks are due to coroners and their staff for their work in preparing these returns.

Information on the quality and consistency of the Coroners statistics can be found in the supporting document published alongside this bulletin.

### **Revisions to statistics for previous years**

The estimated figure for the number of registered deaths in 2015 which was derived from monthly data for the purposes of Table 2 in last year's edition of this bulletin has now been replaced by the annual figure published by the Office for National Statistics.

### **Symbols and conventions**

The following symbols have been used throughout the tables in this bulletin:

- n/a = Not applicable
- = Zero
- .. = No data available
- (p) = provisional data
- (r) = Revised data



## Contacts

Current and previous editions of this publication are available for download at:

[www.gov.uk/government/collections/coroners-and-burials-statistics](http://www.gov.uk/government/collections/coroners-and-burials-statistics)

The spreadsheet file of the statistical tables referred to in this bulletin is also available for download from this address, along with the CSV file and the Coroners Statistical Tool spreadsheet.

Press enquiries should be directed to the Ministry of Justice press office:

Tel: 0203 334 3529

Email: [Sebastian.Walters@justice.gsi.gov.uk](mailto:Sebastian.Walters@justice.gsi.gov.uk)

Other enquiries about these statistics should be directed to:

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7th Floor (7.07)

102 Petty France

London

SW1H 9AJ

Email: [CAJS@justice.gsi.gov.uk](mailto:CAJS@justice.gsi.gov.uk)

A copy of the data collection form which was sent to coroners may be obtained via the contact details above.

General enquiries about the statistical work of the Ministry of Justice can be e-mailed to: [statistics.enquiries@justice.gsi.gov.uk](mailto:statistics.enquiries@justice.gsi.gov.uk)

Other National Statistics publications, and general information about the official statistics system of the UK, are available from [www.statistics.gov.uk](http://www.statistics.gov.uk).

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