



Coroners Statistics Annual 2017

England and Wales

Main points

Decrease in deaths reported to coroners in 2017	↓	229,700 deaths were reported to coroners in 2017, the lowest level since 2014 – down 5% (11,500) compared to 2016. This mainly reflects the decrease in the number of deaths under Deprivation of Liberty Safeguard (DoLS) authorisations reported to coroners.
Excluding DoLS, reported deaths still down 2%	↓	Excluding deaths under DoLS orders, there were 225,834 deaths reported to coroners in 2017, down 2% compared to 2016. This is in contrast to the 2% rise in ONS provisional figures for deaths registered in 2017.
Deaths in state detention (excluding DoLS) down 8%	↓	528 deaths in state detention were reported to coroners in 2017 (down from 574 in 2016), driven by a 22% fall in deaths of individuals under the Mental Health Act 1983.
Reported DoLS deaths decreased following amendment to the Coroners Act 2009	↓	Following amendment to the Coroners and Justice Act 2009, as of 3 April 2017 an individual under a DoLS is no longer considered to be 'otherwise in state detention'. As a result, the number of DoLS deaths reported to coroners fell 66% to 3,900 in 2017 compared to the previous year.
Post-mortem examinations were carried out on 37% of all deaths reported to coroners	↓ ↑	There were 85,600 post-mortem examinations ordered by coroners in 2017, a decrease of 1% on 2016. However, the proportion of reported deaths requiring a post-mortem is up one percentage point since 2016.
18% fewer inquests were opened in 2017, driven by a fall in DoLS deaths	↓	31,500 inquests were opened in 2017, down 18% compared to 2016, driven by fewer DoLS deaths reported to coroners, which prior to the 2009 Act amendment, required an inquest, as all state detention deaths do.
Inquest conclusions down 16%, driven by fall in natural cause conclusions	↓	In 2017, 33,900 inquest conclusions were recorded in total, down 16% on 2016, reflecting the decrease in the number of inquests opened and fewer DoLS deaths (almost all had a natural cause conclusion).

This annual bulletin presents statistics on deaths reported to coroners in England and Wales in 2017. Information is provided on the number of deaths reported to coroners, post-mortem examinations and inquests held, and conclusions recorded at inquests. For previous editions of this report please see: www.gov.uk/government/collections/coroners-and-burials-statistics.

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1. Deaths Reported

5% decrease in the number of deaths reported to coroners in 2017

229,746 deaths were reported to coroners in 2017, the lowest level since 2014. This shows a decrease of 5% (11,465) compared to 2016, reflecting the decrease in the number of deaths under DoLS authorisations reported to coroners.

43% of all registered deaths were reported to coroners in 2017

The proportion of registered deaths in England and Wales reported to coroners has decreased by three percentage points compared to 2016, the lowest proportion since 2003.

All deaths in England and Wales must be registered with the Registrar of Births and Deaths; statistics on all registered deaths are published by the Office for National Statistics (ONS). 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. The Ministry of Justice's coroner statistics provide the number of deaths which are reported to coroners in England and Wales. Further background information is provided in the Guide to Coroners Statistics published alongside this bulletin.

The number of deaths reported to coroners in 2017 fell by 11,465 (5%) to 229,746, but in contrast to ONS registered deaths which rose by 8,070 in 2017 (up 2%)¹. Consequently, the proportion of registered deaths in 2017 reported to coroners fell by three percentage points, to 43%, compared with 2016. This reflects the decrease in the number of deaths of individuals under DoLS authorisations reported to coroners (following the removal of DoLS deaths from the 'otherwise in state detention' category in April 2017 – see section 2).

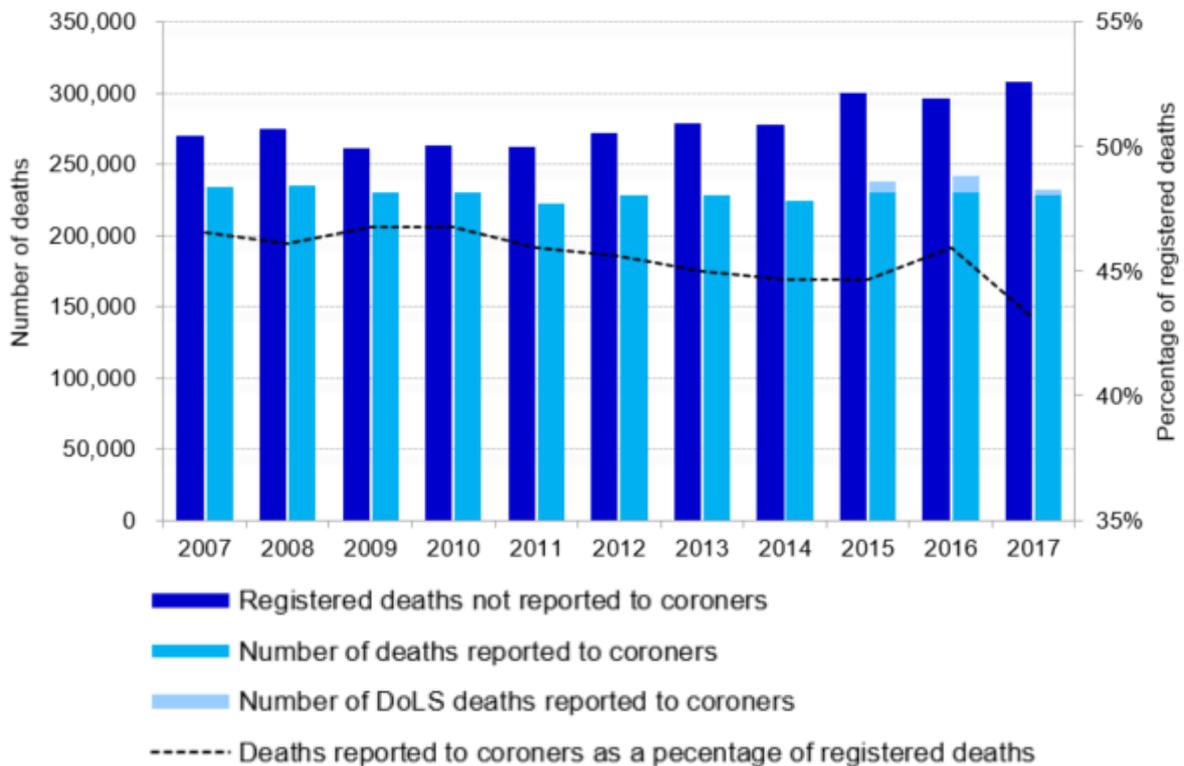
Over the last decade, the number of registered deaths in England and Wales has been broadly increasing, first dipping to a low of 484,367 in 2011 before gradually rising to 525,048 in 2016. Provisional figures for 2017 show a further increase to 533,118, the highest since 2003. The number of deaths reported to coroners has followed a similar trend, falling to 222,371 deaths reported in 2011 and then rising to a high of 241,211 in 2016. However, in contrast to deaths registered in 2017, deaths reported to coroners in 2017 has fallen. This shows a reversal to similar broadly stable levels seen prior to 2015, before the impact of DoLS on 2015 and 2016 figures.

When removing deaths of individuals under DoLS authorisations, the number of deaths reported to the coroner has fallen 2% (3,955 deaths) when compared to 2016. Therefore, whilst the removal of DoLS is a key factor in the decrease in the number of deaths reported to coroners, it is not the main cause.

¹ Provisional figure based on ONS monthly death registration figures for 2017

Figure 1: ONS registered deaths and deaths reported to coroners, England and Wales, 2007-2017

(Source: Table 2)



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 5,698 Out of England and Wales orders in 2017, a decrease of 40 cases on 2016 (1%). The number of orders issued represented 2% of the total number of deaths reported to coroners, and this proportion has remained stable since 2011 (see Table 5).

Deaths Abroad

Of the 229,746 deaths reported to coroners in 2017, around 1% (2,094) were reports of deaths that had occurred outside England and Wales. This proportion has also remained stable since 2011.

2. Deaths in State Detention

Deaths in state detention, excluding DoLS, down 8% in the last year

Excluding DoLS, deaths in state detention decreased from 574 deaths in 2016 to 528 in 2017, driven by a fall in number of deaths of individuals detained under the Mental Health Act 1983 (as amended). This reverses the steady increase seen since 2011.

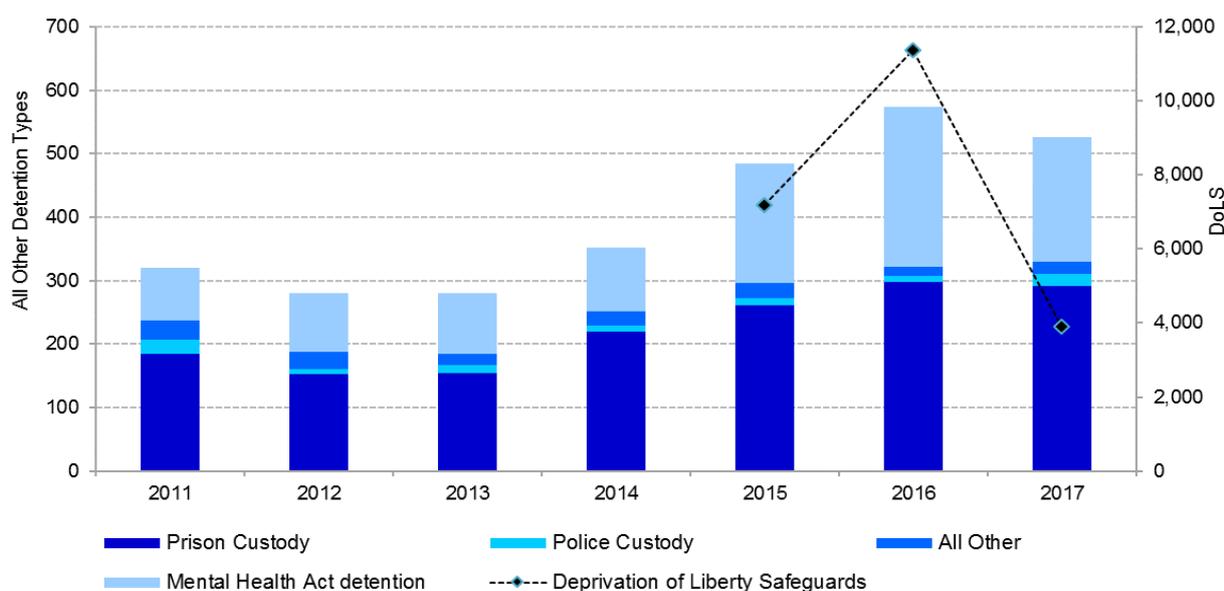
In 2017, 4,440 deaths in state detention were reported to coroners², a decrease of 7,510 deaths (63%) on the previous year and representing 2% of all deaths reported to coroners.

In 2017, there were 3,912 deaths of individuals subject to DoLS authorisations reported to the coroner, down from 11,376 in 2016 – this reflects the amendment to the Coroners and Justice Act 2009 which removed the requirement to report a DoLS death to the coroner as ‘otherwise in state detention’ with effect from 3 April 2017. Despite this, deaths of individuals subject to DoLS authorisations accounted for 88% of all deaths in state in detention reported to coroners in 2017.

Figure 2 below shows that the inclusion of DoLS within the number of deaths in state detention has distorted the long-term trend. However, when excluding DoLS deaths, there has been a general rise in deaths in state detention since 2011.

Figure 2: Number of deaths in state detention, by type of detention, 2011-2017

(Source: Table 6)



Excluding DoLS deaths, the number of deaths in state detention fell by 8% compared with 2016 – reversing the 19% increase seen between 2015 and 2016. The decrease has been driven by a fall in the number of deaths under Mental Health Act detention, with 196 deaths in 2017 (down 22% on 2016). This decrease mirrors the 7% decrease seen in the latest (2016/17) Care Quality Commission statistics on deaths under the Mental Health Act 1983 (as amended)³.

² These data only represent deaths in custody which were referred to a coroner and subsequently reported to the Ministry of Justice in the coroner’s annual return.

³ For further detail please see Figure 22 of ‘Monitoring the Mental Health Act in 2016/17’, available at the following link: http://www.cqc.org.uk/sites/default/files/20180227_mhareport_web.pdf

3. Post-mortem Examinations Held

Post-mortem examinations were carried out on 37% of all deaths reported in 2017

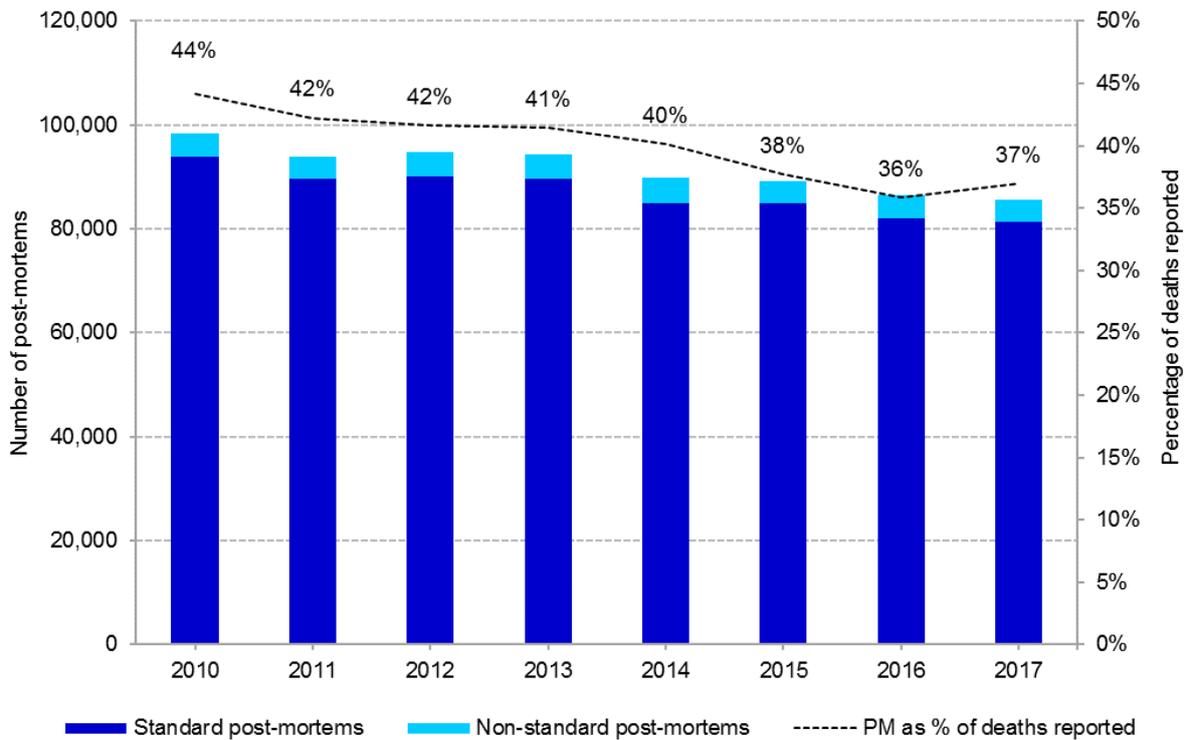
There were 85,552 post-mortem examinations ordered by coroners in 2017, a decrease of 1% on 2016.

Post-mortem examinations were held for 85,552 deaths reported to coroners in 2017, down 993 (1%) from 2016. This represents 37% of all deaths reported to coroners in 2017, up from 36% in 2016. Since 1995, the proportion of deaths for which a post-mortem examination was ordered has steadily decreased from 61% to 37% (see Table 3).

Figure 1 of the supporting guidance document provides an overview of the possible outcomes when a death is reported to a coroner, including circumstances involving a post-mortem.

Figure 3: Post-mortems as a percentage of deaths reported to coroners, England and Wales, 2010-2017

(Source: Tables 3-4)

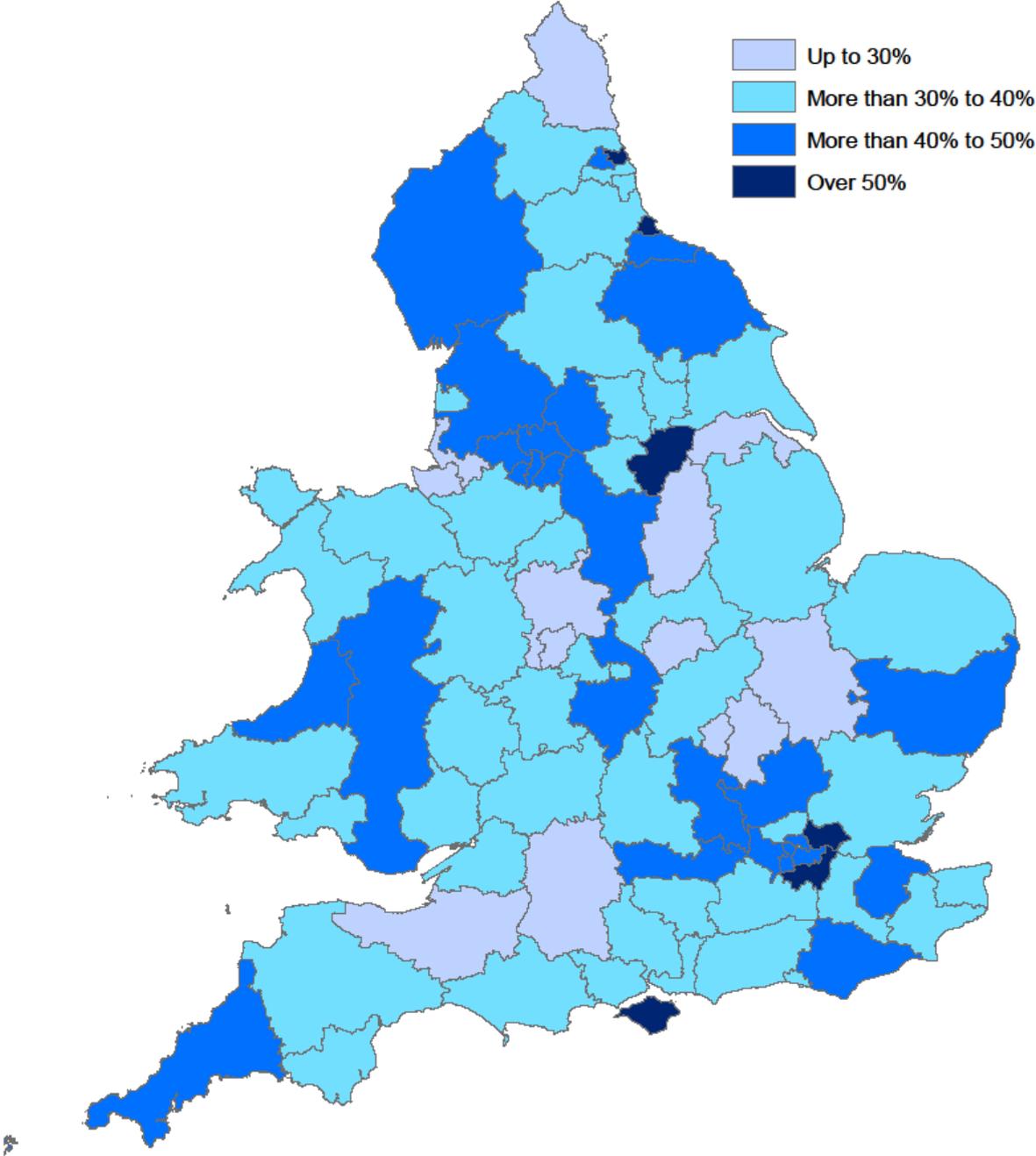


Post-mortem examinations are classified as either standard or non-standard, depending on the cost of the examination. A non-standard post-mortem is charged at a higher rate than a standard post-mortem and is defined as a post-mortem which requires specialist skills, for example, paediatric or specialist pathologist. In 2017, almost all (95%) of post-mortems were ordered at a standard rate - this proportion has remained at the same level since 2011.

The proportion of post-mortems carried out by coroners varies from 21% of deaths reported in North Lincolnshire and Grimsby to 59% in Isle of Wight, as shown in Map 1 below.

Map 1: Post-mortems held as a proportion of deaths reported to coroners, England and Wales, 2017

(Source: Table 11)



Post-mortem examinations in inquest cases

When an inquest is opened, a post-mortem examination is often ordered. In 2017, just over half (55%) of inquest cases involved a post-mortem, up 8 percentage points on 2016. The increase in this proportion is due to the decrease in DoLS deaths, all of which required an inquest - the majority recorded an inquest conclusion of natural causes and so a post-mortem examination was unlikely. Therefore, although the number of inquests held has decreased, the percentage of those requiring a post-mortem has increased.

Post-mortem examinations in non-inquest cases

In the majority (83%) of deaths referred to coroners, there is no inquest. In 2017, there were 61,969 non-inquest cases where a post-mortem was held – 33% of all non-inquest cases in 2017. This percentage has risen one percentage point in the last year, reversing the constant downward trend seen since the beginning of the time series (56% in 1995).

Post-mortem examinations in potential inquest cases

Prior to July 2013 (when the Coroners and Justice Act 2009 and the suite of Rules and Regulations to underpin the Act were implemented), 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. In 2017, there were 8,657 potential inquest cases being dealt with by coroners in England and Wales, with 73% of these cases requiring a post-mortem. The number of potential inquest cases has been steadily rising since the category was introduced in 2013, up 35% in the last year.

Cases requiring neither a post-mortem nor inquest

There were 127,601 cases reported to coroners where there was neither a post-mortem nor an inquest. This type of case has generally been increasing in number over the time series, from 81,701 in 1995 to 133,101 in 2016, before decreasing to 127,601 (down 4%) in 2017. However, as a proportion of all reported deaths, this has remained fairly constant around 56% and is still therefore the most common outcome when a death is reported to a coroner.

Post-mortems involving histology, toxicology and less-invasive techniques

In 2017, 23% (19,257) of all post-mortems included histology, the same proportion as in 2016. Post-mortems including toxicology increased over the same period to 16,934 (up 5%), with 20% of all post-mortems held in 2017 including toxicology. This follows the steady rising trend seen since 2011.

There were 1,671 post-mortems conducted using less-invasive techniques (such as Computerised Tomography (CT) scans) in 2017, up from 764 cases in 2016. 56 of the 89 coroner areas in England and Wales carried out at least one less-invasive post-mortem, while Black Country and South Yorkshire (Western) conducted over a quarter of all their post-mortems using less-invasive techniques.

4. Inquests Opened

18% fewer inquests opened in 2017 due to removal of DoLS requirements

The number of inquests opened in 2017 decreased by 7,107 to 31,519, driven by the removal of the requirement to report DoLS deaths to coroners - all such cases previously required an inquest.

There were 31,519 inquests opened in 2017, down 18% on 2016, driven by the removal of the requirement to report DoLS deaths to coroners – all of which previously required an inquest⁴. The number of inquests opened is the lowest since 2014, the last reporting year before DoLS investigation requirements were introduced.

Inquest cases represented 14% of all deaths reported to coroners in 2017, down from 16% in 2016 due to the changes to DoLS investigation requirements. The number of inquests opened as a proportion of deaths reported in 2017 varied across coroner areas, from 5% in both Hartlepool and Gwent to 25% in Inner North London. However, most coroner areas held inquests for between 10% and 20% of all deaths reported.

Map 2 shows the inquests opened as a proportion of deaths reported in 2016 for all coroner areas in England and Wales.

Inquests with juries and adjourned inquests

There were 501 inquests held with juries in 2017 (representing 1% of all inquests), a decrease of 75 (13%) compared to 2016.

The number of inquests held with juries showed a downward trend until 2014, but then increased year on year to 576 in 2016, the highest level since 2003. Whilst there has been a decrease to 501 in 2017, this mirrors the fall in the number of inquests held and the overall number of deaths reported to coroners. The proportion of inquests held with juries has however remained stable between 1% and 2% over the last decade (see Table 9).

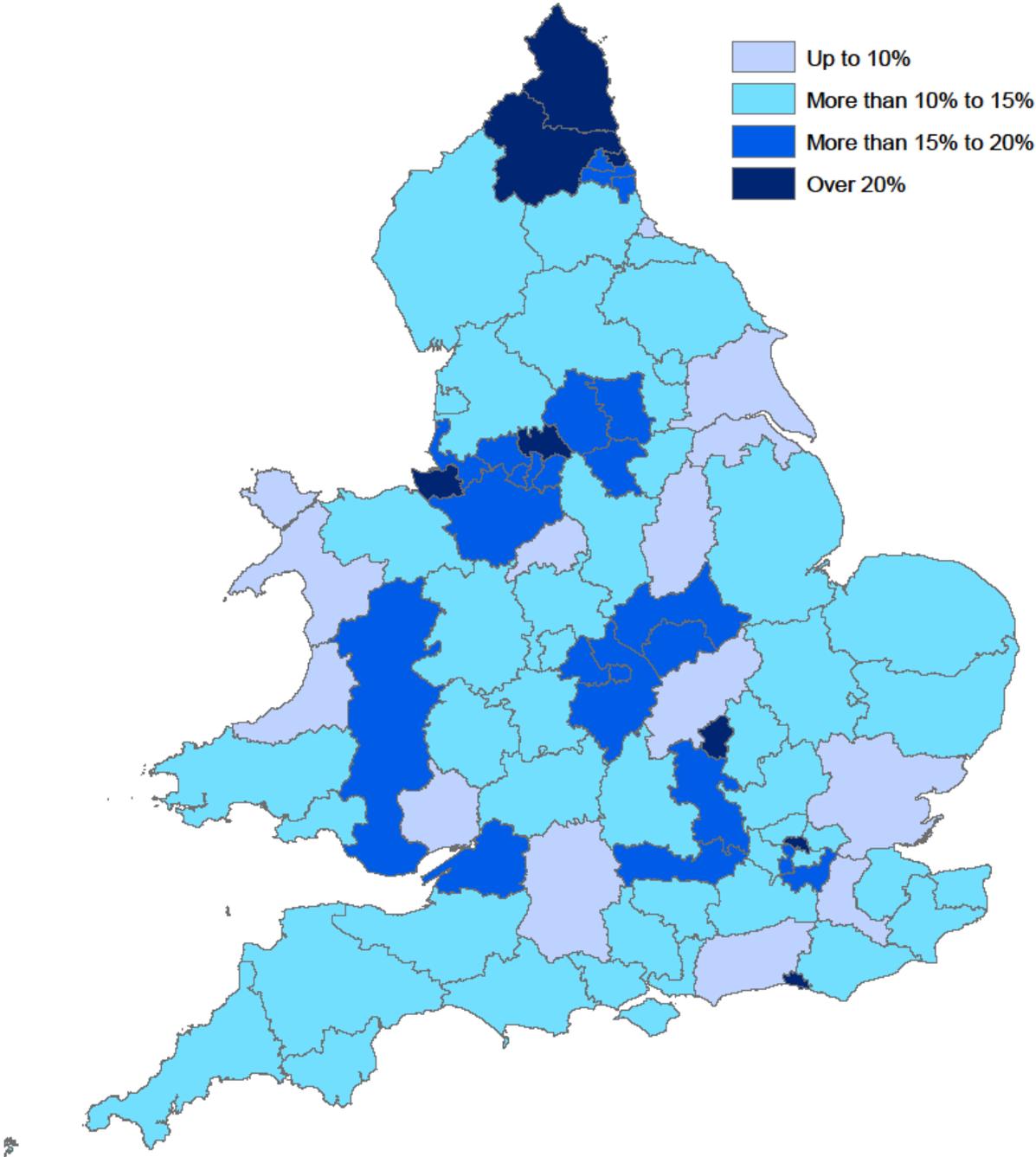
In 2017, 940 inquests were adjourned (and not resumed) by the coroner under Schedule 1⁵ of the Coroners and Justice Act 2009, up 25% on 2016. This represents 3% of all inquests concluded, an increase of one percentage point from 2016.

⁴ More information on DoLS can be found in the Guide to Coroners Statistics published alongside this bulletin.

⁵ Schedule 1 to 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.

Map 2: Inquests opened as a proportion of deaths reported to coroners, England and Wales, 2017

(Source: Table 11)



5. Inquest Conclusions

16% fall in inquest conclusions driven by natural cause conclusions

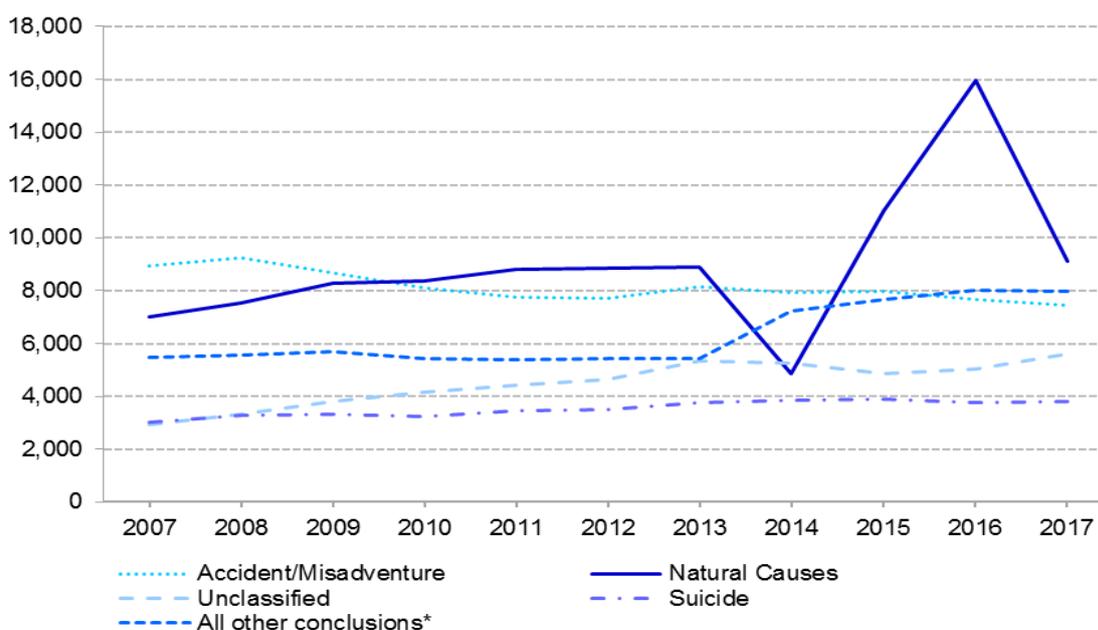
In 2017, 33,945 inquest conclusions were recorded (down 16%), reflecting the decrease in the number of inquests opened. Inquest conclusions of natural causes were down 43% on 2016 to 9,100, reversing the increasing trend driven by DoLS deaths seen in the previous two years.

There were 33,945 inquest conclusions recorded in 2017, down by 6,559 (16%) from 2016, directly reflecting the fall in the number of inquests opened, which has fallen due to the removal of the requirement to investigate deaths under DoLS from April 2017 onwards (see section 4). This is the lowest number of inquest conclusions since 2014 and indicates a return towards pre-DoLS inquest levels. Background information on inquest conclusions is provided in Chapter 2 of the supporting guidance document.

Two of the inquest short form conclusions accounted for almost half (49%) of all conclusions in 2017 – natural causes and deaths by accident or misadventure. As in previous years, these were the two most common short form conclusions (by order of frequency) making up 27% and 22% of all inquest conclusions in 2017, respectively.

Figure 4: Number of conclusions recorded at inquests, England and Wales, 2007-2017

(Source: Table 7)



*Includes 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 Related⁶, and Road traffic collision

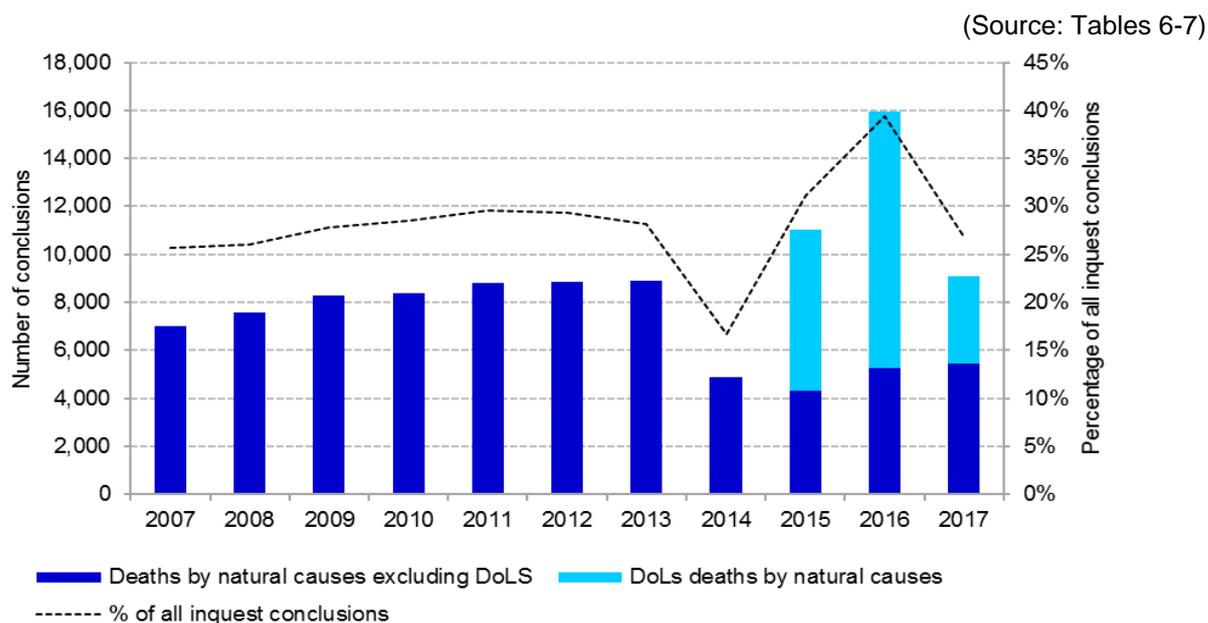
In 2015 and 2016, there were significant increases seen in natural causes conclusions, driven by deaths of individuals subject to DoLS authorisations where the majority (94%) had an inquest conclusion of natural causes. In line with the falls seen in the number of inquests opened and inquest conclusions following the removal of the requirement to report DoLS deaths, there has also been a corresponding decrease in the number of natural cause conclusions in 2017 (down 43%).

⁶ For years 2007-2013, this includes the previously used conclusions "Dependence on Drugs" and "Non-dependence on Drugs"

Historically, natural cause conclusions had been gradually increasing to a peak of 8,881 in 2013, and as a proportion, accounted for 25-30% of all inquest conclusions (between 2006 and 2013). However, since 2014 (excluding DoLS cases) there has been a drop of around 50% in such conclusions.

Figure 5 below shows the time series of natural cause inquest conclusions when including or excluding DoLS. In 2017, natural cause conclusions made up 27% of conclusions, down from 39% of all inquest conclusions in 2016. However, when DoLS cases are excluded, natural causes only made up 16% and 13% of all inquest conclusions in 2017 and 2016 respectively, suggesting the continued impact of the Coroner Act 2009 reforms as above.

Figure 5: Number of natural cause conclusions recorded at inquests, England and Wales, 2007-2017



In 2017, the number of unclassified conclusions increased by 598 cases (up 12%) to 5,630, continuing the increasing trend since 2015 despite the decrease in overall inquest conclusions in 2017. Unclassified conclusions made up 17% of all conclusions in 2017 and can fluctuate due to the 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 conclusions⁷.

The proportion of conclusions recorded as suicide has remained broadly constant over the past five years, increasing from 9% of all conclusions in 2016 to 11% in 2017. This proportion varies from 3% in Portsmouth and South East Hampshire area to 28% in North West Wales⁸, mirroring the latest ONS data release on suicides in the UK⁹ which suggests Wales has the highest suicide rate of regions in England and Wales.

⁷ An analysis on unclassified conclusions can be found in the Coroners Statistics 2012 publication (Annex A), available at: www.gov.uk/government/statistics/coroners-statistics

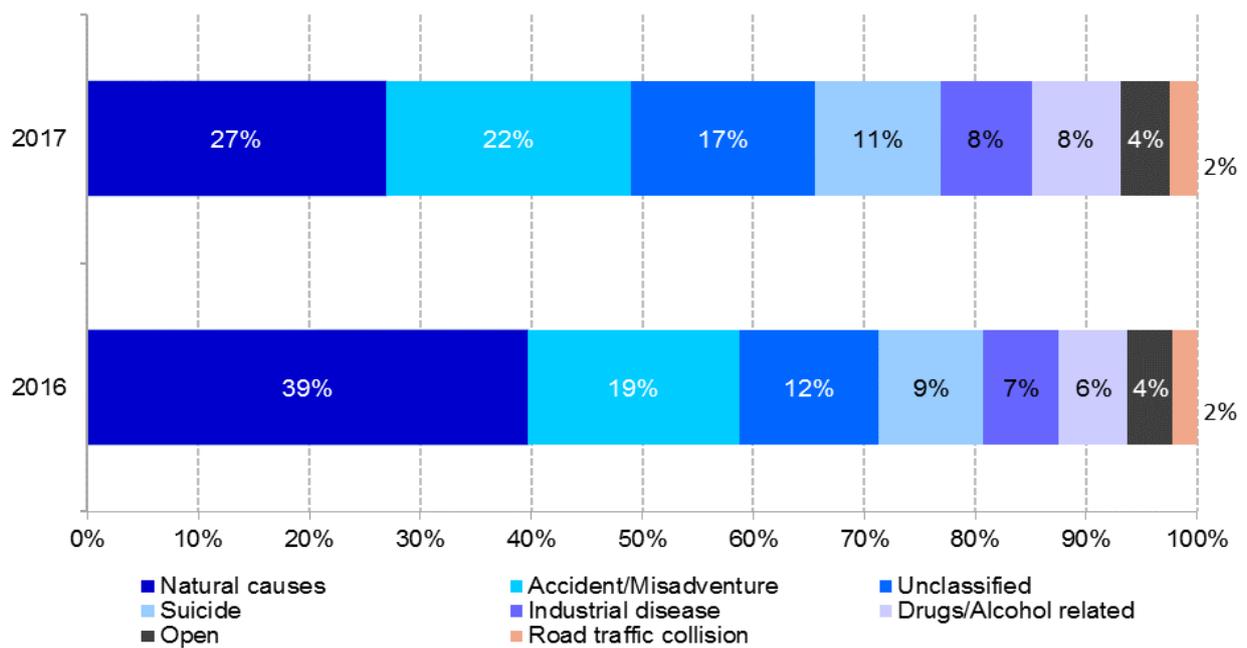
⁸ Note that City of London has been excluded from this analysis due to a disproportionately low number of inquest conclusions (19) distorting the trend.

⁹ Please refer to <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registrations> for data on UK suicide rates released by the ONS; note that 2017 data is not yet available at the time of publication of this bulletin.

For the remaining main conclusion types, drugs and alcohol related cases increased by 201 cases (up 8%) to 2,704 and road traffic collisions decreased by 56 cases (down 6%) to 844. Open conclusions have continued to decrease, following the long-term trend seen in the past 15 years - they accounted for 4% of all conclusions in 2017 compared with 10% in 2002.

Figure 6 shows the proportion changes in inquest conclusions between 2016 and 2017. The natural cause inquest conclusion has had the largest shift, decreasing its share by 12 percentage points compared to 2016, reflecting the reduction in the number of natural causes conclusions. Both accident and misadventure and unclassified inquest conclusions showed increases when compared to 2016, up three and five percentage points respectively.

Figure 6: Conclusions recorded at inquest, by category and as a proportion of all conclusions, England and Wales, 2016 and 2017^{10 11} (Source: Table 7)



¹⁰ Total percentages may not equal 100% due to rounding.

¹¹ 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

6. Inquest Conclusions by Sex

Conclusions recorded at inquests by sex¹²

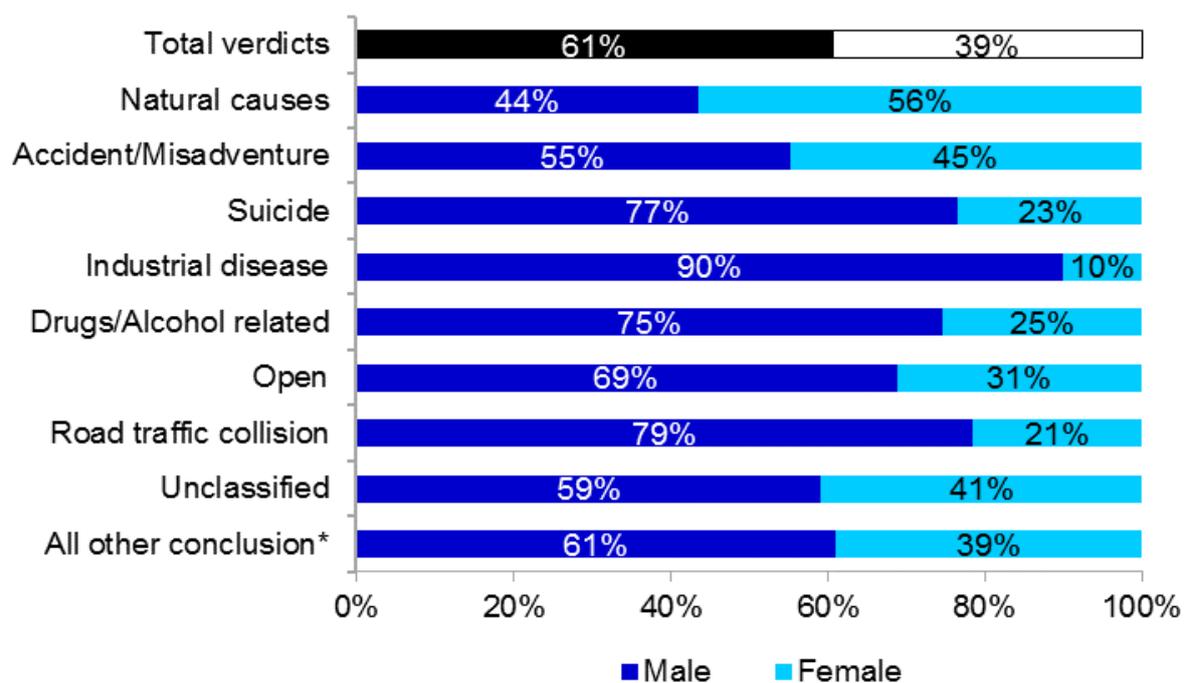
Male deaths accounted for 61% of all conclusions recorded in 2017 while female deaths accounted for 39%. In 2016, the percentages were 57% and 43% respectively.

The pattern of inquest conclusions recorded differs between males and females. Male deaths accounted for 61% of all conclusions recorded in 2017, however they accounted for 55% of deaths reported; this suggests that males are more likely to die in circumstances that lead to an inquest. Correspondingly, female deaths accounted for 39% of all conclusions recorded in 2017 (and 45% of all deaths reported to coroners).

Figure 7 shows the variation in proportions by sex for each inquest conclusion. Industrial disease had the highest proportion of males, at 90%, and natural causes had the highest proportion of females, with 56%.

Figure 7: Conclusions recorded at inquests by sex, England and Wales, 2017

(Source: Table 7)



*Category includes Killed unlawfully, Killed lawfully, Attempted or self-induced abortion, Stillborn, Lack of care or self-neglect, Want of Attention at Birth, and Disaster

¹² The sex of the deceased is based on the 'registrable particulars' which coroners have a duty to record. Death certificates only give two options, 'male' and 'female', and these will normally be completed by the registrar based on the information given to them by the informant. Under normal circumstances there would not be an investigation to ascertain whether what the informant says corresponds to biological sex or DNA of the deceased.

7. Inquest Conclusions by Age

The majority of inquests concluded were for those aged 65 years and over

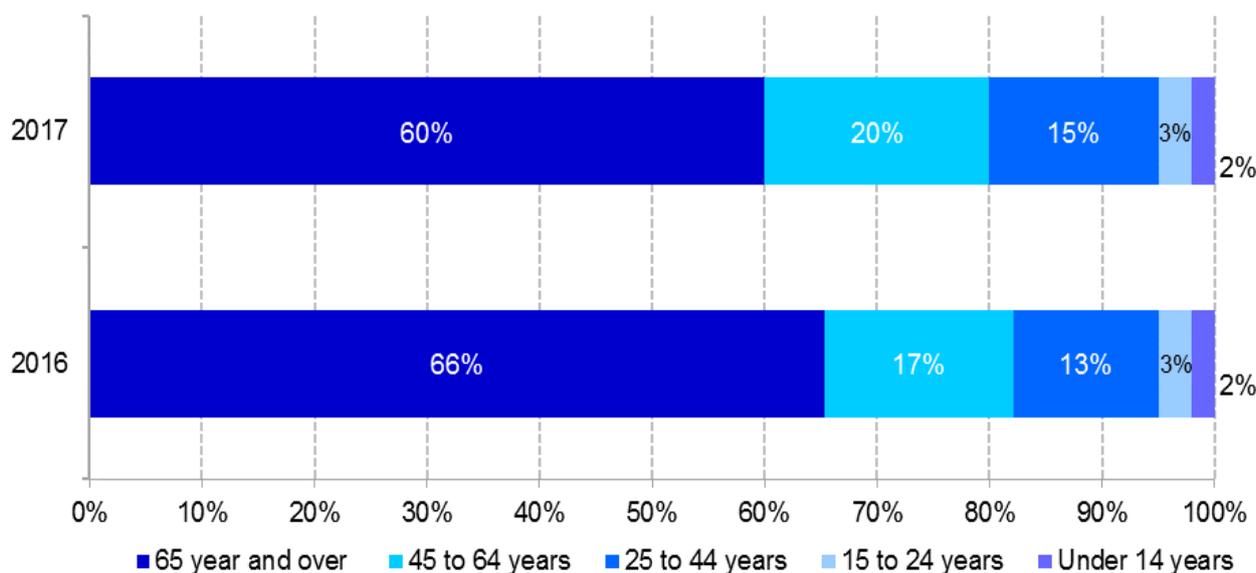
Of the inquests completed in 2017, 60% related to persons who were aged 65 years or over at time of death, compared with 5% related to persons under 25 years of age.

The profile of the age of deceased at inquests in 2017 has changed slightly from 2016. The percentage of inquests completed relating to persons aged 65 or over has fallen from 66% to 60%, while the percentage of those between 25 and 65 years has increased from 30% to 35%. This is likely due to the removal of the requirement to report DoLS deaths to the coroner from April 2017 as these will have predominantly related to the older population.

Although an age breakdown of registered deaths in England and Wales in 2017 is not yet available, ONS figures for 2016¹³ show that 84% of registered deaths in England and Wales were persons aged 65 or over, with only 1% aged under 25 years old.

Figure 8: Proportion of inquest conclusions by age of deceased, England and Wales, 2016 and 2017¹⁴

(Source: Table 8)



¹³ ONS data is available online at:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsregisteredinenlandandwalesseriesdrreferencetables>

¹⁴ 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.

8. Time Taken to Process an Inquest

Average time taken to process an inquest rises by three weeks

The estimated average time taken to process an inquest increased from 18 weeks in 2016 to 21 weeks in 2017.

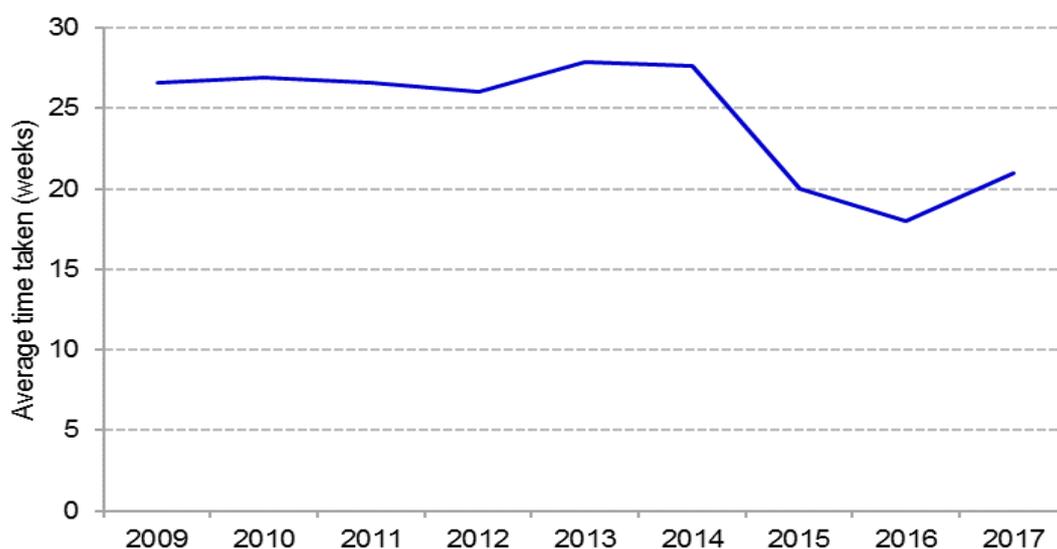
The estimated¹⁵ average time taken to process an inquest in 2017 (defined as being from the date the death was reported until the conclusion of the inquest) was 21 weeks (see Table 13)¹⁶, an increase of three weeks compared to 2016. This can largely be attributed to DoLS deaths where, in accordance with the Chief Coroner's guidance, in uncontroversial cases, there could be a 'paper inquest', i.e. not decided in open court but on papers without the need for witnesses or a post-mortem – such cases took less time to process and as a result, reduced the average time to process inquests overall. Following the removal of the requirement to report DoLS deaths to coroners in April 2017, there has been an increase in the average time to process an inquest, reversing the downward trend seen in the last few years when there were many DoLS cases.

The time taken to process an inquest varies by coroner area - the maximum average time taken to process an inquest in 2017 was 45 weeks in Lincolnshire, and the minimum was 9 weeks in Sefton, Knowsley and St. Helens. The large range of average time (36 weeks – based on 9 and 45 weeks as above) may be because of considerable variations in the profile of coroners' caseloads and a direct comparison between coroner areas is therefore not advised. Map 3 provides an overview of average times taken across England and Wales.

More information about how the average time taken has been estimated can be found in the Guide to Coroners statistics published alongside this report.

Figure 9: Average time taken to process an inquest (in weeks), 2009-2017

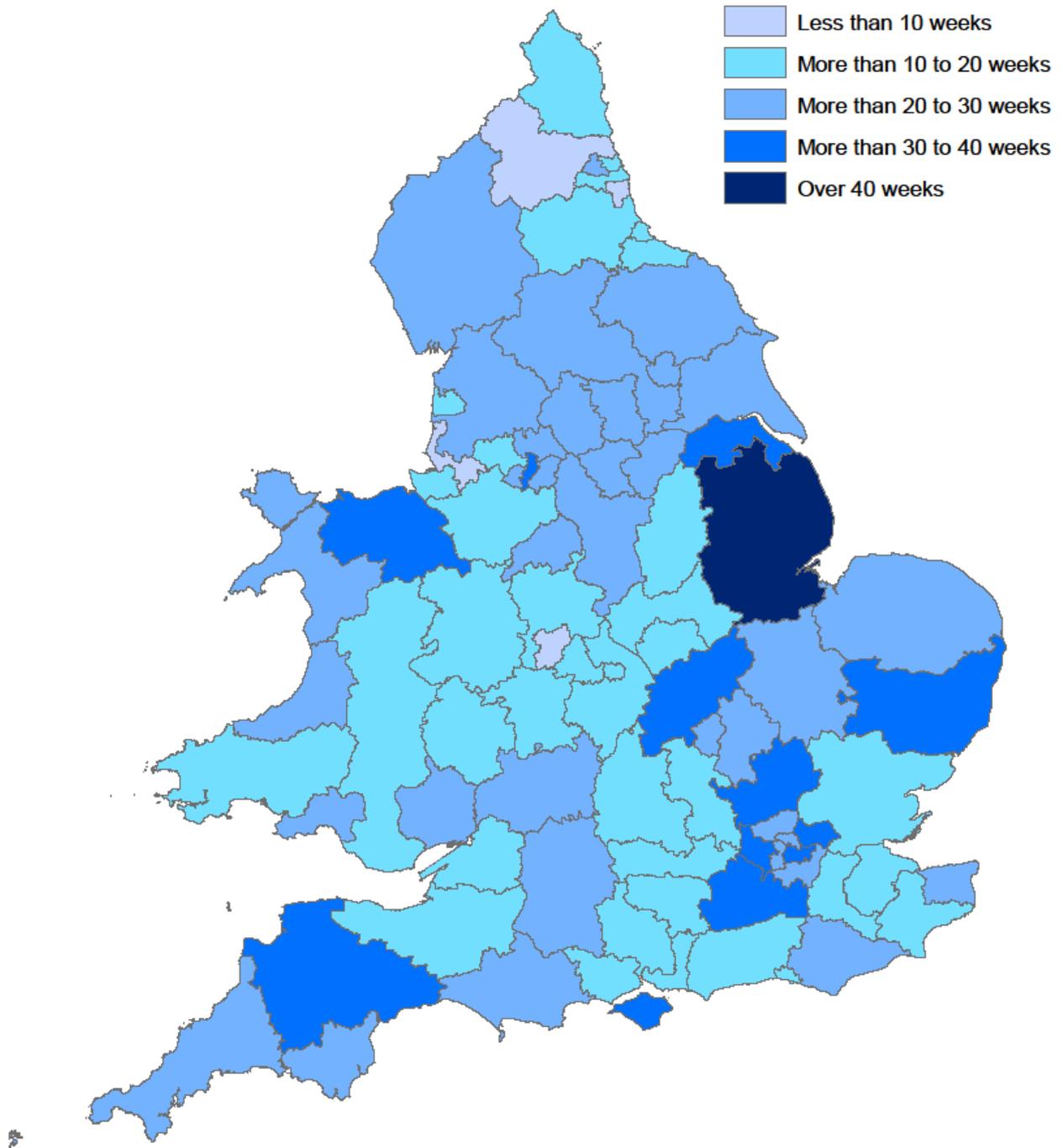
(Source: Table 9)



¹⁵ 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 Guide to Coroners statistics published alongside this report.

¹⁶ Only deaths occurring within England and Wales are included in this estimation.

Map 3: Estimated average time taken to process inquests, England and Wales, 2017
(Source: Table 13)



9. Treasure

Treasure finds up by a third in 2017 compared to the previous year

1,059 finds were reported to coroners in 2017, 255 more than in 2016. 374 inquests were concluded into finds. Of these, 92% (344) returned a verdict of treasure, four percentage points lower than in 2016.

In 2017, there were 1,059 finds reported to coroner, 32% more than in 2016. This is in line with the latest Department for Digital, Culture, Media & Sport (DCMS) figures¹⁷ (for 2016) which show that there were 1,117 finds reported in England and Wales, an increase of 11% on 2015 figures.

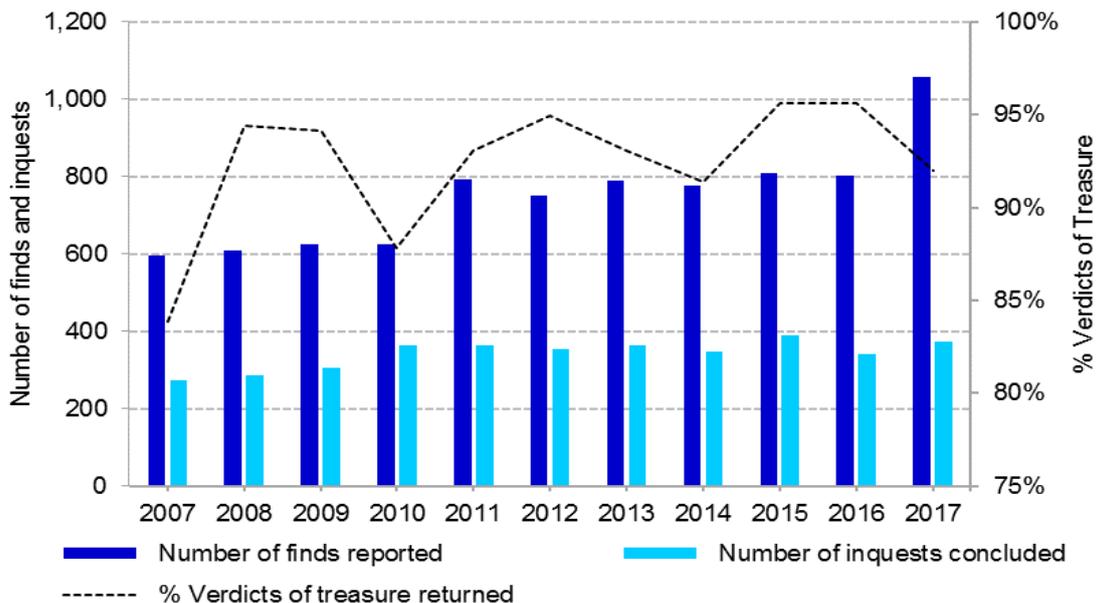
In addition, there were three inquests held into Treasure Trove in 2017 (relating to finds made before the Treasure Act 1996 came into force), and it is likely that a few such inquests will continue to be held from time to time. Please note that treasure trove figures for 2012 to 2016 inclusive have been revised following a routine data review; further information is available in Table 10.

The number of finds reported has steadily increased since the commencement of the 1996 Act in September 1997, from 54 finds in 1997 to 1,059 in 2017.

Of the 374 inquests concluded in 2017, 92% (344) returned a verdict of treasure, a decrease of four percentage points when compared to 2016.

Figure 10: Finds reported to coroners, treasure inquests held under the Treasure Act, and proportion of treasure verdicts returned, 2007-2017¹⁸

(Source: Table 10)



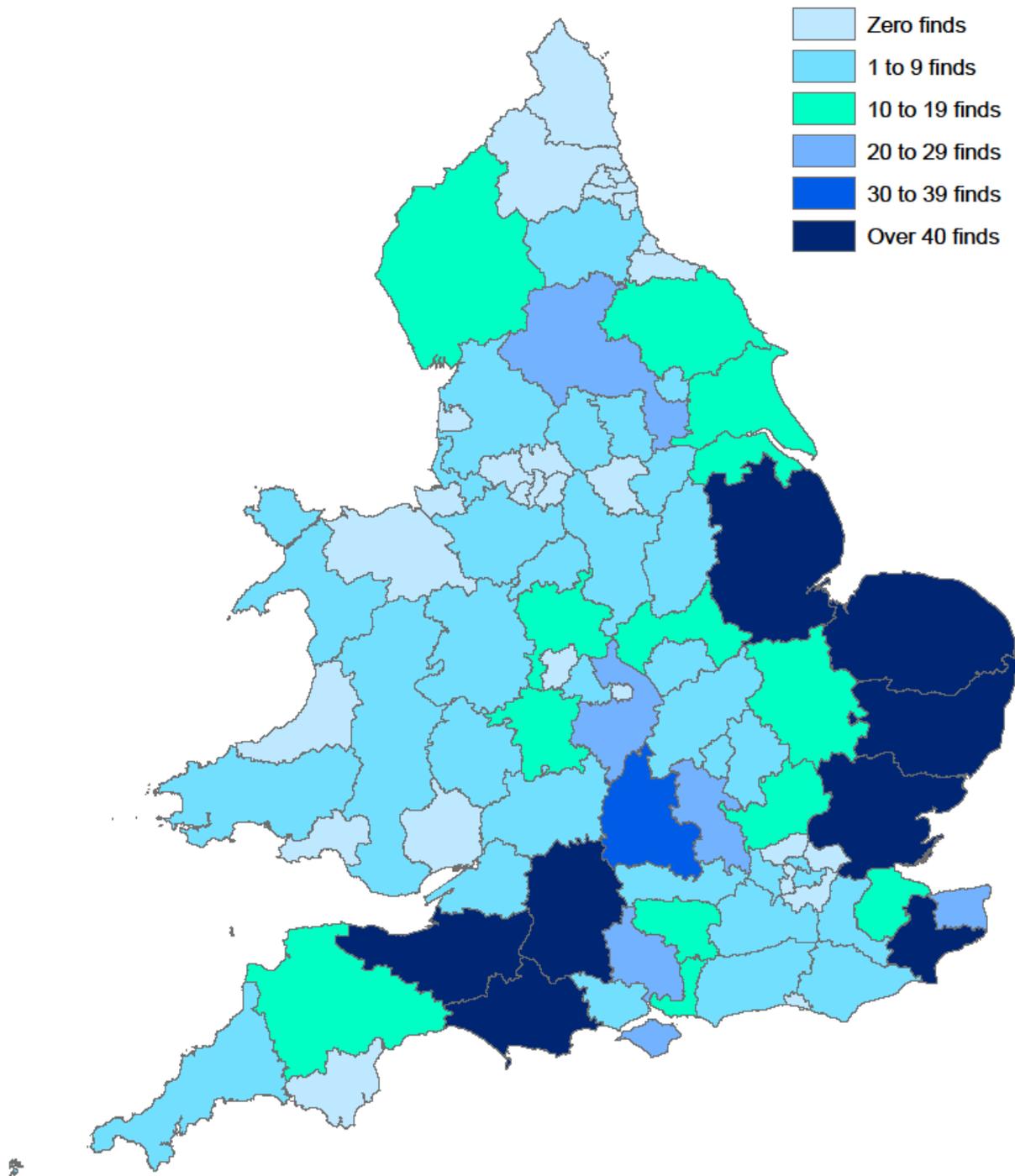
The number of finds and inquests held varies greatly across the country, most likely due to geographical and historical differences between areas. In 2017, 27 coroner areas had no treasure finds reported to them, whilst Norfolk had the highest number of treasure finds at 126. Map 4 shows treasure finds across England and Wales in 2017. More information about the duties of coroners to investigate treasure found within their jurisdiction and the provisions of the 1996 Act (and the previous Treasure Trove provisions) can be found in the supporting guidance document.

¹⁷ DCMS Statistical Release for Reported Treasure DCMS Finds - <https://www.gov.uk/government/collections/treasure-and-portable-antiquities-statistics>

¹⁸ This chart does not include reported findings under "Treasure Trove"

Map 4: Number of treasure finds reported to coroners, England and Wales, 2017

(Source: CSV)



Annex A: Details of recent coroner area amalgamations

The following table summarises the coroner area amalgamations that have occurred during 2016 and 2017. For a list of all historical amalgamations and changes to coroner areas, please refer to the supporting guidance document.

Date effective	Previous coroner area	New coroner area	Nature of merge
01-Apr-16	East Somerset; West Somerset	Somerset ¹⁹	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
01-Apr-17	Central Lincolnshire; South Lincolnshire	Lincolnshire	2 into 1
01-Dec-17	Blackburn, Hyndburn and Ribble Valley; East Lancashire; Preston and West Lancashire	Lancashire and Blackburn with Darwen	3 into 1

¹⁹ 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 coroner areas during this year.

Annex B: Further analysis of deaths reported to coroners

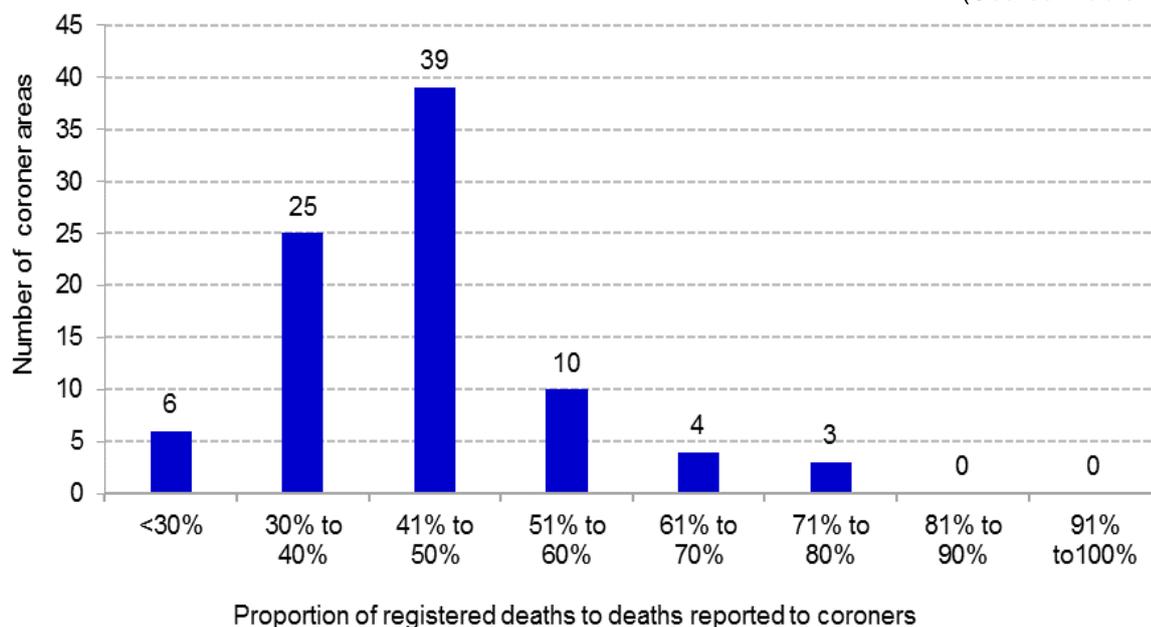
In 2017, the number of deaths reported to coroners as a proportion of registered deaths varied widely across coroner areas, from 24% in Hartlepool to 79% in Newcastle upon Tyne

The number of deaths reported to coroners in 2017 varied by coroner area – from 246 in Hartlepool to 7,372 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.

When looking at the number of deaths reported to coroners in 2017 as a proportion of registered deaths²⁰, which allow for some differences in population characteristics, there is still a wide variation across coroner areas e.g. 24% in Hartlepool compared to 79% in Newcastle upon Tyne²⁰. 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.

Figure 11: Deaths reported to coroners in 2017 as a proportion of registered deaths^{21,22}

(Source: Table 11)



²⁰ 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 638% due to the low levels of residence and high level of commuters.

²¹ Provisional figure based on ONS monthly death registration figures for 2017

²² City of London and Manchester City have been excluded from this analysis due to the percentage of deaths being greater than 100% - please see footnote 20 above for further information. So only 87 coroner areas have been included in this analysis.

Further information

Revisions to statistics for previous years

The estimated figure for the number of registered deaths in 2016 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.

Following identification of an error in the reported number of Treasure Trove inquests concluded in 2016, a data validation exercise has been completed for all Treasure Trove inquest cases reported since 2012. Data in Table 10 of this publication has therefore been revised accordingly.

Symbols and rounding convention

Within the 'Key Findings' sections, figures greater than 1,000 are rounded to the nearest 100. The following symbols have been used throughout the tables in this bulletin:

n/a	=	Not applicable
-	=	Zero
..	=	No data available

Accompanying files

- This publication should be read alongside the [statistical tables](#) which accompany it
- There is also a supporting [comma-separated values file](#) (CSV) to allow users to carry out their own analysis
- In addition to the bulletin and tables, we have published a [coroners' statistical tool](#). 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 and/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. It also includes a map reference of coroner areas in England and Wales, as well as a glossary with brief definitions for some commonly used terms.

National Statistics status

National Statistics status means that official statistics meet the highest standards of trustworthiness, quality and public value.

All official statistics should comply with all aspects of the Code of Practice for Official Statistics. They are awarded National Statistics status following an assessment by the Authority's regulatory arm. The Authority considers whether the statistics meet the highest standards of Code compliance, including the value they add to public decisions and debate.



It is the Ministry of Justice's responsibility to maintain compliance with the standards expected for National Statistics. If we become concerned about whether these statistics are still meeting the appropriate standards, we will discuss any concerns with the Authority promptly. National Statistics status can be removed at any point when the highest standards are not maintained, and reinstated when standards are restored.

Contact

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URL: <https://www.gov.uk/government/collections/coroners-and-burials-statistics>

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