



Coroners Statistics 2010 England and Wales

Ministry of Justice Statistics bulletin



Coroners Statistics 2010 England and Wales

Ministry of Justice Statistics bulletin

Also available on the Ministry of Justice website at

http://www.justice.gov.uk/publications/statistics-and-data/coroners-and-burials/deaths.htm

Executive summary

This bulletin presents statistics of coroners' work during the calendar year 2010, including deaths reported, post-mortems, and inquests (including those for treasure and treasure trove). These figures are used to monitor coroners' workload, throughput of cases, and percentages of post-mortems and inquests. In previous years this report was entitled "Statistics on deaths reported to coroners, England and Wales, (year)".

Main points

- Some 230,600 deaths were reported to coroners in 2010, a rise of 700 (0.3 per cent) from the 2009 figure. (*Tables 1,2, and 3*)
- The proportion of all registered deaths reported to coroners remained at an estimated 47 per cent in 2010, the same as in 2009. This percentage has been relatively consistent over for the last few years. (Table 2)
- The percentage of cases involving post-mortem examinations, as a proportion of all deaths reported to coroners, fell slightly from just below 46 per cent in 2009 to 44 per cent in 2010, continuing the existing downward trend. (Table 3)
- Inquests were opened on 31,000 deaths, representing over 13 per cent of all deaths reported to coroners, the same proportion as in 2009. (Table 3)
- As in recent years, the most common verdicts returned at inquests were death from natural causes (in 29 per cent of cases) and death by accident or misadventure (28 per cent). (Tables 4 and 6)
- Verdicts of suicide fell by two per cent in 2010 compared to the previous year; there were also falls in the number of verdicts of death from industrial disease, from accident or misadventure, and open verdicts. There was a rise of 400, or 10 per cent, in the number of non-specific verdicts, a category which includes narrative verdicts which are a factual record of how and in what circumstances the death occurred; often used where the cause of death does not easily fit any of the standard verdicts. (Table 6)
- The estimated² average time taken to process an inquest in 2010 (defined as being from the time the death was reported until the conclusion of the inquest, where the death occurred in England and Wales) was 27 weeks, the same as in 2009. (Table 7)

¹ Statistics on the number of registered deaths in England and Wales are published by the Office for National Statistics. A final figure for the total number of registered deaths in 2010 has not yet been published, but a provisional figure from ONS, derived from the monthly figures for death registrations in England and Wales, has been used.

² A direct average of the time taken to process an inquest cannot be calculated from the data collected; an estimate has been made instead. Please see Explanatory Notes for more information.

Introduction

This bulletin presents statistics of deaths reported to coroners in England and Wales in 2010 in accordance with section 28 of the Coroners Act 1988. Information is provided on deaths reported to coroners, post-mortem examinations and inquests held, and verdicts returned at inquests. The data are collected via statistical returns completed by coroners. In previous years this report was entitled "Statistics on deaths reported to coroners, England and Wales, (year)".

Background

In England and Wales, coroners are required by law to hold an inquest into violent, unnatural, sudden deaths of unknown cause, and those deaths which occur in prison or police custody. When investigating a death, it is the coroner's duty to establish who the deceased was, and how, when and where the deceased came by his or her death. At the close of an inquest, coroners (or juries if they have been summoned) are required to return a verdict covering these questions and to certify the verdict in an inquisition.

In the majority of deaths reported to them, however, coroners' investigations are concluded without an inquest being held. The coroner will have satisfied himself or herself, by means of a post-mortem examination or other investigation, on the physical cause of death, and that the death was not one on which he or she is required by law to hold an inquest.

Verdicts are returned in nearly all inquests. The exceptions are inquests adjourned by the coroner if, for example, criminal proceedings take place. The inquest is usually not resumed because the relevant evidence has been heard elsewhere. Nearly all inquests are held by a coroner sitting alone, without a jury, but a jury must be summoned in some circumstances, for example where the death occurred in prison or police custody.

A coroner may request that a post-mortem be conducted, whether or not an inquest is held, particularly if the cause of death is not clear. In many cases a post-mortem examination may take place in order to determine whether or not an inquest is necessary.

In England and Wales a coroner also handles investigations regarding finds reported to them under the provisions of the Treasure Act. The coroner will inquire into any treasure which is found in their districts and to establish who were the finders.

These statistical bulletins are available from the Ministry of Justice website at http://www.justice.gov.uk/publications/statistics-and-data/coroners-and-burials/deaths.htm.

The **Explanatory Notes** section at the end of this report provides brief definitions for some of the terms used in this report, information about statistical revisions, and the symbols and conventions used.

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

Quality and consistency of the statistics

Every effort is made to ensure that the figures presented in this publication are accurate and complete. Although care is taken in collating and analysing the returns used to compile these figures, the data are of necessity subject to the inaccuracies inherent in any large-scale collection of this type.

Returns are individually quality-assured and validated in a process that highlights inconsistencies between years, and other areas. Checks are made to ensure that each return is arithmetically correct, including with subtotals and grand totals correctly summed. Unusual values encountered in a return are queried with the data supplier, to confirm whether these are correct, or an error in the information provided which requires amendment.

The Explanatory Notes section provides further information on the quality and consistency of these statistics.

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 verdict returned 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 http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15096

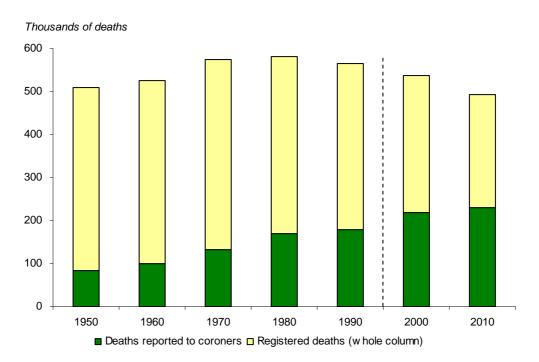
The Ministry of Justice's coroner statistics differ from ONS figures because they count two different, albeit related, events. The Ministry of Justice's coroner statistics provide the number of deaths which are reported to coroners in England and Wales. These include deaths reported to coroners which occurred outside England and Wales. ONS's mortality statistics, based on death registrations, report the number of deaths registered (irrespective of whether a coroner has investigated) in England and Wales in a particular year. ONS figures 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 2010 have been calculated using ONS's monthly provisional figures on death registrations, while estimates for 2009 and earlier years have been calculated using final annual death registration figures for the relevant year.

Deaths reported (Tables 1, 2 and 3, Figures 1 and 2)

The number of deaths reported to coroners in 2010 rose by 700 (0.3 per cent) from the previous year, from 229,900 in 2009 to 230,600 during 2010, reflecting the slight rise in the number of deaths registered in England and Wales. The proportion of registered deaths in the calendar year 2010 that were reported to coroners in 2010 remained at an estimated 47 per cent, the same level as in 2009. This percentage has been relatively consistent for the last few years. Of these reported deaths, around 2,000 (less than one per cent) were reports of deaths that had occurred outside England and Wales.

Figure 1: Registered deaths, and deaths reported to coroners, England and Wales, 1950-2010

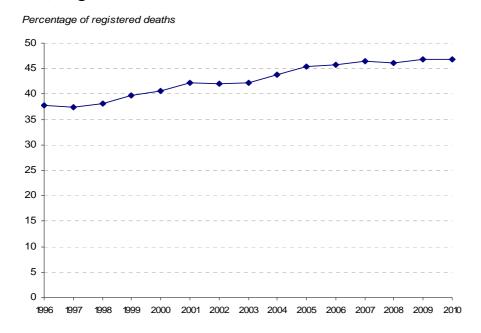


NOTE: The figures for deaths reported to coroners in the columns to the right of the vertical dashed line include no further action (NFA) cases, while those to the left exclude NFA cases (see Explanatory Notes for more information about NFA cases).

The long-term trends of both the number and proportion of deaths reported have generally been upwards. In the most recent few years, however, the increase in the proportion has become shallower than previously, while the number of deaths reported has been generally flat, albeit with some fluctuations, partly reflecting the actual number of registered deaths in any one year.

Since the Shipman murders came to light over a decade ago, there has been more concern about proper process. In the longer term, the rise in the number of deaths reported to coroners is probably also due in part to the growing use, over at least the last twenty years, of deputising services by general practitioners, leading to a greater number of referrals to coroners.

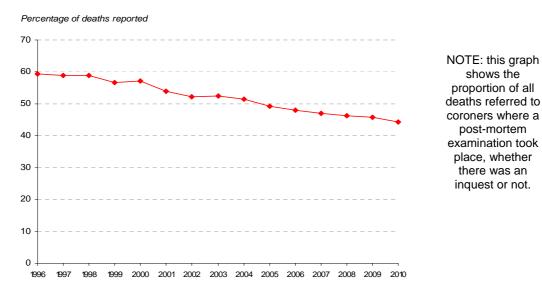
Figure 2: Deaths reported to coroners as a percentage of registered deaths, England and Wales, 1996-2010



Post-mortem examinations held and inquests opened (Tables 1, 2, and 3, Figures 3a and 3b)

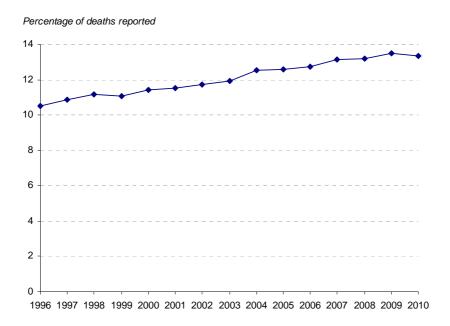
Post-mortem examinations were ordered by coroners in 44 per cent of all cases reported to them in 2010, a fall compared to 2009, and continuing the existing downward trend.

Figure 3a: Post-mortems as a percentage of deaths reported to coroners, England and Wales, 1996-2010



The actual number of deaths reported to coroners in 2010 where a postmortem was held was 101,900, some 3,400 fewer than in the year before, despite the overall increase in reported deaths. Inquests were opened on 30,800 deaths reported to coroners in 2010, 200 fewer than in 2009. Inquest cases represented more than 13 per cent of all the deaths reported to coroners in 2010, a similar proportion of the total as in the previous year.

Figure 3b: Inquests as a percentage of deaths reported to coroners, England and Wales, 1996-2010



Post-mortems in inquest cases (Table 3)

When an inquest is held a post-mortem examination has usually been conducted, and in 2010 post-mortems were conducted in 89 per cent of such cases. This is a lower proportion than in the previous year by around 2 percentage points, and continues a shallow declining trend over the past decade or so. Prior to the late 1990s, the holding of an inquest without a post-mortem examination was comparatively rare, accounting for around 2 per cent or less of inquest cases every year. In 2010 there were nearly 3,400 inquests without a post-mortem, around four and a half times the number so reported ten years ago.

Post-mortems in non-inquest cases (Table 3)

In the majority of cases referred to coroners there is no inquest. In 2010, there were some 75,000 non-inquest cases where a post-mortem was held, and the percentage of non-inquest cases that required a post-mortem fell to just above 37 per cent. This proportion has fallen steadily in recent years; in 1995 it was 56 per cent of all non-inquest cases.

Cases requiring neither an inquest nor a post-mortem (Table 3)

There were also 125,000 cases reported to coroners where there was neither an inquest nor a post-mortem. This particular category of case has generally been increasing in number in recent years. In addition, the percentage of cases where there was neither an inquest nor a post-mortem examination has increased, as a proportion of all coroners' cases, from around 40 per cent or just above in the late 1990s, to 54 per cent in 2010.

Inquest verdicts returned (Tables 4, 5 and 6, Figures 4, 5 and 6)

Verdicts were returned at some 29,400 inquests in 2010, nearly 400 less than in 2009. As in previous years the most common verdicts in 2010 were death from natural causes (8,400, 29 per cent), and death by accident or misadventure (8,100, 28 per cent of all verdicts). Unclassified verdicts, which category includes narrative verdicts, represented 14 per cent of the total, and verdicts of suicide comprised 11 per cent in 2010.

For the first time in 2010, verdicts of death from natural causes were the most frequently recorded. The category to see the largest rise in 2010 was unclassified (including narrative) verdicts, which were up 10 per cent, from 3,800 in 2009 to 4,200 in 2010.

There were decreases in the numbers of verdicts in many categories over the past year, mainly reflecting the overall drop in the numbers of inquests concluded by a verdict. These included:

- A 15 per cent drop in verdicts of deaths from dependence on drugs or non-dependent abuse of drugs, from 570 to 480;
- a 6 per cent drop in the number of verdicts of death by accident or misadventure (down from 8,700 to 8,100);
- a 6 per cent drop in the number of open verdicts (down from 2,200 to 2,100).

The rise in unclassified verdicts is at least in part due to the increasing use of what are known as 'narrative verdicts' by some coroners (see the paragraph on trends, below). A narrative verdict is where, instead of a conventional verdict, at the end of the inquest the coroner records a factual record of how and in what circumstances the death occurred. Recent case law may be responsible for the increased number of narrative verdicts in recent years, including the House of Lords Middleton³ judgement which encouraged their use.

Trends (Table 5 and Figure 4)

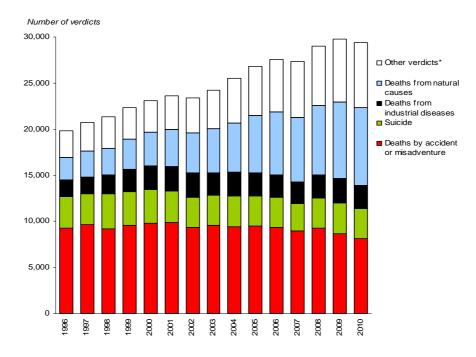
Verdicts of death from natural causes are tending to rise steadily, and there is also a steady and steeper rise in the number of unclassified, including narrative, verdicts. There is a long-term slight downward trend in the numbers of verdicts of suicide, though there are fluctuations within that trend.

As a *proportion* of verdicts delivered by coroners during a calendar year, there are five main trends, two rising, and three falling:

³ R v H.M. Coroner for Western Somersetshire and another ex parte Middleton (2004)

- verdicts of death from natural causes have risen steadily from 13 per cent in 1996 to around 29 per cent in 2010;
- unclassified verdicts (which include narrative verdicts, as explained above) formed less than one per cent of the total up to and including 2001, but accounted for around one in every seven verdicts in 2010;
- verdicts of death by accident or misadventure have been declining steadily, from 47 per cent of verdicts returned in 1996 to 28 per cent in 2010:
- suicide verdicts have been declining slowly over the same period, from 17 per cent in 1996 to around 11 per cent in 2010;
- open verdicts have been falling in percentage terms in the last few years, from around 11 per cent in the mid-1990s to 7 per cent in 2010.

Figure 4: Verdicts returned at inquests, England and Wales, 1996-2010



^{*}Includes open verdicts, and non-specific verdicts, etc. (see Table 6)

Gender differences (Table 4, Figures 5 and 6)

The pattern of verdicts differs between males and females. Male deaths accounted for about 69 per cent of all verdicts returned in 2009; but they also included:

- 92 per cent of verdicts of death from industrial disease;
- 78 per cent of verdicts of suicide, and
- 82 per cent of verdicts of death from dependence on, or nondependent abuse of, drugs.

For females, the most common verdicts were:

- death by accident or misadventure (32 per cent of all female verdicts), and
- death from natural causes (also 32 per cent).

These proportions were all similar to those in recent years. Females also accounted for a relatively high percentage of unclassified or narrative verdicts (39 per cent).

Figure 5: Verdicts returned at inquests by sex, England and Wales, 2010

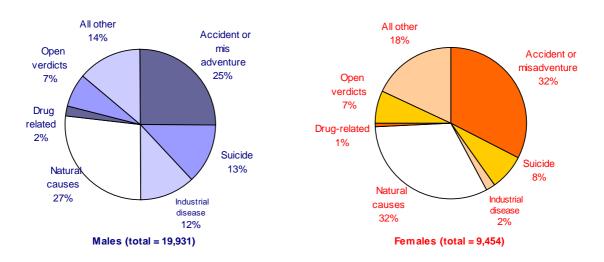
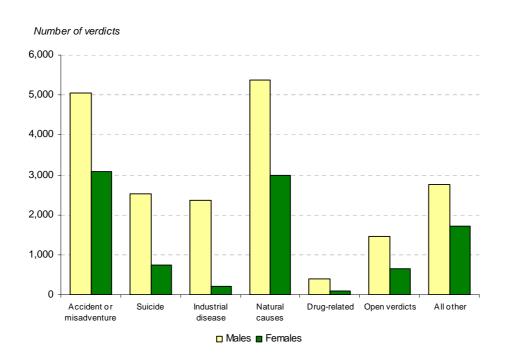


Figure 6: Number of verdicts returned at inquests, by sex, England and Wales, 2010



Age of deceased in inquests where a verdict was returned (Table 5)

From 2008, coroners were asked to provide information (in summary form) on the ages of persons whose deaths proceeded to inquest and a verdict returned during the year. Over 45 per cent of completed inquests in 2010

were on persons who were 65 years of age or more at death. Less than nine per cent of inquests concluded were into deaths of persons aged under 25.

Inquests with juries, and adjourned inquests (Table 7)

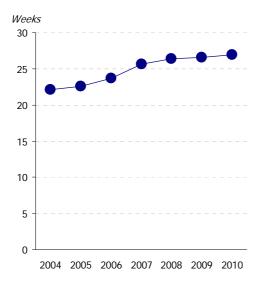
Nearly all inquests concluded in 2010, as in other years, were held without juries. The number of inquests held with juries in 2010 was 440 (representing just under one and a half per cent of all inquests), a modest fall of about 20 compared to 2009. Both the number and proportion of inquests held with juries have shown a downward trend in recent years; the proportion of inquests held with juries has fallen from 3.6 per cent of inquests concluded in 1999 to less than 1.5 per cent in 2010.

Around 1,000 inquests were adjourned by the coroner under Section 16 of the Coroners Act 1988 because criminal proceedings took place, and subsequently were not resumed. This is comparable with the level generally prevailing in recent years.

Time taken to process an inquest (Table 7)

The estimated average time taken to process an inquest in 2010 (defined as being from the time the death was reported until the conclusion of the inquest) was 27 weeks to the nearest whole week, the same as in 2009, but slightly longer than in 2007 and 2008.

Figure 6a: Estimated average time taken to process an inquest, 2004-2010



This period has slightly increased since the present system of estimating this average was introduced in 2004, when it was 22 weeks. Only deaths occurring within England and Wales are included in this estimation. More information about how the average has been estimated can be found in the Explanatory Notes section.

Treasure and Treasure Trove (Table 8 and Figure 7)

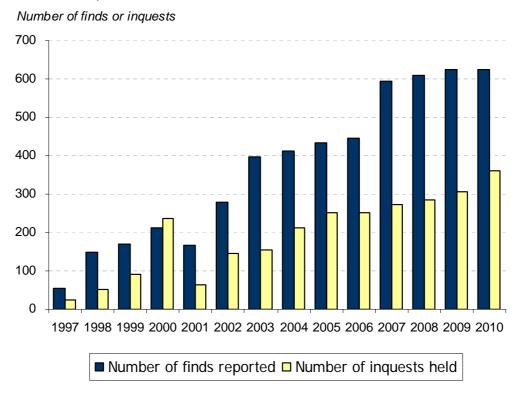
On 24 September 1997, the Treasure Act 1996 came into force and replaced the common law of Treasure Trove in England and Wales. The 1996 Act introduced new requirements for reporting and dealing with finds. Not all finds need be the subject of an inquest.

In 2010, 623 finds were reported and 362 inquests were concluded, from which a verdict declaring a find to be Treasure was returned in 318 cases. There were no inquests held into Treasure Trove in 2010 (relating to finds made before the current Act came into force), but it is likely that a few such inquests will continue to be held for some time.

The number of finds reported has been steadily increasing in recent years—this is probably because of the increasing popularity of treasure-hunting as a hobby. The dip in reported finds in 2001 is almost certainly due to the foot-and-mouth outbreak, which severely restricted access to land during the spring of that year.

An annual report on the operation of the Treasure Act 1996 is published by the Department for Culture, Media and Sport.

Figure 7: Finds reported to coroners and inquests held under the Treasure Act, 1997-2010



Tables

Table 1.	Deaths reported to coroners, 2010
Table 2.	Registered deaths, deaths reported to coroners, and inquests opened, 1950-2010
Table 3.	Deaths reported to coroners, post-mortem examinations held and inquests opened, 1996-2010
Table 4.	Inquest verdicts returned, 2010
Table 5.	Age of deceased in inquests where a verdict was returned, 2010
Table 6.	Inquest verdicts returned, 1996-2010
Table 7.	Inquests concluded which were held with juries and inquests adjourned; High Court orders and exhumations, 1996-2010
Table 8.	Treasure inquests, 1996-2010
Table 9.	Reported deaths, post-mortems and inquests by jurisdiction, 2010, and comparison with 2009
Table 10.	Inquest verdicts returned, by jurisdiction, 2010
Мар	Coroner districts in England and Wales as at 31 December, 2010

Table 1: Deaths reported to coroners, 2010

England and Wales	Engl	and	and	Wa	les
-------------------	------	-----	-----	----	-----

Number of reported deaths

	Males	Females	Total
Total deaths remarked to consumer 2000 (4)(2)	400 400	407.407	220 505
Total deaths reported to coroners, 2009 (1)(2)	123,403	107,127	230,595
<u>Inquests</u>			
Deaths reported where an inquest was opened	20,684	10,104	30,788
Deaths reported where no inquest occurred (1)(2)	102,719	97,023	199,807
Post-mortem examinations			
Deaths reported where a post-mortem took place	61,219	40,724	101,943
Deaths reported without a post-mortem (1)(2)	62,184	66,403	128,652

⁽¹⁾ This row includes deaths referred to the coroner where no certificate of any kind was issued ("no further action" cases).

Table 2: Registered deaths, deaths reported to coroners, and inquests opened, 1950-2010

Find and Wales

Thousands and percentages

Thousands and percentages

Inquests opened

Year

Registered deaths (thousands)

Number (thousands) (1)

As a percentage of registered deaths (thousands) (1)

As a percentage of registered deaths (thousands)

Coroners (1)

Year	deaths (thousands)	Number (thousands) (1)	As a percentage of registered deaths	Number (thousands)	As a percentage of deaths reported to coroners (1)
1950	510.3	83.6	16.4%	25.8	30.9%
1960	526.3	101.1	19.2%	26.3	26.0%
1970	575.2	133.4	23.2%	24.9	18.7%
1980	581.4	170.2	29.3%	23.1	13.6%
1990	564.8	180.1	31.9%	22.1	12.3%
1996	563.0	212.6	37.8%	22.3	10.5%
1997	558.1	208.6	37.4%	22.7	10.9%
1998	553.4	211.4	38.2%	23.6	11.1%
1999	553.5	220.2	39.8%	24.4	11.1%
2000	537.9	218.1	40.5%	24.9	11.4%
2001	532.5	224.3	42.1%	25.8	11.5%
2002	535.4	225.0	42.0%	26.4	11.7%
2003	539.2	227.8	42.2%	27.1	11.9%
2004	514.3	225.5	43.9%	28.3	12.5%
2005	513.0	232.4	45.3%	29.3	12.6%
2006	502.6	230.0	45.8%	29.3	12.8%
2007	504.1	234.5	46.5%	30.8	13.2%
2008	509.1	234.8	46.1%	31.0	13.2%
2009	491.3	229.9	46.8%	31.0	13.5%
2010	493.2 (2)	230.6	46.8%	30.8	13.4%

^{(1) &#}x27;NFA' cases are deaths notified to coroners which required neither an inquest nor a post-mortem, and where no certificate of any kind was issued. From 1995 onwards all 'NFA' cases have been included in the number of reported deaths. Prior to that, these cases were excluded. Figures for 1995 onwards are therefore not directly comparable to those for previous years.

⁽²⁾ The total column includes "no further action" cases which could not be categorized into males and females.

⁽²⁾ provisional figure, based on ONS published monthly death registration figures for 2010

Table 3: Deaths reported to coroners, post-mortem examinations held and inquests opened, 1996-2010

England and Wales

Numbers and percentages

	rtems	Post-mo		ened	inquest op	No				opened	Inquest			
Total deaths reported	% of	Total post	Total non- inquest		No post- hel		Post-mo	% of	Total		No post-n		Post-mo	Year
inc. NFA	deaths reported	mortems held	cases, inc. NFA	% of non- inquest cases	Number, inc. NFA	% of non- inquest cases	Number	deaths reported	inquests opened	% of inquest cases	Number	% of inquest cases	Number	
212,584	59.4%	126,184	190,266	45.2%	85,945	54.8%	104,321	10.5%	22,318	2.0%	455	98.0%	21,863	1996
208,578	59.0%	123,015	185,875	45.8%	85,196	54.2%	100,679	10.9%	22,703	1.6%	367	98.4%	22,336	1997
211,433	58.8%	124,356	187,865	46.2%	86,700	53.8%	101,165	11.1%	23,568	1.6%	377	98.4%	23,191	1998
220,176	56.7%	124,780	195,801	48.5%	94,917	51.5%	100,884	11.1%	24,375	2.0%	479	98.0%	23,896	1999
218,092	57.1%	124,536	193,235	48.0%	92,816	52.0%	100,419	11.4%	24,857	3.0%	740	97.0%	24,117	2000
224,286	54.0%	121,112	198,493	51.4%	101,998	48.6%	96,495	11.5%	25,793	4.6%	1,176	95.4%	24,617	2001
224,999	52.3%	117,684	198,569	53.5%	106,248	46.5%	92,321	11.7%	26,430	4.0%	1,067	96.0%	25,363	2002
227,790	52.5%	119,610	200,677	53.2%	106,821	46.8%	93,856	11.9%	27,113	5.0%	1,359	95.0%	25,754	2003
225,511	51.3%	115,773	197,237	54.8%	108,082	45.2%	89,155	12.5%	28,274	5.9%	1,656	94.1%	26,618	2004
232,401	49.3%	114,620	203,130	57.1%	116,047	42.9%	87,083	12.6%	29,271	5.9%	1,734	94.1%	27,537	2005
230,007	47.9%	110,224	200,680	58.7%	117,761	41.3%	82,919	12.8%	29,327	6.9%	2,022	93.1%	27,305	2006
234,458	47.1%	110,360	203,617	59.8%	121,767	40.2%	81,850	13.2%	30,841	7.6%	2,331	92.4%	28,510	2007
234,784	46.2%	108,360	203,785	60.8%	123,943	39.2%	79,842	13.2%	30,999	8.0%	2,481	92.0%	28,518	2008
229,883	45.8%	105,354	198,906	61.2%	121,765	38.8%	77,141	13.5%	30,977	8.9%	2,764	91.1%	28,213	2009
230,595	44.2%	101,943	199,807	62.7%	125,265	37.3%	74,542	13.4%	30,788	11.0%	3,387	89.0%	27,401	2010

Table 4: Inquest verdicts returned, 2010

England and Wales

Number of verdicts returned

Verdict	Males	Females	Total
Homicide, of which:			
killed unlawfully	180	58	238
killed lawfully	8	2	10
Suicide	2,521	731	3,252
Attempted or self-induced abortion	-	-	-
Cause of death aggravated by lack of			
care, or self-neglect	27	15	42
Dependence on drugs	216	51	267
Non-dependent abuse of drugs	181	35	216
Want of attention at birth	-	1	1
Death from industrial diseases	2,359	201	2,560
Death by accident or misadventure	5,041	3,072	8,113
Stillborn	5	3	8
Deaths from natural causes	5,385	2,997	8,382
Open verdicts	1,467	648	2,115
Disasters	1	-	1
All other verdicts	2,540	1,640	4,180
Total verdicts returned, 2010	19,931	9,454	29,385

Table 5: Age of deceased in inquests where a verdict was returned, 2010

England and Wales	Numbe	r and percentage
Age of deceased at time of death	Number of inquest verdicts returned, 2010	As a % of total verdicts returned
Under 1 year	574	2.0%
1 to 14 years	404	1.4%
15 to 24 years	1,587	5.4%
25 to 44 years	6,045	20.6%
45 to 64 years	7,527	25.6%
65 years and over	13,237	45.0%
Age not known or could not be readily provided	11	0.0%
Total verdicts returned, 2010	29,385	100.0%

Table 6: Inquest verdicts returned, 1996-2010

Total verdicts returned

19,855

20,699

21,333

22,349

23,088

England and Wales Number of verdicts returned Verdict 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 Homicide, of which: killed unlawfully 169 165 142 167 178 192 177 182 206 248 223 257 263 222 238 2 killed lawfully 2 3 2 4 2 6 1 5 4 2 2 5 10 Suicide 3,399 3,355 3,756 3,693 3,626 3,389 3,242 3,255 3,235 3,220 3,007 3,305 3,330 3,252 3,368 Attempted or self-induced abortion 0 Cause of death aggravated by lack 59 59 47 44 33 43 46 50 51 27 30 35 35 36 42 of care, or self-neglect Dependence on drugs 156 177 258 289 323 309 294 248 280 299 328 324 343 316 267 Non-dependent abuse of drugs 199 220 237 284 282 313 260 254 269 261 268 276 274 250 216 Want of attention at birth 5 5 1 4 6 3 2 3 1 1 1 Death from industrial diseases 1,784 1,836 2,091 2,373 2,591 2,661 2,653 2,403 2,571 2,567 2,496 2,332 2,474 2,623 2,560 Death by accident or misadventure 9,286 9,646 9,199 9,558 9,796 9,882 9,379 9,594 9,420 9,498 9,353 8,930 9,230 8,673 8,113 Stillborn 6 6 12 4 4 8 3 10 11 10 12 21 13 7 8 Deaths from natural causes 2.498 2,756 2,852 3,306 3,642 4,068 4,334 4,766 5,296 6,175 6.828 7,011 7,556 8,281 8.382 Open verdicts 2,151 2,319 2,571 2,509 2,449 2,519 2,445 2,619 2,600 2,531 2,378 2,242 2,167 2,240 2,115 Disasters 4 1 All other verdicts 142 154 160 119 156 225 583 873 1,412 1,952 2.406 2,923 3,333 3.797 4.180

23,617

23,423

24,259

25,494

26,814

27,360

27,547

28,996

29,781

29,385

Table 7: Inquests concluded which were held with juries and inquests adjourned; High Court orders and exhumations, 1996-2010, estimated average time taken to process inquests, 2004-2010(1)

England and Wales

Number

		Juries		Verd	icts / adjournme	ents		Average time	Inquests held	Inquisitions	Fb
Year	Inquests without juries	Inquests with juries	% with juries	Verdicts returned	Inquests adjourned and not resumed	% adjourned	concluded	to process an	by order of the High Court	quashed or amended by the High Court	Exhumations ordered by the coroner
1996	19,844	903	4.4%	19,855	892	4.3%	20,747	n/a	7	1	3
1997	20,774	774	3.6%	20,699	849	3.9%	21,548	n/a	3	2	1
1998	21,141	1,035	4.7%	21,333	843	3.8%	22,176	n/a	2	0	5
1999	22,298	823	3.6%	22,349	772	3.3%	23,121	n/a	-	2	2
2000	23,243	824	3.4%	23,088	979	4.1%	24,067	n/a	1	1	7
2001	23,757	759	3.1%	23,617	899	3.7%	24,516	n/a	3	2	5
2002	23,859	687	2.8%	23,423	1,123	4.6%	24,546	n/a	2	1	3
2003	24,531	636	2.5%	24,259	908	3.6%	25,167	n/a	1	4	1
2004	25,869	568	2.1%	25,494	943	3.6%	26,437	22	1	1	2
2005	27,302	520	1.9%	26,814	1,008	3.6%	27,822	23	3	1	3
2006	27,934	569	2.0%	27,547	956	3.4%	28,503	24	2	2	2
2007	27,747	539	1.9%	27,360	926	3.3%	28,286	26	1	1	4
2008	29,344	485	1.6%	28,996	833	2.8%	29,829	26	-	2	1
2009	30,239	466	1.518%	29,781	924	3.0%	30,705	27	(R) 1	1	2
2010	29,938	442	1.455%	29,385	995	3.3%	30,380	27	3	1	0

⁽¹⁾ Only deaths occurring within England and Wales are included in the estimation of average times. Data were not collected on a comparable basis before 2004, and consequently are not shown here.

⁽R) The figure for timeliness in 2009 has been revised; see Explanatory Notes (Revisions to statistics) for more information.

Table 8: Treasure inquests, 1996-2010

England and Wales

Number

	Trea	asure Act 1996		Treasure trove (1)
Year	Number of finds reported	Number of inquests concluded	Verdicts of treasure returned	Inquests held on treasure trove
1996	n/a	n/a	n/a	45
1997	54	25	6	35
1998	147	53	42	20
1999	170	90	86	8
2000	213	236	123	4
2001	168	63	65	5
2002	279	144	133	3
2003	396	154	140	6
2004	412	213	191	16
2005	432	253	228	7
2006	444	252	217	12
2007	595	273	229	13
2008	610	286	270	9
2009	624	307	289	3
2010	623	362	318	0

⁽¹⁾ Relates to finds made before the commencement of the Treasure Act in September 1997

Table 9: Reported deaths, post-mortems and inquests by jurisdiction 2010, and comparison with 2009

		20	10 cases				200	09 cases			% chan	ge, 2009 t	to 2010
County / unitary authority or district	Reported deaths 2010, inc. NFA	Post- mortems 2010	PMs as % of rep. deaths 2010	Inquests 2010	Inquests as % of rep. deaths 2010	Reported deaths 2009, inc. NFA	Post- mortems 2009	PMs as % of rep. deaths 2009	Inquests 2009	Inquests as % of rep. deaths 2009	% change in reported deaths, inc. NFA	change in % PMs	change ir % inquests
The Queen's Household	0	0	n/a	0	n/a	0	0	n/a	0	n/a	n/a	n/a	n/a
ENGLAND													
NORTH EAST													
DURHAM													
Darlington and South Durham	1,172	639	55%	150	13%	1,190	618	52%	145	12%	-1.5%	2.6%	0.6%
North Durham	1,248	747	60%	271	22%	1,313	784	60%	249	19%	-5.0%	0.1%	2.8%
HARTLEPOOL	434	213	49%	78	18%	492	240	49%	50	10%	-11.8%	0.3%	7.8%
NORTHUMBERLAND													
North Northumberland	701	340	49%	132	19%	730	334	46%	154	21%	-4.0%	2.7%	-2.3%
South Northumberland	421	271	64%	96	23%	440	300	68%	117	27%	-4.3%	-3.8%	-3.8%
TEESSIDE	2,566	1,002	39%	315	12%	2,618	1,024	39%	307	12%	-2.0%	-0.1%	0.5%
TYNE AND WEAR													
Gateshead and South Tyneside	1,926	816	42%	238	12%	1,945	823	42%	188	10%	-1.0%	0.1%	2.7%
Newcastle upon Tyne	1,876	799	43%	361	19%	1,849	736	40%	370	20%	1.5%	2.8%	-0.8%
North Tyneside	848	458	54%	206	24%	832	453	54%	226	27%	1.9%	-0.4%	-2.9%
Sunderland	1,538	584	38%	396	26%	1,638	617	38%	394	24%	-6.1%	0.3%	1.7%
NORTH WEST													
CHESHIRE	4,641	2,129	46%	712	15%	5,130	2,444	48%	799	16%	-9.5%	-1.8%	-0.2%
CUMBRIA													
South and East Cumbria	1,062	574	54%	190	18%	1,022	642	63%	175	17%	3.9%	-8.8%	0.8%
North and West Cumbria	1,351	706	52%	235	17%	1,267	655	52%	175	14%	6.6%	0.6%	3.6%
GREATER MANCHESTER													
Manchester city	3,220	1,511	47%	715	22%	3,136	1,853	59%	783	25%	2.7%	-12.2%	-2.8%
Manchester North	2,906	950	33%	446	15%	2,655	914	34%	469	18%	9.5%	-1.7%	-2.3%
Manchester South	3,184	1,672	53%	563	18%	3,106	1,790	58%	585	19%	2.5%	-5.1%	-1.2%
Manchester West	4,427	1,943	44%	604	14%	4,105	1,922	47%	586	14%	7.8%	-2.9%	-0.6%
LANCASHIRE													
Blackburn, Hyndburn and Ribble Valley	2,613	962	37%	325	12%	2,689	1,002	37%	363	13%	-2.8%	-0.4%	-1.1%
Blackpool/Fylde	1,696	811	48%	130	8%	1,694	841	50%	130	8%	0.1%	-1.8%	0.0%
East Lancashire	664	436	66%	153	23%	636	420	66%	135	21%	4.4%	-0.4%	1.8%
Preston and West Lancashire	2,743	1,584	58%	464	17%	2,760	1,545	56%	409	15%	-0.6%	1.8%	2.1%
MERSEYSIDE													
Sefton, Knowsley and St Helens	2,548	867	34%	305	12%	2,406	828	34%	270	11%	5.9%	-0.4%	0.7%
Liverpool	2,815	877	31%	530	19%	2,733	873	32%	507	19%	3.0%	-0.8%	0.3%
Wirral	1,681	615	37%	276	16%	1,737	665	38%	267	15%	-3.2%	-1.7%	1.0%

Table 9: Reported deaths, post-mortems and inquests by jurisdiction 2010, and comparison with 2009 (continued)

		20	10 cases				20	009 cases			% chan	ige, 2009 t	to 2010
County / unitary authority or district	Reported deaths 2010, inc. NFA	Post- mortems 2010	PMs as % of rep. deaths 2010	Inquests 2010	Inquests as % of rep. deaths 2010	Reported deaths 2009, inc. NFA	Post- mortems 2009	PMs as % of rep. deaths 2009	Inquests 2009	Inquests as % of rep. deaths 2009	% change in reported deaths, inc. NFA	change in % PMs	change ir % inquests
YORKSHIRE AND THE HUMBER													
EAST RIDING and HULL	2,822	1,015	36%	293	10%	2,971	1,133	38%	293	10%	-5.0%	-2.2%	0.5%
NORTH LINCOLNSHIRE and GRIMSBY	1,391	435	31%	166	12%	1,477	455	31%	124	8%	-5.8%	0.5%	3.5%
YORK CITY	1,065	428	40%	90	8%	982	411	42%	101	10%	8.5%	-1.7%	-1.8%
North Yorkshire Eastern District	1,192	661	55%	125	10%	1,139	661	58%	132	12%	4.7%	-2.6%	-1.1%
North Yorkshire Western District	1,119	417	37%	139	12%	1,078	368	34%	129	12%	3.8%	3.1%	0.5%
South Yorkshire Eastern District	2,537	1,553	61%	371	15%	2,513	1,550	62%	352	14%	1.0%	-0.5%	0.6%
South Yorkshire Western District	3,091	1,473	48%	496	16%	3,120	1,514	49%	453	15%	-0.9%	-0.9%	1.5%
West Yorkshire Eastern District	3,757	1,473	45%	546	15%	3,686	1,658	45%	513	14%	1.9%	-0.3%	0.6%
West Yorkshire Western District	3,282	1,610	49%	469	14%	3,388	1,749	52%	495	15%	-3.1%	-2.6%	-0.3%
EAST MIDLANDS													
DERBYSHIRE Reduced Courts Reduced in	0.570	4 000	470/	045	400/	0.000	4.405	400/	000	440/	4.00/	4.00/	4 40/
Derby and South Derbyshire	2,570	1,202	47%	315	12%	2,600	1,105	43%	283	11%	-1.2%	4.3%	1.4%
North Derbyshire	2,031	854	42%	350	17%	1,975	814	41%	327	17%	2.8%	0.8%	0.7%
LEICESTERSHIRE													
Leicester City and South Leicestershire	3,502	707	20%	324	9%	3,318	865	26%	413	12%	5.5%	-5.9%	-3.2%
Rutland and North Leicestershire LINCOLNSHIRE	1,012	475	47%	184	18%	866	451	52%	168	19%	16.9%	-5.1%	-1.2%
Boston and Spalding	908	330	36%	48	5%	1,021	413	40%	64	6%	-11.1%	-4.1%	-1.0%
West Lincolnshire	1,586	547	34%	135	9%	1,558	525	34%	136	9%	1.8%	0.8%	-0.2%
Spilsby and Louth	538	284	53%	55	10%	522	279	53%	58	11%	3.1%	-0.7%	-0.9%
Stamford	137	70	51%	11	8%	139	70	50%	20	14%	-1.4%	0.7%	-6.4%
NORTHAMPTONSHIRE	2,716	1,158	43%	229	8%	2,504	1,069	43%	239	10%	8.5%	-0.1%	-1.1%
NOTTINGHAMSHIRE	5,787	1,484	26%	406	7%	6,003	1,577	26%	445	7%	-3.6%	-0.6%	-0.4%
WEST MIDLANDS													
HEREFORDSHIRE	774	373	48%	91	12%	786	371	47%	104	13%	-1.5%	1.0%	-1.5%
SHROPSHIRE													
Mid and North Shropshire	850	361	42%	88	10%	893	410	46%	89	10%	-4.8%	-3.4%	0.4%
South Shropshire STAFFORDSHIRE	258	163	63%	29	11%	256	159	62%	45	18%	0.8%	1.1%	-6.3%
Staffordshire South	2,283	930	41%	355	16%	2,268	862	38%	360	16%	0.7%	2.7%	-0.3%
Stoke-on-Trent and North Staffordshire	3,641	1,423	39%	449	12%	3,712	1,442	39%	468	13%	-1.9%	0.2%	-0.3%
TELFORD and WREKIN	798	362	45%	80	10%	775	377	49%	82	11%	3.0%	-3.3%	-0.6%
WARWICKSHIRE	1,818	741	41%	200	11%	1,816	763	42%	222	12%	0.1%	-1.3%	-1.2%
WEST MIDLANDS	-					•							
Birmingham and Solihull	4,624	1,793	39%	1,184	26%	4,488	1,761	39%	1,082	24%	3.0%	-0.5%	1.5%
Black Country	3,192	868	27%	332	10%	3,166	972	31%	345	11%	0.8%	-3.5%	-0.5%
Coventry	1,743	502	29%	168	10%	2,030	579	29%	220	11%	-14.1%	0.3%	-1.2%
Wolverhampton	1,314	501	38%	210	16%	1,172	436	37%	205	17%	12.1%	0.9%	-1.5%
WORCESTERSHIRE	2,497	1,049	42%	335	13%	2,487	1,120	45%	366	15%	0.4%	-3.0%	-1.3%

Table 9: Reported deaths, post-mortems and inquests by jurisdiction 2010, and comparison with 2009 (continued)

		20	010 cases				20	009 cases			% chan	ige, 2009 i	to 2010
County / unitary authority or district	Reported deaths 2010, inc. NFA	Post- mortems 2010	PMs as % of rep. deaths 2010	Inquests 2010	Inquests as % of rep. deaths 2010	Reported deaths 2009, inc. NFA	Post- mortems 2009	PMs as % of rep. deaths 2009	Inquests 2009	Inquests as % of rep. deaths 2009	% change in reported deaths, inc. NFA		change ir % inquests
EAST OF ENGLAND													
BEDFORDSHIRE AND LUTON CAMBRIDGESHIRE	1,969	774	39%	211	11%	2,025	812	40%	212	10%	-2.8%	-0.8%	0.2%
North and East Cambridgeshire	395	228	58%	54	14%	382	221	58%	57	15%	3.4%	-0.1%	-1.3%
South and West Cambridgeshire	1,903	606	32%	203	11%	2,022	709	35%	195	10%	-5.9%	-3.2%	1.0%
ESSEX and THURROCK	4,992	2,892	58%	520	10%	4,599	2,629	57%	492	11%	8.5%	0.8%	-0.3%
HERTFORDSHIRE	3,134	1,712	55%	359	11%	3,055	1,611	53%	386	13%	2.6%	1.9%	-1.2%
NORFOLK (1)	3,903	1,838	47%	508	13%	4,101	1,889	46%	500	12%	-4.8%	1.0%	0.8%
PETERBOROUGH	1,103	384	35%	90	8%	1,005	381	38%	92	9%	9.8%	-3.1%	-1.0%
SOUTHEND-ON-SEA	1,607	772	48%	173	11%	1,515	674	44%	146	10%	6.1%	3.6%	1.1%
SUFFOLK	2,694	1,290	48%	289	11%	2,647	1,313	50%	286	11%	1.8%	-1.7%	-0.1%
LONDON													
City of London	137	37	27%	15	11%	134	43	32%	19	14%	2.2%	-5.1%	-3.2%
East London	3,612	1,695	47%	371	10%	3,770	1,814	48%	416	11%	-4.2%	-1.2%	-0.8%
Inner North London	2,964	1,336	45%	536	18%	3,538	1.630	46%	597	17%	-16.2%	-1.0%	1.2%
Inner South London	3,399	1,883	55%	496	15%	3,253	1,906	59%	513	16%	4.5%	-3.2%	-1.2%
Inner West London	2,475	1,094	44%	408	16%	2,500	1,182	47%	381	15%	-1.0%	-3.1%	1.2%
North London	4,302	1,703	40%	459	11%	3,840	1,843	48%	490	13%	12.0%	-8.4%	-2.1%
South London	3,186	1,602	50%	329	10%	3,217	1,731	54%	309	10%	-1.0%	-3.5%	0.7%
West London	4,003	1,510	38%	529	13%	3,771	1,553	41%	498	13%	6.2%	-3.5%	0.0%
SOUTH EAST													
BERKSHIRE	2,527	1,078	43%	288	11%	2,529	1,136	45%	301	12%	-0.1%	-2.3%	-0.5%
BRIGHTON AND HOVE	1,281	617	48%	240	19%	1,439	717	50%	234	16%	-11.0%	-1.7%	2.5%
BUCKINGHAMSHIRE	1,458	737	51%	179	12%	1,417	703	50%	150	11%	2.9%	0.9%	1.7%
EAST SUSSEX	2,479	1,408	57%	315	13%	2,318	1,431	62%	322	14%	6.9%	-4.9%	-1.2%
HAMPSHIRE	,					•							
Central Hampshire	1,180	482	41%	161	14%	1,204	580	48%	191	16%	-2.0%	-7.3%	-2.2%
North East Hampshire	1,209	641	53%	141	12%	1,117	608	54%	119	11%	8.2%	-1.4%	1.0%
Portsmouth and South East Hampshire	2,720	1,258	46%	413	15%	2,593	1,229	47%	371	14%	4.9%	-1.1%	0.9%
Southampton and New Forest	2,166	802	37%	243	11%	2,082	772	37%	203	10%	4.0%	-0.1%	1.5%
ISLE OF WIGHT	754	444	59%	75	10%	670	417	62%	75	11%	12.5%	-3.4%	-1.2%
KENT													
Central and South East Kent	1,362	796	58%	163	12%	1,498	1,003	67%	201	13%	-9.1%	-8.5%	-1.5%
Mid Kent and Medway	2,421	1,130	47%	221	9%	2,429	1,292	53%	248	10%	-0.3%	-6.5%	-1.1%
North East Kent	1,828	1,160	63%	226	12%	1,938	1,232	64%	221	11%	-5.7%	-0.1%	1.0%
North West Kent	1,710	919	54%	175	10%	1,578	869	55%	231	15%	8.4%	-1.3%	-4.4%
MILTON KEYNES	791	441	56%	126	16%	781	513	66%	130	17%	1.3%	-9.9%	-0.7%

Table 9: Reported deaths, post-mortems and inquests by jurisdiction 2010, and comparison with 2009 (continued)

County / unitary authority or district		20	10 cases				% change, 2009 to 2010						
	Reported deaths 2010, inc. NFA	Post- mortems 2010	PMs as % of rep. deaths 2010	Inquests 2010	Inquests as % of rep. deaths 2010	Reported deaths 2009, inc. NFA	Post- mortems 2009	PMs as % of rep. deaths 2009	Inquests 2009	Inquests as % of rep. deaths 2009	% change in reported deaths, inc. NFA	change in % PMs	change in %
OXFORDSHIRE	2,139	945	44%	292	14%	2,000	846	42%	290	15%	6.9%	1.9%	-0.8%
SURREY	4,331	2,066	48%	370	9%	4,095	2,051	50%	372	9%	5.8%	-2.4%	-0.5%
WEST SUSSEX	3,154	1,457	46%	274	9%	3,149	1,533	49%	293	9%	0.2%	-2.5%	-0.6%
SOUTH WEST													
AVON	4,727	2,103	44%	790	17%	4,623	2,257	49%	703	15%	2.2%	-4.3%	1.5%
CORNWALL	2,525	1,627	64%	413	16%	2,637	1,674	63%	350	13%	-4.2%	1.0%	3.1%
DEVON	,	,-				,	, -						
Exeter and Greater Devon	2,715	862	32%	303	11%	2,893	931	32%	326	11%	-6.2%	-0.4%	-0.1%
Plymouth and South West Devon	2,125	963	45%	364	17%	2,178	1,078	49%	390	18%	-2.4%	-4.2%	-0.8%
Torbay and South Devon	1,963	750	38%	161	8%	2,071	762	37%	171	8%	-5.2%	1.4%	-0.1%
DORSET	1,000					_,							
Bournemouth, Poole and Eastern Dorset	2,291	849	37%	178	8%	2,269	788	35%	171	8%	1.0%	2.3%	0.2%
Western Dorset	1,002	426	43%	69	7%	1,005	452	45%	95	9%	-0.3%	-2.5%	-2.6%
GLOUCESTERSHIRE	1,941	1,142	59%	401	21%	1,986	1,256	63%	390	20%	-2.3%	-4.4%	1.0%
ISLES OF SCILLY (2)	10	4	*	1	*	4	1	*	1	*	*	*	*
SOMERSET													
Eastern Somerset	941	481	51%	128	14%	1,037	568	55%	145	14%	-9.3%	-3.7%	-0.4%
Western Somerset	1,344	491	37%	123	9%	1,333	569	43%	145	11%	0.8%	-6.2%	-1.7%
WILTSHIRE and SWINDON	2,255	1,010	45%	370	16%	2,306	1,136	49%	402	17%	-2.2%	-4.5%	-1.0%
WALES													
Bridgend and Glamorgan Valleys	2,542	1,145	45%	295	12%	2,646	1,163	44%	285	11%	-3.9%	1.1%	0.8%
Cardiff and Vale of Glamorgan	1,707	828	49%	400	23%	1,665	840	50%	390	23%	2.5%	-1.9%	0.0%
Carmarthenshire	772	359	47%	79	10%	768	353	46%	91	12%	0.5%	0.5%	-1.6%
Central North Wales	1,230	691	56%	179	15%	1,287	768	60%	226	18%	-4.4%	-3.5%	-3.0%
Ceredigion	266	157	59%	34	13%	284	196	69%	34	12%	-6.3%	-10.0%	0.8%
Gwent	2,596	1,012	39%	127	5%	2,510	947	38%	133	5%	3.4%	1.3%	-0.4%
Neath and Port Talbot	451	230	51%	89	20%	466	262	56%	79	17%	-3.2%	-5.2%	2.8%
North East Wales	1,168	679	58%	205	18%	1,165	656	56%	233	20%	0.3%	1.8%	-2.4%
North West Wales	1,058	463	44%	141	13%	1,162	511	44%	151	13%	-9.0%	-0.2%	0.3%
Pembrokeshire	606	255	42%	76	13%	606	259	43%	68	11%	0.0%	-0.7%	1.3%
Powys	350	224	64%	73	21%	301	221	73%	70	23%	16.3%	-9.4%	-2.4%
City and County of Swansea	1,606	498	31%	173	11%	1,638	591	36%	201	12%	-2.0%	-5.1%	-1.5%
ENGLAND and WALES	230,595	101,943	44%	30,788	13%	229,883	105,354	46%	30,977	13%	0.3%	-1.6%	0.2%

NOTE: NFA cases are deaths notified to coroners which required neither an inquest nor a post-mortem, and where no certificate of any kind was issued.

⁽¹⁾ Great Yarmouth and Greater Norfolk were amalgamated into a single coroner district, covering the whole of the county of Norfolk, during 2010. Figures shown for 2009 are for the two previous districts combined.

⁽²⁾ Percentages not shown because of the low volume of caseload. An asterisk shows where figures have been omitted.

Table 10: Inquest verdicts returned, by jurisdiction, 2010

	Verdict category										
County / unitary authority or district	Homicide, killed unlawfully and killed lawfully	Suicide	Lack of care or self- neglect	Dependence on drugs	Non- dependent abuse of drugs	Death from industrial diseases	Death by accident or mis- adventure	Deaths from natural causes	Open verdicts	All other verdicts (1)	Total, all verdicts
The Queen's Household	0	0	0	0	0	0	0	0	0	0	0
ENGLAND											
NORTH EAST DURHAM											
Darlington and South Durham	1	16	0	0	4	15	29	54	14	6	139
North Durham	2	27	0	5	4	22	32	133	17	20	262
HARTLEPOOL	0	6	0	0	3	26	3	13	4	2	57
NORTHUMBERLAND	-	-		-					-	_	-
North Northumberland	0	5	0	1	0	25	22	60	5	32	150
South Northumberland	0	11	0	0	0	10	29	35	9	6	100
TEESSIDE	2	27	0	0	0	46	122	70	19	0	286
TYNE AND WEAR											
Gateshead and South Tyneside	0	16	0	0	0	40	100	45	11	13	225
Newcastle upon Tyne	0	12	0	0	2	35	78	102	12	74	315
North Tyneside	2	10	0	0	0	23	80	93	9	9	226
Sunderland	1	0	0	0	1	61	53	251	8	81	456
NORTH WEST											
CHESHIRE	1	66	0	0	0	73	146	276	32	70	664
CUMBRIA											
South and East Cumbria	0	15	0	0	0	25	37	38	15	44	174
North and West Cumbria GREATER MANCHESTER	1	19	0	4	2	9	41	41	5	13	135
Manchester city	2	46	2	3	2	20	160	246	38	195	714
Manchester North	0	31	0	1	2	13	52	196	14	91	400
Manchester South	2	38	2	0	0	23	173	169	34	15	456
Manchester West	6	48	0	9	13	57	198	84	90	106	611
LANCASHIRE											
Blackburn, Hyndburn and Ribble Valley	1	32	1	1	0	14	58	137	6	70	320
Blackpool/Fylde	1	25	1	5	2	22	46	19	9	1	131
East Lancashire	0	14	0	0	0	6	45	42	6	14	127
Preston and West Lancashire MERSEYSIDE	3	54	0	1	0	20	102	110	18	97	405
Sefton, Knowsley and St Helens	0	35	4	1	1	19	97	107	15	6	285
Liverpool	5	24	0	8	3	33	133	209	13	101	517
Wirral	0	11	0	0	3	29	33	121	13	43	253
wiiai	U	1.1	U	U	3	29	33	121	13	73	233

Table 10: Inquest verdicts returned, by jurisdiction, 2010 (continued)

NORTH LINCOLNSHIRE and GRIMSBY 1 23 0 2 3 YORK CITY 0 13 0 7 2 North Yorkshire Eastern District 0 27 1 0 0 North Yorkshire Western District 2 27 0 5 2 South Yorkshire Eastern District 2 26 0 1 1	strial mis-	Deaths from natural causes 38 23 17 20 34 64 130	Open verdicts 29 1 5 12 0 15	All other verdicts (1) 72 22 3 4	Total, all verdicts 274 120 83
EAST RIDING and HULL 0 26 0 0 1 NORTH LINCOLNSHIRE and GRIMSBY 1 23 0 2 3 YORK CITY 0 13 0 7 2 North Yorkshire Eastern District 0 27 1 0 0 North Yorkshire Western District 2 27 0 5 2 South Yorkshire Eastern District 2 26 0 1 1	19 26 12 24 11 54 8 33 60 69 81 75 73 151	23 17 20 34 64 130	1 5 12 0	22 3 4	120 83
EAST RIDING and HULL 0 26 0 0 1 NORTH LINCOLNSHIRE and GRIMSBY 1 23 0 2 3 YORK CITY 0 13 0 7 2 North Yorkshire Eastern District 0 27 1 0 0 North Yorkshire Western District 2 27 0 5 2 South Yorkshire Eastern District 2 26 0 1 1	19 26 12 24 11 54 8 33 60 69 81 75 73 151	23 17 20 34 64 130	1 5 12 0	22 3 4	120 83
NORTH LINCOLNSHIRE and GRIMSBY 1 23 0 2 3 YORK CITY 0 13 0 7 2 North Yorkshire Eastern District 0 27 1 0 0 North Yorkshire Western District 2 27 0 5 2 South Yorkshire Eastern District 2 26 0 1 1	19 26 12 24 11 54 8 33 60 69 81 75 73 151	23 17 20 34 64 130	1 5 12 0	22 3 4	120 83
YORK CITY 0 13 0 7 2 North Yorkshire Eastern District 0 27 1 0 0 North Yorkshire Western District 2 27 0 5 2 South Yorkshire Eastern District 2 26 0 1 1	12 24 11 54 8 33 60 69 81 75 73 151	17 20 34 64 130	5 12 0	3 4	83
North Yorkshire Eastern District 0 27 1 0 0 North Yorkshire Western District 2 27 0 5 2 South Yorkshire Eastern District 2 26 0 1 1	11 54 8 33 60 69 81 75 73 151	20 34 64 130	12 0	4	
South Yorkshire Eastern District 2 26 0 1 1	60 69 81 75 73 151	64 130			129
	81 75 73 151	130	15	15	126
South Yorkshire Western District 1 28 0 0 2	73 151			51	289
			6	57	380
West Yorkshire Eastern District 6 56 0 19 14	47 144	148	35	37	539
		115	21	16	459
EAST MIDLANDS					
DERBYSHIRE	10 00		40		
,	49 82	52	19	54	288
	46 71	124	28	16	299
LEICESTERSHIRE	0.4	400		0.5	
,	24 128	122	29	65	417
Rutland and North Leicestershire 0 23 0 0 0 LINCOLNSHIRE	8 39	46	8	8	132
Boston and Spalding 0 6 0 0 1	5 23	8	2	5	50
	13 27	31	16	10	123
Spilsby and Louth 0 7 0 0 4	3 10	8	17	0	49
Stamford 0 6 0 0 0	0 5	1	0	0	12
	24 87	41	19	35	244
NOTTINGHAMSHIRE 6 44 0 1 1	55 153	52	61	25	398
WEST MIDLANDS	10 10	20	_		400
	12 40	26	7	2	108
SHROPSHIRE		•		40	
Mid and North Shropshire 3 23 1 0 1	4 34	6	2	13	87
South Shropshire 0 13 0 0 1	1 17	0	1	1	34
STAFFORDSHIRE Chaffordshire South	40	00	7	40	040
	46 125	63		19	310
	39 143 7 33	67	29 3	147 18	475
		13			89
	14 72	44	23	12	215
WEST MIDLANDS Birmingham and Solihull 6 42 0 0 0	18 96	221	31	598	1,012
	26 69	114	23	598 50	342
Coventry 3 21 0 2 1	7 53	62	23 9	11	342 169
•	10 10	62 47	10	32	114
	23 100	47 136	16	32 33	356
WONOLOTENOTINE 1 43 U 3 T	23 100	130	10	33	330

Table 10: Inquest verdicts returned, by jurisdiction, 2010 (continued)

	Verdict category											
County / unitary authority or district	Homicide, killed unlawfully and killed lawfully	Suicide	Lack of care or self- neglect	ependence on drugs	Non- dependent abuse of drugs	Death from industrial diseases	Death by accident or mis- adventure	Deaths from natural causes	Open verdicts	All other verdicts (1)	Total, all verdicts	
EAST OF ENGLAND												
BEDFORDSHIRE and LUTON CAMBRIDGESHIRE	0	50	1	4	3	13	58	64	5	8	206	
North and East Cambridgeshire	2	9	0	1	1	4	18	13	2	9	59	
South and West Cambridgeshire	1	20	1	3	0	14	40	62	2	37	180	
ESSEX and THURROCK	0	85	0	4	0	103	189	120	64	28	593	
HERTFORDSHIRE	1	52	0	0	0	25	109	102	9	38	336	
NORFOLK	2	58	0	0	0	53	152	111	2	99	477	
PETERBOROUGH	0	19	0	0	0	7	25	24	6	7	88	
SOUTHEND-ON-SEA	1	12	0	0	0	12	12	16	18	32	103	
SUFFOLK	2	32	0	0	0	20	52	50	29	90	275	
LONDON												
City of London	2	4	0	0	0	2	4	2	2	0	16	
East London	3	47	0	4	1	46	115	81	53	37	387	
Inner North London	1	69	1	22	15	18	84	179	71	71	531	
Inner South London	3	46	0	12	9	21	84	105	50	52	382	
Inner West London	1	45	1	3	6	12	143	89	35	28	363	
North London	3	23	0	0	0	17	134	142	99	89	507	
South London	2	43	0	1	7	39	82	62	49	11	296	
West London	5	78	2	11	4	29	138	159	40	90	556	
SOUTH EAST												
BERKSHIRE	6	30	0	0	0	9	98	42	30	73	288	
BRIGHTON and HOVE	2	27	3	0	9	9	115	21	11	12	209	
BUCKINGHAMSHIRE	0	24	0	0	0	5	38	16	17	18	118	
EAST SUSSEX	0	66	0	8	1	21	88	96	25	19	324	
HAMPSHIRE												
Central Hampshire	1	22	0	0	0	34	47	66	14	2	186	
North East Hampshire	2	35	0	0	0	13	51	32	9	8	150	
Portsmouth and South East Hampshire	1	21	0	9	1	29	105	200	6	16	388	
Southampton and New Forest	2	30	1	1	0	25	52	58	11	22	202	
ISLE OF WIGHT	0	12	0	0	2	8	28	13	11	1	75	
KENT												
Central and South East Kent	3	17	0	0	0	13	38	33	15	40	159	
Mid Kent and Medway	2	30	0	0	0	35	58	50	13	19	207	
North East Kent	2	17	0	0	0	30	72	57	10	21	209	
North West Kent	4	20	0	0	0	15	44	66	19	3	171	
MILTON KEYNES	0	16	2	0	0	5	50	34	6	11	124	

Table 10: Inquest verdicts returned, by jurisdiction, 2010 (continued)

	Verdict category										
County / unitary authority or district	Homicide, killed unlawfully and killed lawfully	Suicide	Lack of care or self- neglect	Dependence on drugs	Non- dependent abuse of drugs	Death from industrial diseases	Death by accident or mis- adventure	Deaths from natural causes	Open verdicts	All other verdicts (1)	Total, all verdicts
OXFORDSHIRE	1	36	2	0	0	33	110	40	27	34	283
SURREY	4	73	3	0	1	43	109	73	54	34	394
WEST SUSSEX	3	50	0	4	3	30	97	56	15	21	279
SOUTH WEST											
AVON	9	78	0	34	6	63	187	279	61	62	779
CORNWALL DEVON	3	30	3	2	1	22	80	81	48	47	317
Exeter and Greater Devon	4	41	0	5	16	20	124	79	13	10	312
Plymouth and South West Devon	4	26	0	4	4	27	93	145	11	40	354
Torbay and South Devon DORSET	0	17	0	1	0	9	47	9	14	3	100
Bournemouth, Poole and Eastern Dorset	3	38	0	3	1	12	39	31	22	26	175
Western Dorset	0	17	0	0	0	13	24	11	19	1	85
GLOUCESTERSHIRE	2	44	0	1	0	32	135	130	47	26	417
ISLES OF SCILLY SOMERSET	0	1	0	0	0	0	0	0	0	0	1
Eastern Somerset	0	25	0	0	0	4	34	50	12	18	143
Western Somerset	0	22	0	3	1	9	27	48	5	8	123
WILTSHIRE AND SWINDON	50	46	2	2	0	45	88	135	11	38	417
WALES											
Bridgend and Glamorgan Valleys	2	1	0	0	0	9	120	75	33	82	322
Cardiff and Vale of Glamorgan	2	32	0	16	4	16	82	130	30	90	402
Carmarthenshire	0	16	0	0	0	1	44	9	4	0	74
Central North Wales	0	20	0	0	0	8	75	48	15	25	191
Ceredigion	0	3	0	0	0	2	9	8	2	1	25
Gwent	6	25	0	0	0	12	77	10	8	3	141
Neath and Port Talbot	0	11	1	0	0	1	18	31	5	8	75
North East Wales	8	21	0	0	0	6	86	37	13	33	204
North West Wales	1	18	2	2	1	7	41	45	7	23	147
Pembrokeshire	0	16	0	0	1	6	16	31	4	0	74
Powys	0	4	0	0	0	3	28	20	7	12	74
City and County of Swansea	1	16	0	2	0	9	51	82	7	14	182
TOTAL ENGLAND and WALES	248	3,252	42	267	216	2,560	8,113	8,382	2,115	4,190	29,385

⁽¹⁾ All other verdicts include those categories from Tables 4 and 6 for which separate columns are not shown in this table.

NB: A table showing inquest verdicts by district broken down by males and females can be found in the spreadsheet version of the coroners statistics tables.

Key to jurisdictions

North East

101 - Darlington and South Durham

102 - North Durham

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 - South and East Cumbria

204 - North and West Cumbria

205 - Manchester (city)

206 - Manchester North

North West (continued)

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

215 - 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 South Derbyshire

402 - North Derbyshire

403 - Leicester and South Leicestershire

404 - North Leicestershire and Rutland

405 - Boston and Spalding

406 - West Lincolnshire

407 - Spilsby and Louth

408 - Stamford

409 - Northamptonshire

410 - Nottinghamshire

West Midlands

501 - Herefordshire

502 - North Shropshire

503 - South Shropshire

504 - Staffordshire South

505 - Stoke-on-Trent and North Staffordshire

506 - Telford and Wrekin

507 - Warwickshire

508 - Birmingham and Solihull

509 - Black Country

510 - Coventry

511 - Wolverhampton

512 - Worcestershire

East of England

601 - Bedfordshire and Luton

602 - North and East Cambridgeshire

603 - South and West Cambridgeshire

604 - Essex and Thurrock

605 - Hertfordshire

607 - Norfolk

609 - Peterborough

610 - Southend on Sea

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

903 - Exeter and Greater Devon

904 - Plymouth and South West Devon

905 - Torbay and South Devon

906 - Bournemouth and Eastern Dorset

907 – Western Dorset

908 - Gloucestershire

909 - Isles of Scilly

910 - Eastern Somerset

911 - Western Somerset

912 - Wiltshire and Swindon

Wales

1001 - Bridgend and Glamorgan Valleys

1002 - Cardiff and Vale of Glamorgan

1003 - Carmarthenshire

1004 - Central North Wales

1005 - Ceredigion

1006 - Gwent

1007 - Neath and Port Talbot

1008 - North East Wales

1009 - North West Wales

1010 - Pembrokeshire

1011 - Powys

1012 - City and County of Swansea

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.

2. The data analysed in this publication are based on annual returns from H.M. Coroners. Coroners are required under the provisions of Section 28 of the Coroners Act 1988 to furnish to the Secretary of State returns in relation to inquests held and deaths inquired into by him (or her) in such form and containing such particulars as the Secretary of State may direct. Thanks are due to coroners and their staff for their work in preparing these returns.

Definitions

The following brief definitions are intended as a guide to the meaning of terms in this bulletin concerning coroners and their work; more detailed definitions will be found in the Coroners Act 1988 and the Treasure Act 1996.

Coroner; deaths reported

In England and Wales, all violent and unnatural deaths, sudden deaths of unknown cause, and all deaths of persons in custody, are reported to coroners. Coroners are appointed by local authorities; they must be barristers, solicitors or registered medical practitioners and must have at least five years' standing in the relevant profession. The relevant legislation and guidance is contained within the Coroners Act 1988 and the Coroners Rules 1984 (S.I 1984/552 and subsequent amendments). A link to the Act is here: http://www.legislation.gov.uk/ukpga/1988/13/contents
The more recent amendments to the Coroners Rules may be found at: http://www.legislation.gov.uk/ (home page)

Non-inquest cases

The coroner's investigation is concluded most often without an inquest being held. The coroner will have satisfied himself or herself, by means of a post-

mortem examination or other investigation, on the physical cause of death, and that the death was not one on which he or she is required by law to hold an inquest.

Post mortem examinations

A coroner may request that a post-mortem examination be conducted, whether or not an inquest is held, particularly if the cause of death is not clear. In many cases a post-mortem examination is conducted in order to determine whether or not an inquest is necessary. Other post-mortem examinations are held which are not ordered by the coroner. Details of these are collected by the Office for National Statistics (ONS). See the further information section below for details of how to obtain statistics on this and other related topics.

Inquests

A coroner must hold an inquest if the body of a person ('the deceased') lies within his or her district⁴ and if he or she has reasonable cause to suspect that the deceased:

- (a) died a violent or unnatural death;
- (b) died a sudden death the cause of which is unknown; or
- (c) died in prison or in such place or in such circumstances as to require an inquest under any other Act.

The holding of an inquest requires the coroner to determine:

- (a) who the deceased was:
- (b) how, when and where the deceased came by his or her death, and any further particulars necessary to enable the death to be registered.

Verdicts are returned in nearly all coroners' inquests. The exceptions are those inquests adjourned by the coroner which he or she later decides not to resume, and are mainly inquests into deaths by unlawful killing and deaths by dangerous driving or careless driving when under the influence of alcohol or drugs, in which court proceedings have been instituted. This avoids the need for two tribunals to consider the same evidence. A "narrative verdict" is where the coroner makes a brief and factual statement at the conclusion of the inquest but does not return one of the suggested short-form verdicts.

<u>Timeliness of inquests</u>

For the purpose of determining the timeliness of inquests, the time taken to conduct an inquest is deemed to be from the day the death was reported to the coroner until either (a) the day the inquest is concluded by the delivery of a verdict or (b) the day the coroner certifies that an adjourned inquest will not be resumed.

⁴ The cause of death does not need to have arisen within the coroner's district.

The average time for an inquest to be conducted is estimated in the following way: Coroners are asked in their annual return to state how many inquests were concluded within certain time periods. There are five time bands, which are: within one month; 1-3 months; 3-6 months; 6-12 months; and over 12 months. All the inquests falling within a time-band are then assumed to have been completed at or near the mid-point of the various time-bands for the purposes of calculating the average, although inquests within the "under one month" band are assumed to have taken 3 weeks for this purpose of this estimation, and those inquests taking over a year to conclude were deemed to have taken 18 months, although the time-band itself is open-ended. Numbers are then aggregated and the average figure (in weeks) calculated in the normal way.

Only deaths occurring within England and Wales are included in the calculation. Statistics are not collected on the time taken for inquests where the death occurred outside England and Wales. Deaths occurring abroad are often significantly delayed because of the difficulty, for example, of obtaining reports from other countries.

Juries

Nearly all inquests are held by a coroner sitting alone, without a jury. A jury must be summoned where the death occurred:

- (a) in prison, or in such a place or such circumstances as to require an inquest under another Act;
- (b) in police custody, or resulted from an injury caused by a police officer in the purported execution of his or her duty;
- (c) where there are certain statutory reporting obligations under the Health and Safety Act 1974 or any other Act, and in certain other circumstances, especially where there may be a continuing or recurring danger to the public.

Treasure and treasure trove

In addition to inquiring into certain deaths, coroners also have jurisdiction to inquire into any treasure which is found in their districts and to establish who were the finders. With the commencement of the Treasure Act 1996 on 24 September 1997 inquests into finds which previously might have been declared treasure trove are supplemented by those now conducted to determine whether finds made on or after that date are treasure.

Registered deaths

All deaths in England and Wales must be registered with the Registrar of Births and Deaths. The term 'registered deaths' in this bulletin refers to deaths registered within a specific time period (in this case, calendar years).

Statistics on registered deaths in England and Wales are published by the ONS in their series on mortality statistics. At the time of going to press, final figures had not been published for the number of registered deaths in 2010, but a provisional figure has been derived from the monthly registration figures which are published by ONS at regular intervals.

Quality and consistency of the statistics

The figures presented in this report are collected via statistical returns completed by coroners. The process by which coroners provide their returns can vary according to the case management system they use. Many coroners use a system provided by an external contractor, while other coroners use alternative computer systems or a paper-based system. Although care is taken in completing, analysing and quality-assuring the data provided on the statistical returns, the figures are, of necessity, subject to possible inaccuracies inherent in any large-scale collection of this type. For this reason, figures may not be accurate to the final digit. In the text, numbers have been rounded, usually to the nearest 100, although some smaller figures may be given exactly.

Coroners are independent office-holders, and there is considerable variation in the way each coroner's district is structured and managed, and in the mechanisms they have in place for discharging their duties under the Coroners Act. From a statistical perspective one of these differences relates to the way they approach the handling of "NFA" cases.

Many deaths referred to coroners require no further action being taken by them – these are known as "NFA" cases. These are deaths reported to coroners where there was no inquest, no post-mortem, and no certificate was issued by the coroner for registration or any other purpose. The statistics for 1995 onwards include all NFA cases within the figures for deaths reported that required neither an inquest nor a post-mortem. Prior to 1995, however, some coroners did not report some or all of their NFA cases in their annual statistics (figures for some earlier years are shown in Table 2), and the inclusion of all NFA cases in the statistics addressed this inconsistency in reporting.

Despite the inclusion of all NFA cases in the statistics since 1995 however, there may still be some differences between coroners as to which cases they consider constitute a substantive "reported death" (and are therefore reported in their statistics) where little or no action is required on their part and no post-mortem or inquest is held. As such, the statistics reflect those cases which each individual coroner considers to be a death reported to them, and the figures for different coroner districts can be compared on this basis.

Uses of the statistics

The main users of these statistics are coroners themselves, and Ministers and officials in central government responsible for developing policy with regard to coroners. Other users include local authorities (who are responsible for the appointment and remuneration of coroners), 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.

Revisions to statistics for previous years

The estimated figure for the number of registered deaths in 2009 which was derived for the purposes of Table 2 in last year's edition of this bulletin has now been replaced by an actual figure subsequently published by the Office for National Statistics.

The figure for the estimated average time to process an inquest in 2009 reported in Table 7 has been revised. After the publication of the 2009 statistics in May 2010, one coroner revised the timeliness statistics for their completed inquests in 2009, which had the effect of altering (due to rounding) the overall national estimated average inquest timeliness in Table 7 from 26 weeks to 27.

Symbols and conventions

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

n/a = Not applicable

- = Nil

.. = Not available

* = Percentage not shown due to being based on small numbers of cases

(R) = Revised data

Further notes

Prior to 1 June 2005, policy responsibility for H.M. Coroners lay with the Home Office, but on that date it passed to the Department for Constitutional Affairs as part of machinery of government changes following the 2005 general election. Responsibility now lies with the Ministry of Justice, which was created on 9 May 2007.

Prior to the transfer of responsibility, the Home Office published statistical bulletins based on coroners' annual returns, from 1980. The last four bulletins published in the Home Office Statistical Bulletin series were as follows: for year 2003, bulletin 9/04; for 2002, bulletin 6/03; for 2001, bulletin 3/02; and for year 2000, bulletin 7/01. These may be found at: http://homeoffice.gov.uk/science-research/research-statistics.

Previous editions of this bulletin published by the Ministry of Justice, the Department for Constitutional Affairs, and the Home Office, were entitled "Statistics on deaths reported to coroners, England and Wales, (year)".

Further information on deaths occurring annually in England and Wales is published by the Office for National Statistics in their Mortality Statistics series; these may be downloaded from their website at www.statistics.gov.uk.

Contact points for further information

Current and previous editions of this publication are available for download at http://www.justice.gov.uk/publications/statistics-and-data/coroners-and-

<u>burials/deaths.htm</u> A spreadsheet file of the statistics tables in this bulletin are also available for download from this address.

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

Tel: 020 3334 3573

Email: andrew.chiles@justice.gsi.gov.uk

Other enquiries about these statistics should be directed to:

Richard Allen

Ministry of Justice 7th Floor (7.20) 102 Petty France London SW1H 9AJ

Tel: 020 3334 3737

Email: statistics.enquiries@justice.gsi.gov.uk

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

The Department for Culture, Media and Sport's annual reports on the Treasure Act 1996 may be found on their website: www.culture.gov.uk.

General enquiries about the statistical work of the Ministry of Justice can be e-mailed to: 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.

© Crown copyright Produced by the Ministry of Justice

Alternative formats are available on request from statistics.enquiries@justice.gsi.gov.uk