Coroners Statistics 2012 England and Wales

Ministry of Justice Statistics bulletin

Published 16 May 2013

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Executive Summary

This bulletin presents statistics of coroners' work during the calendar year 2012, 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)".

- Some 227,721 deaths were reported to coroners in 2012, an increase of 5,350 (two per cent) from the 2011 figure.
- The proportion of all registered deaths reported to coroners was an estimated 46 per cent in 2012, the same as in 2011. Over the last five years this proportion has been relatively consistent, within the range 46 to 47 per cent.
- The estimated average time taken to process an inquest in 2012 (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 26 weeks, slightly less than the last three years' figure of 27 weeks. The maximum time taken to process an inquest in 2012 was 53 weeks, and the minimum time was eight weeks.
- Verdicts of suicide rose by one per cent in 2012 compared to 2011, from 3,471 to 3,515.
- Also rising were the number of unclassified verdicts, a category which includes narrative verdicts, which are a factual record of how and in what circumstances the death occurred, often returned where the cause of death does not easily fit any of the standard short-form verdicts.
- 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 (26 per cent).

Introduction

This annual bulletin presents statistics of deaths reported to coroners in England and Wales in 2012 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)". For previous editions of this report please see:

www.gov.uk/government/publications/coroners-statistics-ns

This publication should be read alongside the statistical tables which accompany it, also found via the link above.

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 death occurred. 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 (the written record of the inquest).

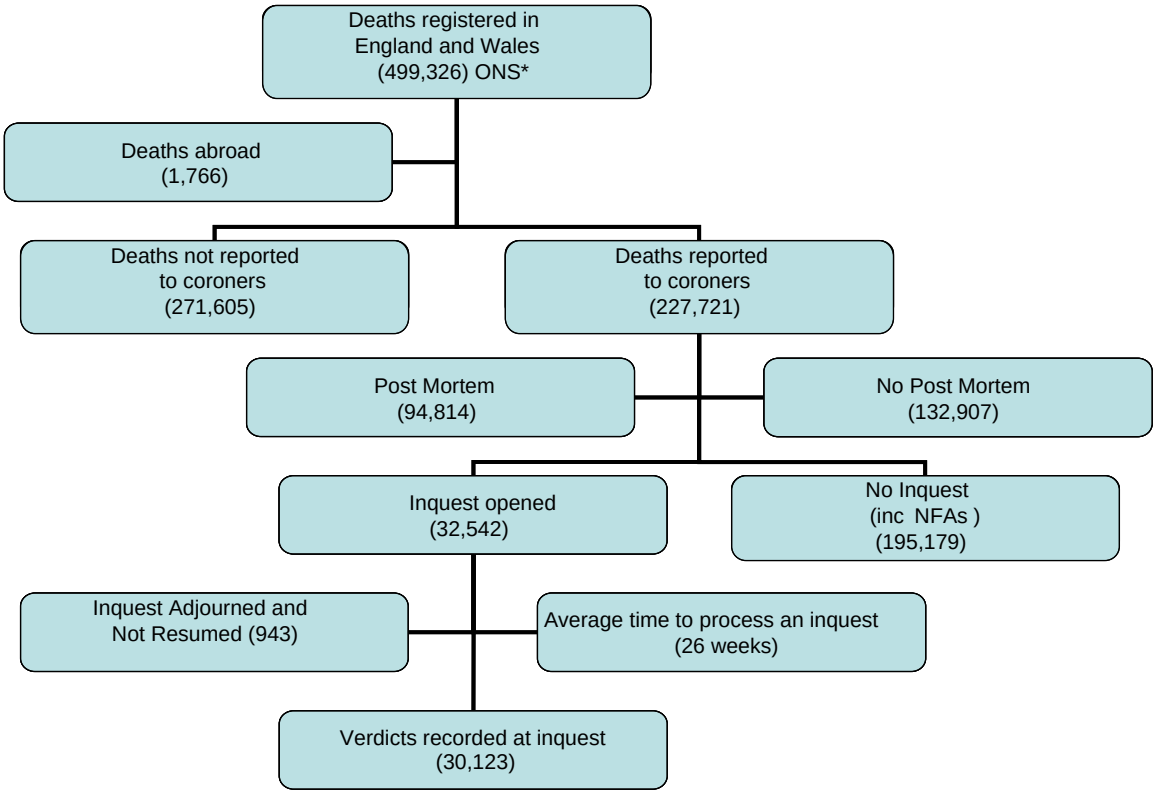
In the majority (86 per cent) of deaths reported to them, however, coroners' investigations are concluded without an inquest being held. The coroner will have satisfied themselves, by means of a post-mortem examination or other investigation, on the physical cause of death, and that the death was not one on which he or she is required by law to hold an inquest.

Verdicts are returned in nearly all inquests (97 per cent). 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 (98 per cent) 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.

Figure 1 shows the possible outcomes involved when a death is reported to a coroner.

Figure 1: Deaths reported to coroners, 2012[1]



*Provisional ONS figure

In England and Wales a coroner also handles investigations regarding finds reported to them under the provisions of the Treasure Act 1996. The coroner will inquire into any treasure which is found in their districts and establish who the finders were.

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.

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

[1] This covers events during 2012, for example the verdicts in 2012 may relate to cases from 2012 or earlier years. It is not possible to follow the flow of cases through the system due to the way the data is collected.

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

www.statistics.gov.uk/hub/population/deaths/mortality-rates/index.html

For annual summary of monthly figures please see:

www.ons.gov.uk/ons/rel/vsob2/monthly-figures-on-deaths-registered-by-area-of-usual-residence--england-and-wales/index.html

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

The proportion of deaths which are reported to coroners has been estimated[2] using death registration figures published by ONS. Estimates for 2012 have been calculated using ONS' monthly provisional figures on death registrations, while percentages for 2011 and earlier years have been calculated using final annual death registration figures for the relevant year.

For the first time this publication includes figures for deaths which occurred in state custody. Statistics on deaths in prison custody are also published by NOMS, accessible via the following link:

www.gov.uk/government/publications/safety-in-custody

The figures for deaths in custody in this publication relate only to those deaths which have been reported to a coroner, whereas the NOMS publication includes all deaths which have occurred in prison custody and those which occurred whilst the offender was released on temporary licence (ROTL) for medical reasons.

The Youth Justice Board also include figures for deaths of young people (under 18) in custody in the Youth Justice Statistics publication, accessible via the link below:

www.gov.uk/government/publications/youth-justice-statistics

[2] 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 2012 has not yet been published, so a provisional figure from ONS, derived from the monthly figures for death registrations in England and Wales, has been used.

For further information on criminal convictions of homicide please refer to Volume 5 of the Ministry of Justice publication Criminal Justice Statistics, available at the following link:

www.gov.uk/government/organisations/ministry-of-justice/series/criminal-justice-statistics

The Criminal Justice Statistics publication includes figures on the number of prosecutions and convictions of homicide. The Coroner Statistics publication records the number of verdicts of homicide recorded by coroners at inquests so these numbers are not directly comparable as the Criminal Justice Statistics covers all prosecutions and convictions for homicide, while the coroner data only covers cases where a verdict of homicide has been given at an inquest.

Deaths reported

The number of deaths reported to coroners in 2012 rose by 5,350 (two per cent) from the previous year, from 222,371 in 2011 to 227,721 during 2012, reflecting the increase in the number of deaths registered in England and Wales. The proportion of registered deaths in the calendar year 2012 that were reported to coroners in 2012 was an estimated 46 per cent, the same as in 2011. This percentage has shown a slight downward trend over the last few years.

Map 1 below shows deaths reported in each coroner jurisdiction in 2012 as a percentage of the population.

Map 1: Deaths reported to coroners as a percentage of the population, England and Wales, 2012

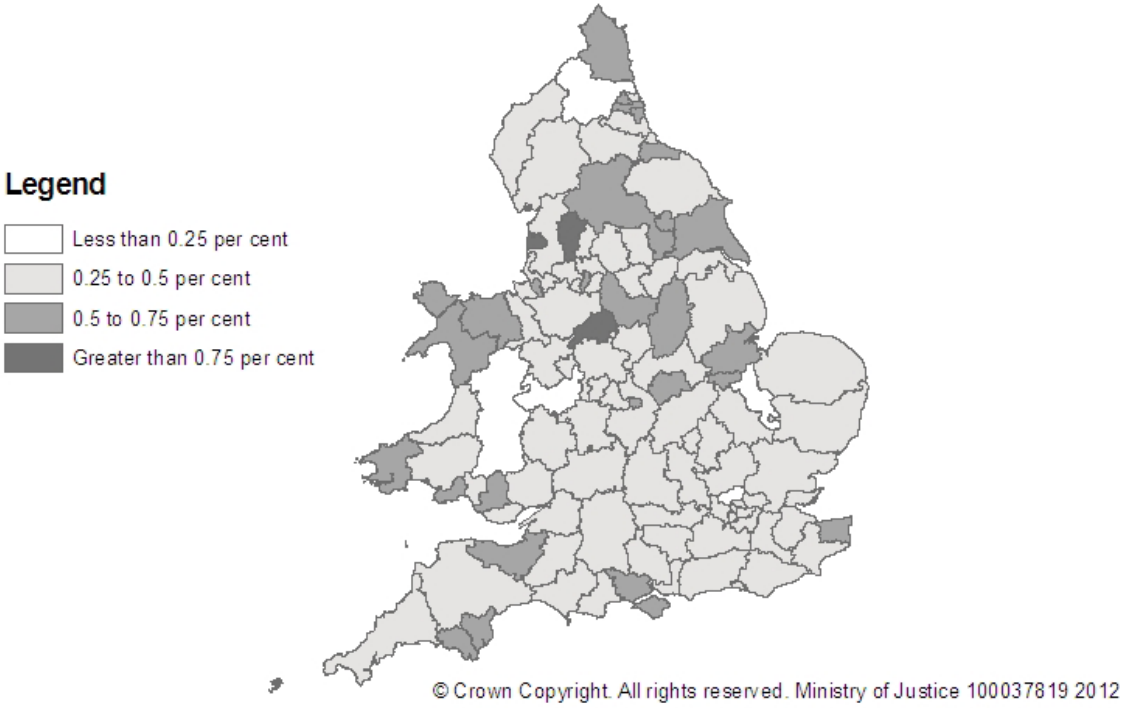
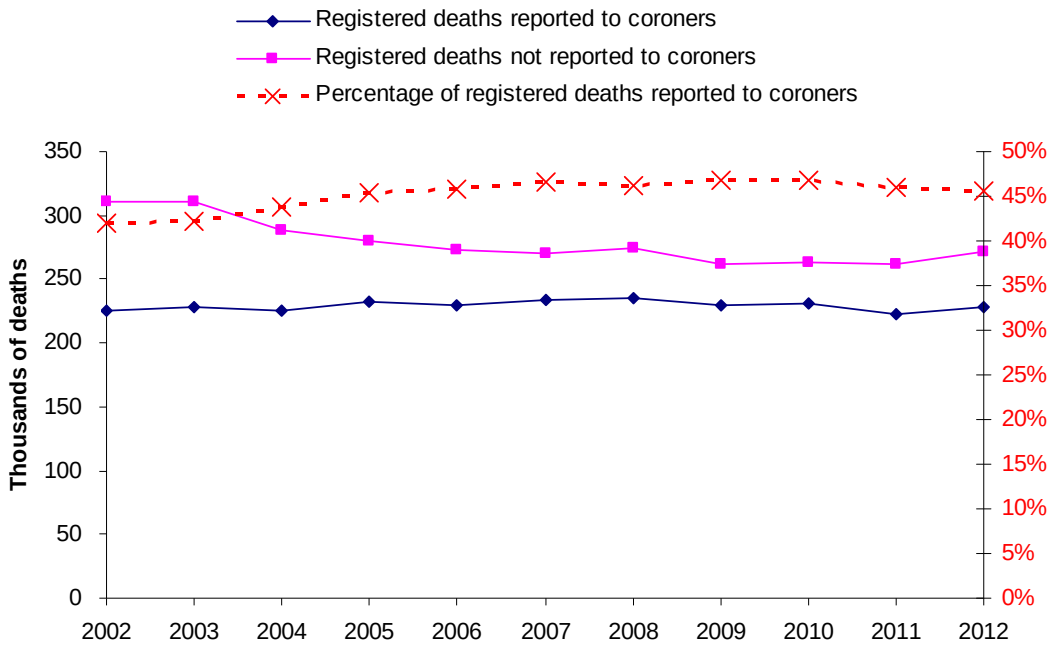


Figure 2: Registered deaths, and deaths reported to coroners, England and Wales, 2002-2012



Over the last decade, the number of registered deaths has decreased from 535,356 in 2002 to 499,326[3] in 2012; however the number has fluctuated in recent years. The number of deaths reported to coroners has stayed within the range of 222,371 and 234,784 over the last ten years, varying between 42 and 47 per cent of registered deaths (see Table 2 in the statistical tables).

[3] Provisional figure based on ONS monthly death registration figures for 2012

Post-mortem examinations held and inquests opened

Post-mortem examinations were ordered by coroners in 42 per cent of all cases reported to them in 2012, a slight decrease compared to 2011, and continuing the existing downward trend (see Table 3). Over the last ten years the percentage of post-mortems ordered has decreased by ten percentage points from 117,684 to 94,814.

The actual number of deaths reported to coroners in 2012 where a post-mortem was held was 94,814, some 860 more than in the previous year, reflecting in part the increase in the total number of reported deaths.

Map 2: Post-mortems as a proportion of deaths reported to coroners, England and Wales, 2012

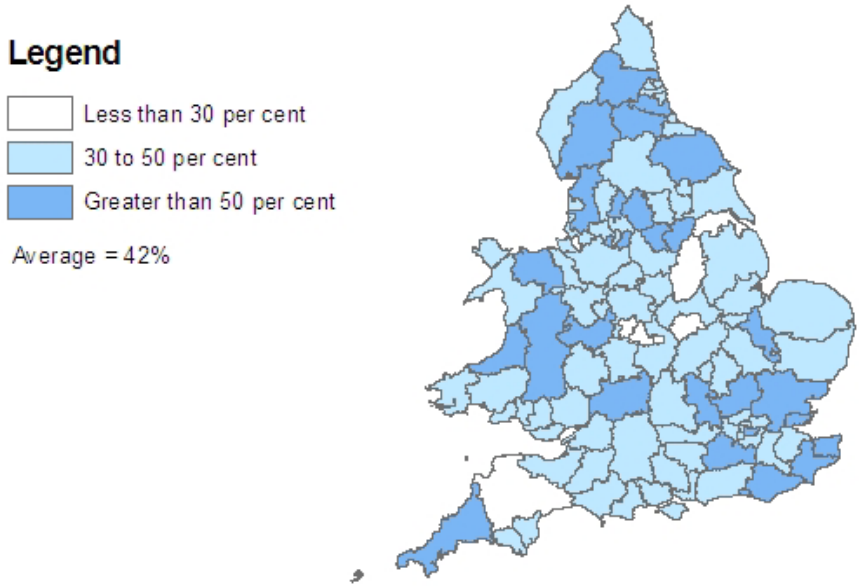
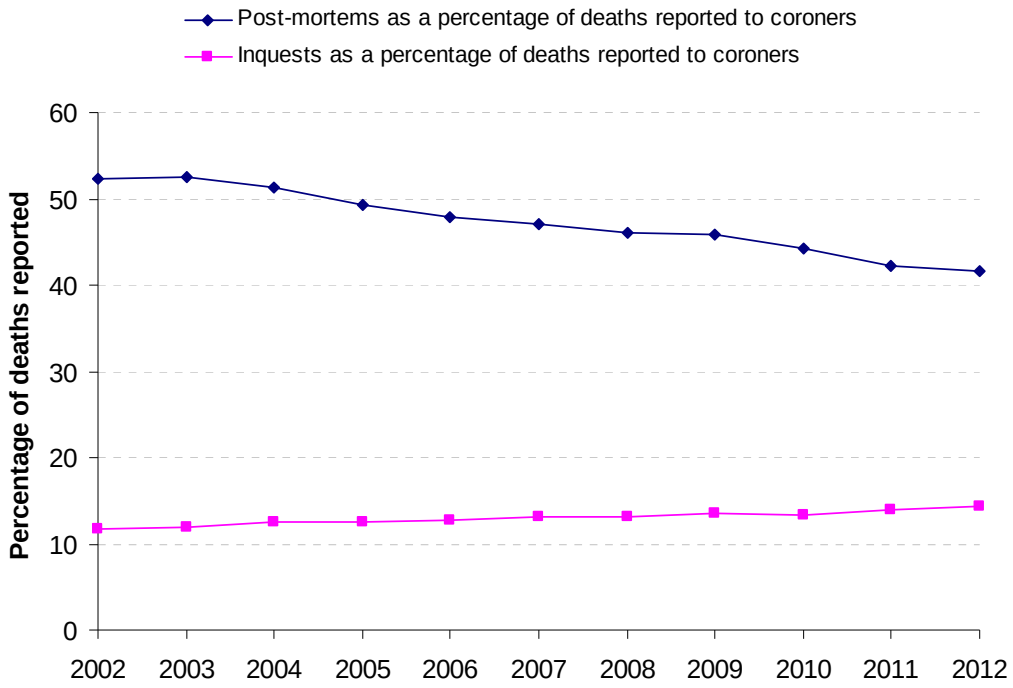
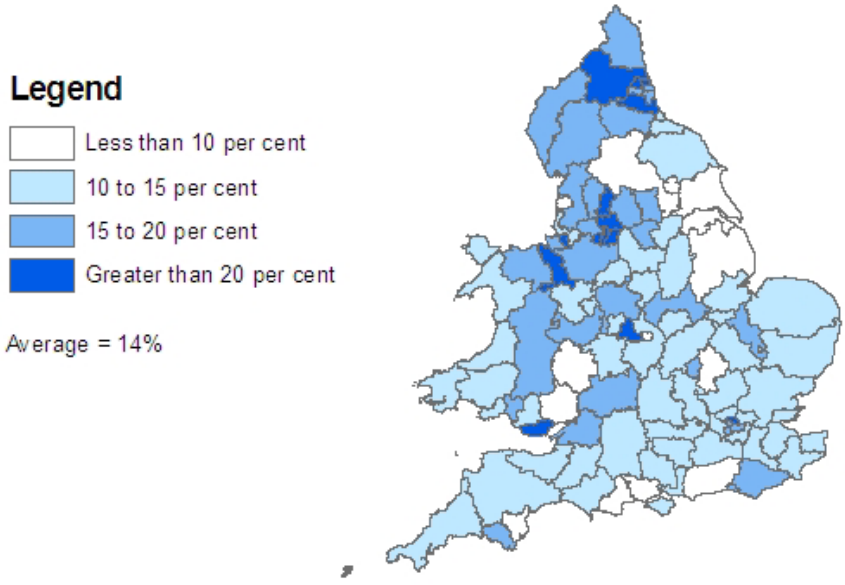


Figure 3: Post-mortems and inquests as a percentage of deaths reported to coroners, England and Wales, 2002-2012



Inquests were opened on 32,542 deaths reported to coroners in 2012, an increase of 1,561 on 2011. Inquest cases represented 14 per cent of all the deaths reported to coroners in 2012, a small increase, and continuing a long-term rising trend. Over the last ten years the percentage of inquest cases has increased by three percentage points.

Map 3: Inquests held as a proportion of deaths reported to coroners, England and Wales, 2012



Post-mortems in inquest cases

When an inquest is held a post-mortem examination has usually been conducted, and in 2012 post-mortems were conducted in 87 per cent of such cases. This is a lower proportion than in the previous year by one percentage point, and continues a shallow declining trend over the past decade. Prior to the late 1990s, the holding of an inquest without a post-mortem examination was comparatively rare, accounting for around two per cent or less of inquest cases every year. In 2012 there were 4,263 inquests without a post-mortem representing 13 per cent of inquests, this is over three times the number reported ten years ago.

Post-mortems in non-inquest cases

In the majority (86 per cent) of cases referred to coroners there is no inquest. In 2012, there were 66,535 non-inquest cases where a post-mortem was held, and the percentage of non-inquest cases that required a post-mortem fell to 34 per cent. This proportion has fallen steadily in recent years; in 2002 it was 47 per cent of all non-inquest cases.

Cases requiring neither an inquest nor a post-mortem

There were also 128,578 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 2002 there were 106,248 such cases). In addition, the percentage of cases where there was neither an inquest nor a post-mortem examination has increased, as a proportion of all deaths reported to coroners, from around 47 per cent in 2002, to 56 per cent in 2012.

Post-mortem rates, histology[4] and toxicology[5]

Post-mortems can be classed as either standard or non-standard, depending on the cost of the examination. A non-standard post-mortem is charged at a higher rate than a standard post-mortem and is defined as a post-mortem which requires special skills. A non-standard post-mortem could, for example, require a paediatric or specialist pathologist. In 2012, 95 per cent of post-mortems were ordered at a standard rate, a slight decrease compared to 96 per cent in 2011 (see Table 4).

In 2012, 18,700 post-mortems included histology (20 per cent of post-mortems held), which was 750 more than in 2011, an increase of one percentage point. 12,613 post-mortems held in 2012 included toxicology (13 per cent of post-mortems held), the same percentage as in 2011.

[4] Histology in the context of post-mortems is the examination of tissues under a microscope.

[5] Toxicology in the context of post-mortems is the study of body fluids and tissues for the detection of drugs.

Out of England Orders

Every person who wishes to remove a body of a deceased person out of England and Wales must give notice of such intention to the coroner within whose jurisdiction the body is lying. When the coroner gives permission for the removal of the body an Out of England order is issued.

Coroners issued 5,030 Out of England orders in 2012, compared with 5,008 issued in 2011. In both years the number of orders issued represented just over two per cent of the total number of deaths reported to coroners (see Table 5).

Of the 227,721 deaths reported to coroners in 2012, some 1,766 (less than one per cent) were reports of deaths that had occurred outside England and Wales, the same percentage reported in 2011.

Deaths in Custody

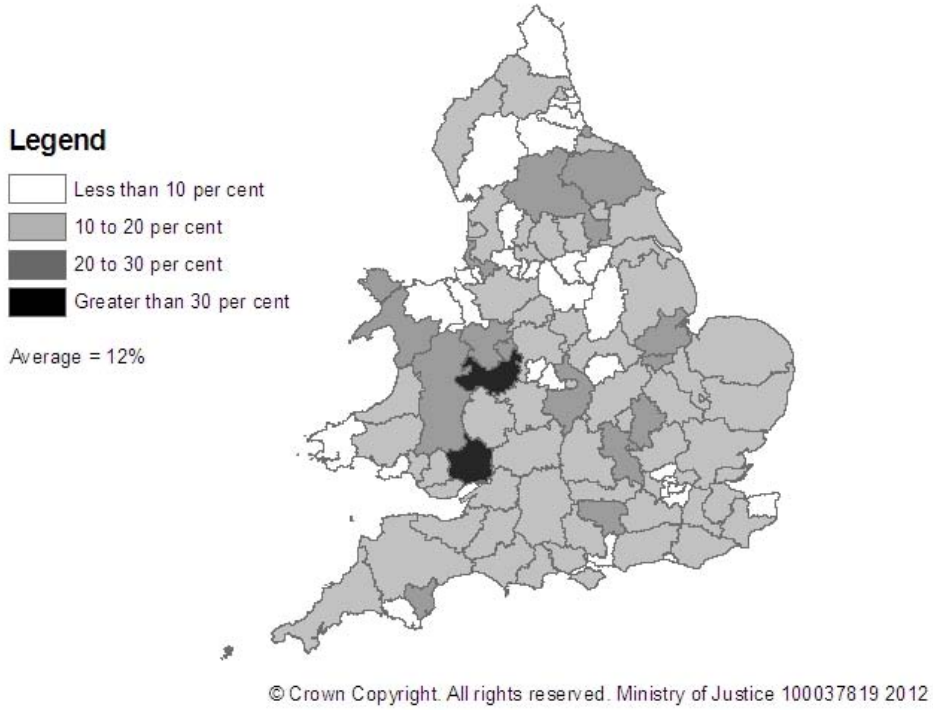
In 2012 a total of 281 deaths were reported to coroners which occurred in state custody[6]; less than one per cent of the total number of deaths reported. The highest number (152 or 54 per cent of the total) occurred in Prison custody, followed by 93 (33 per cent) in Mental Health Act detention centres (see Table 6).

[6] This data only represents deaths in custody which were referred to a coroner.

Inquest verdicts returned

Verdicts were returned at 30,123 inquests in 2012, which was 265 more than in 2011. As in previous years the most common verdicts in 2012 were death from natural causes (8,849, or 29 per cent), and death by accident or misadventure (7,705, or 26 per cent). Unclassified verdicts, which include narrative verdicts, represented 15 per cent of the total, and verdicts of suicide comprised 12 per cent in 2012 (see Tables 7 and 9). Map 4 shows the percentage of suicide verdicts in each coroner district.

Map 4: Suicide verdicts as a proportion of all inquest verdicts, England and Wales, 2012



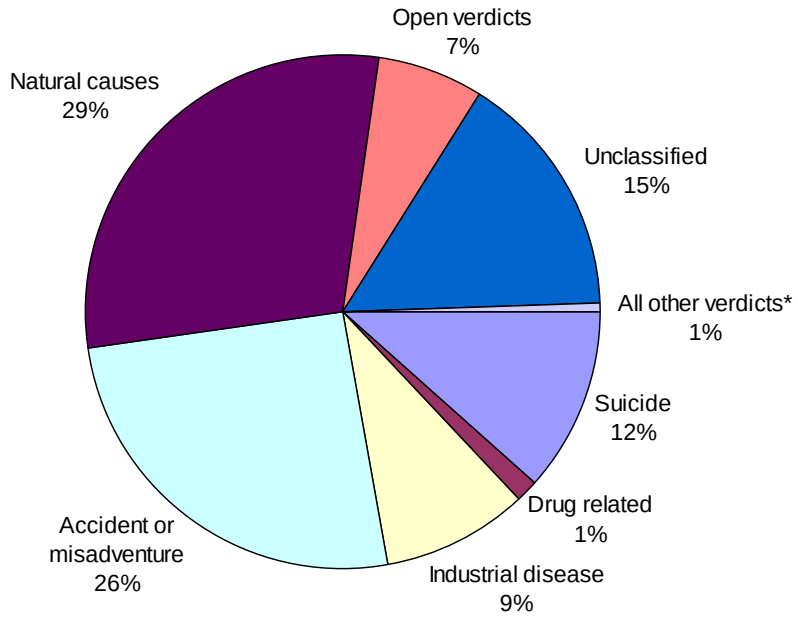
In 2010, verdicts of death from natural causes for the first time became the most frequently recorded. This category was again the most frequent in 2011 and 2012. Unclassified verdicts saw the largest rise in terms of numbers; an increase of 234 (five per cent) from 4,400 in 2011 to 4,634 in 2012. Because of the overall rise in the number of verdicts returned, there were rises in several categories.

There were decreases in the numbers of verdicts in a few categories over the past year, which included a 34 per cent drop in verdicts of homicide (Killed lawfully or Killed unlawfully), from 237 to 158[7]. The number of verdicts of

[7] For information on criminal convictions of homicide please refer to the Criminal Justice System Statistics publication, available at www.gov.uk/government/organisations/ministry-of-justice/series/criminal-justice-statistics

death from non-dependent abuse of drugs dropped by 27 per cent (down from 188 to 138), however this is effectively cancelled out by the 23 per cent increase in verdicts of death from dependence on drugs (up from 215 to 265).

Figure 4: Verdicts returned at inquest, by category, England and Wales, 2012



*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

The rise in unclassified verdicts is 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. As well as narrative verdicts, this category also includes short non-standard verdicts which a coroner or jury might return when the circumstances do not easily fit any of the standard verdicts. Please see Annex A for further analysis of narrative verdicts.

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, and a more definite downward trend in the number of verdicts of accidental death.

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

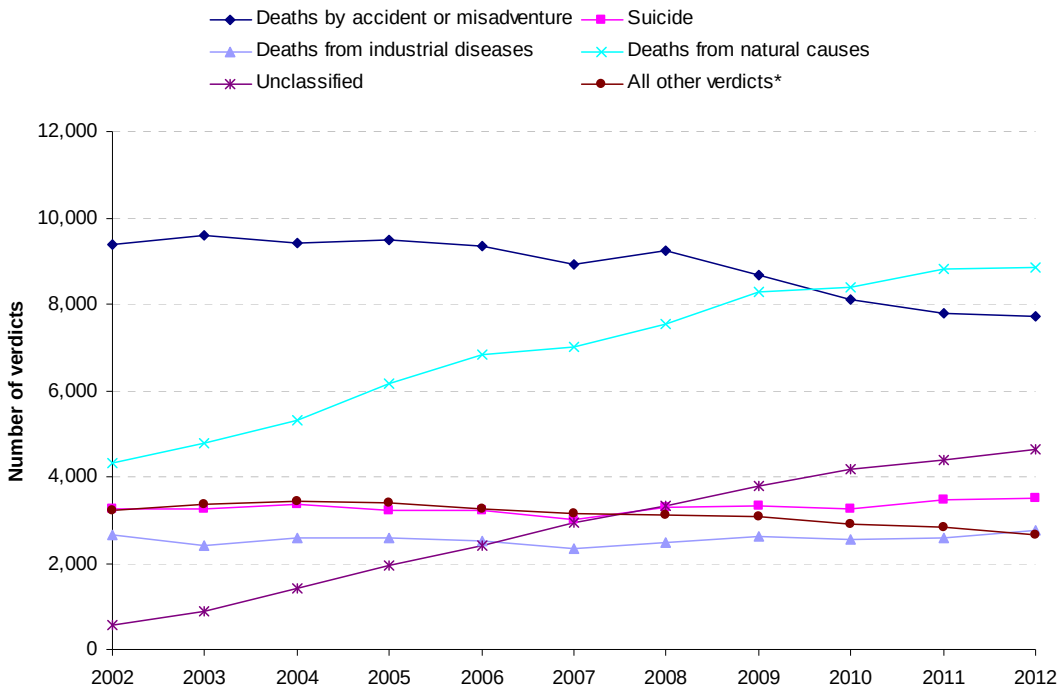
- verdicts of death from natural causes have risen steadily from 19 per cent in 2002 to more than 29 per cent in 2012;

- unclassified verdicts (which include narrative verdicts, as explained above) formed two per cent of the total in 2002, but have since risen steadily to account for over 15 per cent of verdicts in 2012;

- verdicts of death by accident or misadventure have been declining steadily, from 40 per cent of verdicts in 2002 to 26 per cent in 2012;

- open verdicts have been declining over the same period, particularly over the last few years, they accounted for just under seven per cent of the total in 2012 compared with ten per cent in 2002.

Figure 5: Number of verdicts returned at inquests, England and Wales, 2002-2012



*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, Dependence on drugs, Non-dependent abuse of drugs, Open verdicts

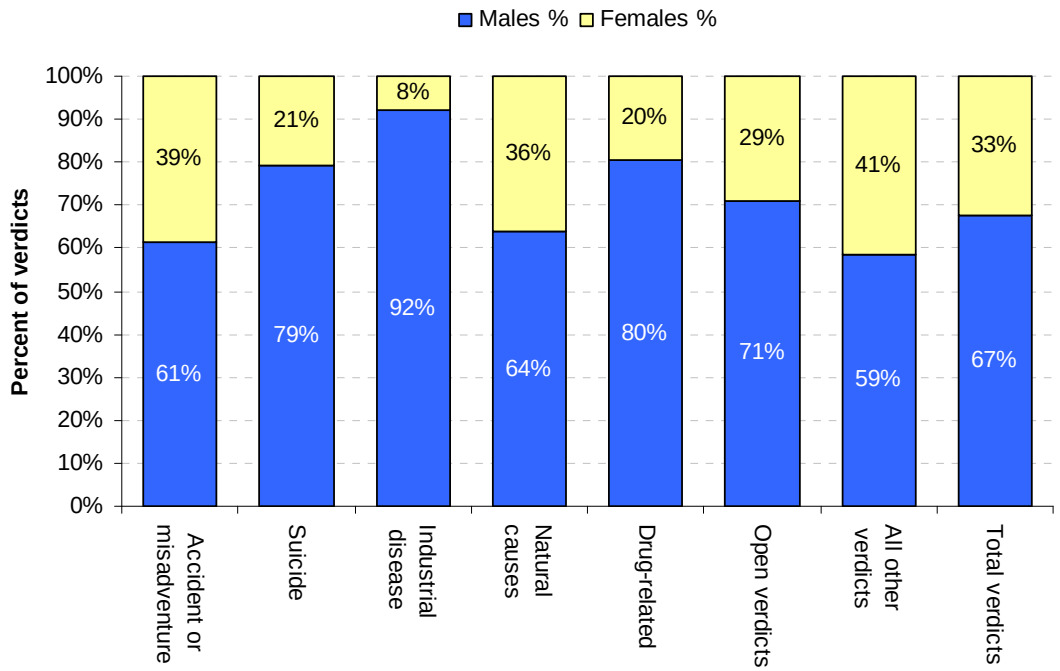
Differences in verdicts by sex

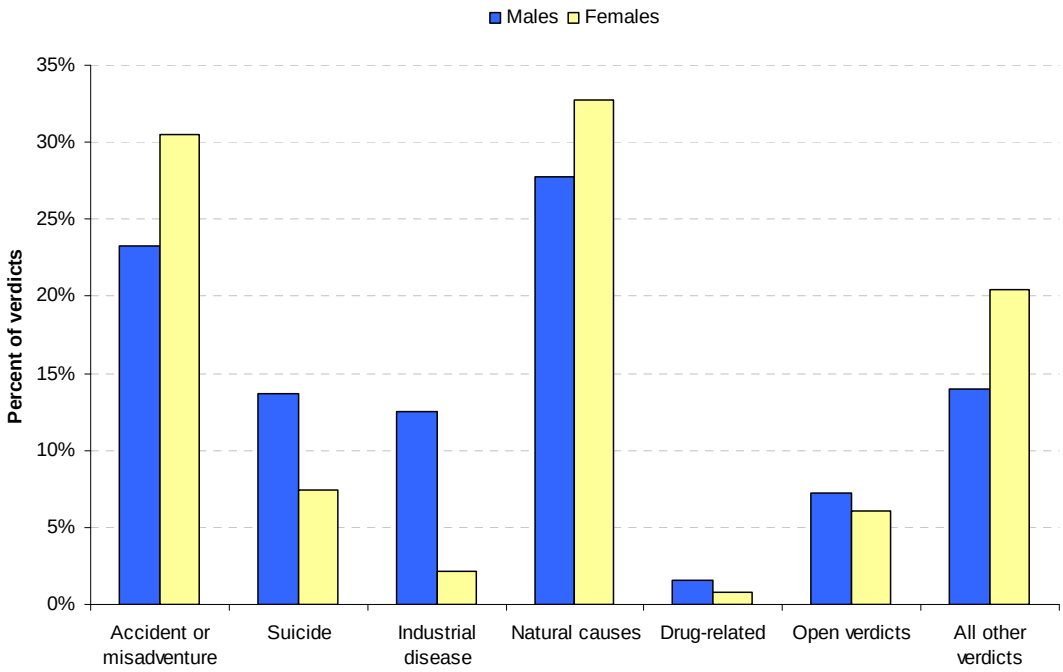
The pattern of verdicts differs between males and females. Male deaths accounted for about 67 per cent of all verdicts returned in 2012, however they accounted for 53 per cent of deaths reported; suggesting males are more likely to die in circumstances that lead to an inquest. Female deaths accounted for about 33 per cent of all verdicts returned in 2012 (and 47 per cent of deaths reported).

- Of the 3,515 verdicts of suicide, 79 per cent were for males and 21 per cent for females

- Of the 2,059 open verdicts, 71 per cent were for males and 29 per cent for females, and
- 36 per cent of the 8,849 verdicts of death from natural causes were for females, the remaining 64 per cent were for males.

Figure 6: Verdicts returned at inquests by sex, England and Wales, 2012

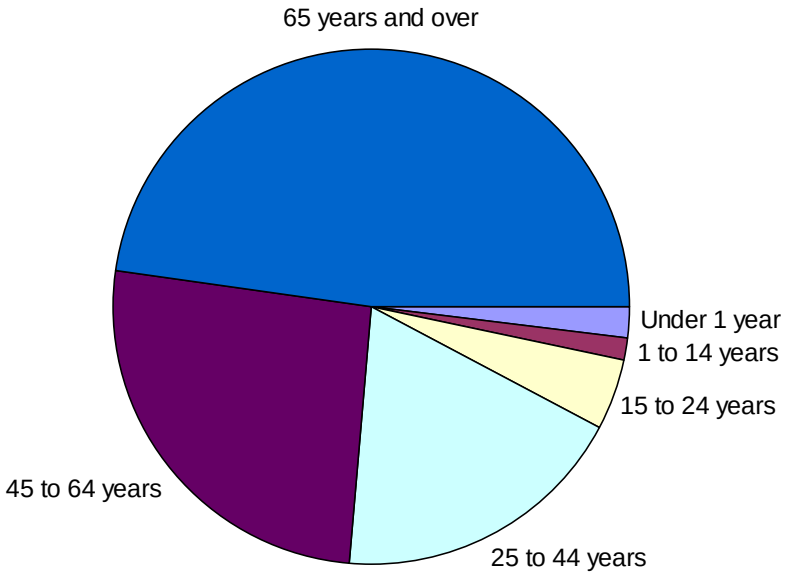




Age of deceased in inquests where a verdict was returned

Since 2008, coroners have been asked to provide information (in summary form) on the ages of persons whose deaths proceeded to inquest and a verdict returned during the year. Of the inquests completed in 2012, 48 per cent were on persons who were aged 65 years or over at death. Less than eight per cent of inquests concluded were into deaths of persons aged under 25 (see Table 8).

Figure 7: Age of deceased in inquests where a verdict was returned, England and Wales, 2012



Inquests with juries, and adjourned inquests

Nearly all inquests concluded in 2012, as in other years, were held without juries. The number of inquests held with juries in 2012 was 472 (representing just two per cent of all inquests), and a decrease of 10 compared to 2011. Both the number and proportion of inquests held with juries showed a downward trend until recent years but the trend appears now to have halted, with the proportion remaining around two per cent for the last five years. Nevertheless, the proportion of inquests held with juries has fallen from three per cent of inquests concluded in 2002, to two per cent in 2012 (see Table 10).

Some 943 inquests (representing three per cent of all inquests concluded) were adjourned by the coroner under Section 16[8] of the Coroners Act 1988 because criminal proceedings took place, and subsequently were not resumed. This level is comparable to that generally prevailing in recent years.

[8] Section 16 of the Coroners Act 1988 states that the coroner should adjourn an inquest in the event of criminal proceedings.

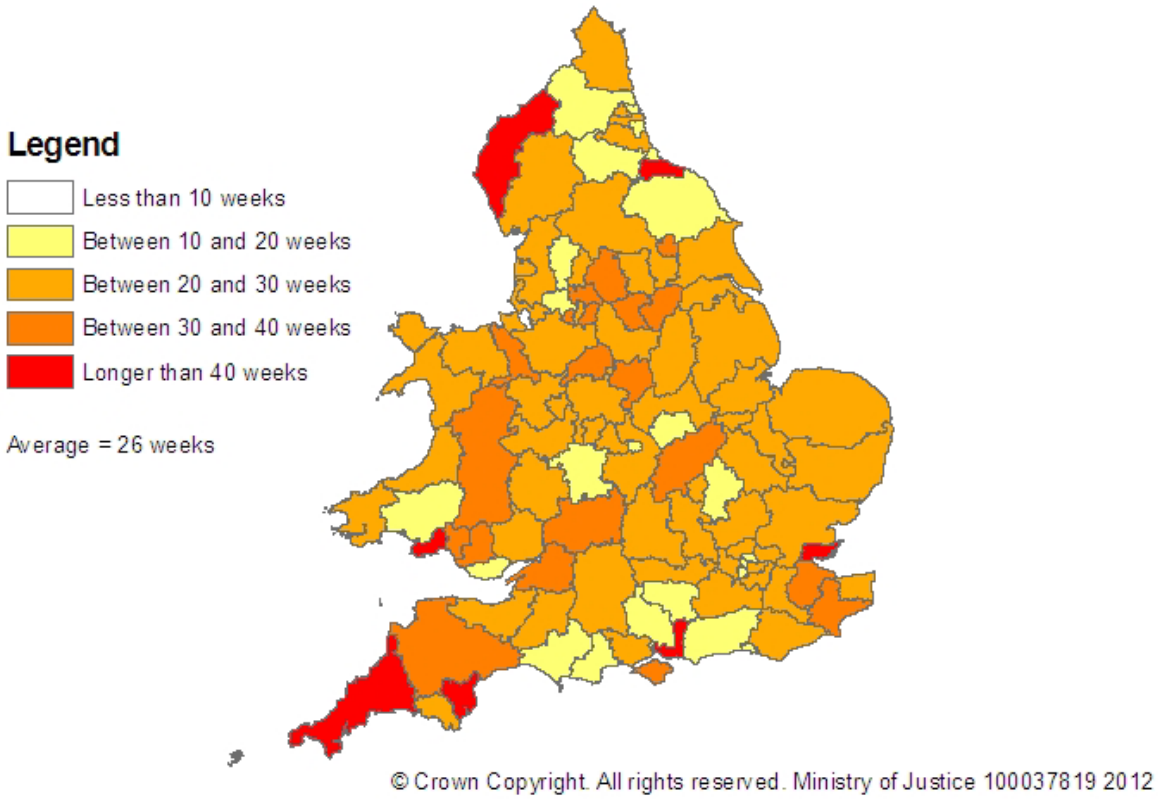
Time taken to process an inquest

The estimated[9] average time taken to process an inquest in 2012 (defined as being from the time the death was reported until the conclusion of the inquest) was 26 weeks to the nearest whole week (see Table 10).

The average time taken has slightly increased since the present system of estimating this average was introduced in 2004, when it was 22 weeks, although it has decreased slightly from the 2011 average of 27 weeks. Only deaths occurring within England and Wales are included in this estimation. More information about how the average time has been estimated can be found in the Explanatory Notes section.

The maximum time taken to process an inquest in 2012 was 53 weeks, and the minimum time was eight weeks. The time taken has a relatively large range of 45 weeks, which could be due to the fact that coroners' caseloads can vary greatly and a direct comparison is therefore not advised.

Map 5: Average time taken to process inquests, England and Wales, 2012



[9] 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.

Treasure and Treasure Trove

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

www.legislation.gov.uk/ukpga/1996/24/contents

In 2012, 750 finds were reported and 355 inquests were concluded, from which a verdict declaring a find to be treasure was returned in 337 cases (see Table 11). There were two inquests held into Treasure Trove in 2012 (relating to finds made before the current Act came into force), and it is likely that a few such inquests will continue to be held from time to time.

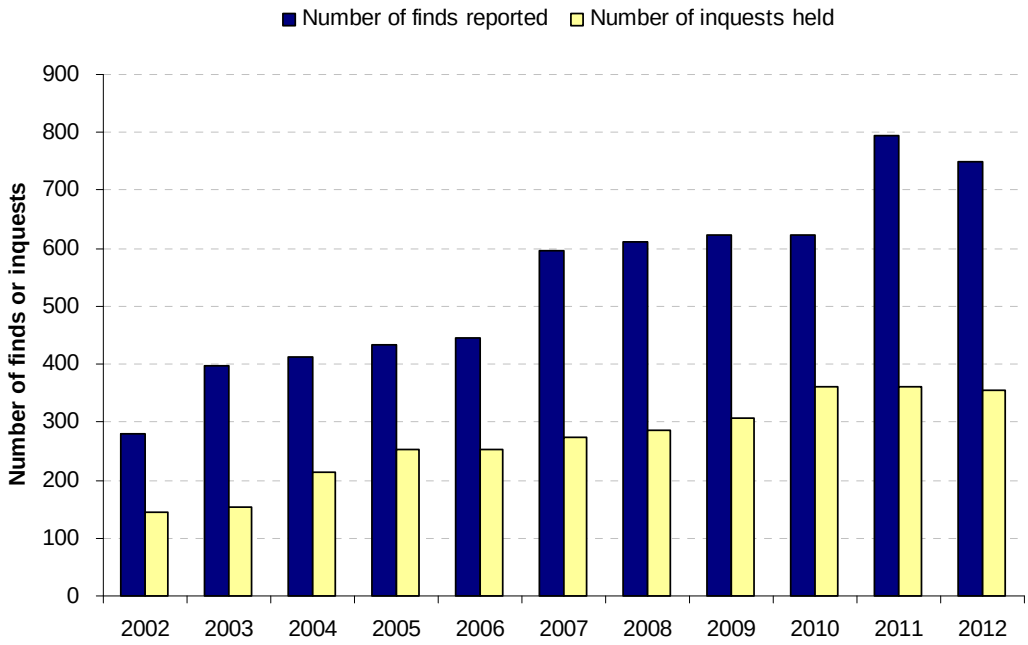
The number of finds reported has been steadily increasing over the last ten years, although in 2012 there was a slight decrease of six per cent compared to 2011.

The number of verdicts of treasure in 2012 was exactly the same as the number recorded in 2011 (337), however the proportion of treasure inquests which resulted in a verdict of treasure increased slightly, from 93 per cent in 2011 to 95 per cent in 2012.

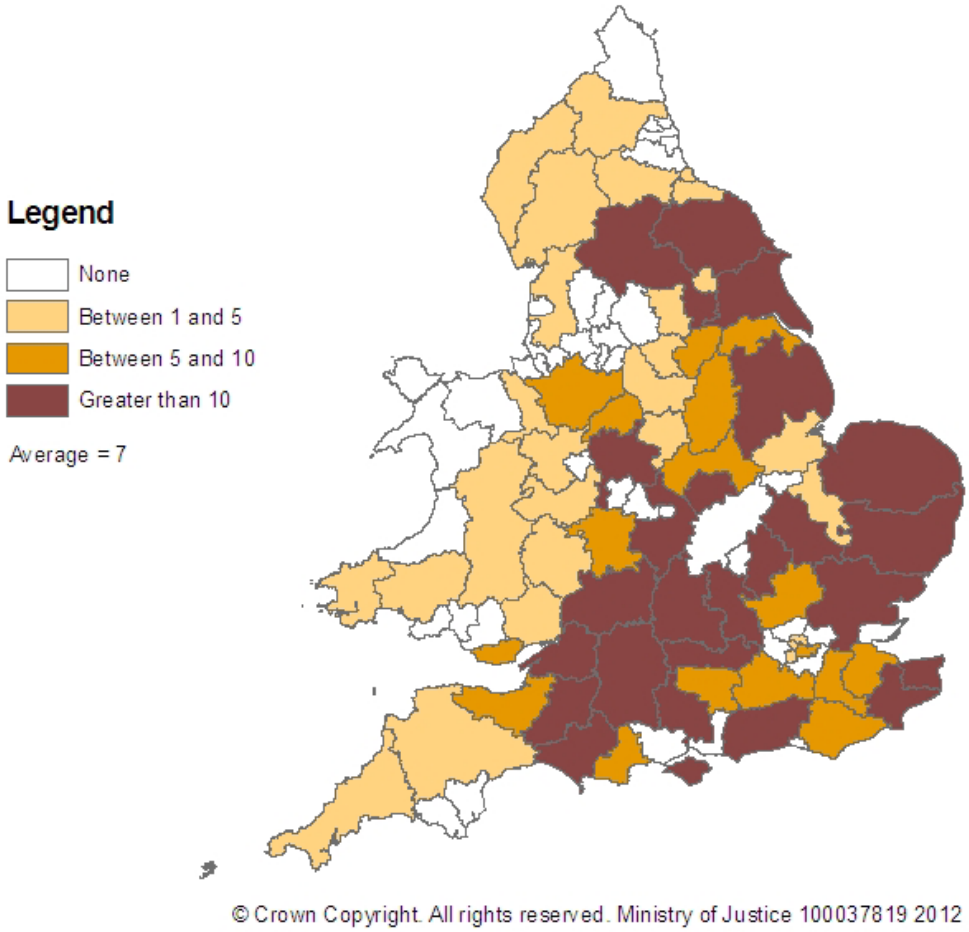
An annual report on the operation of the Treasure Act 1996 is published by the Department for Culture, Media and Sport. For more information please see:

www.gov.uk/government/organisations/department-for-culture-media-sport/series/treasure-and-portable-antiquities-statistics

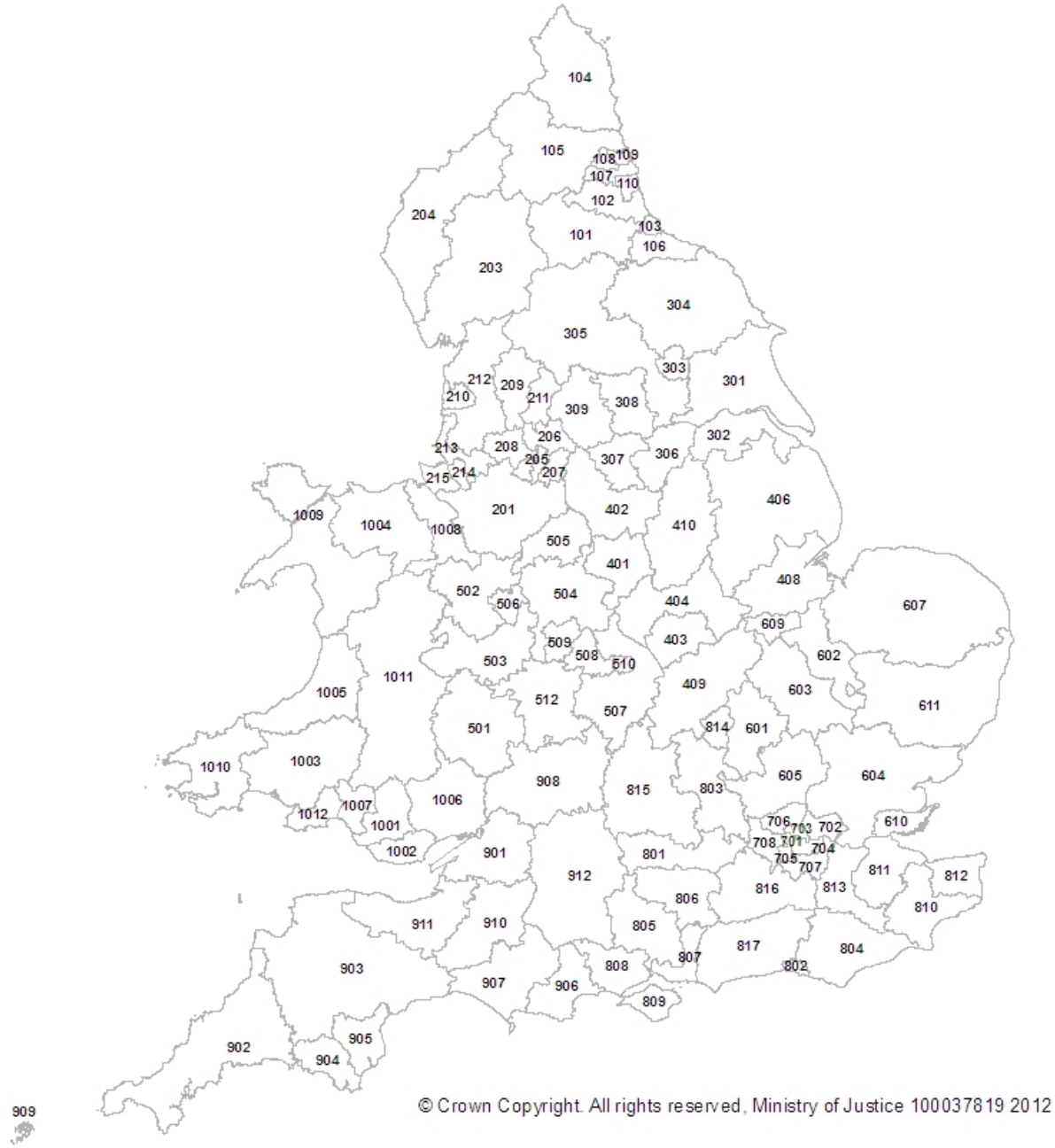
Figure 8: Finds reported to coroners and inquests held under the Treasure Act, 2002-2012



Map 6: Number of treasure finds reported to coroners, England and Wales, 2012



Map 7 Coroner districts in England and Wales, 2012



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
406 – Central Lincolnshire
408 – South Lincolnshire
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
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

Annex A: Analysis of Unclassified verdicts

Summary

This research aims at unpacking the reasons behind the rise of 1,477 in the "Unclassified verdicts" category over the last five years. To investigate this increase we asked two independent assessors to analyse a random sample of 2,196 "Unclassified verdicts" recorded between 2007 and 2011.

The analysis shows that there is scope for introducing a new short-form category: "Medical or surgical intervention unsuccessful". This category accounts for around 25 per cent of the total (varying between 17 and 33 per cent).

The analysis also shows a substantial agreement between the two independent assessors (Kappa coefficient of 0.61). However, there could be tighter guidance on the definition of which verdicts belong to each short-form category – there was some disagreement on whether some verdicts were correctly classified.

The paper also explored the hypothesis that suicide verdicts are 'hidden' within the "Unclassified verdicts" category. The analysis showed that the overall percentage of "Could indicate suicide" verdicts within the "Unclassified verdicts" category is around six per cent.

Introduction

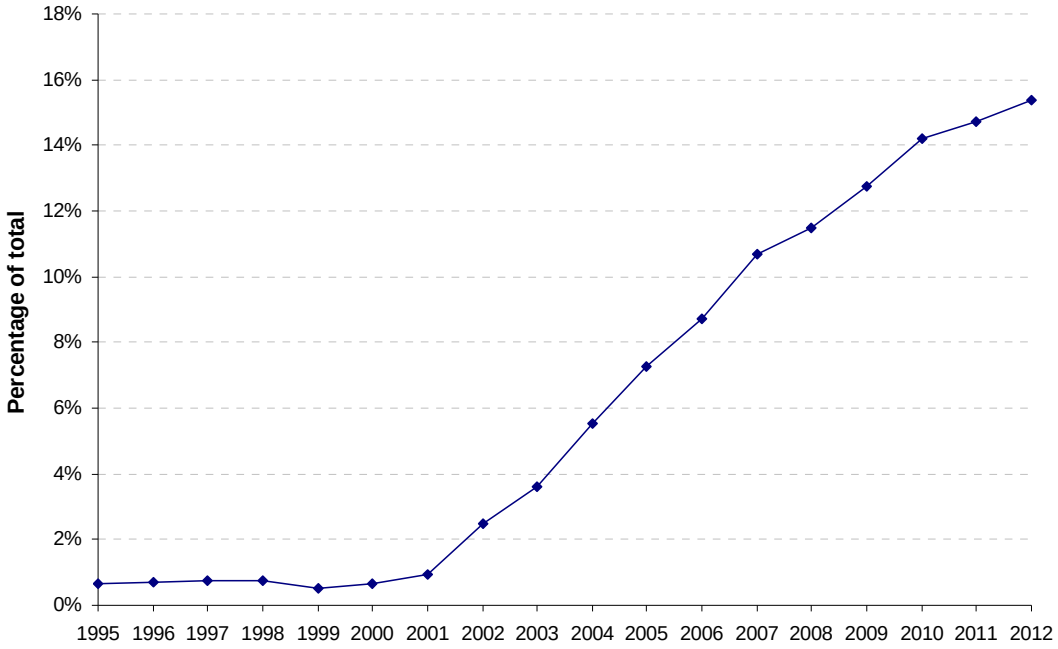
Coroners in England and Wales are required to submit at the end of each calendar year a statistical return to the MoJ, which includes the number of inquest verdicts returned, broken down by category of verdict. In addition to the fourteen short-form categories[10] there is a category for "Unclassified verdicts", which includes narrative verdicts. Narrative verdicts are where, at the end of the inquest instead of a conventional short-form verdict the coroner records a factual description of how and in what circumstances the death occurred.

Coroners are requested to provide details of all "Unclassified verdicts" they have recorded on a supplementary sheet as part of their annual return; however this is not always provided, or is sometimes not provided in sufficient detail to explain the cause of death.

[10] The current short-form categories are: Killed unlawfully; Killed lawfully; Suicide; Attempted or self-induced abortion; Cause of death aggravated by lack of care, or self-neglect; Dependence on drugs; Non-dependent abuse of drugs; Want of attention at birth; Deaths from industrial diseases; Deaths by accident or misadventure; Stillborn; Deaths from natural causes; Open verdicts; Disasters.

Since 2000, the number and percentage of "Unclassified verdicts" returned at inquests has been steadily increasing (see Figure A1). In the last five years the number has increased from 2,923 in 2007 (11 per cent of total verdicts) to 4,400 in 2011 (15 per cent of total verdicts).

Figure A1: "Unclassified verdicts" as a percentage of all verdicts returned at inquests, England and Wales, 1995-2012



Recent case law could be responsible for this increase in narrative verdicts, in particular the House of Lords judgement in R v HM Coroner for West Somerset ex parte Middleton in 2004, which encouraged their use.[11]

Coroners are unable to record a short-form verdict of suicide unless they are convinced beyond any reasonable doubt that the deceased intended to take his/her own life. This has caused concerns regarding the number of suicides which could potentially be 'hidden' in the "Unclassified verdicts" category.

In 2011 the Office for National Statistics published a study entitled 'Narrative verdicts and their impact on mortality statistics in England and Wales'. The study was conducted as the ONS was 'concerned about the impact of narrative verdicts on the quality of statistics on cause of death'[12]. They concluded that:

[11] The Middleton case suggested that a narrative verdict could be used instead of a short-form verdict, in order to provide information on the circumstances surrounding the death. The judgement can be found at the following link: www.publications.parliament.uk/pa/ld200304/ldjudgmt/jd040311/midd-1.htm

[12] 'Narrative verdicts and their impact on mortality statistics in England and Wales' in Health Statistics Quarterly 49, Spring 2011 (ONS)

> The increase in the use of narrative verdicts by coroners has not had a statistically significant impact on published suicide rates in England and Wales… A recommendation has been made to coroners to consider ways of recording narrative verdicts to allow more accurate coding of cause of death.[13]

Following on from the Office for National Statistics' study, we conducted this analysis for the period 2007 – 2011 in order to examine what verdicts are actually included in the "Unclassified verdicts" category, and whether, based on the findings, there is any scope for new guidance or changing the short-form categories.

Methodology

We asked two independent assessors (in this case two retired coroners) to analyse a sample taken from the "Unclassified verdicts" category, for the years 2007 – 2011. The sample was determined using stratified sampling across all coroner districts. The size was determined to be around ten per cent of all "Unclassified verdicts" and it aimed at providing 95 per cent confidence intervals of around six percentage points width. This means that the size was around 450 verdicts each year.

To obtain our sample we randomly selected verdicts from the "Unclassified verdicts" list provided by each coroner district[14]. The sample verdicts were then categorised independently by the assessors into one of six groups:

1. Could indicate suicide – i.e. a verdict which implies the deceased took his/her own life

2. Indicates alcohol abuse (with or without other factors)

3. Medical or surgical intervention unsuccessful

4. Error – verdict should be in one of the existing short-form categories (in this case the assessor was asked to provide a description of which category the verdict should, in his opinion, be placed in)

5. Correct – verdict could not be in any other category

6. Unknown – insufficient data is provided to determine cause of death

The first category was chosen due to the existing hypothesis that suicide verdicts are 'hidden' within the "Unclassified verdicts" category.

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[13] 'Narrative verdicts and their impact on mortality statistics in England and Wales' in Health Statistics Quarterly 49, Spring 2011 (ONS)

[14] Samples were taken from each coroner district which had a total number of "Unclassified verdicts" greater than or equal to five

The second and third categories were chosen as these are recurring themes within the “Unclassified verdicts” category for which no relevant short-form verdict currently exists.

The “Error” category was used to capture any verdicts which were incorrectly placed in the “Unclassified verdicts” category, while the “Correct” and “Unknown” groups captured the remainder; respectively those which could not be placed elsewhere and those where the data was missing or incomplete.

The categorisation of verdicts completed by the independent assessors was based on their own individual opinions; it is therefore important to note the subjectivity of this analysis.

Once the data had been analysed by the assessors we collated the data for each year and calculated 95 per cent confidence intervals for each category (see Tables A2a and A2b). The 95 per cent confidence intervals were based on the exact binomial distribution and, therefore, are not symmetric.

To measure the agreement between the two assessors the Kappa coefficient was used. This coefficient is a measure of inter-rater agreement particularly suited for categorical items such as the six groups. It is commonly understood that Kappa coefficient values less than zero indicate no agreement, between zero and 0.2 as slight agreement, between 0.21 and 0.40 as fair agreement, between 0.41 and 0.60 as moderate agreement, between 0.61 and 0.80 as substantial agreement, and between 0.81 and 1 as almost perfect agreement[15].

Results

Overall, across the 2,196 verdicts, the results showed an agreement between the two assessors using the Kappa Statistic Test (see Table A1), indicated by a Kappa coefficient value of 0.61 (95 per cent confidence interval between 0.59 and 0.63).

Table A1: Agreement between the two assessors

Category	Correct	Could indicate suicide	Error	Indicates alcohol abuse	Medical or surgical intervention unsuccessful	Unknown
Correct	**2**	0	36	0	2	4
Could indicate suicide	5	**96**	39	0	1	2
Error	291	12	**50**	6	117	87
Indicates alcohol abuse	2	2	0	**113**	0	1
Medical or surgical intervention unsuccessful	16	1	0	7	**463**	10
Unknown	8	0	1	0	3	**819**

[15] Landis, J.R.; & Koch, G.G. (1977). "The measurement of observer agreement for categorical data". Biometrics 33 (1): 159–174.

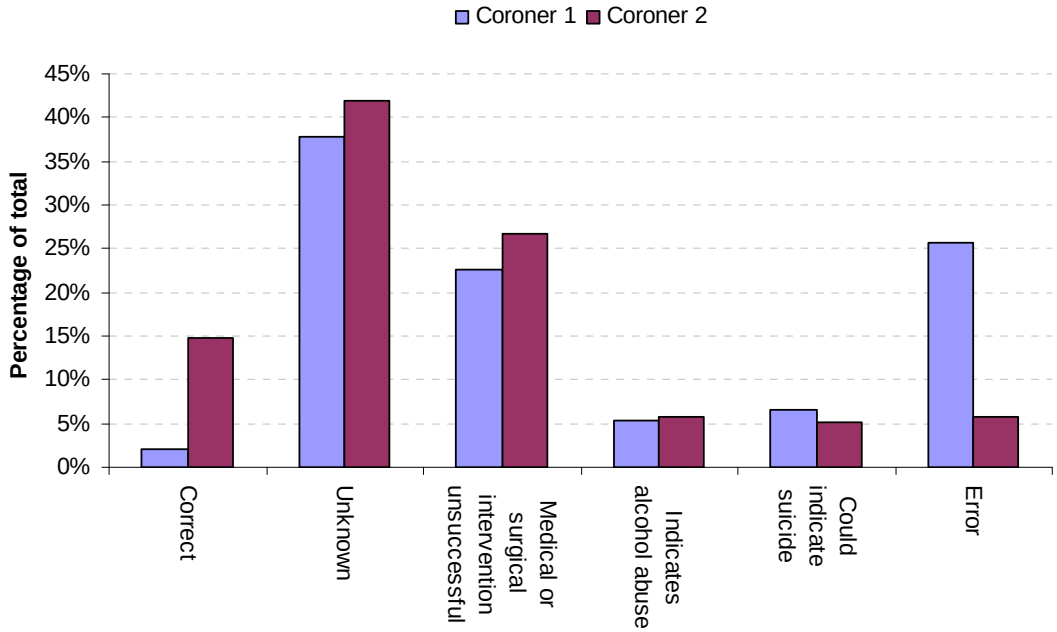
In 2011, the category containing the highest number of sample verdicts was "Unknown" (40 per cent according to Coroner 1, 48 per cent according to Coroner 2). This category has consistently had the highest number of sample verdicts since 2007 (see Tables A2a and A2b).

The percentage of verdicts in "Could indicate suicide" in 2011 was between five per cent (Coroner 1) and six per cent (Coroner 2). This percentage has been fairly stable since 2007, fluctuating between five and eight per cent of the total. The percentage is relatively low, which corresponds with the findings from the ONS study on narrative verdicts.

Between 2007 and 2009 the number of verdicts in the "Indicates alcohol abuse" category decreased, however since 2009 this number has been increasing.

The "Medical or surgical intervention unsuccessful" category represented between 22 per cent of sample verdicts in 2011 (Coroner 1) and 23 per cent (Coroner 2). The number in this category has fluctuated since 2007, although there was an increase of between three (Coroner 2) and five (Coroner 1) percentage points from 2010 to 2011.

Figure A2: Classification of "Unclassified verdicts" returned at inquests, England and Wales, 2007-2011



There was a large difference between the number of verdicts classified as "Error" by the two assessors. Coroner 1 recorded 25 per cent of verdicts in this category in 2011, compared to only seven per cent recorded by Coroner 2. This highlights the subjective nature of the analysis.

The analysis performed by Coroner 1 showed 66 per cent of verdicts within the "Error" category were classed as 'Accident/ Misadventure', looking at the period 2007 – 2011 as a whole (see Table A4a). The next most common

error was ‘Natural Causes’, which accounted for 16 per cent of error verdicts across the period.

The analysis completed by Coroner 2 placed 31 per cent of “Error” verdicts within the ‘Suicide’ category, followed by 17 per cent allocated to ‘Accident/Misadventure’ (see Table A4b).

Table A2a: Classification of “Unclassified verdicts” sample by Coroner 1, with 95 per cent confidence intervals, 2007-2011

Unclassified verdicts	2011		2010		2009		2008		2007	
	Mean	C.I.	Mean	C.I.	Mean	C.I.	Mean	C.I.	Mean	C.I.
Correct	2%	(1% - 4%)	2%	(1% - 4%)	3%	(1% - 4%)	2%	(1% - 4%)	1%	(0% - 3%)
Could indicate suicide	5%	(3% - 7%)	7%	(5% - 10%)	8%	(6% - 11%)	6%	(4% - 9%)	6%	(4% - 9%)
Error	25%	(21% - 30%)	28%	(23% - 32%)	23%	(19% - 27%)	25%	(21% - 29%)	27%	(23% - 32%)
Indicates alcohol abuse	6%	(4% - 8%)	4%	(3% - 7%)	3%	(2% - 6%)	6%	(4% - 8%)	8%	(5% - 11%)
Medical or surgical intervention unsuccessful	22%	(18% - 26%)	17%	(14% - 21%)	23%	(19% - 27%)	28%	(24% - 33%)	24%	(20% - 28%)
Unknown	40%	(35% - 45%)	42%	(37% - 46%)	40%	(36% - 45%)	33%	(29% - 38%)	34%	(30% - 39%)
n	**444**		**438**		**440**		**435**		**439**	

Table A2b: Classification of “Unclassified verdicts” sample by Coroner 2, with 95 per cent confidence intervals, 2007-2011

Unclassified verdicts	2011		2010		2009		2008		2007	
	Mean	C.I.	Mean	C.I.	Mean	C.I.	Mean	C.I.	Mean	C.I.
Correct	12%	(9% - 15%)	21%	(17% - 25%)	12%	(9% - 16%)	14%	(11% - 18%)	15%	(11% - 18%)
Could indicate suicide	6%	(4% - 8%)	5%	(4% - 8%)	5%	(3% - 7%)	5%	(3% - 7%)	5%	(3% - 7%)
Error	7%	(4% - 9%)	6%	(4% - 9%)	5%	(3% - 7%)	6%	(4% - 9%)	5%	(3% - 7%)
Indicates alcohol abuse	6%	(4% - 8%)	5%	(3% - 7%)	4%	(2% - 6%)	6%	(4% - 8%)	9%	(6% - 12%)
Medical or surgical intervention unsuccessful	23%	(19% - 27%)	20%	(17% - 24%)	28%	(24% - 33%)	33%	(28% - 37%)	30%	(26% - 34%)
Unknown	48%	(43% - 53%)	42%	(37% - 47%)	45%	(41% - 50%)	37%	(32% - 42%)	38%	(33% - 43%)
n	**444**		**438**		**440**		**435**		**439**	

Table A3: Overall average for each category over the period 2007-2011

Category	Average for Coroner 1	Average for Coroner 2	Overall average
Correct	2%	15%	**8%**
Could indicate suicide	7%	5%	**6%**
Error	26%	6%	**16%**
Indicates alcohol abuse	5%	6%	**6%**
Medical or surgical intervention unsuccessful	23%	27%	**25%**
Unknown	38%	42%	**40%**

Notes

The average for "Medical or surgical intervention unsuccessful" for Coroner 1, for example, is calculated by averaging the five percentages recorded in this category for the years 2007 - 2011 (see Table A2a).

The Overall average in the third column of this table is calculated by averaging the averages for Coroner 1 and Coroner 2

Table A4a: Error breakdown for Coroner 1, 2007-2011

Type of error	2011		2010		2009		2008		2007		Totals	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Death aggravated by neglect or self neglect	1	1%	0	0%	0	0%	1	1%	0	0%	**2**	**0%**
Deaths by accident (including misadventure)	71	63%	70	58%	58	57%	83	78%	88	73%	**370**	**66%**
Deaths from industrial diseases	11	10%	15	12%	15	15%	10	9%	8	7%	**59**	**10%**
Deaths from natural causes	20	18%	25	21%	19	19%	7	7%	20	17%	**91**	**16%**
Dependence on drugs	1	1%	0	0%	0	0%	0	0%	0	0%	**1**	**0%**
Drug abuse	0	0%	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
Inquest adjourned	0	0%	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
Killed lawfully/ unlawfully	2	2%	2	2%	6	6%	3	3%	1	1%	**14**	**2%**
Non-dependent abuse of drugs	0	0%	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
Not classified	1	1%	1	1%	0	0%	1	1%	0	0%	**3**	**1%**
Open verdicts	6	5%	8	7%	4	4%	2	2%	3	3%	**23**	**4%**
Suicide	0	0%	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
Total	**113**	100%	**121**	100%	**102**	100%	**107**	100%	**120**	100%	**563**	**100%**

Table A4b: Error breakdown for Coroner 2, 2007-2011

Type of error	2011		2010		2009		2008		2007		Totals	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Death aggravated by neglect or self neglect	0	0%	0	0%	0	0%	0	0%	1	5%	**1**	**1%**
Deaths by accident (including misadventure)	12	41%	7	25%	1	5%	1	4%	0	0%	**21**	**17%**
Deaths from industrial diseases	4	14%	3	11%	7	32%	2	7%	1	5%	**17**	**13%**
Deaths from natural causes	4	14%	2	7%	2	9%	1	4%	4	20%	**13**	**10%**
Dependence on drugs	0	0%	3	11%	0	0%	1	4%	3	15%	**7**	**6%**
Drug abuse	2	7%	0	0%	0	0%	0	0%	0	0%	**2**	**2%**
Inquest adjourned	0	0%	0	0%	0	0%	1	4%	1	5%	**2**	**2%**
Killed lawfully/ unlawfully	1	3%	1	4%	1	5%	2	7%	0	0%	**5**	**4%**
Non-dependent abuse of drugs	2	7%	0	0%	0	0%	5	19%	0	0%	**7**	**6%**
Not classified	0	0%	1	4%	0	0%	0	0%	3	15%	**4**	**3%**
Open verdicts	2	7%	2	7%	1	5%	3	11%	0	0%	**8**	**6%**
Suicide	2	7%	9	32%	10	45%	11	41%	7	35%	**39**	**31%**
Total	**29**	100%	**28**	100%	**22**	100%	**27**	100%	**20**	100%	**126**	**100%**

Explanatory notes

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

Designation can be broadly interpreted to mean that the statistics:

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

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

The data analysed in this publication are based on annual returns from 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.

Quality and consistency of the statistics

The figures presented in this report are collected via statistical returns completed by coroners. For the calendar year 2012, returns were received from all 111 coroner districts. The process by which coroners provide their returns can vary according to the case management system they use. Many coroners (90 per cent) 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. Every effort is made, however, to ensure that the figures presented in this publication are accurate and complete.

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.

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.

Users 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 the Chief Coroner’s Office, 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 2011 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.

Symbols and conventions

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

n/a = Not applicable

- = Nil

.. = Not available

* = Number or percentage not shown due to being based on small numbers of cases

(R) = Revised data

Maps

The maps used in this publication are experimental and any feedback would be welcomed. The categories used in each map have been created using appropriate bandwidths.

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:

webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/hosbarchive.html

Editions of this bulletin for years up to and including 2009, 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

Glossary

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, unnatural or accidental deaths, deaths of unknown cause, deaths that might have been due to an industrial disease or related to the deceased's employment, and all deaths of persons in prison or police 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:

www.legislation.gov.uk/ukpga/1988/13/contents

The more recent amendments to the Coroners Rules may be found at:

www.legislation.gov.uk/uksi?title=coroners%20rules

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.

Out of England Orders

Every person wanting to remove a body of a deceased person out of England and Wales must give notice of such intention to the coroner within whose jurisdiction the body is lying. This notice allows the coroner to consider whether an inquest or post-mortem is necessary before the coroner gives permission for the removal of the body.

Inquests

A coroner must hold an inquest if the body of a person ('the deceased') lies within his or her district 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.

Timeliness of inquests

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.

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 the finders were. 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 2012, but a provisional figure has been derived from the monthly registration figures which are published by ONS at regular intervals.

Contacts

Current and previous editions of this publication are available for download at www.gov.uk/government/organisations/ministry-of-justice/series/coroners-and-burials-statistics

The spreadsheet file of the statistical tables referred to in this bulletin is also available for download from this address.

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

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

Other National Statistics publications, and general information about the official statistics system of the UK, are available from www.statistics.gov.uk.

Produced by the Ministry of Justice

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