Ministry of JUSTICE

Coroners Statistics 2011 England and Wales

Ministry of Justice
Statistics bulletin

Published 17 May 2012

Ministry of JUSTICE

Coroners Statistics 2011 England and Wales

Ministry of Justice

Statistics bulletin

Also available on the Ministry of Justice website at

www.justice.gov.uk/statistics/coroners-and-burials/deaths

Executive summary

This bulletin presents statistics of coroners' work during the calendar year 2011, 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 222,371 deaths were reported to coroners in 2011, a fall of 8,224 (3.6 per cent) from the 2010 figure. *(Tables 1,2, and 3)*
- The proportion of all registered deaths reported to coroners was an estimated[1] 46 per cent in 2011, one percentage point lower than in 2010, although in recent years this proportion has been relatively consistent. *(Table 2)*
- The percentage of cases involving post-mortem examinations, as a proportion of all deaths reported to coroners, fell slightly from just above 44 per cent in 2010 to 42 per cent in 2011, continuing the existing downward trend. *(Table 3)*
- Inquests were opened on 30,981 deaths, representing nearly 14 per cent of all deaths reported to coroners, a slightly higher proportion than in 2010. *(Table 3)*
- As in recent years, the most common verdicts returned at inquests were death from natural causes (in 29.5 per cent of cases) and death by accident or misadventure (26 per cent). *(Tables 4 and 6)*
- Verdicts of suicide rose by 7 per cent in 2011 compared to 2010; there were also rises in the number of verdicts of death from natural causes. *(Table 6)*
- Also rising were 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 returned where the cause of death does not easily fit any of the standard verdicts. *(Table 6)*
- There were falls in the number of verdicts of death from accident or misadventure, and specific drug-related causes. *(Table 6)*
- The estimated[2] average time taken to process an inquest in 2011 (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 and 2010. *(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 2011 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.

[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 2011 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 (web address).

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:

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

or, for annual series on mortality statistics:
www.statistics.gov.uk/hub/population/deaths/mortality-rates/index.html

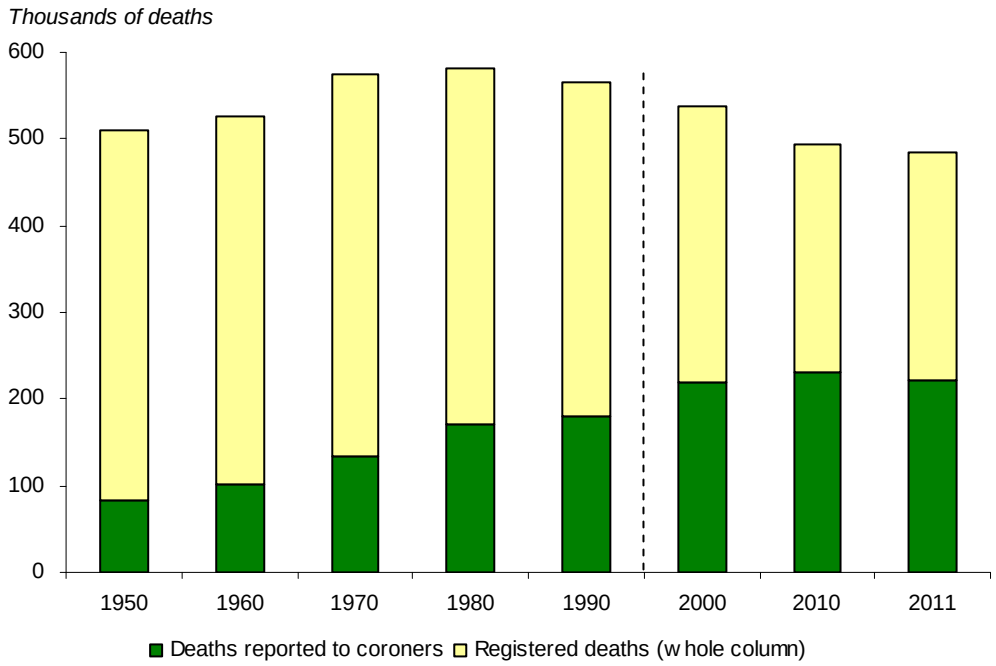
The Ministry of Justice's coroner statistics differ from ONS figures because they count two different, albeit related, events. The Ministry of Justice's coroner statistics provide the number of deaths which are reported to coroners in England and Wales. These include deaths reported to coroners which occurred outside England and Wales. 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 2011 have been calculated using ONS's monthly provisional figures on death registrations, while percentages for 2010 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 2011 fell by 8,224 (3.6 per cent) from the previous year, from 230,595 in 2010 to 222,371 during 2011, reflecting the fall in the number of deaths registered in England and Wales. The proportion of registered deaths in the calendar year 2011 that were reported to coroners in 2011 was an estimated 46 per cent, one percentage point lower than in 2010. This percentage has shown a shallow upward trend, but with fluctuations, for the last few years. Of these reported deaths, some 1,837 (0.8 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 (ten–yearly intervals), and 2011

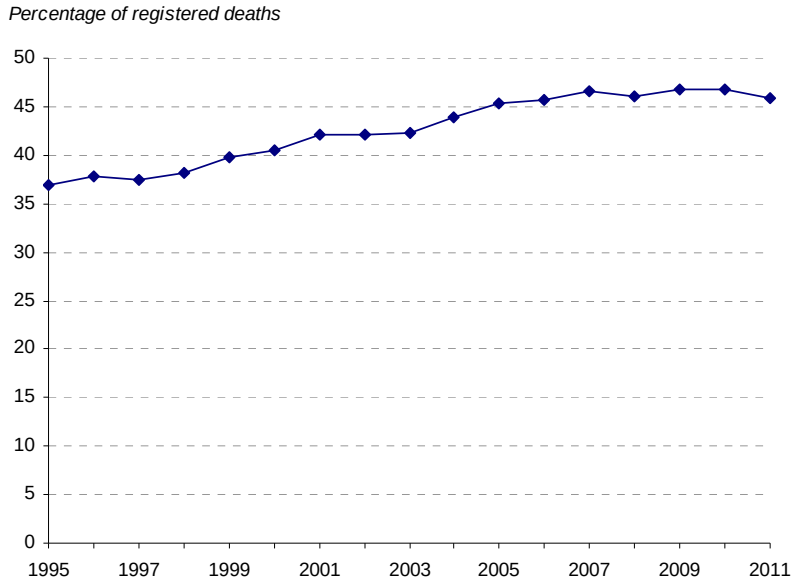


NOTE: The figures for deaths reported to coroners in the columns to the right of the vertical dashed line include no further action (NFA) cases, while those to the left exclude NFA cases (see Explanatory Notes for more information about NFA cases).

The long-term trends of both the number and proportion of deaths reported have generally been upwards. In the most recent few years, however, these increases have become shallower than previously, and 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.

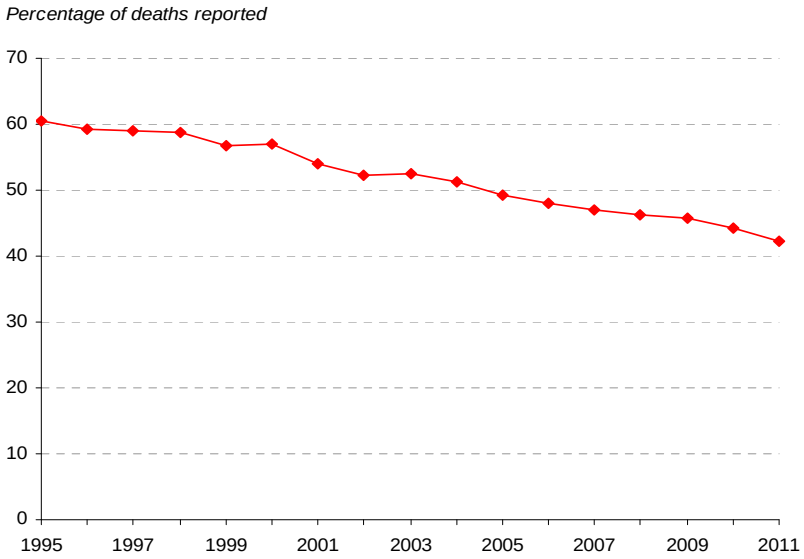
Figure 2: Deaths reported to coroners as a percentage of registered deaths, England and Wales, 1995-2011



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

Post-mortem examinations were ordered by coroners in 42 per cent of all cases reported to them in 2011, a fall compared to 2010, and continuing the existing downward trend.

Figure 3a: Post-mortems as a percentage of deaths reported to coroners, England and Wales, 1995-2011

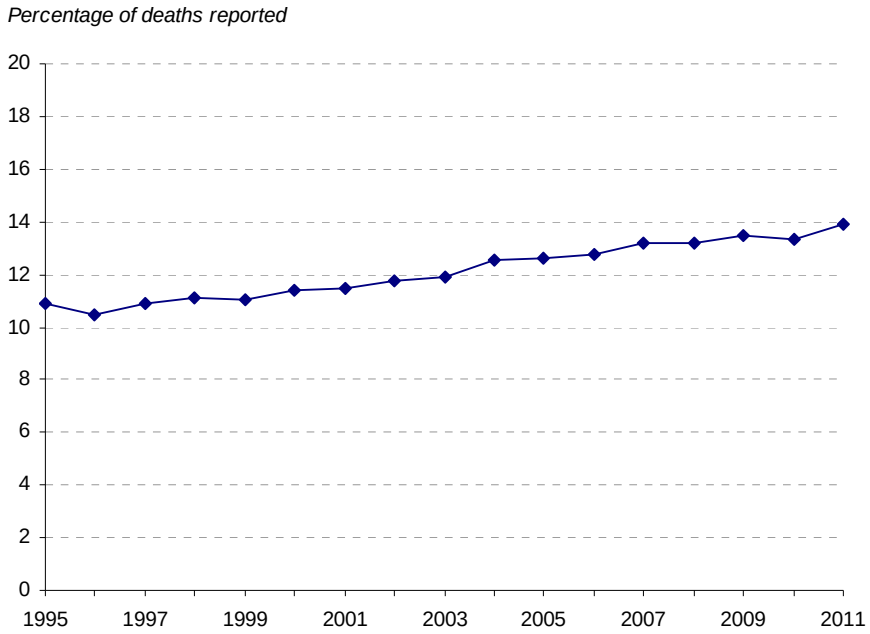


NOTE: This graph shows the proportion of all deaths referred to coroners where a post-mortem examination took place, whether there was an inquest or not.

The actual number of deaths reported to coroners in 2011 where a post-mortem was held was 93,954, some 7,989 fewer than in the year before, reflecting in part the overall decrease in reported deaths.

Inquests were opened on 30,981 deaths reported to coroners in 2011, which was 193 more than in 2010. Inquest cases represented nearly 14 per cent of all the deaths reported to coroners in 2011, a small increase, and continuing a long-term rising trend.

Figure 3b: Inquests as a percentage of deaths reported to coroners, England and Wales, 1995-2011



Post-mortems in inquest cases (Table 3)

When an inquest is held a post-mortem examination has usually been conducted, and in 2011 post-mortems were conducted in 88 per cent of such cases. This is a lower proportion than in the previous year by a single percentage point, 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 2011 there were 3,819 inquests without a post-mortem, over three 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 2011, there were some 66,792 non-inquest cases where a post-mortem was held, and the percentage of non-inquest cases that required a post-mortem fell to just below 35 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 124,598 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 45 per cent or just above ten years ago, to 56 per cent in 2011.

Out of England Orders

Coroners issued 5,008 orders in 2011, compared with 5,173 issued in 2010, the decrease exactly reflecting the fall in the overall number of deaths reported. In both years the number of orders issued represented just over two per cent of the total number of deaths reported.

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

Verdicts were returned at 29,858 inquests in 2011, which was 473 more than in 2010. As in previous years the most common verdicts in 2011 were death from natural causes (8,818, or 29.5 per cent), and death by accident or misadventure (7,775, representing 26 per cent of all verdicts). Unclassified verdicts, which category includes narrative verdicts, represented 15 per cent of the total, and verdicts of suicide comprised 12 per cent in 2011.

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 it was also the category to see the largest rise in terms of numbers, up 436 (5 per cent) from 8,382 in 2010 to 8,818 in 2011. 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 17 per cent drop in verdicts of deaths from dependence on drugs or non-dependent abuse of drugs, from 483 to 403 and a 4 per cent drop in the number of verdicts of death by accident or misadventure (down from 8,113 to 7,775).

The rise in unclassified verdicts (shown as 'All other verdicts' in Tables 4 and 6) 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.

Recent case law might be responsible for the increased number of narrative verdicts in recent years, including the House of Lords Middleton[3] 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

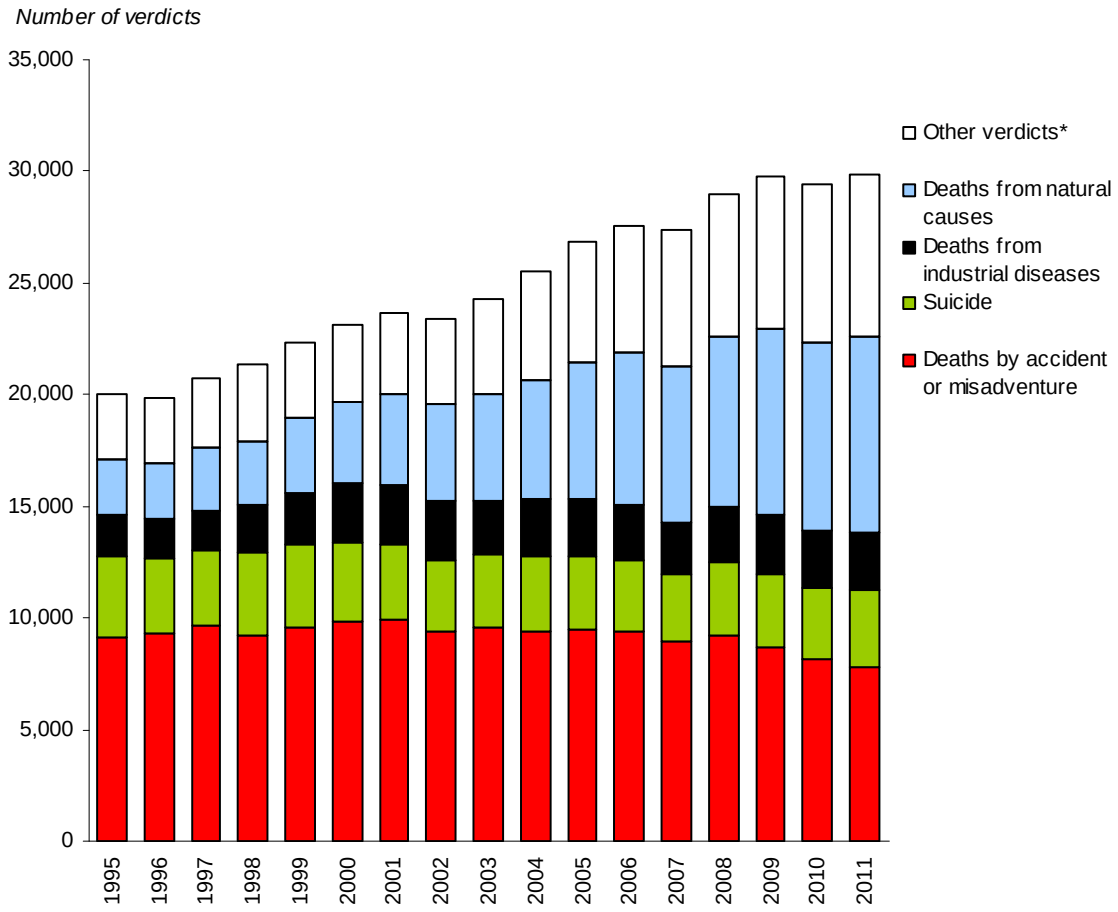
[3] R v H.M. Coroner for Western Somersetshire and another *ex parte* Middleton (2004)

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 five main trends, two rising, and three falling:

- verdicts of death from natural causes have risen steadily from 12 per cent in 1995 to more than 29 per cent in 2011;
- unclassified verdicts (which include narrative verdicts, as explained above) formed less than one per cent of the total up to and including 2001, but have since risen steadily to account for nearly 15 per cent of verdicts in 2011;
- verdicts of death by accident or misadventure have been declining steadily, from 46 per cent of verdicts returned in 1995 to 26 per cent in 2011;
- suicide verdicts have been declining slowly over the same period, from 18 per cent in 1995 to below 12 per cent in 2011;
- 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 2011.

Figure 4: Verdicts returned at inquests, England and Wales, 1995-2011



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

Differences in verdicts by sex (Table 4, Figures 5 and 6)

The pattern of verdicts differs between males and females. Male deaths accounted for about 67 per cent of all verdicts returned in 2011; but they also included:

- 93 per cent of verdicts of death from industrial disease;
- 79 per cent of verdicts of suicide, and
- 82 per cent of verdicts of death from dependence on, or non-dependent abuse of, drugs.

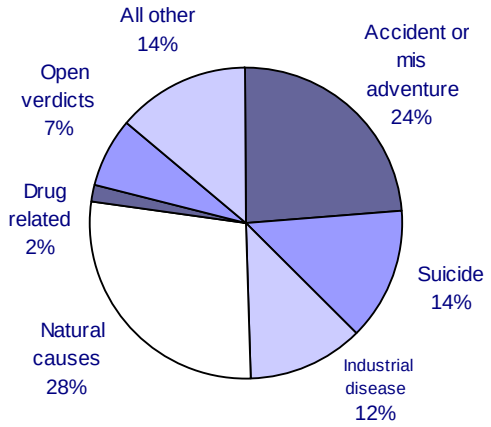
These proportions are similar to those in recent years.

For females, common verdicts included:

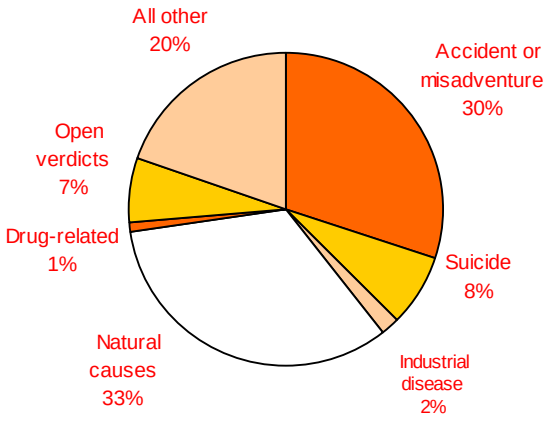
- death by accident or misadventure (38 per cent of all female verdicts), and
- death from natural causes (also 37 per cent).

Compared with 2010, both proportions have risen by about five percentage points. Females also accounted for a relatively high percentage of unclassified or narrative verdicts (41 per cent, against 39 per cent in 2010).

Figure 5: Verdicts returned at inquests by sex, England and Wales, 2011

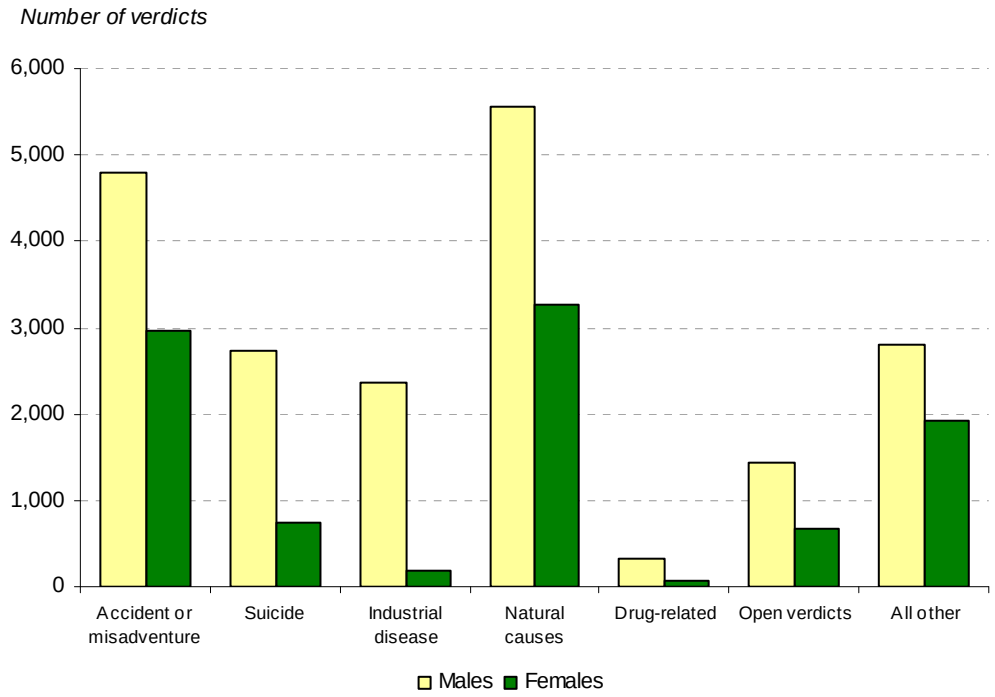


Males (total = 20,041)



Females (total = 9,817)

Figure 6: Number of verdicts returned at inquests, by sex, England and Wales, 2011



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

From 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. Over 46 per cent of completed inquests in 2011 were on persons who were 65 years of age or more at death. Less than eight per cent of inquests concluded were into deaths of persons aged under 25.

Inquests with juries, and adjourned inquests (Table 7)

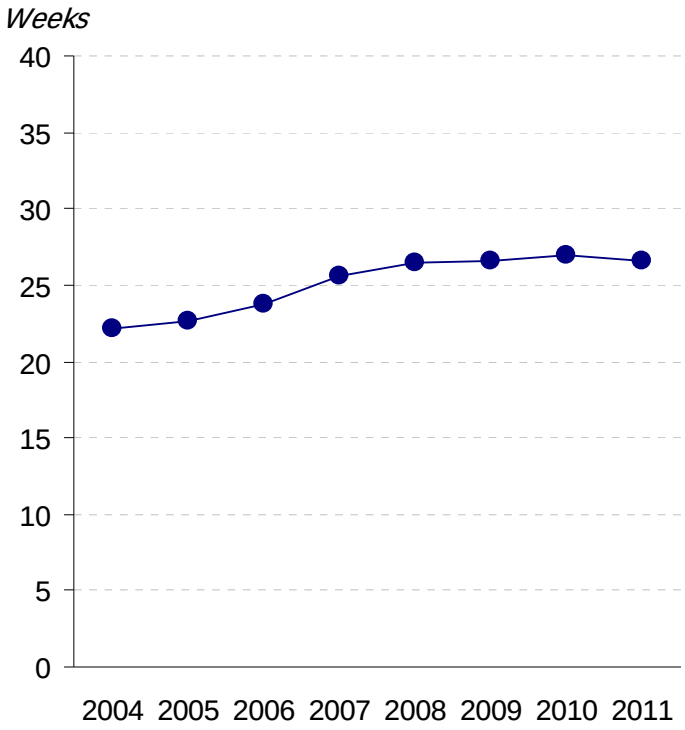
Nearly all inquests concluded in 2011, as in other years, were held without juries. The number of inquests held with juries in 2011 was 482 (representing just over one and a half per cent of all inquests), a rise of 40 compared to 2010. Both the number and proportion of inquests held with juries showed a downward trend until recent years but the trend appears now to have halted. Nevertheless, the proportion of inquests held with juries has fallen from 3.1 per cent of inquests concluded in 2001, to just over 1.5 per cent in 2011.

Some 943 inquests (representing just over 3 per cent of all inquests concluded) were adjourned by the coroner under Section 16 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.

Time taken to process an inquest (Table 7)

The estimated average time taken to process an inquest in 2011 (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 and 2010.

Figure 6a: Estimated average time taken to process an inquest, 2004-2011



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 time has been estimated can be found in the Explanatory Notes section.

Treasure and Treasure Trove (Table 8 and Figure 7)

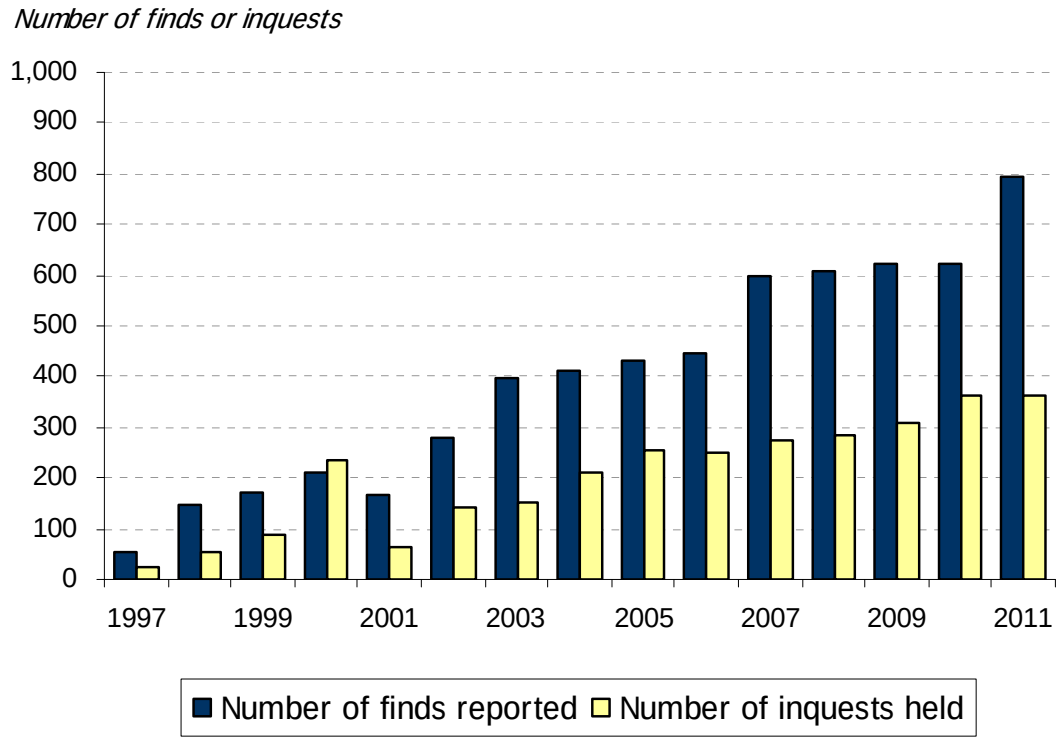
On 24 September 1997, the Treasure Act 1996 came into force and replaced the common law of Treasure Trove in England and Wales. The 1996 Act introduced new requirements for reporting and dealing with finds. Not all finds need be the subject of an inquest.

In 2011, 794 finds were reported and 362 inquests were concluded, from which a verdict declaring a find to be Treasure was returned in 337 cases. There were three inquests held into Treasure Trove in 2011 (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 in recent years. This is probably because of the increasing popularity of treasure-hunting as a hobby. The dip in reported finds in 2001 was 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, 1997-2011



Tables

Table 1: Deaths reported to coroners, 2011

England and Wales — Number of reported deaths

	Males	Females	Total
Total deaths reported to coroners, 2011 (1)(2)	**119,596**	**102,694**	**222,371**
Inquests			
Deaths reported where an inquest was opened	20,825	10,156	30,981
Deaths reported where no inquest occurred (1)(2)	98,771	92,538	191,390
Post-mortem examinations			
Deaths reported where a post-mortem took place	56,942	37,012	93,954
Deaths reported without a post-mortem (1)(2)	62,654	65,682	128,417

(1) This row includes deaths referred to the coroner where no certificate of any kind was issued ("no further action" cases).
(2) The **total** column also includes "no further action" cases that could not be categorized into males and females.

Table 2: Registered deaths, deaths reported to coroners, and inquests opened, 1950-2011

England and Wales — Thousands and percentages

Year	Registered deaths (thousands)	Deaths reported to coroners		Inquests opened	
		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%
1995	565.9	208.5	36.8%	22.7	10.9%
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	230.6	46.8%	30.8	13.4%
2011	484.4 (2)	222.4	45.9% (2)	31.0	13.9%

(1) '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) provisional figure, based on ONS monthly death registration figures for 2011

Table 3: Deaths reported to coroners, post-mortem examinations held and inquests opened, 1995-2011

England and Wales — Numbers and percentages

Year	Inquest opened						No inquest opened					Post-mortems		
	Post-mortem examination held		No post-mortem held		Total inquests opened	% of deaths reported (1)	Post-mortem examination held		No post-mortem held		Total non-inquest cases, inc. NFA	Total post-mortems held	% of deaths reported (1)	Total deaths reported inc. NFA
	Number	% of inquest cases	Number	% of inquest cases			Number	% of non-inquest cases (1)	Number, inc. NFA	% of non-inquest cases (1)				
1995	22,247	98.1%	423	1.9%	**22,670**	10.9%	104,151	56.0%	81,701	44.0%	**185,852**	**126,398**	60.6%	**208,522**
1996	21,863	98.0%	455	2.0%	**22,318**	10.5%	104,321	54.8%	85,945	45.2%	**190,266**	**126,184**	59.4%	**212,584**
1997	22,336	98.4%	367	1.6%	**22,703**	10.9%	100,679	54.2%	85,196	45.8%	**185,875**	**123,015**	59.0%	**208,578**
1998	23,191	98.4%	377	1.6%	**23,568**	11.1%	101,165	53.8%	86,700	46.2%	**187,865**	**124,356**	58.8%	**211,433**
1999	23,896	98.0%	479	2.0%	**24,375**	11.1%	100,884	51.5%	94,917	48.5%	**195,801**	**124,780**	56.7%	**220,176**
2000	24,117	97.0%	740	3.0%	**24,857**	11.4%	100,419	52.0%	92,816	48.0%	**193,235**	**124,536**	57.1%	**218,092**
2001	24,617	95.4%	1,176	4.6%	**25,793**	11.5%	96,495	48.6%	101,998	51.4%	**198,493**	**121,112**	54.0%	**224,286**
2002	25,363	96.0%	1,067	4.0%	**26,430**	11.7%	92,321	46.5%	106,248	53.5%	**198,569**	**117,684**	52.3%	**224,999**
2003	25,754	95.0%	1,359	5.0%	**27,113**	11.9%	93,856	46.8%	106,821	53.2%	**200,677**	**119,610**	52.5%	**227,790**
2004	26,618	94.1%	1,656	5.9%	**28,274**	12.5%	89,155	45.2%	108,082	54.8%	**197,237**	**115,773**	51.3%	**225,511**
2005	27,537	94.1%	1,734	5.9%	**29,271**	12.6%	87,083	42.9%	116,047	57.1%	**203,130**	**114,620**	49.3%	**232,401**
2006	27,305	93.1%	2,022	6.9%	**29,327**	12.8%	82,919	41.3%	117,761	58.7%	**200,680**	**110,224**	47.9%	**230,007**
2007	28,510	92.4%	2,331	7.6%	**30,841**	13.2%	81,850	40.2%	121,767	59.8%	**203,617**	**110,360**	47.1%	**234,458**
2008	28,518	92.0%	2,481	8.0%	**30,999**	13.2%	79,842	39.2%	123,943	60.8%	**203,785**	**108,360**	46.2%	**234,784**
2009	28,213	91.1%	2,764	8.9%	**30,977**	13.5%	77,141	38.8%	121,765	61.2%	**198,906**	**105,354**	45.8%	**229,883**
2010	27,401	89.0%	3,387	11.0%	**30,788**	13.4%	74,542	37.3%	125,265	62.7%	**199,807**	**101,943**	44.2%	**230,595**
2011	27,162	87.7%	3,819	12.3%	**30,981**	13.9%	66,792	34.9%	124,598	65.1%	**191,390**	**93,954**	42.3%	**222,371**

(1) Percentages shown are of deaths reported including "no further action" (NFA) cases. 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. There are therefore no directly comparable figures for the total number of reported deaths including 'NFA' cases prior to 1995.

Table 4: Inquest verdicts returned, 2011

England and Wales — Number of verdicts returned

Verdict	Males	Females	Total
Homicide, of which:			
killed unlawfully	167	62	229
killed lawfully	5	3	8
Suicide	2,733	738	3,471
Attempted or self-induced abortion	-	1	1
Cause of death aggravated by lack of care, or self-neglect	27	23	50
Dependence on drugs	175	40	215
Non-dependent abuse of drugs	157	31	188
Want of attention at birth	1	-	1
Death from industrial diseases	2,379	190	2,569
Death by accident or misadventure	4,811	2,964	7,775
Stillborn	9	5	14
Deaths from natural causes	5,551	3,267	8,818
Open verdicts	1,447	670	2,117
Disasters	1	1	2
All other verdicts	2,578	1,822	4,400
Total verdicts returned, 2011	**20,041**	**9,817**	**29,858**

Table 5: Age of deceased in inquests where a verdict was returned, 2011

England and Wales — Number and percentage

Age of deceased at time of death	Number of inquest verdicts returned, 2011	As a % of total verdicts returned
Under 1 year	631	2.1%
1 to 14 years	417	1.4%
15 to 24 years	1,388	4.6%
25 to 44 years	5,849	19.6%
45 to 64 years	7,762	26.0%
65 years and over	13,806	46.2%
Age not known or could not be readily provided	5	0.0%
Total verdicts returned, 2011	**29,858**	**100.0%**

Table 6: Inquest verdicts returned, 1995-2011

England and Wales — Number of verdicts returned

Verdict	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Homicide, of which:																	
killed unlawfully	217	169	165	142	167	178	192	177	182	206	248	223	257	263	222	238	229
killed lawfully	6	1	2	3	2	4	2	6	1	5	4	2	2	2	5	10	8
Suicide	3,579	3,399	3,355	3,756	3,693	3,626	3,389	3,242	3,255	3,368	3,235	3,220	3,007	3,305	3,330	3,252	3,471
Attempted or self-induced abortion	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	1
Cause of death aggravated by lack of care, or self-neglect	35	59	59	47	44	33	43	46	50	51	27	30	35	35	36	42	50
Dependence on drugs	139	156	177	258	289	323	309	294	248	280	299	328	324	343	316	267	215
Non-dependent abuse of drugs	162	199	220	237	284	282	313	260	254	269	261	268	276	274	250	216	188
Want of attention at birth	9	5	4	5	1	4	6	1	4	3	2	3	-	1	1	1	1
Death from industrial diseases	1,878	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	2,569
Death by accident or misadventure	9,142	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	7,775
Stillborn	8	6	6	12	4	4	8	3	10	11	10	12	21	13	7	8	14
Deaths from natural causes	2,483	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	8,818
Open verdicts	2,257	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	2,117
Disasters	-	-	-	-	-	-	-	-	-	2	4	-	-	-	-	1	2
All other verdicts	136	142	154	160	119	156	225	583	873	1,412	1,952	2,406	2,923	3,333	3,797	4,180	4,400
Total verdicts returned	**20,051**	**19,855**	**20,699**	**21,333**	**22,349**	**23,088**	**23,617**	**23,423**	**24,259**	**25,494**	**26,814**	**27,547**	**27,360**	**28,996**	**29,781**	**29,385**	**29,858**

Table 7: Inquests concluded which were held with juries and inquests adjourned; High Court orders and exhumations, 1995-2011, estimated average time taken to process inquests, 2004-2011(1)

England and Wales — Number

Year	Juries			Verdicts / adjournments			Total inquests concluded	Average time to process an inquest (weeks)(1)	Inquests held by order of the High Court (2)	Inquisitions quashed or amended by the High Court	Exhumations ordered by the coroner
	Inquests without juries	Inquests with juries	% with juries	Verdicts returned	Inquests adjourned and not resumed	% adjourned					
1995	20,093	857	4.1%	20,051	899	4.3%	20,950	n/a	50	2	4
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	1.5%	29,781	924	3.0%	30,705	27	1	1	2
2010	29,938	442	1.5%	29,385	995	3.3%	30,380	27	3	1	0
2011	30,319	482	1.6%	29,858	943	3.1%	30,801	27	1	3	3

(1) Only deaths occurring within England and Wales are included in the estimation of average times. Estimates available only from 2004 onwards.
(2) The 1995 figure for inquests held by order of the High Court includes 48 inquests arising from the Marchioness pleasure boat disaster.

Table 8: Treasure inquests, 1995-2011

England and Wales — Number

Year	Treasure Act 1996			Treasure trove (1)
	Number of finds reported	Number of inquests concluded	Verdicts of treasure returned	Inquests held on treasure trove
1995	n/a	n/a	n/a	66
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(R)	596	273	229	13
2008	610	286	270	9
2009	624	307	289	3
2010(R)	624	362	318	0
2011	794	362	337	3

(R) The figures for finds made in 2007 and 2010 have been revised slightly; see Explanatory Notes for more information.

(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 2011, and comparison with 2010

County / unitary authority or district	2011 cases					2010 cases					% change, 2010 to 2011		
	Reported deaths 2011, inc. NFA	Post-mortems 2011	PMs as % of rep. deaths 2011	Inquests 2011	Inquests as % of rep. deaths 2011	**Reported deaths 2010, inc. NFA**	Post-mortems 2010	PMs as % of rep. deaths 2010	Inquests 2010	Inquests as % of rep. deaths 2010	% change in reported deaths, inc. NFA	change in % PMs	change in % 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	**1,064**	562	53%	153	14%	**1,172**	639	55%	150	13%	-9.2%	-1.7%	1.6%
North Durham	**1,272**	731	57%	277	22%	**1,248**	747	60%	271	22%	1.9%	-2.4%	0.1%
HARTLEPOOL	**387**	156	40%	46	12%	**434**	213	49%	78	18%	-10.8%	-8.8%	-6.1%
NORTHUMBERLAND													
North Northumberland	**654**	289	44%	108	17%	**701**	340	49%	132	19%	-6.7%	-4.3%	-2.3%
South Northumberland	**379**	236	62%	96	25%	**421**	271	64%	96	23%	-10.0%	-2.1%	2.5%
TEESSIDE	**2,659**	968	36%	292	11%	**2,566**	1,002	39%	315	12%	3.6%	-2.6%	-1.3%
TYNE AND WEAR													
Gateshead and South Tyneside	**1,867**	927	50%	285	15%	**1,926**	816	42%	238	12%	-3.1%	7.3%	2.9%
Newcastle upon Tyne	**1,797**	727	40%	365	20%	**1,876**	799	43%	361	19%	-4.2%	-2.1%	1.1%
North Tyneside	**743**	385	52%	212	29%	**848**	458	54%	206	24%	-12.4%	-2.2%	4.2%
Sunderland	**1,485**	492	33%	341	23%	**1,538**	584	38%	396	26%	-3.4%	-4.8%	-2.8%
NORTH WEST													
CHESHIRE	**4,711**	2,007	43%	737	16%	**4,641**	2,129	46%	712	15%	1.5%	-3.3%	0.3%
CUMBRIA													
South and East Cumbria	**977**	518	53%	186	19%	**1,062**	574	54%	190	18%	-8.0%	-1.0%	1.1%
North and West Cumbria	**1,255**	639	51%	205	16%	**1,351**	706	52%	235	17%	-7.1%	-1.3%	-1.1%
GREATER MANCHESTER													
Manchester city	**2,944**	1,335	45%	626	21%	**3,220**	1,511	47%	715	22%	-8.6%	-1.6%	-0.9%
Manchester North	**2,729**	907	33%	524	19%	**2,906**	950	33%	446	15%	-6.1%	0.5%	3.9%
Manchester South	**3,178**	1,652	52%	677	21%	**3,184**	1,672	53%	563	18%	-0.2%	-0.5%	3.6%
Manchester West	**4,297**	1,805	42%	624	15%	**4,427**	1,943	44%	604	14%	-2.9%	-1.9%	0.9%
LANCASHIRE													
Blackburn, Hyndburn and Ribble Valley	**2,510**	970	39%	343	14%	**2,613**	962	37%	325	12%	-3.9%	1.8%	1.2%
Blackpool/Fylde	**1,762**	821	47%	145	8%	**1,696**	811	48%	130	8%	3.9%	-1.2%	0.6%
East Lancashire	**660**	429	65%	145	22%	**664**	436	66%	153	23%	-0.6%	-0.7%	-1.1%
Preston and West Lancashire	**2,717**	1,563	58%	474	17%	**2,743**	1,584	58%	464	17%	-0.9%	-0.2%	0.5%
MERSEYSIDE													
Sefton, Knowsley and St Helens	**2,223**	707	32%	251	11%	**2,548**	867	34%	305	12%	-12.8%	-2.2%	-0.7%
Liverpool	**2,777**	801	29%	529	19%	**2,815**	877	31%	530	19%	-1.3%	-2.3%	0.2%
Wirral	**1,501**	463	31%	267	18%	**1,681**	615	37%	276	16%	-10.7%	-5.7%	1.4%

Table 9: Reported deaths, post-mortems and inquests by jurisdiction 2011, and comparison with 2010 *(continued)*

County / unitary authority or district	2011 cases					2010 cases					% change, 2010 to 2011		
	Reported deaths 2011, inc. NFA	Post-mortems 2011	PMs as % of rep. deaths 2011	Inquests 2011	Inquests as % of rep. deaths 2011	**Reported deaths 2010, inc. NFA**	Post-mortems 2010	PMs as % of rep. deaths 2010	Inquests 2010	Inquests as % of rep. deaths 2010	% change in reported deaths, inc. NFA	change in % PMs	change in % inquests
YORKSHIRE AND THE HUMBER													
EAST RIDING and HULL	**2,965**	991	33%	291	10%	**2,822**	1,015	36%	293	10%	5.1%	-2.5%	-0.6%
NORTH LINCOLNSHIRE and GRIMSBY	**1,378**	372	27%	124	9%	**1,391**	435	31%	124	9%	-0.9%	-4.3%	0.1%
YORK CITY	**1,037**	435	42%	105	10%	**1,065**	428	40%	101	9%	-2.6%	1.8%	0.6%
North Yorkshire Eastern District	**1,059**	600	57%	117	11%	**1,192**	661	55%	132	11%	-11.2%	1.2%	0.0%
North Yorkshire Western District	**1,048**	382	36%	120	11%	**1,119**	417	37%	129	12%	-6.3%	-0.8%	-0.1%
South Yorkshire Eastern District	**2,493**	1,406	56%	344	14%	**2,537**	1,553	61%	352	14%	-1.7%	-4.8%	-0.1%
South Yorkshire Western District	**3,127**	1,476	47%	616	20%	**3,091**	1,473	48%	453	15%	1.2%	-0.5%	5.0%
West Yorkshire Eastern District	**3,327**	1,385	42%	508	15%	**3,757**	1,682	45%	513	14%	-11.4%	-3.1%	1.6%
West Yorkshire Western District	**3,234**	1,615	50%	489	15%	**3,282**	1,610	49%	495	15%	-1.5%	0.9%	0.0%
EAST MIDLANDS													
DERBYSHIRE													
Derby and South Derbyshire	**2,574**	1,087	42%	328	13%	**2,570**	1,202	47%	283	11%	0.2%	-4.5%	1.7%
North Derbyshire	**2,015**	809	40%	305	15%	**2,031**	854	42%	327	16%	-0.8%	-1.9%	-1.0%
LEICESTERSHIRE													
Leicester City and South Leicestershire	**3,339**	761	23%	371	11%	**3,502**	707	20%	413	12%	-4.7%	2.6%	-0.7%
Rutland and North Leicestershire	**1,116**	488	44%	221	20%	**1,012**	475	47%	168	17%	10.3%	-3.2%	3.2%
LINCOLNSHIRE													
Boston and Spalding	**962**	384	40%	83	9%	**908**	330	36%	64	7%	5.9%	3.6%	1.6%
West Lincolnshire	**1,717**	616	36%	166	10%	**1,586**	547	34%	136	9%	8.3%	1.4%	1.1%
Spilsby and Louth	**481**	202	42%	41	9%	**538**	284	53%	58	11%	-10.6%	-10.8%	-2.3%
Stamford	**126**	50	40%	16	13%	**137**	70	51%	20	15%	-8.0%	-11.4%	-1.9%
NORTHAMPTONSHIRE	**2,658**	1,065	40%	263	10%	**2,716**	1,158	43%	239	9%	-2.1%	-2.6%	1.1%
NOTTINGHAMSHIRE	**5,588**	1,440	26%	480	9%	**5,787**	1,484	26%	445	8%	-3.4%	0.1%	0.9%
WEST MIDLANDS													
HEREFORDSHIRE	**797**	333	42%	95	12%	**774**	373	48%	104	13%	3.0%	-6.4%	-1.5%
SHROPSHIRE													
Mid and North Shropshire	**917**	333	36%	74	8%	**850**	361	42%	89	10%	7.9%	-6.2%	-2.4%
South Shropshire	**225**	146	65%	27	12%	**258**	163	63%	45	17%	-12.8%	1.7%	-5.4%
STAFFORDSHIRE													
Staffordshire South	**2,122**	805	38%	347	16%	**2,283**	930	41%	360	16%	-7.1%	-2.8%	0.6%
Stoke-on-Trent and North Staffordshire	**3,622**	1,365	38%	445	12%	**3,641**	1,423	39%	468	13%	-0.5%	-1.4%	-0.6%
TELFORD and WREKIN	**702**	308	44%	83	12%	**798**	362	45%	82	10%	-12.0%	-1.5%	1.5%
WARWICKSHIRE	**1,731**	733	42%	217	13%	**1,818**	741	41%	222	12%	-4.8%	1.6%	0.3%
WEST MIDLANDS													
Birmingham and Solihull	**5,037**	1,700	34%	1,195	24%	**4,624**	1,793	39%	1,082	23%	8.9%	-5.0%	0.3%
Black Country	**3,538**	970	27%	549	16%	**3,192**	868	27%	345	11%	10.8%	0.2%	4.7%
Coventry	**1,754**	498	28%	175	10%	**1,743**	502	29%	220	13%	0.6%	-0.4%	-2.6%
Wolverhampton	**921**	357	39%	200	22%	**1,314**	501	38%	205	16%	-29.9%	0.6%	6.1%
WORCESTERSHIRE	**2,346**	952	41%	344	15%	**2,497**	1,049	42%	366	15%	-6.0%	-1.4%	0.0%

Table 9: Reported deaths, post-mortems and inquests by jurisdiction 2011, and comparison with 2010 *(continued)*

County / unitary authority or district	2011 cases					2010 cases					% change, 2010 to 2011		
	Reported deaths 2011, inc. NFA	Post-mortems 2011	PMs as % of rep. deaths 2011	Inquests 2011	Inquests as % of rep. deaths 2011	**Reported deaths 2010, inc. NFA**	Post-mortems 2010	PMs as % of rep. deaths 2010	Inquests 2010	Inquests as % of rep. deaths 2010	% change in reported deaths, inc. NFA	change in % PMs	change in % inquests
EAST OF ENGLAND													
BEDFORDSHIRE AND LUTON	**1,946**	752	39%	200	10%	**1,969**	774	39%	211	11%	-1.2%	-0.7%	-0.4%
CAMBRIDGESHIRE													
North and East Cambridgeshire	**384**	199	52%	50	13%	**395**	228	58%	54	14%	-2.8%	-5.9%	-0.7%
South and West Cambridgeshire	**1,867**	586	31%	230	12%	**1,903**	606	32%	203	11%	-1.9%	-0.5%	1.7%
ESSEX and THURROCK	**4,605**	2,555	55%	458	10%	**4,992**	2,892	58%	520	10%	-7.8%	-2.4%	-0.5%
HERTFORDSHIRE	**2,949**	1,577	53%	326	11%	**3,134**	1,712	55%	359	11%	-5.9%	-1.2%	-0.4%
NORFOLK	**3,800**	1,643	43%	507	13%	**3,903**	1,838	47%	508	13%	-2.6%	-3.9%	0.3%
PETERBOROUGH	**979**	347	35%	93	9%	**1,103**	384	35%	90	8%	-11.2%	0.6%	1.3%
SOUTHEND-ON-SEA	**1,329**	688	52%	160	12%	**1,607**	772	48%	173	11%	-17.3%	3.7%	1.3%
SUFFOLK	**2,680**	1,178	44%	314	12%	**2,694**	1,290	48%	289	11%	-0.5%	-3.9%	1.0%
LONDON													
City of London	**135**	18	13%	10	7%	**137**	37	27%	15	11%	-1.5%	-13.7%	-3.5%
East London	**3,429**	1,547	45%	432	13%	**3,612**	1,695	47%	371	10%	-5.1%	-1.8%	2.3%
Inner North London	**2,589**	1,157	45%	384	15%	**2,964**	1,336	45%	536	18%	-12.7%	-0.4%	-3.3%
Inner South London	**3,272**	1,750	53%	528	16%	**3,399**	1,883	55%	496	15%	-3.7%	-1.9%	1.5%
Inner West London	**2,621**	1,242	47%	490	19%	**2,475**	1,094	44%	408	16%	5.9%	3.2%	2.2%
North London	**3,357**	1,418	42%	418	12%	**4,302**	1,703	40%	459	11%	-22.0%	2.7%	1.8%
South London	**3,128**	1,375	44%	333	11%	**3,186**	1,602	50%	329	10%	-1.8%	-6.3%	0.3%
West London	**3,886**	1,501	39%	528	14%	**4,003**	1,510	38%	529	13%	-2.9%	0.9%	0.4%
SOUTH EAST													
BERKSHIRE	**2,416**	932	39%	282	12%	**2,527**	1,078	43%	288	11%	-4.4%	-4.1%	0.3%
BRIGHTON AND HOVE	**1,200**	613	51%	226	19%	**1,281**	617	48%	240	19%	-6.3%	2.9%	0.1%
BUCKINGHAMSHIRE	**1,444**	723	50%	170	12%	**1,458**	737	51%	179	12%	-1.0%	-0.5%	-0.5%
EAST SUSSEX	**2,241**	1,215	54%	388	17%	**2,479**	1,408	57%	315	13%	-9.6%	-2.6%	4.6%
HAMPSHIRE													
Central Hampshire	**1,119**	466	42%	181	16%	**1,180**	482	41%	161	14%	-5.2%	0.8%	2.5%
North East Hampshire	**1,135**	544	48%	125	11%	**1,209**	641	53%	141	12%	-6.1%	-5.1%	-0.6%
Portsmouth and South East Hampshire	**2,737**	1,220	45%	417	15%	**2,720**	1,258	46%	413	15%	0.6%	-1.7%	0.1%
Southampton and New Forest	**2,105**	741	35%	223	11%	**2,166**	802	37%	243	11%	-2.8%	-1.8%	-0.6%
ISLE OF WIGHT	**733**	363	50%	79	11%	**754**	444	59%	75	10%	-2.8%	-9.4%	0.8%
KENT													
Central and South East Kent	**1,334**	675	51%	137	10%	**1,362**	796	58%	163	12%	-2.1%	-7.8%	-1.7%
Mid Kent and Medway	**2,090**	1,064	51%	252	12%	**2,421**	1,130	47%	221	9%	-13.7%	4.2%	2.9%
North East Kent	**1,898**	1,150	61%	264	14%	**1,828**	1,160	63%	226	12%	3.8%	-2.9%	1.5%
North West Kent	**1,636**	786	48%	155	9%	**1,710**	919	54%	175	10%	-4.3%	-5.7%	-0.8%
MILTON KEYNES	**718**	340	47%	121	17%	**791**	441	56%	126	16%	-9.2%	-8.4%	0.9%

Table 9: Reported deaths, post-mortems and inquests by jurisdiction 2011, and comparison with 2010 *(continued)*

County / unitary authority or district	2011 cases					2010 cases					% change, 2010 to 2011		
	Reported deaths 2011, inc. NFA	Post-mortems 2011	PMs as % of rep. deaths 2011	Inquests 2011	Inquests as % of rep. deaths 2011	**Reported deaths 2010, inc. NFA**	Post-mortems 2010	PMs as % of rep. deaths 2010	Inquests 2010	Inquests as % of rep. deaths 2010	% change in reported deaths, inc. NFA	change in % PMs	change in % inquests
OXFORDSHIRE	**2,034**	819	40%	237	12%	**2,139**	945	44%	292	14%	-4.9%	-3.9%	-2.0%
SURREY	**4,079**	1,830	45%	357	9%	**4,331**	2,066	48%	370	9%	-5.8%	-2.8%	0.2%
WEST SUSSEX	**3,193**	1,344	42%	256	8%	**3,154**	1,457	46%	274	9%	1.2%	-4.1%	-0.7%
SOUTH WEST													
AVON	**4,493**	1,842	41%	708	16%	**4,727**	2,103	44%	790	17%	-5.0%	-3.5%	-1.0%
CORNWALL	**2,505**	1,426	57%	365	15%	**2,525**	1,627	64%	413	16%	-0.8%	-7.5%	-1.8%
DEVON													
Exeter and Greater Devon	**2,765**	724	26%	319	12%	**2,715**	862	32%	303	11%	1.8%	-5.6%	0.4%
Plymouth and South West Devon	**1,884**	906	48%	356	19%	**2,125**	963	45%	364	17%	-11.3%	2.8%	1.8%
Torbay and South Devon	**1,655**	655	40%	174	11%	**1,963**	750	38%	161	8%	-15.7%	1.4%	2.3%
DORSET													
Bournemouth, Poole and Eastern Dorset	**2,215**	759	34%	173	8%	**2,291**	849	37%	178	8%	-3.3%	-2.8%	0.0%
Western Dorset	**966**	371	38%	77	8%	**1,002**	426	43%	69	7%	-3.6%	-4.1%	1.1%
GLOUCESTERSHIRE	**1,938**	1,028	53%	372	19%	**1,941**	1,142	59%	401	21%	-0.2%	-5.8%	-1.5%
ISLES OF SCILLY	**7**	5	71%	2	29%	**10**	4	*	1	*	*	*	*
SOMERSET													
Eastern Somerset	**921**	405	44%	118	13%	**941**	481	51%	128	14%	-2.1%	-7.1%	-0.8%
Western Somerset	**1,301**	390	30%	113	9%	**1,344**	491	37%	123	9%	-3.2%	-6.6%	-0.5%
WILTSHIRE and SWINDON	**2,240**	829	37%	364	16%	**2,255**	1,010	45%	370	16%	-0.7%	-7.8%	-0.2%
WALES													
Bridgend and Glamorgan Valleys	**2,381**	1,093	46%	288	12%	**2,542**	1,145	45%	295	12%	-6.3%	0.9%	0.5%
Cardiff and Vale of Glamorgan	**1,535**	656	43%	313	20%	**1,707**	828	49%	400	23%	-10.1%	-5.8%	-3.0%
Carmarthenshire	**773**	353	46%	73	9%	**772**	359	47%	79	10%	0.1%	-0.8%	-0.8%
Central North Wales	**1,179**	672	57%	215	18%	**1,230**	691	56%	179	15%	-4.1%	0.8%	3.7%
Ceredigion	**281**	167	59%	30	11%	**266**	157	59%	34	13%	5.6%	0.4%	-2.1%
Gwent	**2,642**	989	37%	145	5%	**2,596**	1,012	39%	127	5%	1.8%	-1.5%	0.6%
Neath and Port Talbot	**465**	226	49%	89	19%	**451**	230	51%	89	20%	3.1%	-2.4%	-0.6%
North East Wales	**1,232**	589	48%	234	19%	**1,168**	679	58%	205	18%	5.5%	-10.3%	1.4%
North West Wales	**951**	414	44%	140	15%	**1,058**	463	44%	141	13%	-10.1%	-0.2%	1.4%
Pembrokeshire	**626**	237	38%	75	12%	**606**	255	42%	76	13%	3.3%	-4.2%	-0.6%
Powys	**283**	209	74%	61	22%	**350**	224	64%	73	21%	-19.1%	9.9%	0.7%
City and County of Swansea	**1,561**	497	32%	199	13%	**1,606**	498	31%	173	11%	-2.8%	0.8%	2.0%
ENGLAND and WALES	**222,371**	**93,954**	**42%**	**30,981**	**14%**	**230,595**	**101,943**	**44%**	**30,848**	**13%**	**-3.6%**	**-2.0%**	**0.8%**

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.

* Percentages not shown because of the low volume of caseload.

(1) Wolverhampton coroner district was absorbed into that of the Black Country on 1 October 2011, so figures here are for January-September 2011 only.

Table 10: Inquest verdicts returned, by jurisdiction, 2011

County / unitary authority or district	Verdict category										Total, all verdicts
	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)	
The Queen's Household	0	0	0	0	0	0	0	0	0	0	**0**
ENGLAND											
NORTH EAST											
DURHAM											
Darlington and South Durham	1	15	0	0	0	19	37	73	11	13	**169**
North Durham	0	35	0	2	1	36	56	173	24	26	**353**
HARTLEPOOL	0	11	0	0	2	14	13	4	2	0	**46**
NORTHUMBERLAND											
North Northumberland	1	12	0	0	1	14	12	58	1	24	**123**
South Northumberland	0	13	0	0	0	8	22	33	7	6	**89**
TEESSIDE	0	27	2	1	0	59	119	46	26	4	**284**
TYNE AND WEAR											
Gateshead and South Tyneside	3	18	0	0	0	41	116	52	10	21	**261**
Newcastle upon Tyne	2	22	0	3	5	31	96	100	12	85	**356**
North Tyneside	1	19	0	0	0	18	66	81	11	9	**205**
Sunderland	0	17	0	0	0	49	44	218	8	37	**373**
NORTH WEST											
CHESHIRE	6	65	0	2	0	79	161	295	22	94	**724**
CUMBRIA											
South and East Cumbria	1	4	0	0	0	27	39	61	6	48	**186**
North and West Cumbria	14	26	0	1	1	26	52	57	5	11	**193**
GREATER MANCHESTER											
Manchester city	3	36	1	1	4	30	179	288	39	157	**738**
Manchester North	2	50	0	1	0	14	55	236	10	108	**476**
Manchester South	6	31	1	0	0	30	211	240	42	22	**583**
Manchester West	1	67	0	14	9	43	144	88	78	197	**641**
LANCASHIRE											
Blackburn, Hyndburn and Ribble Valley	1	28	0	1	0	12	53	124	4	89	**312**
Blackpool/Fylde	1	14	0	6	1	8	69	14	10	3	**126**
East Lancashire	2	11	0	0	0	8	54	56	7	15	**153**
Preston and West Lancashire	2	50	0	1	0	15	94	145	35	130	**472**
MERSEYSIDE											
Sefton, Knowsley and St Helens	0	37	2	2	0	18	90	77	24	5	**255**
Liverpool	6	29	0	10	9	21	149	210	5	86	**525**
Wirral	0	21	0	0	1	36	34	118	19	30	**259**

Table 10: Inquest verdicts returned, by jurisdiction, 2011 *(continued)*

County / unitary authority or district	Verdict category										Total, all verdicts
	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)	
YORKSHIRE AND THE HUMBER											
EAST RIDING and HULL	3	23	0	0	0	18	71	53	43	74	**285**
NORTH LINCOLNSHIRE and GRIMSBY	0	28	1	0	3	22	27	40	2	25	**148**
YORK CITY	0	13	0	8	1	18	42	21	9	1	**113**
North Yorkshire Eastern District	0	29	0	0	0	13	47	17	4	1	**111**
North Yorkshire Western District	0	32	0	3	3	9	49	15	3	7	**121**
South Yorkshire Eastern District	1	21	0	0	0	65	68	84	25	74	**338**
South Yorkshire Western District	1	53	1	0	0	82	88	147	1	104	**477**
West Yorkshire Eastern District	3	82	0	9	4	66	124	119	28	50	**485**
West Yorkshire Western District	4	84	6	9	11	54	133	109	31	13	**454**
EAST MIDLANDS											
DERBYSHIRE											
Derby and South Derbyshire	0	25	0	0	0	48	76	59	21	50	**279**
North Derbyshire	1	13	0	1	6	43	101	93	24	32	**314**
LEICESTERSHIRE											
Leicester City and South Leicestershire	2	35	0	0	0	22	84	133	13	55	**344**
Rutland and North Leicestershire	2	28	0	0	0	13	64	75	5	20	**207**
LINCOLNSHIRE											
Boston and Spalding	0	10	0	1	0	2	26	12	3	2	**56**
West Lincolnshire	2	15	0	2	4	16	34	25	24	19	**141**
Spilsby and Louth	0	3	0	0	0	3	19	8	7	1	**41**
Stamford	1	3	0	0	0	1	4	1	0	1	**11**
NORTHAMPTONSHIRE	0	52	0	0	0	26	80	60	23	25	**266**
NOTTINGHAMSHIRE	2	41	0	0	0	87	115	52	61	47	**405**
WEST MIDLANDS											
HEREFORDSHIRE	2	10	0	0	0	7	38	19	9	13	**98**
SHROPSHIRE											
Mid and North Shropshire	0	15	0	0	0	7	28	4	4	16	**74**
South Shropshire	0	10	1	0	1	2	13	0	1	4	**32**
STAFFORDSHIRE											
Staffordshire South	1	70	0	4	3	50	121	86	5	23	**363**
Stoke-on-Trent and North Staffordshire	6	25	0	6	0	48	129	65	27	136	**442**
TELFORD and WREKIN	0	8	0	0	0	9	21	14	0	17	**69**
WARWICKSHIRE	3	42	0	2	5	14	58	49	11	4	**188**
WEST MIDLANDS											
Birmingham and Solihull	3	19	0	0	0	13	15	278	30	773	**1,131**
Black Country	3	37	0	5	1	41	77	139	26	60	**389**
Coventry	0	30	0	1	8	8	47	71	20	10	**195**
Wolverhampton	0	2	0	0	0	11	7	34	14	17	**85**
WORCESTERSHIRE	1	36	0	2	6	23	71	129	17	42	**327**

Table 10: Inquest verdicts returned, by jurisdiction, 2011 *(continued)*

County / unitary authority or district	Verdict category										Total, all verdicts
	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)	
EAST OF ENGLAND											
BEDFORDSHIRE and LUTON	0	36	0	2	1	24	41	72	2	9	**187**
CAMBRIDGESHIRE											
North and East Cambridgeshire	0	8	0	2	1	1	17	11	1	2	**43**
South and West Cambridgeshire	2	35	0	1	0	8	53	62	4	35	**200**
ESSEX and THURROCK	2	104	0	2	6	69	201	111	85	37	**617**
HERTFORDSHIRE	6	59	0	0	2	18	119	91	7	33	**335**
NORFOLK	2	63	1	0	1	44	154	147	11	65	**488**
PETERBOROUGH	2	11	0	0	0	5	48	28	9	10	**113**
SOUTHEND-ON-SEA	1	8	0	0	0	10	18	23	15	26	**101**
SUFFOLK	1	43	0	0	0	23	46	38	32	91	**274**
LONDON											
City of London	1	1	0	0	0	1	3	0	2	2	**10**
East London	4	46	0	2	0	41	83	83	54	16	**329**
Inner North London	0	42	3	12	8	21	80	113	48	57	**384**
Inner South London	2	47	0	2	7	31	111	96	79	90	**465**
Inner West London	3	57	1	11	7	17	126	147	54	38	**461**
North London	8	34	0	0	0	19	99	94	78	60	**392**
South London	2	46	2	2	4	29	82	80	50	9	**306**
West London	2	93	0	4	5	30	133	142	29	80	**518**
SOUTH EAST											
BERKSHIRE	0	40	0	0	0	22	128	48	27	24	**289**
BRIGHTON and HOVE	0	29	5	11	0	14	106	15	13	20	**213**
BUCKINGHAMSHIRE	0	33	0	0	0	10	62	33	13	7	**158**
EAST SUSSEX	4	78	1	6	9	24	86	134	27	15	**384**
HAMPSHIRE											
Central Hampshire	3	23	0	0	0	37	34	63	13	1	**174**
North East Hampshire	1	28	0	0	0	10	36	14	14	5	**108**
Portsmouth and South East Hampshire	3	47	0	9	0	42	82	236	8	17	**444**
Southampton and New Forest	7	36	0	3	0	22	68	69	6	24	**235**
ISLE OF WIGHT	1	10	1	1	1	11	14	15	7	1	**62**
KENT											
Central and South East Kent	0	19	0	0	0	13	40	47	14	25	**158**
Mid Kent and Medway	1	23	0	1	1	41	57	51	9	15	**199**
North East Kent	0	15	0	0	0	22	55	71	27	21	**211**
North West Kent	2	31	0	0	0	18	33	57	11	2	**154**
MILTON KEYNES	1	12	2	0	0	9	38	29	10	12	**113**

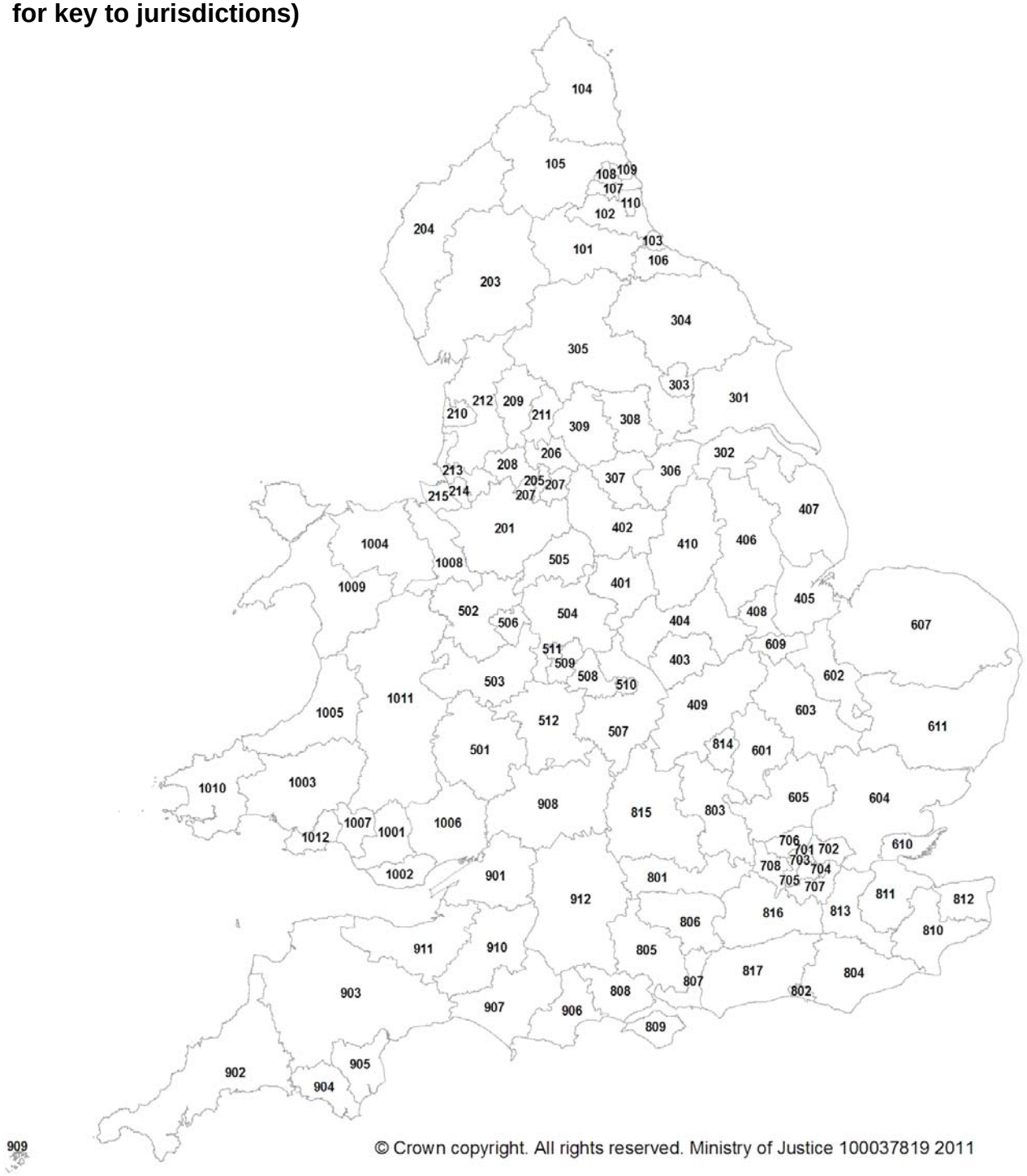
Table 10: Inquest verdicts returned, by jurisdiction, 2011 *(continued)*

County / unitary authority or district	Verdict category										Total, all verdicts
	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)	
OXFORDSHIRE	0	31	0	1	0	20	123	28	14	50	**267**
SURREY	3	48	3	1	1	31	90	60	33	43	**313**
WEST SUSSEX	0	57	0	1	2	25	99	50	11	16	**261**
SOUTH WEST											
AVON	13	80	2	11	11	47	181	330	53	65	**793**
CORNWALL	1	31	5	1	0	20	89	106	56	34	**343**
DEVON											
Exeter and Greater Devon	3	52	0	2	17	31	133	91	17	10	**356**
Plymouth and South West Devon	1	28	0	3	2	36	69	142	14	41	**336**
Torbay and South Devon	1	15	0	0	0	4	24	10	11	6	**71**
DORSET											
Bournemouth, Poole and Eastern Dorset	2	43	1	3	1	18	30	33	18	19	**168**
Western Dorset	1	5	0	0	0	4	25	8	21	3	**67**
GLOUCESTERSHIRE	1	51	1	0	1	26	119	159	41	20	**419**
ISLES OF SCILLY	0	0	0	0	0	0	0	0	0	0	**0**
SOMERSET											
Eastern Somerset	1	20	0	0	0	11	36	47	9	19	**143**
Western Somerset	0	22	0	5	3	3	22	29	4	12	**100**
WILTSHIRE AND SWINDON	39	39	2	2	0	30	69	110	15	28	**334**
WALES											
Bridgend and Glamorgan Valleys	0	50	1	0	2	20	128	120	31	65	**417**
Cardiff and Vale of Glamorgan	0	30	0	11	2	12	63	90	39	83	**330**
Carmarthenshire	0	13	0	0	0	1	18	12	5	0	**49**
Central North Wales	0	17	2	0	0	6	86	35	10	42	**198**
Ceredigion	0	5	0	0	0	1	7	8	4	0	**25**
Gwent	8	41	0	0	0	5	66	7	8	3	**138**
Neath and Port Talbot	0	12	1	0	0	2	12	40	3	12	**82**
North East Wales	3	20	1	0	0	8	84	53	9	17	**195**
North West Wales	3	18	0	5	3	11	40	35	8	13	**136**
Pembrokeshire	0	6	0	0	0	5	14	36	9	2	**72**
Powys	0	12	0	0	0	1	26	11	3	9	**62**
City and County of Swansea	2	16	0	0	0	8	27	90	3	21	**167**
TOTAL ENGLAND and WALES	**237**	**3,471**	**50**	**215**	**188**	**2,569**	**7,775**	**8,818**	**2,117**	**4,418**	**29,858**

(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.

Map of coroner jurisdictions in England and Wales during 2011 (see below for key to jurisdictions)



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

28

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.

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, 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 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: http://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[4] 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.

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

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 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 2011, 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.

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 2010 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.

Some figures for the number of finds reported in 2007 and 2010 have been revised following information which came to light during the data collection for the 2011 statistics. The revised figures are shown in Table 8.

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://webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/hosbarchive.html
(this is an archive page; click on the year required)

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.

Contact points for further information

Current and previous editions of this publication are available for download at www.justice.gov.uk/publications/statistics-and-data/coroners-and-burials/deaths.htm 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 3535
Email: catherine.macdonald@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 may 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.

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