Ministry of Justice

Coroners Statistics 2013 England and Wales

Ministry of Justice Statistics bulletin

Published 15 May 2014

Contents

Executive Summary

This bulletin presents statistics of coroners' work during the calendar year 2013, 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 proportion of post-mortems and inquests. In July 2013, various provisions of the Coroners and Justice Act 2009 came into force. For further information please see the Introduction, or refer to 'A Guide to Court and Administrative Justice Statistics', which is available at:

www.gov.uk/government/publications/guide-to-court-and-administrative-justice-statistics

Key Findings

- Some 227,984 deaths were reported to coroners in 2013, an increase of 263 (less than 1%) from the 2012 figure, reflecting in part the 1% increase in registered deaths from 2012 to 2013.
- Just under half (45%) of all registered deaths[1] were reported to coroners in 2013, a slightly lower proportion than in 2012. Over the last ten years this proportion has been relatively consistent, within the range 42% to 47%.
- The estimated average time taken to process an inquest in 2013 (defined as being from the date the death was reported until the conclusion of the inquest, where the death occurred in England and Wales) was 28 weeks. This is two weeks higher than last year's figure of 26 weeks. Comparing across coroner areas, the maximum average time taken to process an inquest in 2013 was 50 weeks, and the minimum average time was nine weeks. Over the last five years, the average time has remained in the range 26 to 28 weeks.
- The two most common conclusions recorded at inquest were death from natural causes (in 28% of cases) and death by accident or misadventure (26%), which has been the case for the last decade.
- The number of conclusions of suicide recorded by a coroner rose by 7% in 2013 compared to 2012, from 3,515 to 3,754, reflecting in part the 5% increase in total conclusions recorded. Since 2007 the number of suicide conclusions has shown a slight upward trend, however, the number of suicide conclusions as a proportion of the total has remained at 12% since 2011.
- Also rising were the number of unclassified conclusions, a category which includes narrative conclusions, which are a factual record of how and in what circumstances the death occurred, often recorded where the cause of death does not easily fit any of the standard short-form conclusions.

[1] A provisional figure for the number of registered deaths in England and Wales has been used, derived from monthly figures produced by the Office for National Statistics.

Introduction

This annual bulletin presents statistics of deaths reported to coroners in England and Wales in 2013. Information is provided on the number of deaths reported to coroners, post-mortem examinations and inquests held, and conclusions recorded at inquests. The data are collected via statistical returns completed by coroners. For previous editions of this report please see:

www.gov.uk/government/collections/coroners-and-burials-statistics

This publication should be read alongside the statistical tables which accompany it, also found via the link above. There is also a supporting CSV file to allow users to do their own analysis.

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

The Explanatory Notes section at the end of this report provides 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.

Recent changes to legislation

Part 1 of the Coroners and Justice Act 2009 (the 2009 Act) provided for a number of structural and procedural changes to the coroner system in England and Wales. The provisions of the 2009 Act, as well as the rules and regulations made under it, came into force in July 2013. The 2009 Act essentially replaces the Coroners Act 1988[2] (the 1988 Act) as the legislation governing coroner services.

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

www.legislation.gov.uk/ukpga/2009/25/contents

www.legislation.gov.uk/2013?title=coroners

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

Chief Coroner

The 2009 Act created the new post of Chief Coroner to provide judicial oversight of the coroner system. The Chief Coroner's main responsibilities are to:

- approve all coroner appointments (along with the Lord Chancellor);
- keep a register of coroner investigations lasting more than 12 months; and
- collate, monitor and publish coroners' reports to authorities to prevent future deaths.

Further information on the Chief Coroner is available at:

www.judiciary.gov.uk/about-the-judiciary/office-chief-coroner

Coroner areas and structure

The 2009 Act replaced 'coroner districts' with 'coroner areas'. For further information on changes to coroner areas please see Annex B.

The hierarchy of coroners under the Coroners Act 1988 consisted (in descending order) of coroners, deputy coroners and assistant deputy coroners. Under the 2009 Act, they became senior coroners, area coroners and assistant coroners, with one senior coroner per coroner area.

Investigations

The 2009 Act introduced the new concept of the coroner's 'investigation' into a death (which may or may not include an inquest). This recognises that much of the coroner's work actually takes place before any formal inquest hearing. It also allows the coroner to consider whether the duty to hold an inquest applies to an individual case, rather than having to open an inquest straight away in order to release a body for funeral. This may lead to fewer natural cause deaths proceeding to inquest.

In England and Wales, a coroner has a duty under the 2009 Act to investigate a death if:

1) the coroner is made aware that the body is within that coroner's area, and
2) the coroner has reason to suspect that:
    a) the deceased died a violent or unnatural death;
    b) the cause of the death is unknown; or
    c) the deceased died while in custody or state detention.

The coroner must then establish who has died and how, when, and where they died.

A coroner's inquest must be held for all deaths in custody or state detention, but a jury is no longer required in all such cases. An inquest must be held with a jury where the deceased died while in custody or state detention and the

death was violent or unnatural, or of unknown cause; where the death resulted from an act or omission of a police officer or member of a service police force in the purported execution of their duties; or where the death was caused by an accident, poisoning or disease which must be reported to a government department or inspector. Jury inquests are no longer required where the deceased died in custody but from natural causes.

Once the post-mortem examination (including any histology or toxicology) has concluded, the coroner must decide how to proceed. There are three main options:

- The post-mortem examination reveals that the deceased died of natural causes and the coroner thinks that it is not necessary to (investigate or) continue the investigation. There will be no inquest.

- The post-mortem examination reveals that the deceased died of natural causes but the coroner considers that it is necessary to (investigate or) continue the investigation. The coroner must then hold an inquest.

- After the post-mortem examination the coroner (still) has reason to suspect that the deceased died a violent or unnatural death, or the cause of death is unknown, or the deceased died while in custody/state detention. The coroner must then hold an inquest.

Inquest conclusions

Under the 1988 Act the coroner (or jury if applicable) completed an 'Inquisition' form at the end of an inquest, including a 'verdict' that set out the conclusions of the coroner or jury as to who had died and how, when, and where they died.

Under the 2009 Act the 'Inquisition' form has been replaced by a form entitled 'Record of an inquest'. 'Verdicts' have been replaced with 'conclusions'. A conclusion consists of the legal 'determination', which states who died, and where, when and how they died; and 'findings' which allow the cause of death to be registered. The coroner or jury may use one of the following short form conclusions:

- accident or misadventure

- alcohol/drug related

- industrial disease

- lawful killing

- unlawful killing

- natural causes

- open

- road traffic collision
- stillbirth
- suicide

'Alcohol/drug related' and 'road traffic collision' are new terms under the 2009 Act. These short form inquest conclusions will be presented for the first time in the Coroners Statistics 2014 publication, which will be published on 14 May 2015.

Suspension of investigation / adjournment of inquest

Under Schedule 1 to the 2009 Act a coroner must suspend an investigation (and if an inquest has been opened, adjourn that inquest) in the following circumstances:

- If asked to do so by a prosecuting authority because someone may be charged with a homicide or related offence involving the death of the deceased (paragraph 1 of Schedule 1);
- When criminal proceedings have been brought in connection with the death (paragraph 2, based on Section 16 of the 1988 Act);
- Where there is an inquiry under the Inquiries Act 2005 (paragraph 3, based on Section 17A of the 1988 Act);
- If it appears to the coroner that it would be appropriate to do so (paragraph 5).

Other changes in the 2009 Act

The post of the coroner of the Queen's Household was abolished by the 2009 Act. The data for this coroner area therefore covers the period 1 January 2013 to 24 July 2013 only.

Under the 2009 Act the Chief Coroner is required to produce an annual report to the Lord Chancellor. The report will be a statement on the coroner system for the previous calendar year. The report must contain an assessment of consistency of standards between coroner areas; information about investigations that have taken over 12 months to complete; and a summary of reports to prevent future deaths and the responses to these (previously known as Rule 43 reports). The annual report will be published on the Chief Coroner's section of the judiciary website.

Coroners are therefore now required to notify the Chief Coroner of any investigation that lasts more than a year and to notify the Chief Coroner of the date on which any such investigation was subsequently concluded.

For further background information on coroners and a flow-chart detailing the possible outcomes involved when a death is reported to a coroner, please

refer to 'A Guide to Court and Administrative Justice Statistics', which is available at:

www.gov.uk/government/publications/guide-to-court-and-administrative-justice-statistics

A Glossary providing brief definitions for some of the terms used in this bulletin can also be found at the link above.

Related statistics

All deaths in England and Wales must be registered with the Registrar of Births and Deaths. For those deaths where a coroner conducts an inquest, the death will be registered at the conclusion of the inquest, and the cause of death classified according to the conclusion recorded by the coroner. Statistics on registered deaths in England and Wales are published by the Office for National Statistics (ONS) in their series on mortality statistics. These can be accessed from the ONS website at:

www.ons.gov.uk/ons/taxonomy/index.html?nscl=Mortality+Rates

For summaries 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[3] using death registration figures published by ONS. Estimates for 2013 have been calculated using ONS' monthly provisional figures on death registrations, while percentages for 2012 and earlier years have been calculated using final annual death registration figures for the relevant year.

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:

[3] 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 2013 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.

www.gov.uk/government/collections/safety-in-custody-statistics

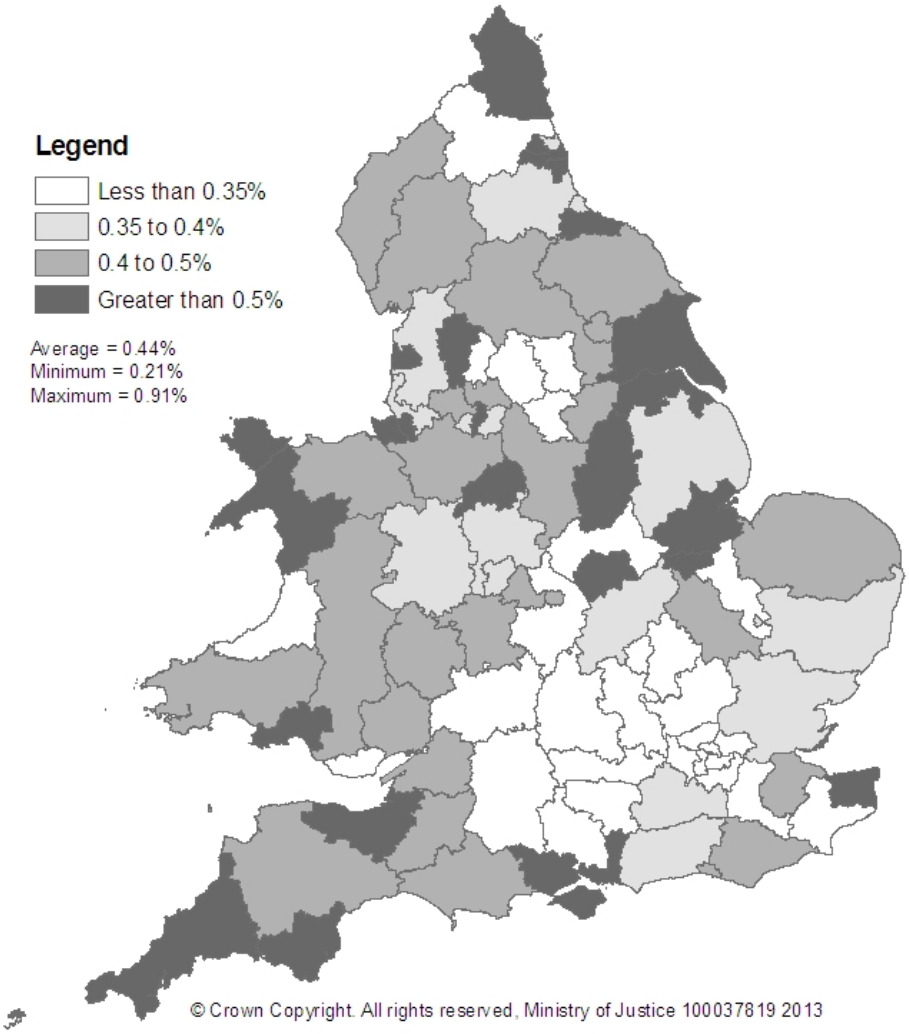
The figures for deaths in custody in this publication relate only to those deaths which have been reported to a coroner and then reported to MoJ, whereas the NOMS publication includes all deaths which have occurred in prison custody and those which occurred whilst the offender was released on temporary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

Deaths reported

The number of deaths reported to coroners in 2013 rose by 263 (less than 1%) from the previous year, from 227,721 in 2012 to 227,984 during 2013, reflecting in part the 1% increase in the number of deaths registered in England and Wales. The proportion of registered deaths in the calendar year 2013 that were reported to coroners in 2013 was an estimated 45%, slightly less than the 46% reported in 2012. This percentage has shown a slight downward trend over the last few years.

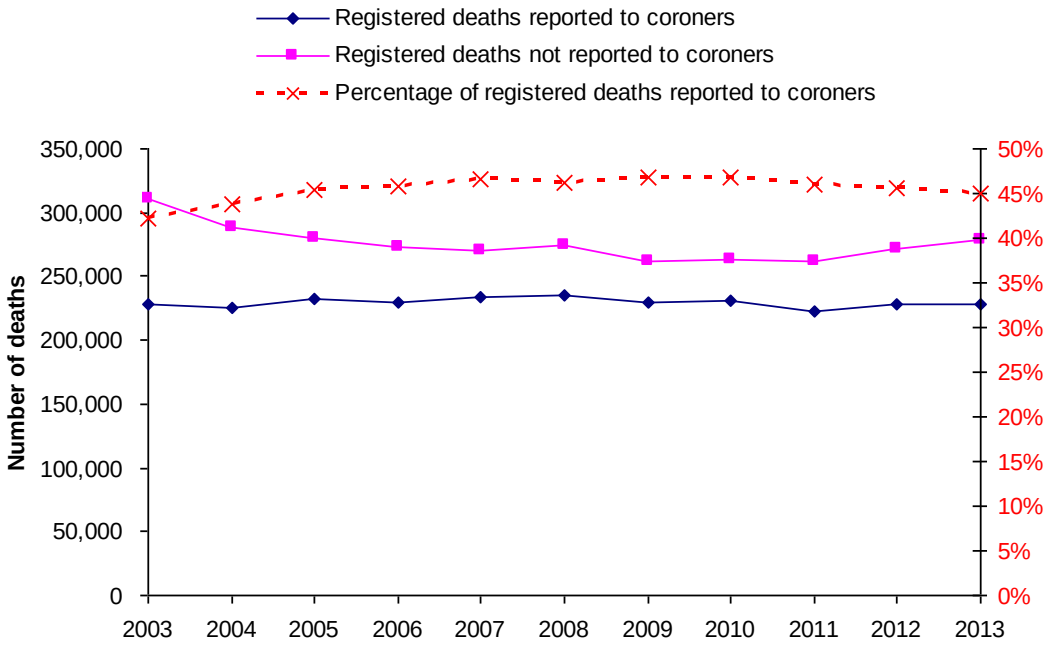
Map 1 below shows deaths reported in each coroner area in 2013 as a percentage of the population[4].

Map 1: Deaths reported to coroners as a percentage of the population, England and Wales, 2013



[4] Population figures are produced by the Office for National Statistics. Figures for 2013 have not yet been published; mid-2012 population estimates produced by the ONS have therefore been used.

Figure 2: Registered deaths and deaths reported to coroners, England and Wales, 2003-2013



Over the last decade, the number of registered deaths in England and Wales has decreased from 539,151 in 2003 to 506,740[5] in 2013; 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% of registered deaths (see Table 2).

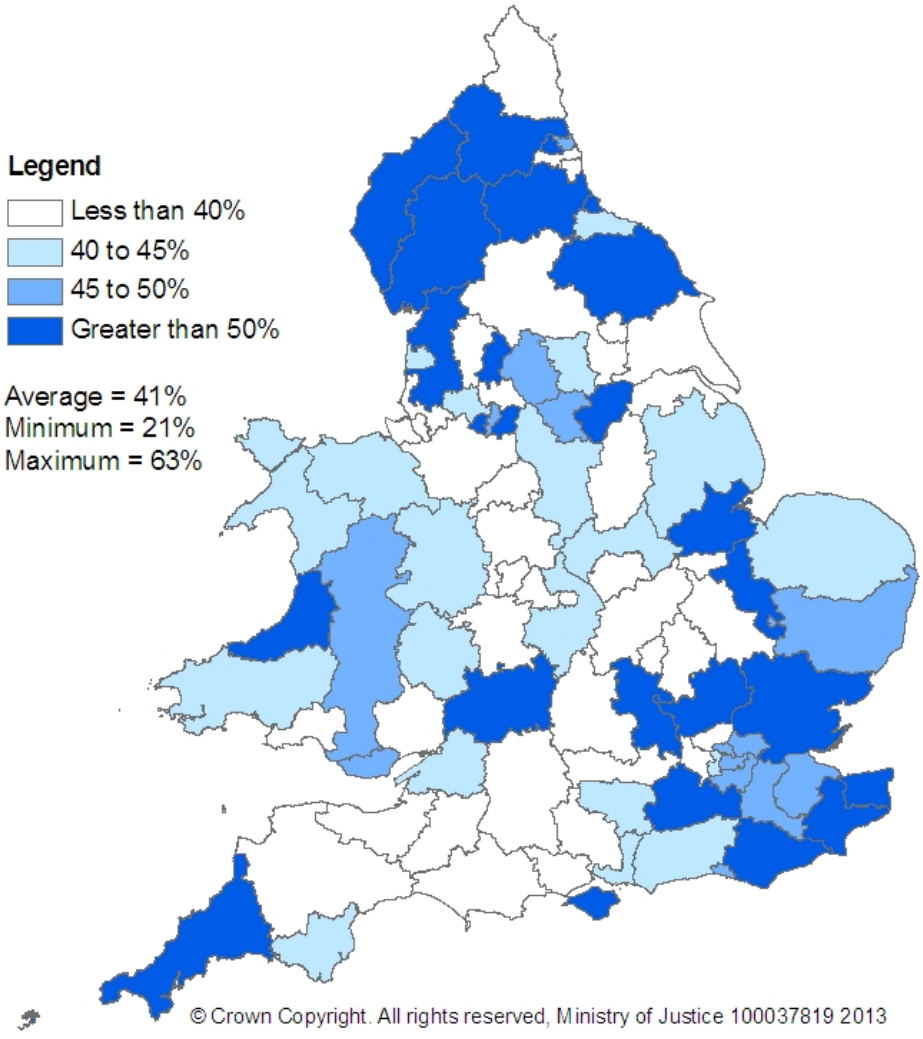
[5] Provisional figure based on ONS monthly death registration figures for 2013

Post-mortem examinations held and inquests opened

The actual number of deaths reported to coroners in 2013 where a post-mortem was held was 94,455, which is 359 less than in the previous year.

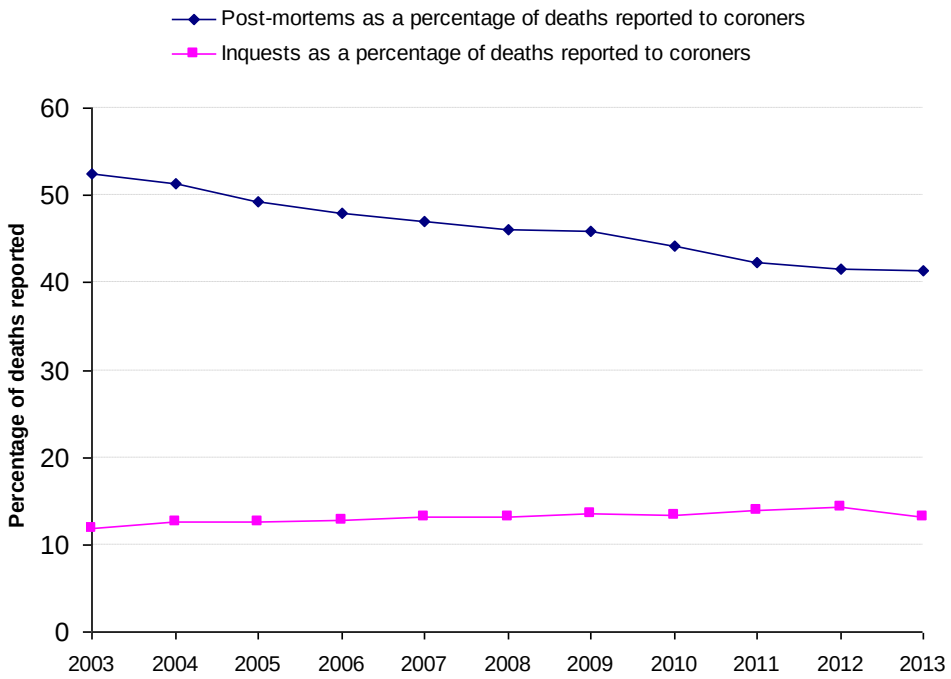
Post-mortem examinations were ordered by coroners in 41% of all cases reported to them in 2013, consistent with the existing downward trend (see Table 3). Over the last ten years the proportion of post-mortems ordered has decreased by 12 percentage points, from 53% to 41%.

Map 2: Post-mortems as a proportion of deaths reported to coroners, England and Wales, 2013



Note: Data for the Isles of Scilly have been excluded from the calculations shown above due to the low caseload in this area

Figure 3: Post-mortems and inquests as a percentage of deaths reported to coroners, England and Wales, 2003-2013



Inquests were opened on 29,942 deaths reported to coroners in 2013, a decrease of 2,600 on 2012. Inquest cases represented 13% of all the deaths reported to coroners in 2013, a small decrease. Over the last ten years the percentage of inquest cases has been relatively stable.

Cases requiring neither an inquest nor a post-mortem

There were 128,702 cases reported to coroners where there was neither an inquest nor a post-mortem. This type of case has generally been increasing in number in recent years (in 2003 there were 106,821 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% in 2003, to 56% in 2013.

Post-mortems in potential inquest cases

Prior to July 2013, cases were either categorised as ‘inquest’ or ‘non-inquest’ cases. Changes in the way coroners are able to conduct an investigation mean that there is now a third category, of ‘potential inquest’ cases. This means that the coroner is investigating the death, but has not yet decided whether it is necessary to hold an inquest. Depending on whether or not the coroner deems it necessary to hold an inquest, these cases will all eventually end up in either the ‘inquest’ or ‘non-inquest’ category. As of 31 December 2013, there were 1,811 potential inquest cases being dealt with by coroners in England and Wales where a post-mortem was held, which comprised 94% of all potential inquest cases. The remaining 6% did not require a post-mortem.

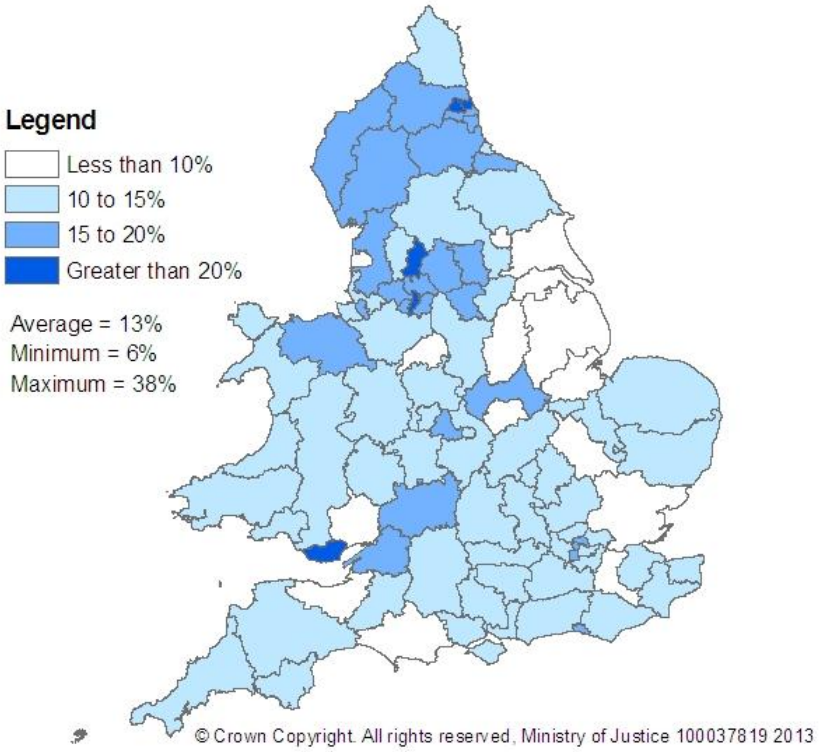
Post-mortems in inquest cases

When an inquest is held a post-mortem examination has usually been conducted. In 2013 the proportion of post-mortems conducted in inquest cases was 84%. This is a lower proportion than in the previous year by three percentage points, and continues a declining trend over the past decade. Historically it was quite rare for an inquest to be held without a post-mortem; however, since 1998 this proportion has been gradually increasing. In 2013 there were 4,721 inquests without a post-mortem, representing 16% of inquest cases, compared to only 5% in 2003.

Post-mortems in non-inquest cases

In the majority (86%) of cases referred to coroners there is no inquest. In 2013 there were 67,423 non-inquest cases where a post-mortem was held, and the percentage of non-inquest cases that required a post-mortem remained at 34%. This proportion has fallen steadily in the last decade; in 2003 it was 47%.

Map 3: Inquests held as a proportion of deaths reported to coroners, England and Wales, 2013



Note: The bands in this map have been created using quartiles and then set to the nearest 5 percentage points. The upper band of 20% has been selected to show the variation in the data.

Post-mortem rates[6], histology[7] and toxicology[8]

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 2013, 95% of post-mortems were ordered at a standard rate, the same proportion as in 2012 (see Table 4).

In 2013, 19,086 post-mortems included histology (20% of post-mortems held), the same percentage as in 2012. In 2013, 13,285 post-mortems held included toxicology (14% of post-mortems held), which was 672 more than in 2012, an increase of one percentage point.

Out of England Orders

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

Coroners issued 5,051 Out of England orders in 2013, compared with 5,030 issued in 2012. In both years the number of orders issued represented just over 2% of the total number of deaths reported to coroners (see Table 5).

Deaths abroad

Of the 227,984 deaths reported to coroners in 2013, some 1,815 (less than 1%) were reports of deaths that had occurred outside England and Wales, the same percentage reported in 2012.

Deaths in Custody

In 2013 a total of 281 deaths were reported to coroners which occurred in state custody[9]; less than 1% of the total number of deaths reported. The highest number (155 or 55% of the total) occurred in Prison custody, followed by 97 (35%) in Mental Health Act detention centres (see Table 6).

---

[6] The fee charged by a pathologist for a standard rate post-mortem is currently £96.80. Non-standard post-mortems cost £276.90.

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

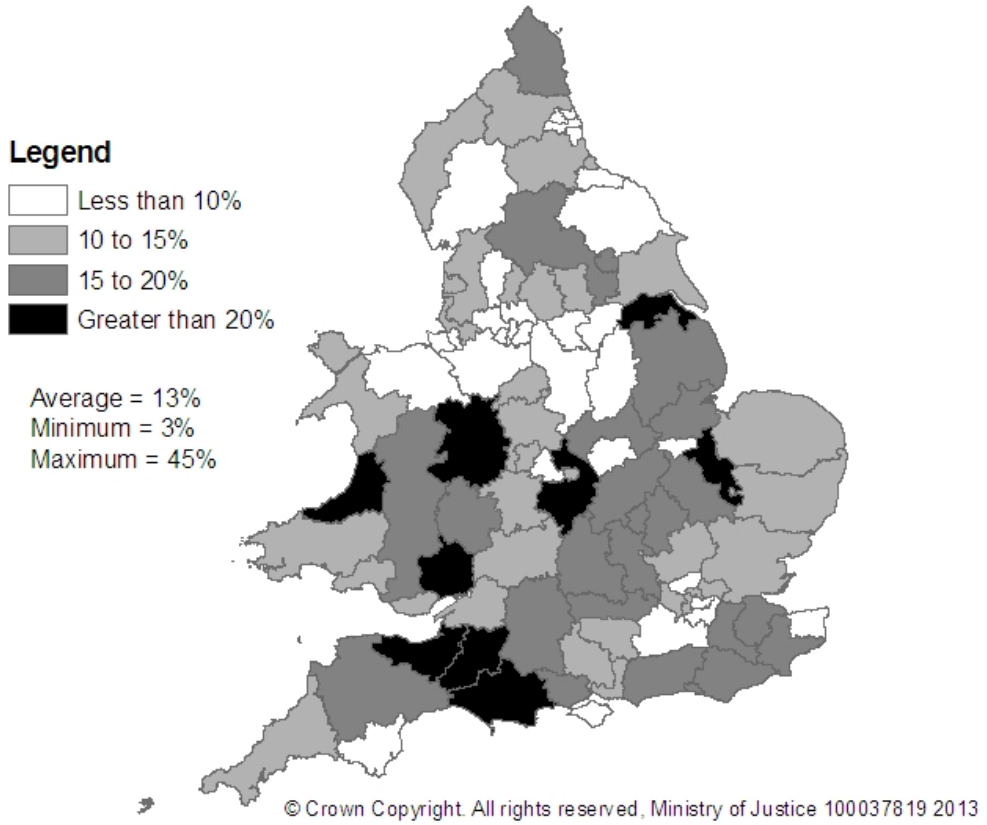
[8] Toxicology in the context of post-mortems is the study of body fluids and tissues for the detection of drugs.

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

Inquest conclusions recorded

Conclusions were recorded at 31,579 inquests in 2013, which was 1,456 more than in 2012, continuing the upward trend. The conclusions recorded in 2013 may relate to cases opened in 2013 or earlier years. The proportion of inquests where a conclusion was recorded also increased, from 97% in 2012 to 98% in 2013. As in previous years the most common conclusions in 2013 were death from natural causes (8,881, or 28%), and death by accident or misadventure (8,166, or 26%). Unclassified conclusions, which include narrative conclusions, represented 17% of the total in 2013, and conclusions of suicide comprised 12% (see Tables 7 and 9). The proportion of suicide conclusions has remained at 12% since 2011. Map 4 shows the percentage of suicide conclusions recorded in each coroner area.

Map 4: Suicide conclusions as a proportion of all inquest conclusions, England and Wales, 2013



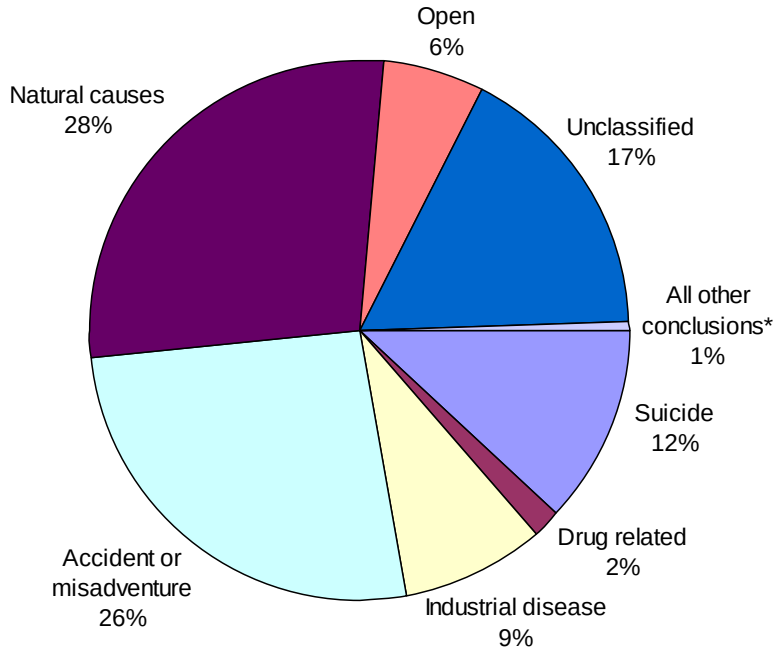
Unclassified conclusions saw the largest rise in terms of numbers; an increase of 709 (15%) from 4,634 in 2012 to 5,343 in 2013.[10] The rise in unclassified conclusions is partly due to the increasing use of what are known as 'narrative

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

conclusions' by some coroners. A narrative conclusion is where, instead of a conventional conclusion, 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 conclusions, this category includes short non-standard conclusions which a coroner or jury might return when the circumstances do not easily fit any of the standard conclusions.

The unclassified conclusions category also includes any conclusions of 'Alcohol/Drug related' and 'Road traffic collision' which were recorded by coroners in the period July to December 2013.[11]

Figure 4: Conclusions recorded at inquest, by category, England and Wales, 2013[12]



*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

Conclusions of death from natural causes have risen steadily over the last two decades, and since 2010 this category has comprised the highest number of deaths reported. There is a steady and steeper rise in the number of unclassified conclusions, and a long-term downward trend in the number of conclusions of accidental death.

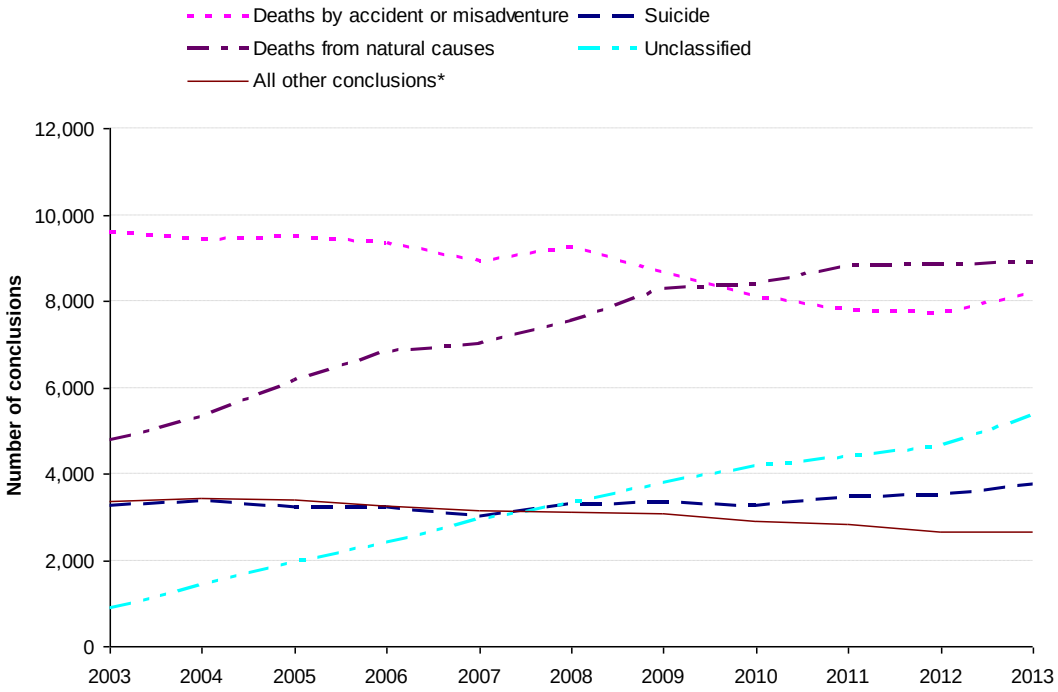
There are four main trends regarding the proportion of conclusions recorded by coroners over the last decade:

[11] Please note that next year's publication will include the new short-form conclusions (which were introduced in July 2013) shown separately. For further information please see the Introduction.

[12] Figures may not equal 100% due to rounding.

- conclusions of death from natural causes have risen steadily from 20% in 2003 to 28% in 2013;
- unclassified conclusions (which include narratives, as explained above) formed 4% of the total in 2003, but have since risen steadily to account for over 17% of conclusions in 2013;
- conclusions of death by accident or misadventure have been declining steadily, from 40% of conclusions in 2003 to 26% in 2013;
- open conclusions have been declining over the same period, particularly over the last few years, they accounted for just over 6% of the total in 2013 compared with 11% in 2003.

Figure 5: Number of conclusions recorded at inquests, England and Wales, 2003-2013



*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.

Differences in conclusions recorded by sex

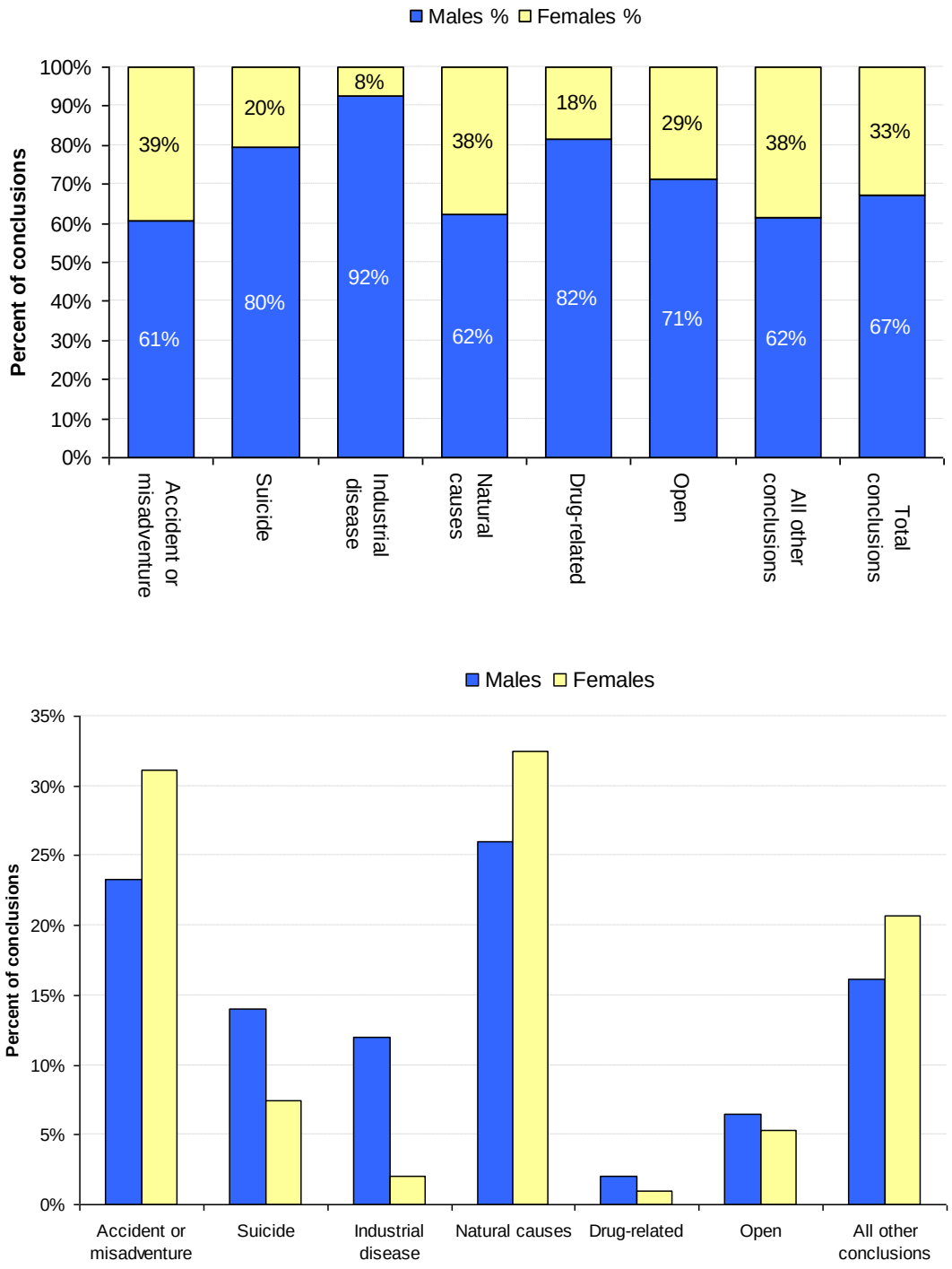
The pattern of conclusions differs between males and females. Male deaths accounted for about 67% of all conclusions recorded in 2013, however they accounted for 54% of deaths reported; suggesting males are more likely to die in circumstances that lead to an inquest. Female deaths accounted for about 33% of all conclusions recorded in 2013 (and 46% of deaths reported).

- Of the 3,754 conclusions of suicide, 80% were for males and 20% for females;

- Of the 1,920 open conclusions, 71% were for males and 29% for females; and

- 38% of the 8,881 conclusions of death from natural causes were for females, the remaining 62% were for males.

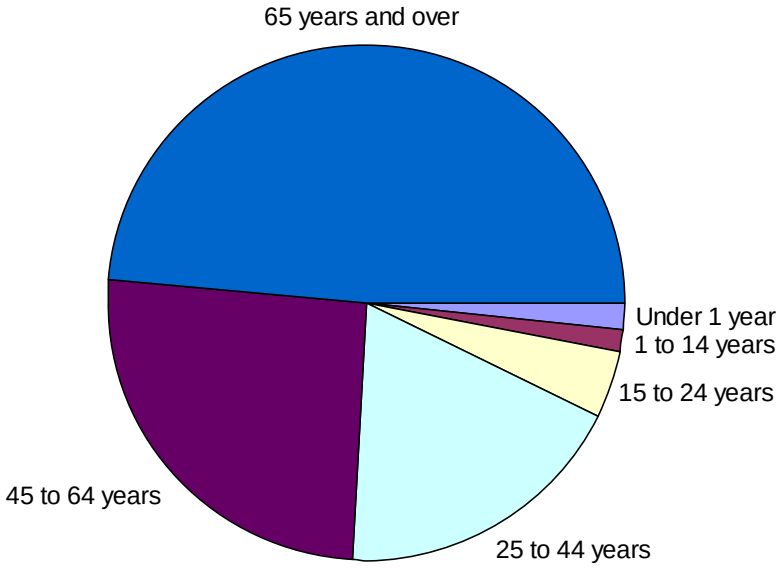
Figure 6: Conclusions recorded at inquests by sex, England and Wales, 2013



Age of deceased in inquests where a conclusion was recorded

Since 2008, coroners have been asked to provide information (in summary form) on the ages of persons whose deaths proceeded to inquest and a conclusion recorded during the year. Of the inquests completed in 2013, 49% were on persons who were aged 65 years or over at death. Less than 8% of inquests concluded were into deaths of persons aged under 25 (see Table 8). Although an age breakdown of registered deaths in England and Wales in 2013 is not yet available, ONS figures for 2012 show that 84% of registered deaths in England and Wales were persons aged 65 or over, with only 1% aged under 25 years old.

Figure 7: Age of deceased in inquests where a conclusion was recorded, England and Wales, 2013



Inquests with juries, and adjourned inquests

The number of inquests held with juries in 2013 was 456 (representing just 1% of all inquests), and a decrease of 16 compared to 2012. Both the number and proportion of inquests held with juries showed a downward trend until recent years but the trend appears now to have stabilised, with the proportion remaining between 1% and 2% for the last five years (see Table 10).

In 2013, 728 inquests (representing 2% of all inquests concluded) were adjourned (and not resumed) by the coroner under Schedule 1[13] of the Coroners and Justice Act 2009 because criminal proceedings took place. This is slightly less than the proportion of adjourned inquests in recent years, which had remained at around 3% since 2006.

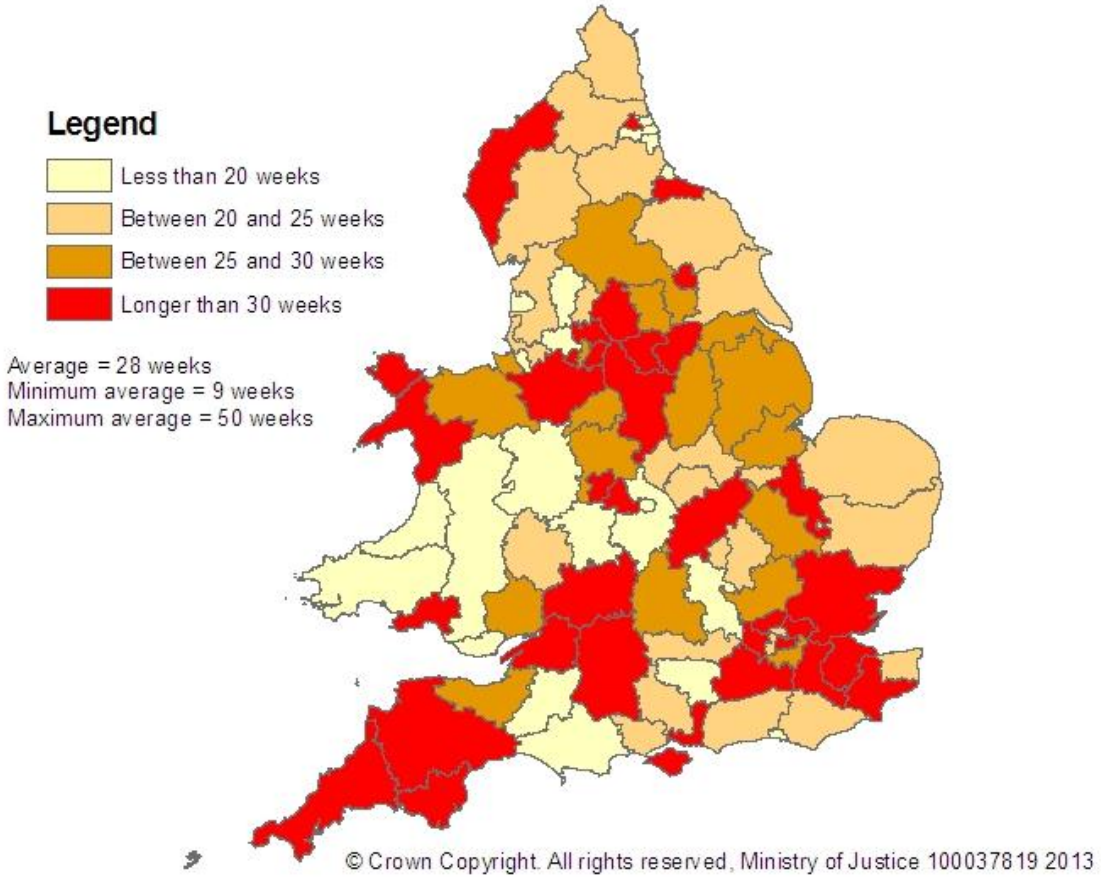
[13] Schedule 1 of the Coroners and Justice Act 2009 states that the coroner should adjourn an inquest in the event that criminal proceedings may or will take place.

Time taken to process an inquest

The estimated[14] average time taken to process an inquest in 2013 (defined as being from the date the death was reported until the conclusion of the inquest) was 28 weeks, which is an increase from the 2012 average of 26 weeks (see Table 10). Only deaths occurring within England and Wales are included in this estimation. Over the last five years, the average time has remained in the range 26 to 28 weeks. More information about how the average time has been estimated can be found in the Explanatory Notes section.

The maximum average time taken to process an inquest in 2013 was 50 weeks, and the minimum average time was 9 weeks. The average time taken has a relatively large range of 41 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, 2013



[14] A direct average of the time taken to process an inquest cannot be calculated from the summary data collected; an estimate has been made instead. Please see 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 2013, 789 finds were reported and 362 inquests were concluded, from which a verdict declaring a find to be treasure was returned in 337 cases (see Table 11). There were 4 inquests held into Treasure Trove in 2013 (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.

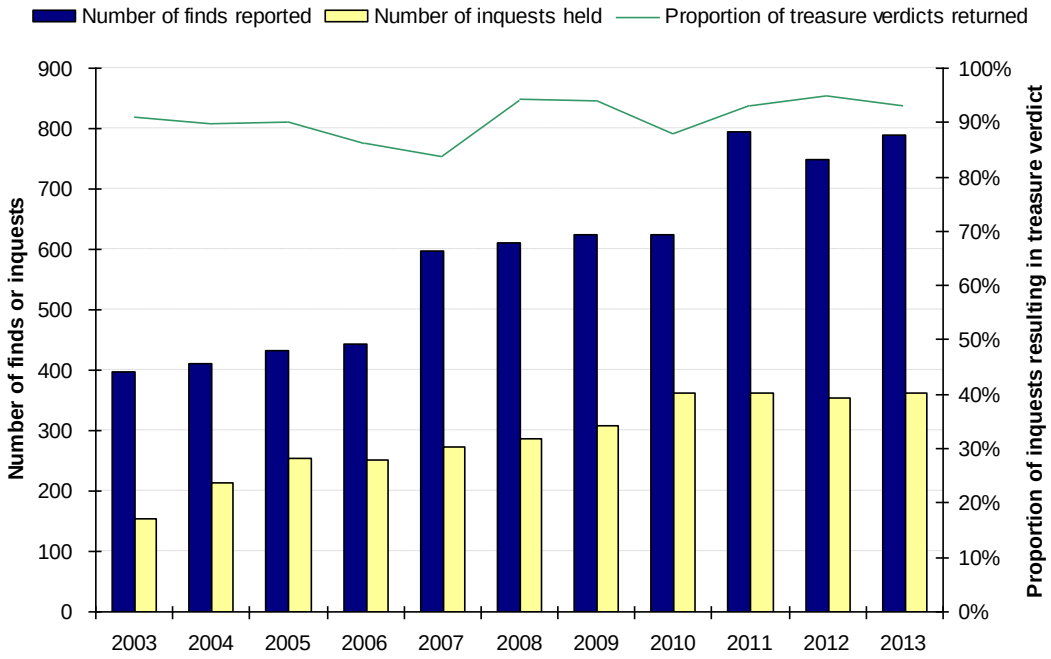
The number of finds reported has been steadily increasing over the last ten years, and in 2013 there was a slight increase of 5% compared to 2012.

There were 337 verdicts of treasure in 2013, exactly the same as the number recorded in 2012. The proportion of treasure inquests which resulted in a verdict of treasure dropped from 95% in 2012 to 93% in 2013.

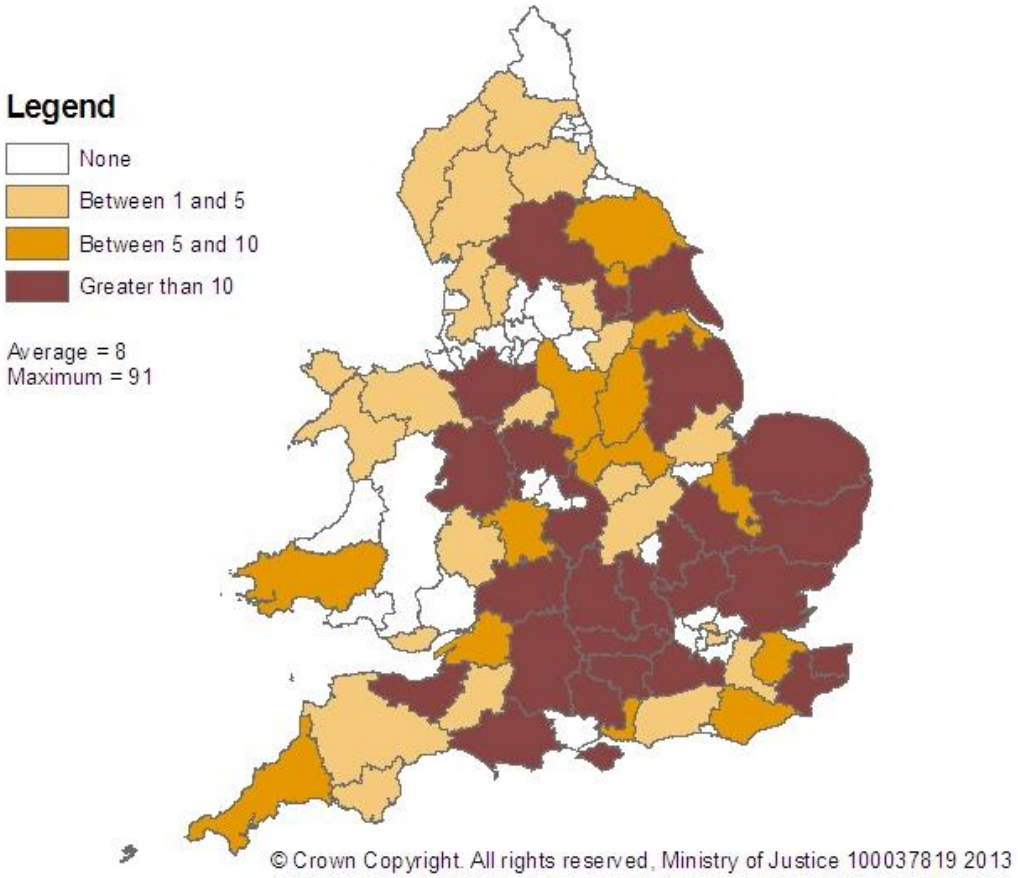
An annual report on the operation of the Treasure Act 1996 is published by the Department for Culture, Media and Sport. For more information please see:

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

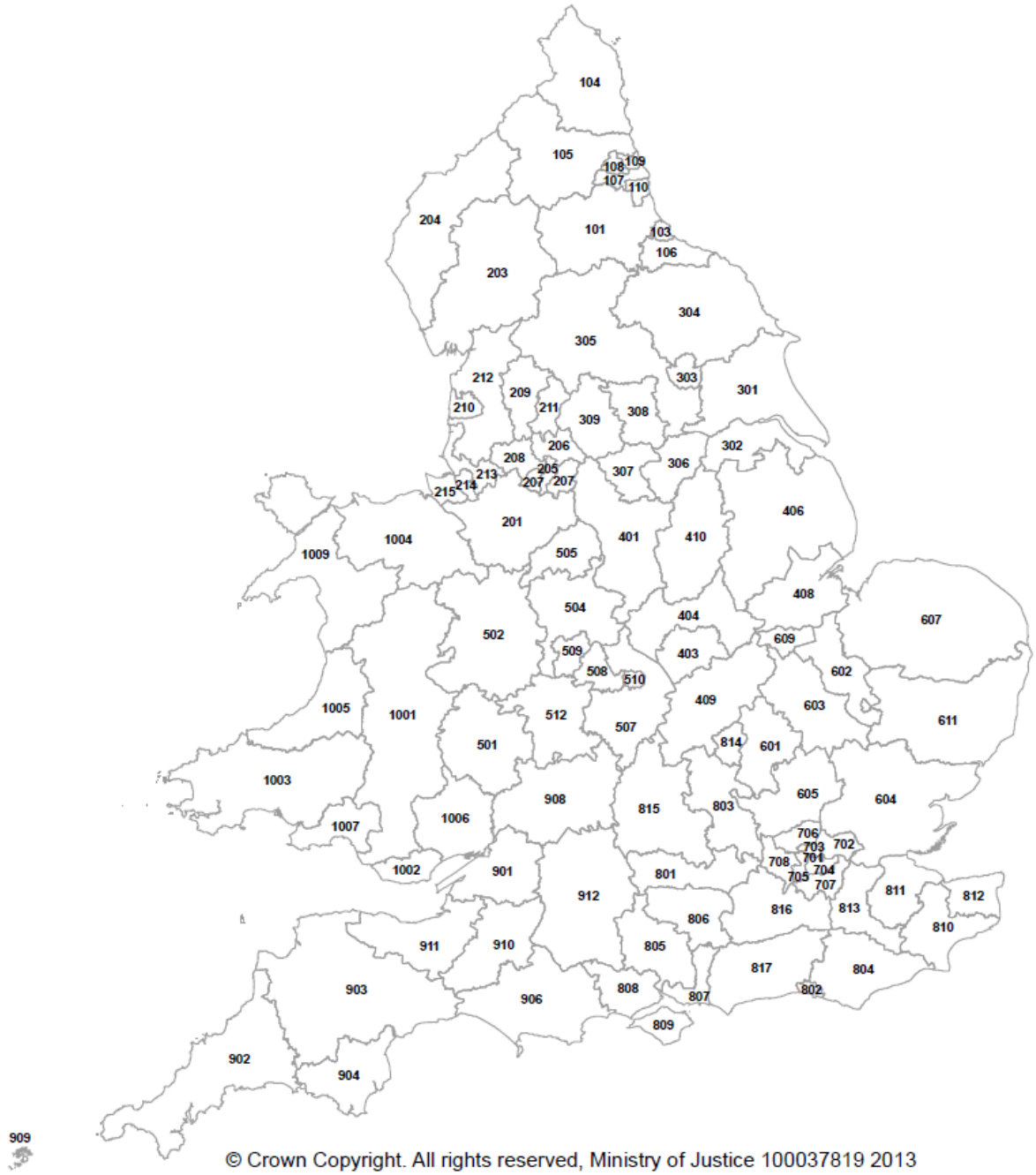
Figure 8: Finds reported to coroners, treasure inquests held under the Treasure Act, and proportion of treasure verdicts returned, 2003-2013



Map 6: Number of treasure finds reported to coroners, England and Wales, 2013



Annex A: Map of coroner areas in England and Wales, 2013



Key to coroner areas

North East

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

North West
201 – Cheshire
203 – South and East Cumbria
204 – North and West Cumbria
205 – Manchester (city)
206 – Manchester North
207 – Manchester South
208 – Manchester West
209 – Blackburn, Hyndburn and Ribble Valley
210 – Blackpool and Fylde
211 – East Lancashire
212 – Preston and West Lancashire
213 – Sefton, Knowsley and St Helens
214 – Liverpool
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 Derbyshire
403 – Leicester and South Leicestershire
404 – North Leicestershire and Rutland
406 – Central Lincolnshire
408 – South Lincolnshire
409 – Northamptonshire
410 – Nottinghamshire

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

East of England
601 – Bedfordshire and Luton
602 – North and East Cambridgeshire
603 – South and West Cambridgeshire
604 – Essex
605 – Hertfordshire
607 – Norfolk
609 – Peterborough
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, Torbay and South Devon
906 – Dorset
908 – Gloucestershire
909 – Isles of Scilly
910 – Eastern Somerset
911 – Western Somerset
912 – Wiltshire and Swindon

Wales
1001 – Powys, Bridgend and Glamorgan Valleys
1002 – Cardiff and Vale of Glamorgan
1003 – Carmarthenshire and Pembrokeshire
1004 – North Wales (East and Central)
1005 – Ceredigion
1006 – Gwent
1007 – Swansea and Neath Port Talbot
1009 – North West Wales

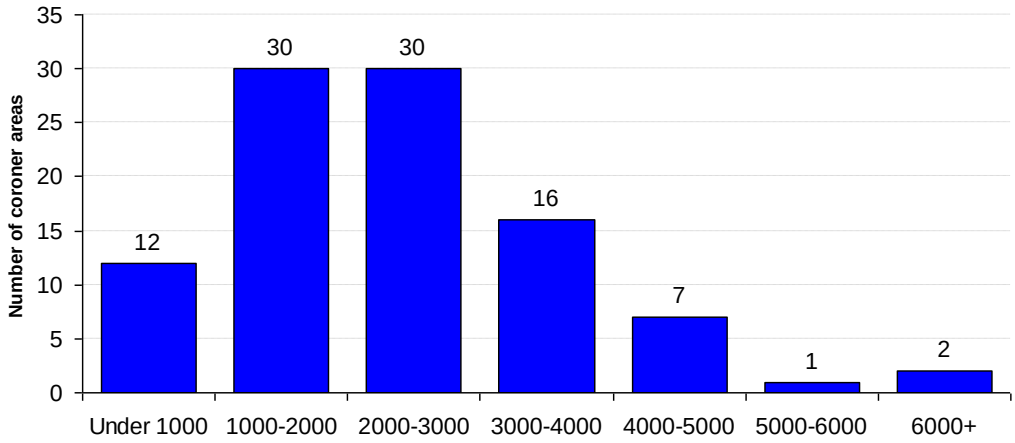
Annex B: Details of coroner area amalgamations in 2013

Date effective	County	Previous coroner areas	New coroner area	Nature of merge
01-Jan-13	Denbighshire	Central North Wales; North East Wales	North Wales (East and Central)	2 into 1
26-Jul-13	Wales	Carmarthenshire; Pembrokeshire	Carmarthenshire and Pembrokeshire	2 into 1
	Durham	Darlington and South Durham; North Durham	County Durham and Darlington	2 into 1
	Derbyshire	Derby and South Derbyshire; North Derbyshire	Derby and Derbyshire	2 into 1
	Dorset	Bournemouth, Poole and Eastern Dorset; Western Dorset	Dorset	2 into 1
	Essex	Essex and Thurrock; Southend-on-Sea	Essex	2 into 1
	Devon	Plymouth and South West Devon; Torbay and South Devon	Plymouth, Torbay and South Devon	2 into 1
	Shropshire	Mid and North Shropshire; South Shropshire; Telford & Wrekin	Shropshire, Telford and Wrekin	3 into 1
	Wales	Bridgend and Glamorgan Valleys; Powys	Powys, Bridgend and Glamorgan Valleys	2 into 1
	Wales	Neath and Port Talbot; City and County of Swansea	Swansea and Neath Port Talbot	2 into 1

Annex C: Further analysis on number and proportion of deaths reported to coroners[15]

The number of deaths reported to coroners in 2013 varied within the range of 8 (Isles of Scilly) to 6,373 (Essex). In addition to Essex, over 6,000 deaths were also reported in the Nottinghamshire coroner area (6,252).

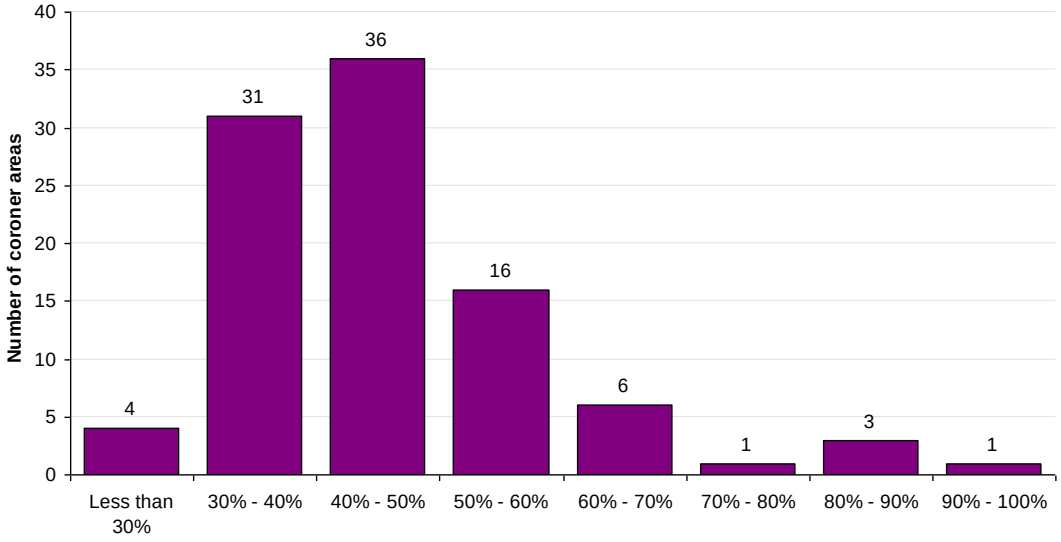
Figure C1: Number of deaths reported to coroners, 2013



[15] Data for the City of London has been excluded from this analysis due to the small size of this coroner area. The total number of coroner areas shown in Figures C1 and C2 is therefore 98.

The number of deaths reported to coroners in 2013 as a proportion of registered deaths varied within the range 20% (South Northumberland) to over 99% (Blackburn, Hyndburn and Ribble Valley).

Figure C2: Deaths reported to coroners in 2013 as a proportion of registered deaths[16]



[16] Provisional figure based on ONS monthly death registration figures for 2013

Explanatory notes

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

Designation can be broadly interpreted to mean that the statistics:

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

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

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

Quality and consistency of the statistics

The figures presented in this report are collected via statistical returns completed by coroners. For the calendar year 2013, returns were received from all 100 coroner areas electronically. The process by which coroners provide their returns can vary according to the case management system they use. Many coroners (97%) 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. 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 area 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 areas 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 2012 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. Please note that the figure for deaths reported to coroners in 2009 in Table 2 has been amended, as the incorrect figure was included in the 2012 publication.

Please also note that the 2012 figures for ‘No inquest, no post-mortem’ and ‘Total non-inquest cases, inc. NFA’ in Table 3 have been corrected to include cases where the sex of the deceased was unknown; which were missing in the 2012 publication.

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 rounded quartiles.

Further notes

Prior to 1 June 2005, policy responsibility for 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

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)".

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, along with the CSV file and the Coroners Statistical Tool spreadsheet.

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

Tel: 020 3334 3535

Email: philippa.silverman@justice.gsi.gov.uk

Other enquiries about these statistics should be directed to:

Caroline Nauth-Misir

Ministry of Justice

7th Floor (7.06)

102 Petty France

London

SW1H 9AJ

Tel: 020 3334 3111

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.

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