

# **Coroners Statistics 2014 England and Wales**

Ministry of Justice  
Statistics bulletin

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## Introduction

This annual bulletin presents statistics of deaths reported to coroners in England and Wales in 2014. Information is provided on the number of deaths reported to coroners, post-mortem examinations, inquests opened, and inquests concluded. 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](http://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 up to four 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 bulletin provides information about statistical revisions, and the symbols and conventions used.

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

### **The legislation**

Coroner services in England and Wales are governed by Part 1 of the Coroners and Justice Act 2009 (the 2009 Act), as well as the rules and regulations made under it. The 2009 Act came into force in July 2013, largely replacing the Coroners Act 1988<sup>1</sup> (the 1988 Act).

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

[www.legislation.gov.uk/ukpga/2009/25/contents](http://www.legislation.gov.uk/ukpga/2009/25/contents)

[www.legislation.gov.uk/2013?title=coroners](http://www.legislation.gov.uk/2013?title=coroners)

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<sup>1</sup> The Coroners Act 1988 was repealed in July 2013 with the exceptions of section 13 (application for a fresh coroner investigation or inquest) and 4A(8) (a coroner in Wales being regarded as a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 post of Chief Coroner to provide judicial oversight of the coroner system and leadership, guidance and support to coroners. The Chief Coroner's main statutory responsibilities are to:

- approve all coroner appointments (along with the Lord Chancellor);
- keep a register of coroner investigations lasting more than 12 months;
- collate, monitor and publish coroners' reports to authorities to prevent future deaths; and
- give the Lord Chancellor an annual report, which is published and laid before Parliament (see 'Chief Coroner's annual report' section below).

On 8 April 2015, it was announced that the Lord Chief Justice, after consultation with the Lord Chancellor, has extended the term of office of His Honour Judge Peter Thornton QC as Chief Coroner of England and Wales to 1 October 2016.

Further information on the Chief Coroner is available at:

[www.judiciary.gov.uk/about-the-judiciary/office-chief-coroner](http://www.judiciary.gov.uk/about-the-judiciary/office-chief-coroner)

## **Coroner areas and structure**

Under the 2009 Act, each coroner area has one senior coroner, and one or more assistant coroners. A coroner area may also have an area coroner (who may function as a deputy to the senior coroner).

For information on changes to coroner areas, please see Annex B.

## **Investigations**

Under the 2009 Act, a coroner conducts an 'investigation' into a death (which may or may not include an inquest). Much of the coroner's investigation takes place before any formal inquest hearing, and includes the coroner considering whether the duty to hold an inquest applies to an individual case.

A coroner has a duty 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 is held for all deaths in custody or state detention. An inquest with a jury is held 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 not 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**

At the end of an inquest, the coroner (or jury if applicable) completes a form entitled 'Record of an inquest'. This form documents the 'conclusion' of the coroner or jury as to who died and how, when, and where they died.<sup>2</sup>

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<sup>3</sup>:

- accident or misadventure
- alcohol/drug related
- industrial disease

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<sup>2</sup> The 1988 Act term 'verdict' was replaced by the 2009 Act term 'conclusion'.

<sup>3</sup> 'Alcohol/drug related' and 'road traffic collision' are new short form inquest conclusions under the 2009 Act, which came into effect from 2013. They have been presented for the first time in this publication.

- lawful killing
- unlawful killing
- natural causes
- open
- road traffic collision
- stillbirth
- suicide

### **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 of Schedule 1) ;
- Where there is an inquiry under the Inquiries Act 2005 (paragraph 3 of Schedule 1);
- If it appears to the coroner that it would be appropriate to do so (paragraph 5 of Schedule 1).

### **Chief Coroner's annual report**

The Chief Coroner's annual report to the Lord Chancellor is a statement on the coroner system for the previous calendar year. It 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 is published on the Chief Coroner's section of the judiciary website. The Chief Coroner's first annual report was published in July 2014<sup>4</sup>.

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.

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<sup>4</sup> [www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/chief-coroners-annual-report-2013-14/](http://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/chief-coroners-annual-report-2013-14/)

## Further information

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 Civil and Administrative Justice Statistics', which is available at:

[www.gov.uk/government/statistics/guide-to-civil-and-administrative-justice-statistics](http://www.gov.uk/government/statistics/guide-to-civil-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](http://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](http://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<sup>5</sup> using death registration figures published by ONS. Estimates for 2014 have been calculated using ONS' monthly provisional figures on death registrations, while percentages for 2013 and earlier years have been calculated using final annual death registration figures for the relevant year.

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<sup>5</sup> 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 2014 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.

This publication includes figures for deaths which occurred in state custody. Statistics on deaths in prison custody are also published by the National Offender Management Service (NOMS), accessible via the following link:

[www.gov.uk/government/collections/safety-in-custody-statistics](http://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 for medical reasons.



## Executive Summary

### Key Findings

- 223,841 deaths were reported to coroners in 2014, a decrease of 4,143 (2%) from 2013, reflecting in part the fall in the number of registered deaths<sup>6</sup> from 2013 to 2014 (down 1%).
- Just under half (45%) of all registered deaths<sup>6</sup> were reported to coroners in 2014, the same level as seen in 2013. Over the last ten years this proportion has been relatively consistent, within the range of 45% to 47%.
- The number of inquests opened in 2014 reduced by 14% to 25,889, which coincide with the Coroners Act 2009 coming into effect in July 2013. This means coroners can now conduct a brief investigation prior to deciding whether an inquest should take place.
- Post-mortem examinations were ordered by coroners in 40% of all cases reported to them in 2014, down by one percentage point since 2013 and consistent with the long-term downward trend. Since 1995, the proportion of post-mortems ordered has decreased by 21 percentage points, from 61% to 40%.
- In 2014, the proportion of post-mortems conducted in inquest cases was 76%, down eight percentage points on 2013. Following the implementation of the Coroners Act 2009 in July 2013, coroners are allowed to hold post-mortems as part of a brief investigation before deciding if an inquest needs to be opened which may account for the drop in the figures.
- Despite a fall of 8% in the total number of conclusions recorded (in part due to the fall in the number of deaths reported to coroners), the number of suicide conclusions in 2014 has increased by almost 3% from 2013 and has been steadily rising since 2007.
- Just three of the ten possible inquest conclusion short forms account for almost 62% of all conclusions recorded (accident and misadventure: 27%, unclassified: 18% and natural causes: 17%).
- Between 2010 and 2013, 'natural causes' was the most commonly used inquest conclusion - however compared with 2013, the number of natural causes fell by 45% in 2014. This may partly be due to the decrease in the number of cases reported to coroners, but in addition, may also be due to the Coroners Act 2009 coming into effect in July 2013. This means that coroners can now issue a death certificate without holding an inquest when it is known that a death has occurred naturally.
- The estimated average time taken to process an inquest in 2014 (from the date the death was reported until the conclusion of the inquest, where the death occurred in England and Wales) was 28 weeks, with a minimum of 3 weeks and maximum 53 weeks across coroner areas.

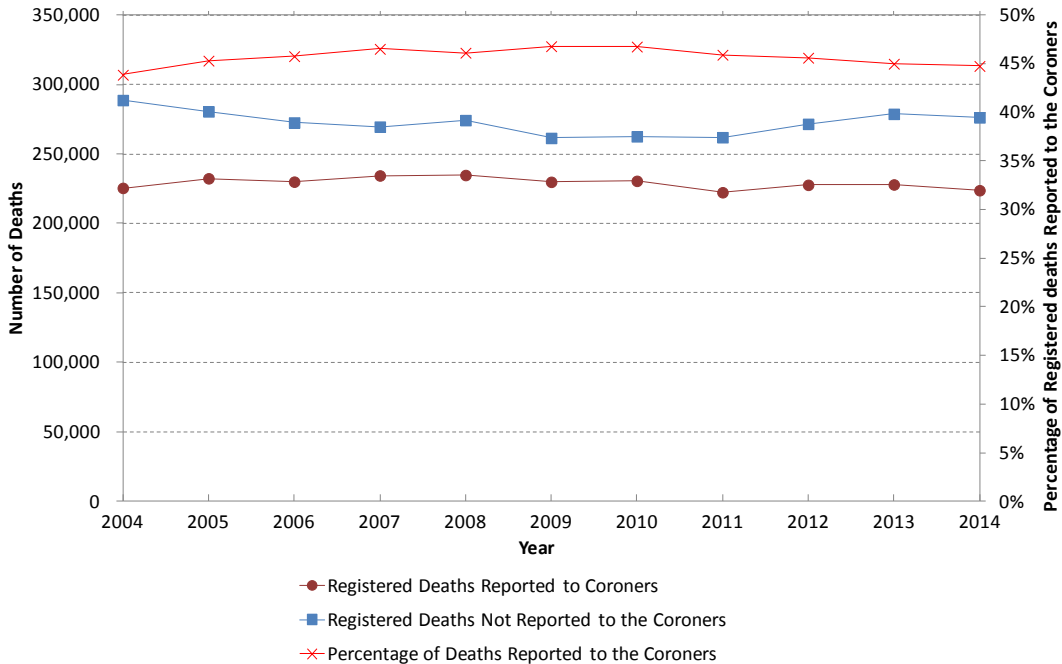
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<sup>6</sup> A provisional figure for the number of registered deaths in England and Wales has been used, derived from monthly figures produced by the Office for National Statistics.

## Deaths reported

The number of deaths reported to coroners in 2014 fell by 4,143 (2%) from the previous year - from 227,984 in 2013 to 223,841 in 2014 which reflects in part the decrease in the number of deaths registered in England and Wales (down 1%). The proportion of registered deaths in 2014 that were reported to coroners was an estimated 45%, no change from 2013 and stabilising the slight downward trend seen over the last few years.

**Figure 1: Registered deaths and deaths reported to coroners, England and Wales, 2004-2014**



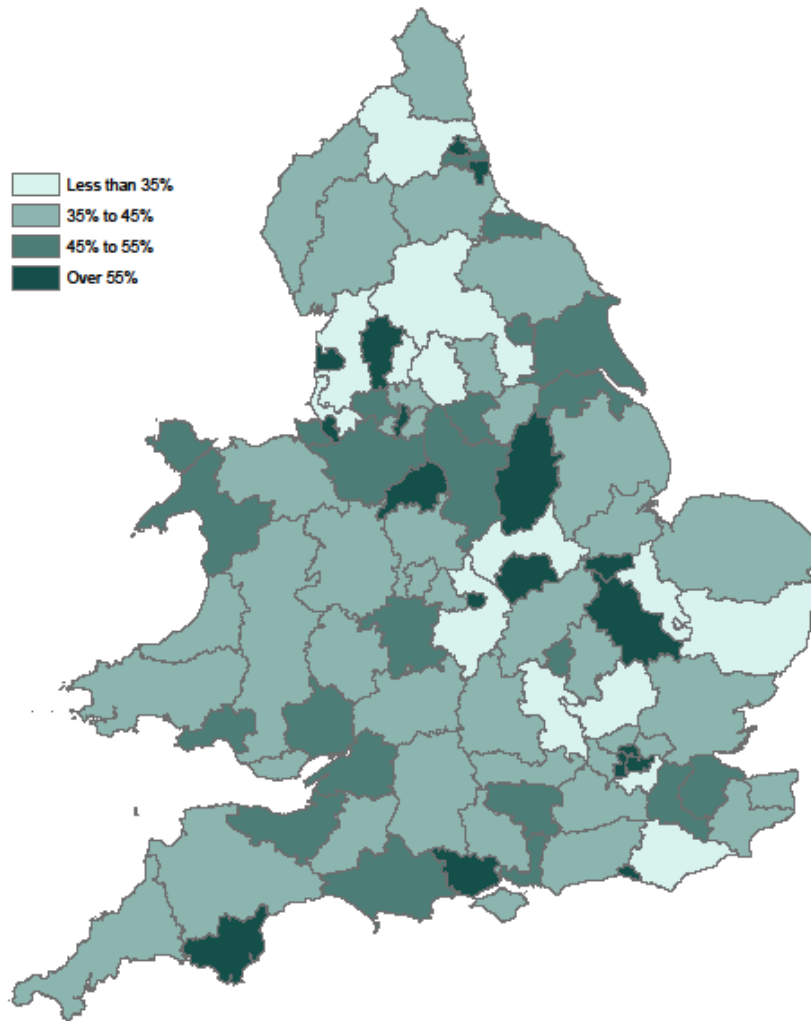
Over the last decade, the number of registered deaths in England and Wales has decreased from 512,993 in 2005 to 500,122<sup>7</sup> in 2014; however the number has fluctuated in recent years. The number of deaths reported to coroners has also fluctuated over the last ten years with 232,401 deaths reported in 2005, rising to a high of 234,784 in 2008. The figure then fell to 222,371 in 2011, rising briefly to 227,984 in 2013 before falling to 223,841 in 2014.

Map 1 below shows deaths reported in each coroner area in 2014 as a percentage of the total deaths in each area<sup>8</sup>.

<sup>7</sup> Provisional figure based on ONS monthly death registration figures for 2014

<sup>8</sup> The reported deaths figure for 2014 is provisional, based on ONS monthly death registration figures

**Map 1: Deaths reported to coroners as a percentage of total deaths in each area, England and Wales, 2014<sup>9</sup>**



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The proportion of deaths reported to the coroner varies from 24% in Hartlepool and North and East Cambridgeshire to 96% in Blackburn, Hyndburn and Ribble Valley<sup>10</sup>.

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<sup>9</sup> Map does not include the Isles of Scilly due to small numbers.

<sup>10</sup> The ONS death registration figures are based on area of usual residence whereas the coroners' figures are based on the area where a person died. Therefore the coroner office for the City of London may show a distorted figure of 264% due to the low levels of residence and high level of commuters.

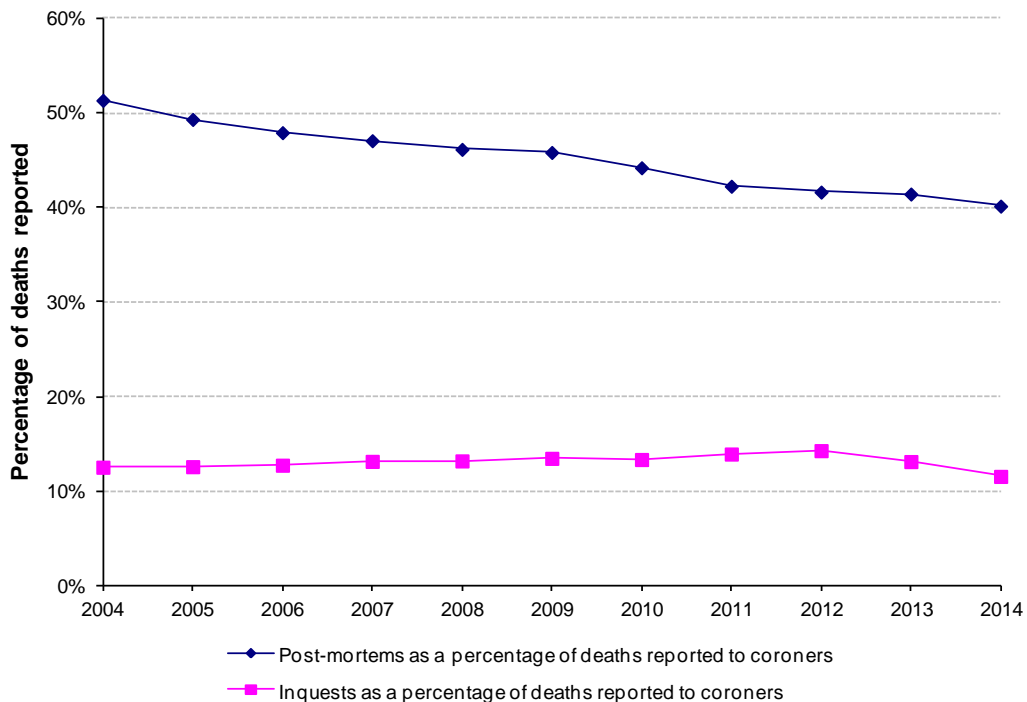
## Post-mortem examinations held and inquests opened

Post-mortems were held for 89,875 deaths reported to coroners in 2014, down 4,580 (5%) from 2013.

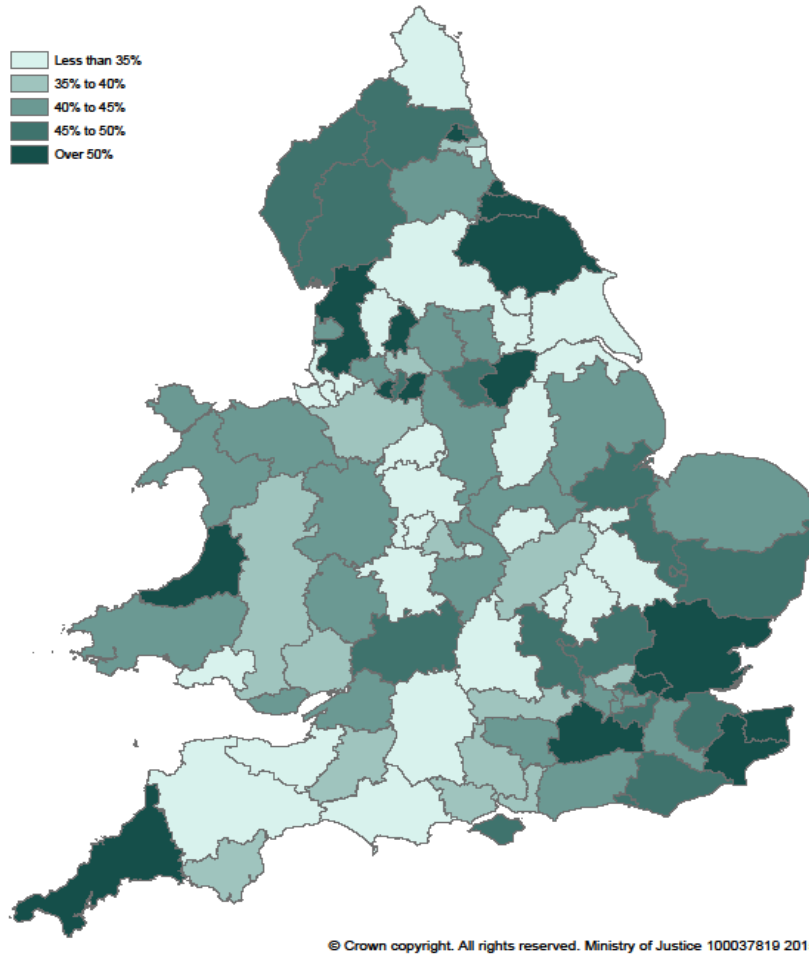
Post-mortem examinations were ordered by coroners in 40% of all cases reported to them in 2014, down by one percentage point from 2013, and consistent with the existing long-term downward trend. Since 1995, the proportion of post-mortems ordered has decreased by 21 percentage points, from 61% to 40% (see Table 3).

Inquest cases represented 12% of all the deaths reported to coroners in 2014, a decrease of 1 percentage point from 2013. Although this difference in proportion seems small, the actual number of inquests that were opened in 2014 fell 14% to 25,899 compared to 2013. In July 2013, the Coroners Act 2009 came into effect which allowed coroners to conduct a brief investigation prior to making a decision on whether an inquest should be opened. This allowed coroners to close cases without having to hold an inquest.

**Figure 2: Post-mortems and inquests as a percentage of deaths reported to coroners, England and Wales, 2004-2014**



**Map 2: Post-mortems held as a proportion of deaths reported to coroners, England and Wales, 2014<sup>11</sup>**

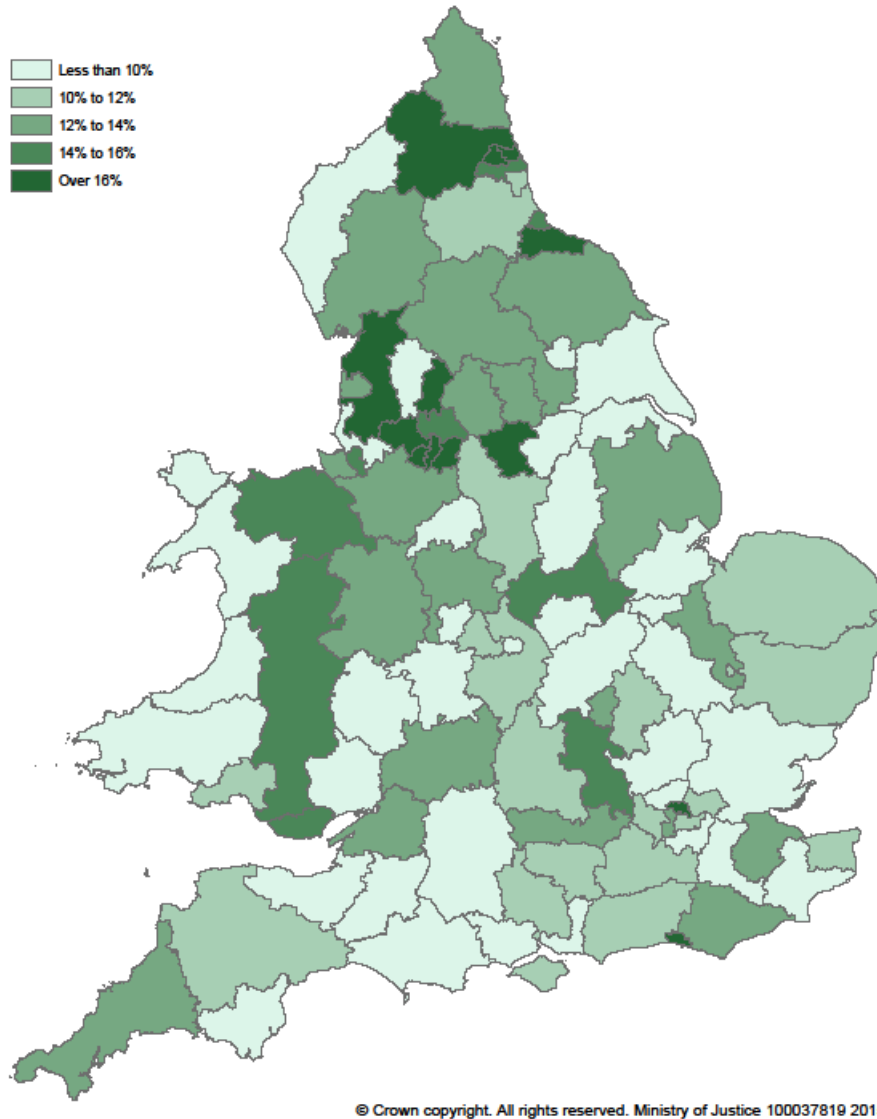


The proportion of post mortems carried out varies from 22% in the Wirral to 62% in North East Kent.

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<sup>11</sup> Map does not include Isles of Scilly due to small numbers

**Map 3: Inquests opened as a proportion of deaths reported to coroners, England and Wales, 2014<sup>12</sup>**



**The proportion of inquests carried out varies from 5% in Gwent to 22% in City of London.**

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<sup>12</sup> Map does not include Isles of Scilly due to small numbers

### **Post-mortems in inquest cases**

When an inquest is opened, a post-mortem examination has usually been conducted. In 2014, around three quarters of inquest cases involved a post-mortem, down eight percentage points on 2013 continuing the declining trend seen over the past decade (from 94% in 2005). Historically it was quite rare for an inquest to be opened without a post-mortem; however, since 1997 this proportion has been gradually increasing, with a sharp increase seen this year (from 16% to 24% of all inquest cases in 2013 and 2014 respectively) which may be attributed to the provisions in the Coroners Act 2009 which came into effect in July 2013, allowing a coroner to conduct a brief investigation (including a post mortem) prior to making a decision on whether to hold a formal inquest. These are captured in the potential inquest cases below.

### **Post-mortems in non-inquest cases**

In the majority (87%) of cases referred to coroners, there is no inquest. In 2014 there were 67,108 non-inquest cases where a post-mortem was held. The percentage of non-inquest cases that required a post-mortem has remained at 34% for the past three years although this proportion has fallen steadily prior to this; in 2005 it was 43%.

### **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 2014, there were 3,198 potential inquest cases being dealt with by coroners in England and Wales with almost all (95%) requiring a post-mortem.

### **Cases requiring neither an inquest nor a post-mortem**

There were 127,646 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 2005 there were 116,047 such cases), although this year has seen a slight decrease from 2013 (down 1,056 or less than 1%). The proportion 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 50% in 2005, to 57% in 2014.

### **Post-mortem rates<sup>13</sup>, histology<sup>14</sup> and toxicology<sup>15</sup>**

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 2014, almost all (95%) of post-mortems were ordered at a standard rate - this has remained at the same level since 2011.

In 2014, 18,433 post-mortems included histology; and despite a decrease in the overall number by 653 from last year, the proportion of post-mortems which included histology increased by one percentage point to 21% of all post mortems. In 2014, 13,704 post-mortems held included toxicology (15% of post-mortems held), which was 419 more than in 2013, an increase of one percentage point. This follows the slow rising trend seen since 2011.

### **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 a body, an Out of England order is issued.

Coroners issued 5,232 Out of England orders in 2014, compared with 5,051 issued in 2013. In both years the number of orders issued represented 2% of the total number of deaths reported to coroners which has not changed since 2011 (see Table 5).

### **Deaths abroad**

Of the 223,841 deaths reported to coroners in 2014, some 1,860 (less than 1%) were reports of deaths that had occurred outside England and Wales. This has remained at the same level since 2011.

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<sup>13</sup> The fee charged by a pathologist for a standard rate post-mortem is currently £96.80. Non-standard post-mortems cost £276.90.

<sup>14</sup> Histology in the context of post-mortems is the examination of tissues under a microscope.

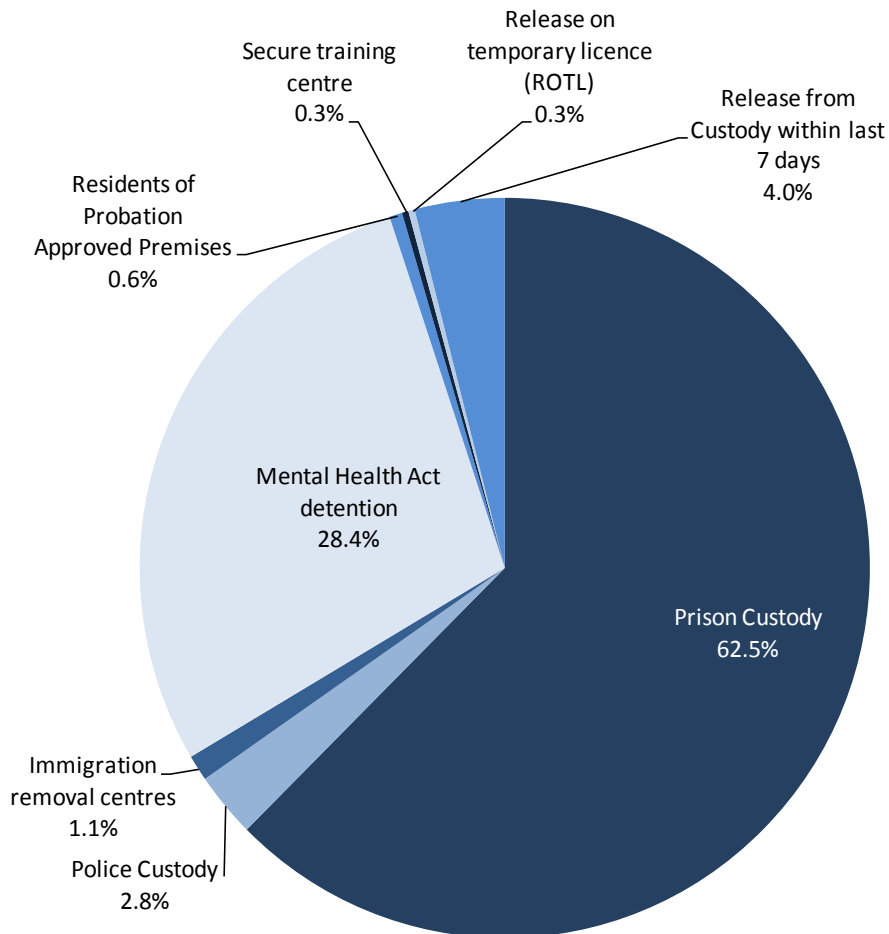
<sup>15</sup> Toxicology in the context of post-mortems is the study of body fluids and tissues for the detection of drugs.



### Deaths in State Detention

In 2014 a total of 352 deaths were reported to coroners which occurred in state detention<sup>16</sup>; 1% of the total number of deaths reported. Deaths in prison custody and mental health act detention account for 91% of all deaths in state detention cases (63% and 28% respectively).

**Figure 3: Deaths in State Detention by type, England and Wales, 2014<sup>17</sup>**



<sup>16</sup> This data only represents deaths in custody which were referred to a coroner and subsequently reported to MoJ in the coroner's annual return.

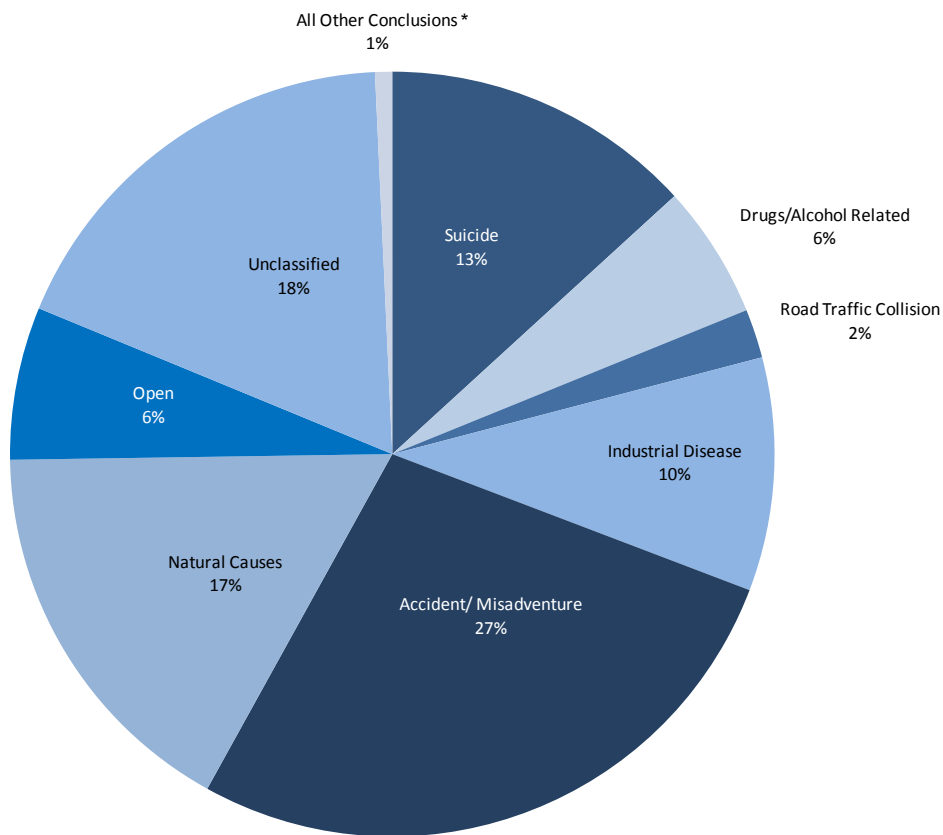
<sup>17</sup> There were no deaths within "Local authority secure children's homes"

## Inquests Completed

Conclusions were recorded for 29,153<sup>18</sup> inquests in 2014, down by 2,426 (8%) from 2013, reversing the continuing upward trend seen since 1996. The conclusions recorded in 2014 may relate to cases opened in 2014 or earlier years. Almost all inquests have a conclusion recorded (98%) and this has remained at the same level since 2012

Historically the most common conclusions (in order of frequency observed) were death from natural causes, death by accident or misadventure and unclassified conclusions. In 2014 the most common conclusions (by order of frequency) were death by accident and misadventure (7,941 or 27%), Unclassified (5,261 or 18%) and death by natural causes (4,873 or 17%).

**Figure 4: Conclusions recorded at inquest, by category, England and Wales, 2014<sup>19</sup>**



\*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

<sup>18</sup> This includes a small discrepancy with the data received from the West London coroners office, therefore, the sum of conclusion types may not equal the total number reported.

<sup>19</sup> Figures may not equal 100% due to rounding.

The conclusion of death by natural causes fell by 4,008 or 45% compared to 2013. This may partly be due to the decrease in the number of cases reported to coroners, but in addition, may also be due to the Coroners Act 2009 coming into effect in July 2013. This means that coroners can now issue a death certificate without holding an inquest when it is known that a death has occurred naturally.

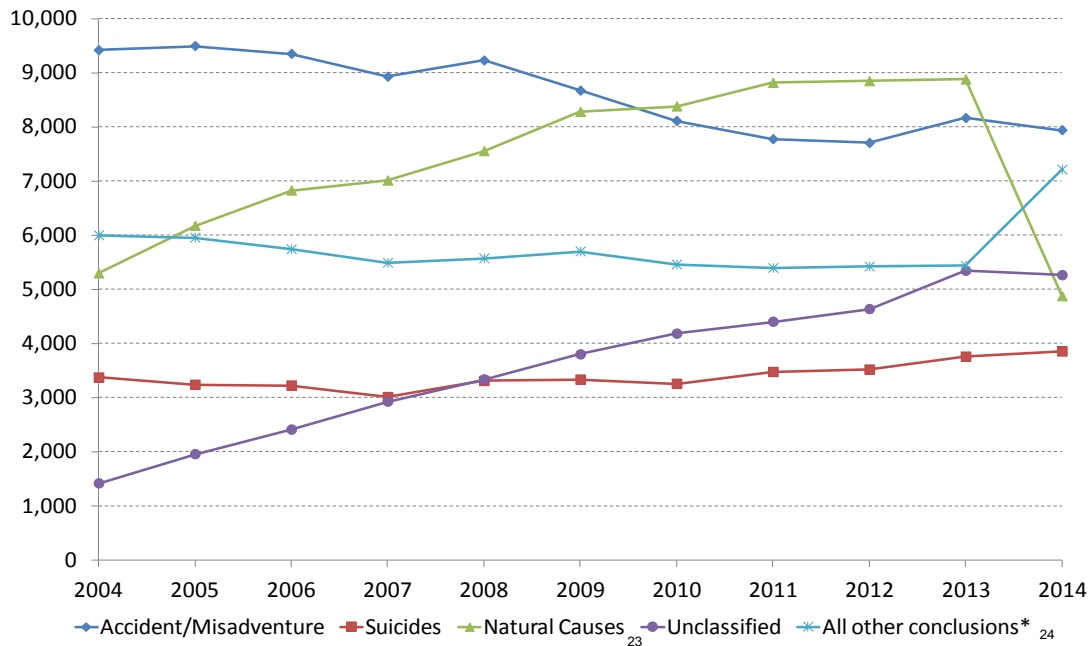
There has been a small drop in the number of unclassified conclusions (82 cases, or 2%), however the proportion of all conclusions recorded as unclassified increased to 18%, continuing the ongoing steady rise from 1% in 1995. The rise in proportion of unclassified conclusions is partly due to the increasing use of what are known as 'narrative conclusions' by some coroners. A narrative conclusion is where at the end of the inquest, instead of a conventional conclusion, the coroner records a factual record of how and in what circumstances the death occurred. In these cases the conclusion is recorded as unclassified. As well as narrative conclusions, this category includes short non-standard conclusions which a coroner or jury might return when the circumstances do not easily fit any of the standard conclusions<sup>20</sup>.

Two new short form conclusions have been introduced this year: drugs/alcohol related and road traffic collision. These conclusions accounted for 8% of all conclusions recorded (1,645 for Drugs/Alcohol related and 602 for Road Traffic collision).

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<sup>20</sup> 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](http://www.gov.uk/government/publications/coroners-statistics)

**Figure 5: Number of conclusions recorded at inquests, England and Wales, 2004-2014**



\*Killed unlawfully, Killed lawfully, Attempted or self-induced abortion, Cause of death aggravated by lack of care, or self-neglect, Want of attention at birth, Stillborn, Disasters, Open, Industrial Diseases, Drugs/Alcohol Related<sup>21</sup>, Road traffic collision and industrial diseases

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

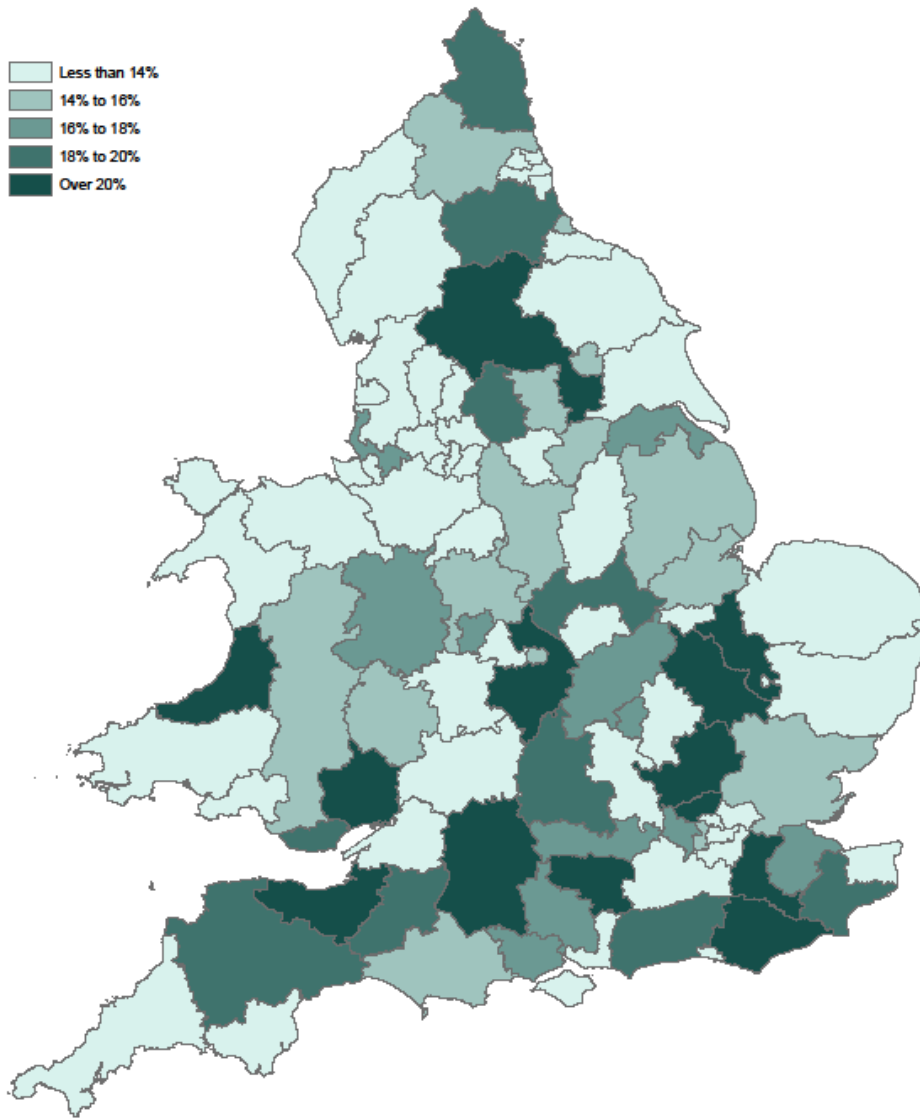
- Unclassified conclusions (including narratives, as explained above) accounted for 7% of all conclusions in 2005, but have since risen steadily to account for 18% of all conclusions in 2014.
- Conclusions of death by accident or misadventure have been declining steadily, from 35% of conclusions in 2005 to 26% in 2013; however there has been a small rise to 27% in 2014.
- Open conclusions have been decreasing over the same period, particularly over the last few years - they accounted for 6% in 2014 compared with 9% in 2005; and
- Despite a fall from 12% of all conclusions in 2005 to 11% of all conclusions in 2007, the proportion of inquests that have been concluded as suicide have slowly risen to 13% of all conclusions in 2014.

<sup>21</sup> for years 2004-2013, this includes the previously used conclusions “dependence on Drugs” and “Non-dependence on Drugs”

<sup>24</sup>The fall in natural causes in 2014 may be partly due to the fall in the total number of deaths referred to the coroner and partly due to the introduction of the two new conclusions “Drugs/Alcohol Related” and “Road Traffic Collision”.

<sup>25</sup>The rise for “All other conclusions” in 2014 is due to the inclusion of the two new conclusions “Drugs/Alcohol Related” and “Road Traffic Collision”.

**Map 4: Suicide conclusions as a proportion of all inquest conclusions, England and Wales, 2014<sup>22</sup>**



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**The proportion of conclusions recorded as suicide varies from 4% in Peterborough to 31% in East Sussex and Ceredigion.**

### **Differences in conclusions recorded by sex**

The pattern of conclusions recorded differs between males and females. Male deaths accounted for around two thirds of all conclusions recorded in 2014,

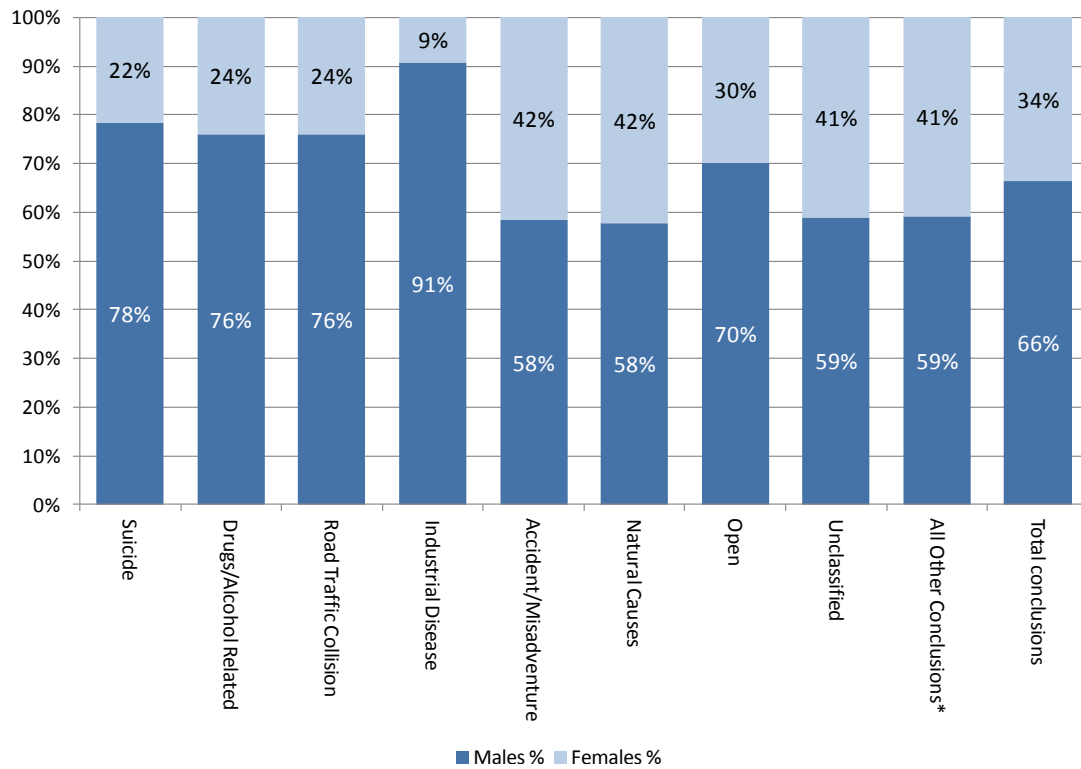
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<sup>22</sup> Map does not include Isles of Scilly due to small numbers

however they accounted for just over half of deaths reported; this suggests that males are more likely to die in circumstances that lead to an inquest. Female deaths accounted for about 34% of all conclusions recorded in 2014 (and 46% of deaths reported).

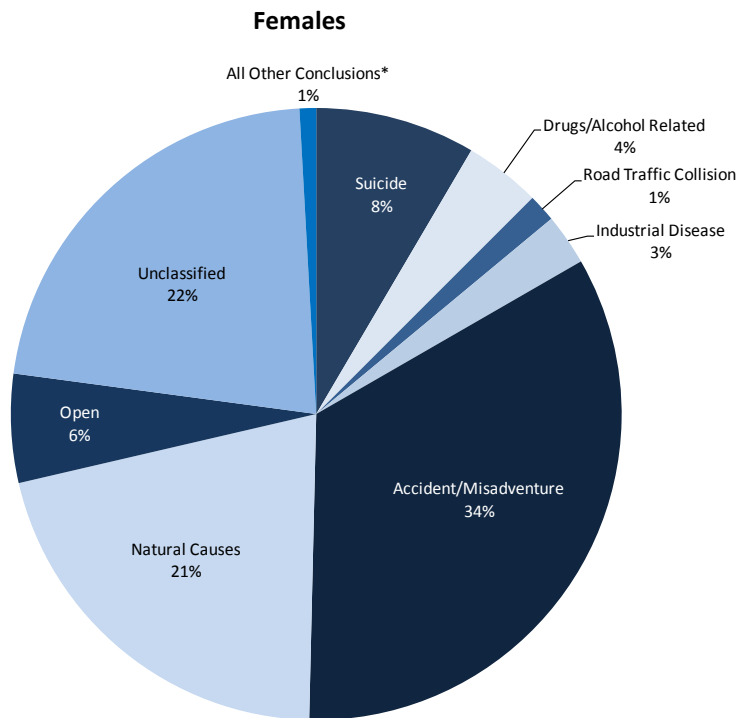
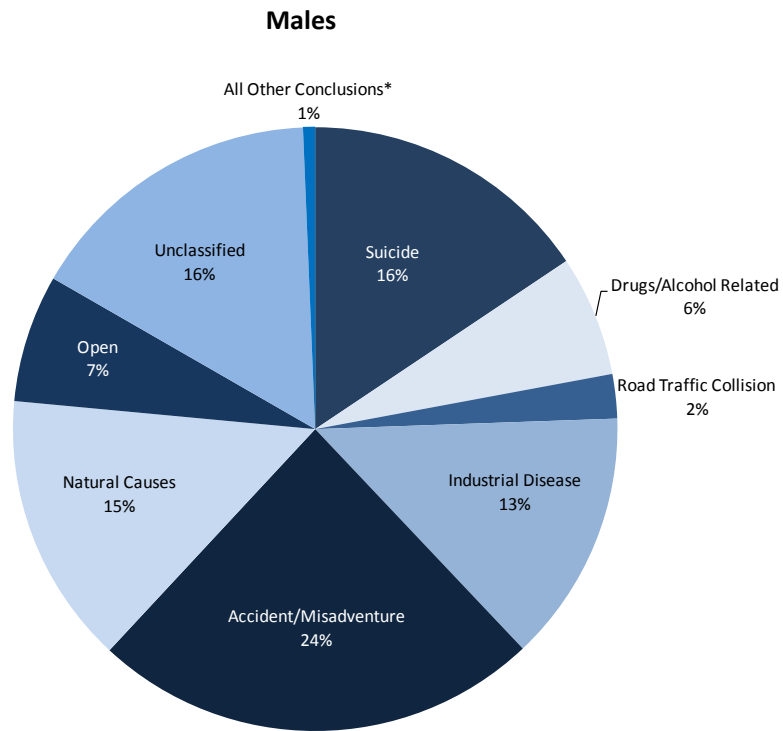
- Of the 3,851 conclusions of suicide, 78% were for males and 22% for females.
- Of the 1,882 open conclusions, 70% were for males and 30% for females.
- 58% of the 4,873 conclusions of death from natural causes were for males, the remaining 42% were for females.

**Figure 6: Conclusions recorded at inquests by sex, England and Wales, 2014**



\*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

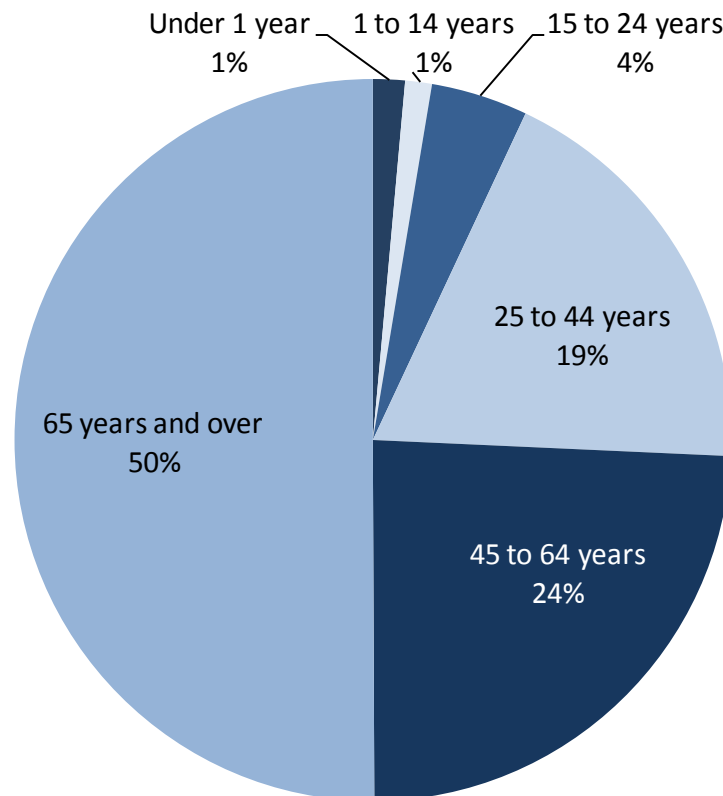
**Figure 7: Conclusions recorded at inquests by sex, England and Wales, 2014**



### 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 in inquest cases where a conclusion was recorded. Of the inquests completed in 2014, half related to persons who were aged 65 years or over at time of death compared with 7% which related to persons aged under 25 (see Table 8). Although an age breakdown of registered deaths in England and Wales in 2014 is not yet available, ONS figures for 2013 show that 84% of registered deaths in England and Wales were persons aged 65 or over, with only 1% aged under 25 years old.

**Figure 8: Age of deceased in inquests where a conclusion was recorded, England and Wales, 2014**



### Inquests with juries and adjourned inquests

The number of inquests held with juries in 2014 was 397 (representing 1% of all inquests), and a decrease of 59 compared to 2013. 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 eleven years (see Table 10).

In 2014, 698 inquests (representing 2% of all inquests concluded) were adjourned (and not resumed) by the coroner under Schedule 1<sup>23</sup> of the

<sup>23</sup> 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.



Coroners and Justice Act 2009 because criminal proceedings took place. This is the same proportion as 2013 and slightly less than in recent years - around 3% since 2006.

### **Time taken to process an inquest**

The estimated<sup>24</sup> average time taken to process an inquest in 2014 (defined as being from the date the death was reported until the conclusion of the inquest) was 28 weeks (see Table 10). Only deaths occurring within England and Wales are included in this estimation.

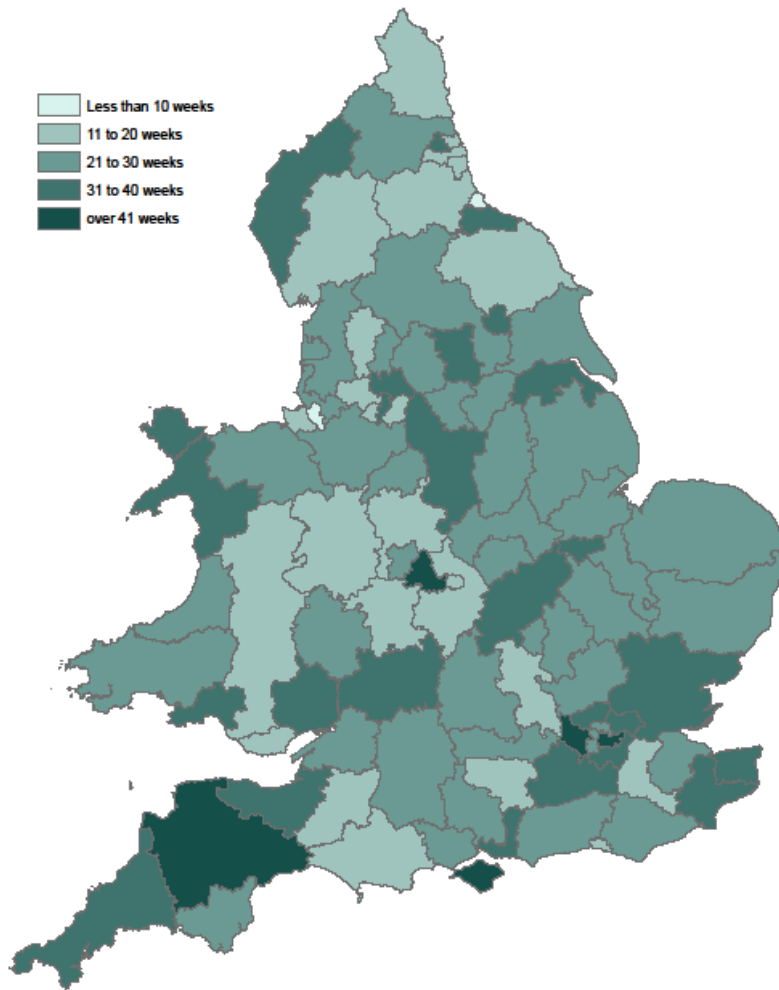
The maximum average time taken to process an inquest in 2014 was 53 weeks, and the minimum average time was 3 weeks. The large range of average time (50 weeks – based on 3 and 53 weeks) could be due to the fact that coroners' caseloads can vary greatly and a direct comparison is therefore not advised.

More information about how the average time has been estimated can be found in [the Guide to Civil and Administrative Justice Statistics](#).

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<sup>24</sup> 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 Guide for more information.

**Map 5: Average time taken to process inquests, England and Wales, 2014<sup>25</sup>**



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**The average time taken to process an inquest varies from 3 weeks in Hartlepool to 53 weeks in Inner South London.**

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<sup>25</sup> Map does not include Isles of Scilly due to small numbers

## 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](http://www.legislation.gov.uk/ukpga/1996/24/contents)

In 2014, 778 finds were reported and 347 inquests were concluded. In addition, there were 14 inquests held into Treasure Trove in 2014 (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.

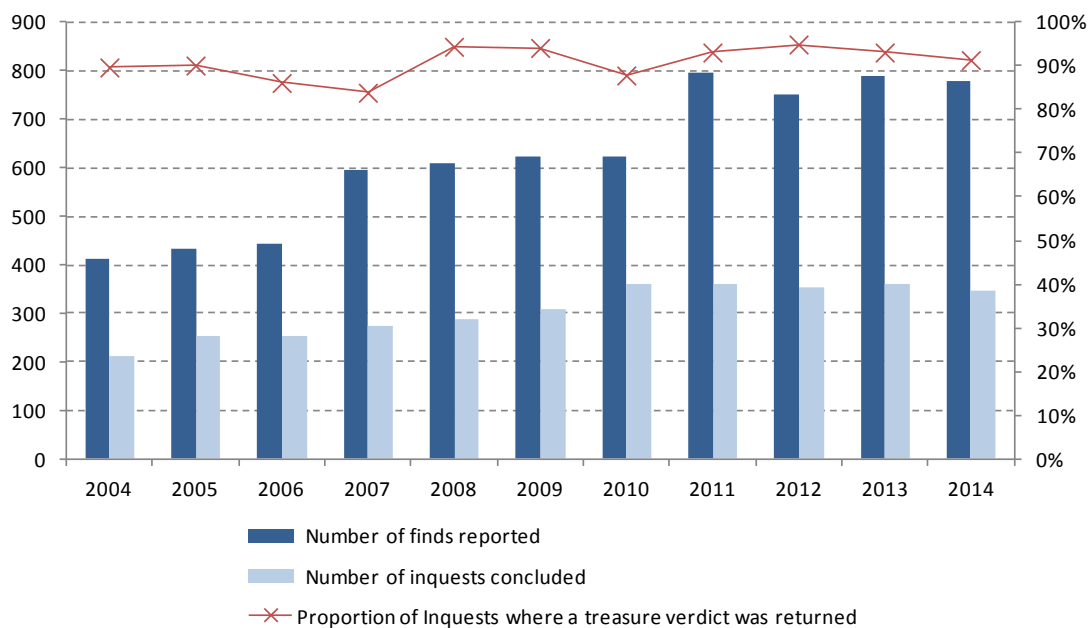
The number of finds reported has been generally increasing over the last ten years; however, in 2014 there was a slight decrease of 1% compared to 2013.

Of those 347 inquests concluded in 2014, 317 (91%) returned a verdict of treasure, a slight drop from 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:

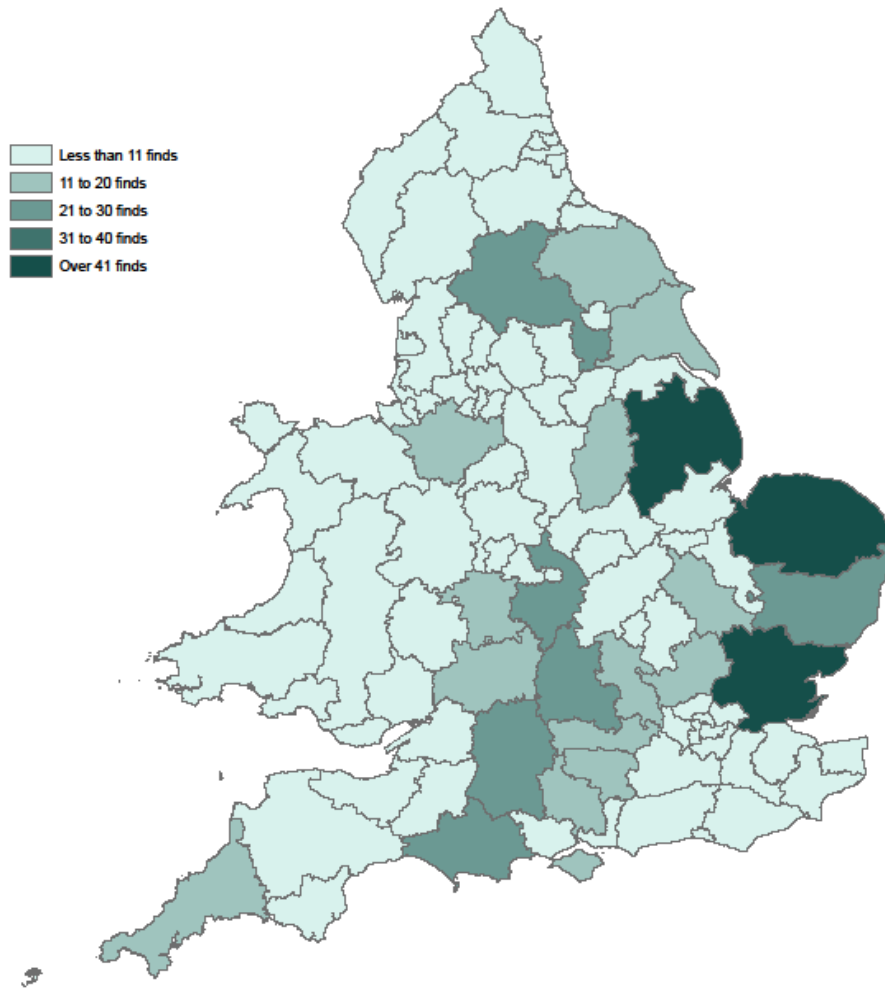
[www.gov.uk/government/organisations/department-for-culture-media-sport/series/treasure-and-portable-antiquities-statistics](http://www.gov.uk/government/organisations/department-for-culture-media-sport/series/treasure-and-portable-antiquities-statistics)

**Figure 9: Finds reported to coroners, treasure inquests held under the Treasure Act, and proportion of treasure verdicts returned, 2004-2014<sup>26</sup>**



<sup>26</sup> This chart does not include reported findings under "Treasure Trove"

**Map 6: Number of treasure finds reported to coroners, England and Wales, 2014<sup>27</sup>**



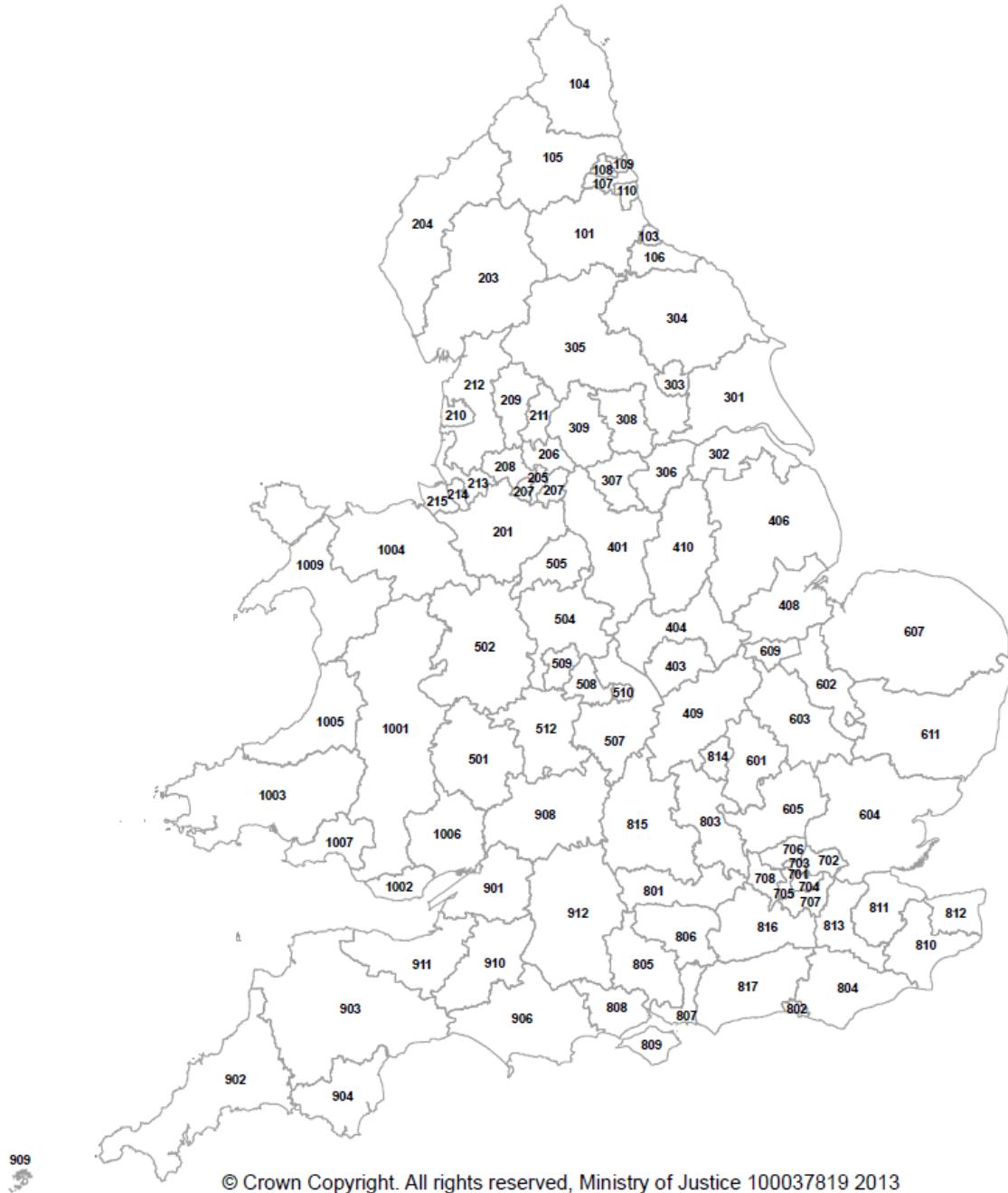
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**The highest number of treasure finds reported to coroner areas were in Norfolk and Essex, each with 87. Thirty four coroners' areas had no treasure finds reported to them.**

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<sup>27</sup> Map does not include Isles of Scilly due to small numbers

## 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

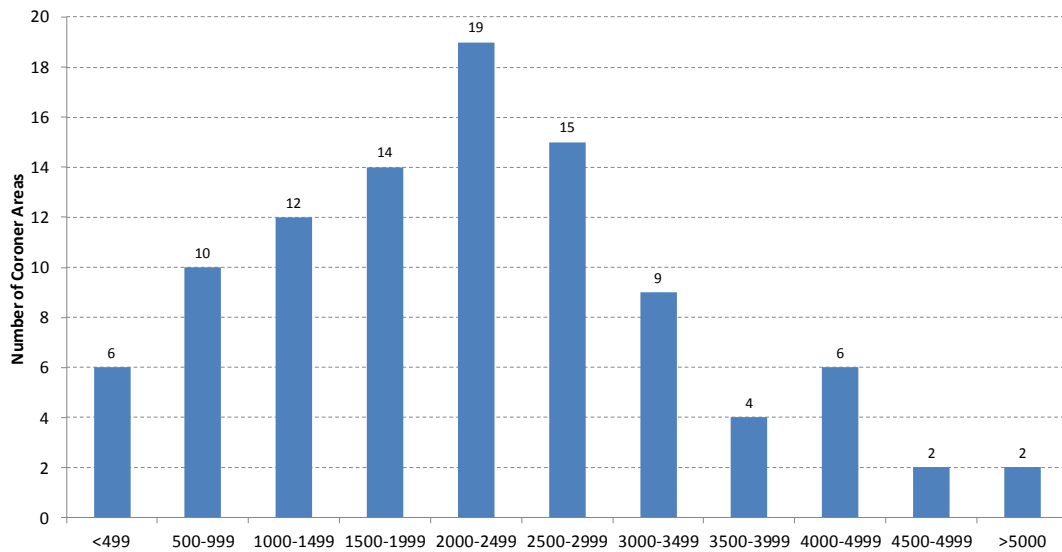
**Wales**

1001 – Powys, Bridgend & 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: Further analysis on number and proportion of deaths reported to coroners

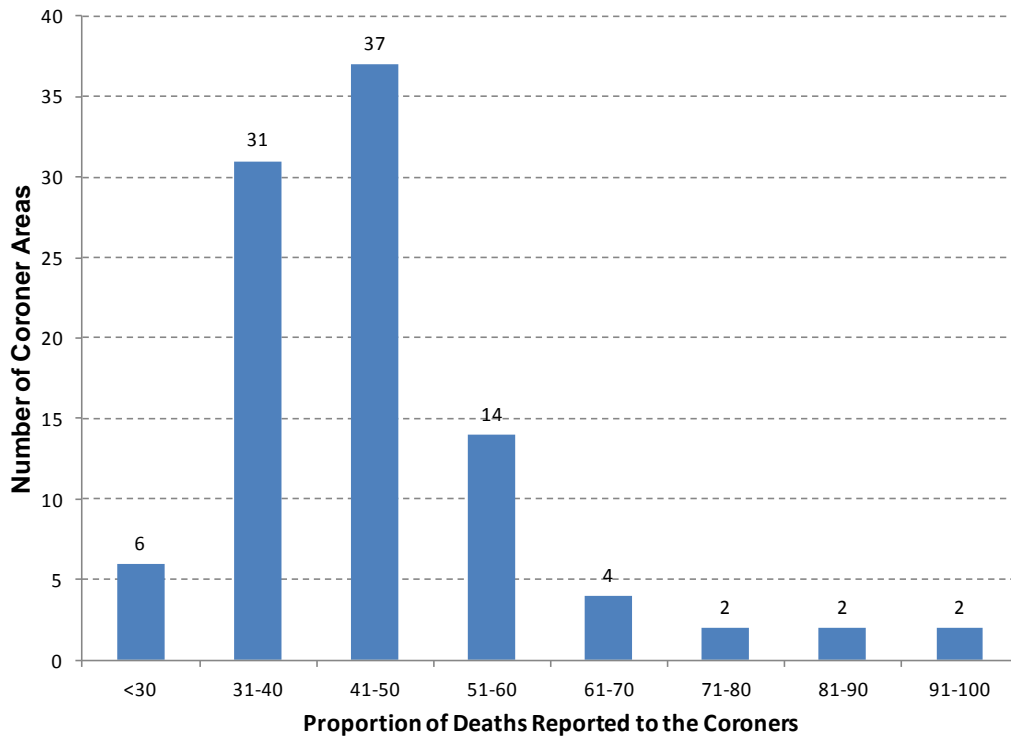
The number of deaths reported to coroners in 2014 varied by coroner area – from 5 in the Isles of Scilly to 6,432 in Essex. There were also over 6,000 deaths reported in the Nottinghamshire coroner area (6,378). The number of deaths reported in each area will be affected by the size, population and demographic breakdown of its area so comparisons of deaths reported to the coroner across coroner areas should be treated with caution,

**Figure C1: Number of deaths reported to coroners, 2014**



However, when looking at the number of deaths reported to coroners in 2014 as a proportion of registered deaths, which should allow for differences in population characteristics, there is still a wide variation across coroner areas e.g. 24% in North and East Cambridgeshire compared with 96% in Blackburn, Hyndburn and Ribble Valley.

**Figure C2: Deaths reported to coroners in 2014 as a proportion of registered deaths<sup>28,29</sup>**



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<sup>28</sup> Provisional figure based on ONS monthly death registration figures for 2014

<sup>29</sup> 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 Figure C2 is therefore 98.



## 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 2014, returns were received nearly all coroner areas electronically (2 were received via post). 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 between areas. Checks are made to ensure that each return is arithmetically correct, e.g subtotals and overall totals are correctly summed. Unusual or outlying values found within returns are queried with the data supplier, to confirm whether these are correct, or that an error exists 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, there may still however 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 2013 which was derived for the purposes of Table 2 in last year’s edition of this bulletin has now been replaced by an actual figure subsequently published by the Office for National Statistics.

### **Symbols and conventions**

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

n/a = Not applicable

- = Zero

.. = No data 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.

## 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:

[webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/hosbarchive.html](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/collections/coroners-and-burials-statistics](http://www.gov.uk/government/collections/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: [Hugo.biggs@justice.gsi.gov.uk](mailto:Hugo.biggs@justice.gsi.gov.uk)

Other enquiries about these statistics should be directed to:

**Bridgette Miles**

Ministry of Justice

7th Floor (7.07)

102 Petty France

London

SW1H 9AJ

Email: [statistics.enquiries@justice.gsi.gov.uk](mailto: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](mailto: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](http://www.statistics.gov.uk).

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