CHIEF CORONER

Report of the Chief Coroner to the Lord Chancellor

Fifth Annual Report: 2017-2018

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Introduction

1. This is the Chief Coroner's annual report to the Lord Chancellor. It is the fifth such report. It is the second report from the second Chief Coroner of England and Wales, His Honour Judge Mark Lucraft QC. In this report the Chief Coroner will provide an assessment of the current state of the coroner service and make recommendations for the future direction and progress of the service.

2. Section 36 of the Coroners and Justice Act 2009 (the 2009 Act) provides that the Chief Coroner must give the Lord Chancellor a report for each year.

Contents of report

3. As required by section 36(2) of the 2009 Act the Chief Coroner wishes to bring a number of matters to the attention of the Lord Chancellor. These include the development of the statutory reforms which came into force in July 2013, the additional reforms which the first Chief Coroner devised and which the second Chief Coroner continues to develop, and actions taken by the Chief Coroner under his powers and duties in the 2009 Act.

The Chief Coroner

4. The post of Chief Coroner of England and Wales was created by section 35 and Schedule 8 of the 2009 Act which came into force for appointment purposes on 1 February 2010.

5. His Honour Sir Peter Thornton QC took up the post with effect from September 2012 for a three-year term. In April 2015, the then Lord Chief Justice, Lord Thomas, after consultation with the then Lord Chancellor, the Rt. Hon. Chris Grayling MP, extended Judge Thornton's term of office as Chief Coroner of England and Wales until 1 October 2016. Peter Thornton completed his term as Chief Coroner on 30 September 2016 and retired as a Senior Circuit Judge on 18 October 2016.

6. On 18 August 2016 it was announced that the Lord Chief Justice, after consultation with the then Lord Chancellor, the Rt. Hon. Liz Truss MP, had appointed His Honour Judge Mark Lucraft QC as the Chief Coroner of England and Wales with effect from 1 October 2016 for a three-year term.

7. The extent of the Chief Coroner's jurisdiction is England and Wales.

8. His Honour Judge Mark Lucraft QC was authorised to sit as a Deputy High Court Judge under section 9(1) of the Senior Courts Act 1981 on 22 November 2016 and was appointed as a Senior Circuit Judge at the Central Criminal Court (Old Bailey) on 7 February 2017.

9. The Chief Coroner sits in the Divisional Court of the High Court on coroner cases, either applications for judicial review or applications for a fresh inquest (brought with

permission of the Attorney General) under section 13 of the Coroners Act 1988 (as amended). He divides his time between his duties as Chief Coroner and sitting as a judge at the Central Criminal Court and in the Court of Appeal (Criminal Division).

The Chief Coroner's role

10. The Chief Coroner leads the coroner service of England and Wales, sets national standards in the coroner system, maintains a national judicial framework in which coroners operate, and oversees the implementation and development of statutory and other coroner reforms.

Reforms and planning for the future

11. The first Chief Coroner devised and developed a package of reforms. They were designed to create across England and Wales a more modern, open, consistent and just coroner service, and to reduce unnecessary delays. The second Chief Coroner has continued with those reforms. In these reforms, statutory and otherwise, the Chief Coroner maintains as central to his thinking the essential concept that bereaved families must at all times be at the heart of the coroner process.

12. In April 2015 the first Chief Coroner formulated a 77-point Development Plan for 2015-2016. The Plan set out objectives and progress under a number of headings: structures, investigation, inquests, reporting to prevent future deaths, High Court, changes in the law, treasure, training, guidance, speeches, meetings, visits and complaints. The second Chief Coroner has updated the Development Plan and continues to do so. The amended document is to be found at Annex A.

13. The first Chief Coroner drafted a blueprint for now and the future entitled 'A Model Coroner Area' (June 2016). The blueprint remains an aspirational document for the coroner service in its present local area structure. Some sections of the plan have been amended. The current version of the document is to be found at Annex B.

The Coroner Service

14. The coroner service of England and Wales remains essentially a local service. There is no national structure. Coroners are appointed and paid locally, the service is funded locally including the provision of courts and other accommodation and IT systems and coroners' officers and support staff are employed locally by police and or local authorities.

15. There have been numerous calls for a national service, with coroners appointed and the service funded and run centrally, like other judicial services. This has not happened. The Chief Coroner supports calls for a national service. There is much to be gained from such a move in terms of standardisation, consistency and implementation of reform. The operational infrastructure provided by a national service would address, over time, many of the issues about inconsistency of experience by bereaved families; that experience can occur in many situations outside the formality of the court room – for example in the interaction with the processes that follow immediately after a death is

reported to the coroner.

16. In the meantime, the localised nature of the present service produces inevitable inconsistencies between coroner areas. Coroners have to an extent worked in isolation, unsupported by a sound framework and network of coroner resilience. The Chief Corner has continued to work towards greater consistency utilising many of the plans put in place by his predecessor.

17. There is inconsistency in the provision of resources across coroner areas depending on the approach of individual local authorities. Some areas are well resourced in terms of the provision of coroners' officers and support staff, others are not. As set out in the third annual report, taking in coroner areas with relatively similar sizes (approximately 2500-300 deaths reported annually) the number of officers ranges from 2 to 11. Shortage of coroners' officers adds to the stress on those staff in post with inevitable knock-on delays. The Chief Coroner has continued to meet with representatives of the local authorities. Most local authorities play a supportive role in working with the senior coroner. We all appreciate that public funding is tight, but careful planning – merging areas together, tendering for services, bringing the coroner and all support staff together into one location, sharing resources and working collaboratively with other areas – help to reduce costs and generate greater resilience.

18. The Chief Coroner has devised an appraisal scheme for coroners. The scheme will apply, at least initially, to all assistant coroners. It will then be extended to area coroners and senior coroners as well. The Chief Coroner will work with the local authorities on the scheme.

19. An appraisal scheme should help to improve a consistent approach to practices and procedures as well as consistency in outcomes. It should also assist in monitoring the bedding-in of the national training carried out through the Judicial College. The feedback to the Chief Coroner from coroners and local authorities on an appraisal scheme is very positive. Many assistant coroners welcome a scheme that will appraise their abilities and performance against the whole spectrum of skills required to undertake the post and to help in tailoring training needs. A pilot scheme has been in operation in two coroner areas since October 2017. At the conclusion of the pilot (12 months) it will be reviewed and it is envisaged that all assistant coroners will be appraised as from January 2019.

Positive developments

20. Although there remain some problems with a local as opposed to a national coroner system, there are positive developments to report.

21. The Chief Coroner has continued to meet with the Judicial Office to look at support that may be provided on issues such as human resources and in dealing with the media. All full-time and part-time coroners and assistant (fee paid) coroners are judicial office holders. Complaints against coroners are dealt with through the Judicial Complaints Investigation Office, and yet there is a perception that coroners are not always within the wider judicial family. At a training event in March 2018 the Lord Chief Justice set out his support for ensuring that all coroners are included within the broader judicial family. The Chief Coroner

is seeking to address this by discussing what scope there might be for greater support on issues such as human resources and media assistance, particularly in those cases where the coroner may not have support on that issue from his or her local authority. It is hoped that, alongside some support from the Judicial Office on these issues all coroners will be supplied soon with access to ejudiciary, the secure email environment provided to other judicial office holders. This will make communication far easier with all coroners.

Statutory framework

22. The view expressed in the 2015-2016 Report that the structure set out in the 2009 Act has worked well, remains to be the case.

23. The Government's promised review of the coroner service is still awaited. Reference was made to the review in the fourth annual report last year, but as yet it has not been published.

Mergers: reduction in number of coroner areas

24. There continues to be considerable benefit from the reduction in the number of coroner areas across England and Wales. In the period since implementation of the 2009 Act in July 2013, the number of areas has reduced from 110 to 88. In the First Annual Report of the Chief Coroner it was stated that under the then current planning with the Ministry of Justice, the target of a reduction to about 80 coroner areas in total for England and Wales in the relatively short to medium term was realistic and that 75 was the longer-term objective. That remains to be the case. The natural time to consider a merger is with the retirement of a senior coroner for an area and part of the audit carried out by the Chief Coroner in 2016-2017 had this issue in mind. To date all mergers have taken place by consensus and agreement.

25. There are a number of advantages to mergers. Not only does it lead to areas of similar size throughout England & Wales, but it helps in achieving greater consistency of approach to issues.

26. There have been three mergers in 2017-18: Central Lincolnshire and South Lincolnshire were merged to form the new Lincolnshire Area, Preston and West Lancashire, East Lancashire and Blackburn, Hyndburn and Ribble Valley were merged to form the Lancashire and Blackburn with Darwen Area and most recently the Teeside and Hartlepool areas were merged to form a combined Teeside and Hartlepool Area.

27. The Chief Coroner is keen to ensure that there is adequate coroner cover and resilience in each coroner area. A number of coroner areas have both a full-time senior coroner and a full-time area coroner. The Chief Coroner hopes that a number of other coroner areas will look to appoint an area coroner.

Model Coroner Area

28. As at paragraph 13 above the latest version of the blueprint 'A model Coroner Area' is is appended to this report.

29. The document sets out recommendations for the ideal coroner area. It describes the

recommended size for coroner areas, the need for smaller jurisdictions to merge, the role of the senior coroner and the team of coroners, assisted by coroners' officers and administrative support staff. The document also outlines the work of coroners in investigations and inquests, in reports to prevent future deaths, timescales for referrals of deaths to the coroner, release of the body by the coroner, opening and completing inquests and the holding of pre-inquest review hearings. The document also deals with pathology services, 'out-of-hours' services, tendering for contracts, training and discipline.

Statistics

30. The Chief Coroner is pleased to report to the Lord Chancellor further positive trends in a number of this year's statistics.

Cases over 12 months

31. The Chief Coroner has a statutory duty[1] to report to the Lord Chancellor on these cases. Set out in annex C is a table by coroner area showing the numbers of cases over 12 months, and the percentage those cases represent by reference to the number of cases reported to the coroner in that area. The table sets out the figures for each of the years 2015 through to 2018.

32. As can be seen from the table, following the introduction by the Chief Coroner in 2014 of a standard procedure for reporting on cases over 12 months, there has been a marked decrease in the numbers of cases outstanding. There has been a reduction from 2,673 cases first reported in 2014 to 2,161 cases reported in 2018. This figure is approximately 0.5% of all deaths reported. The number of cases over 12 months has increased slightly over the last two years due to the increase of more complex and lengthy inquests. Suspended cases have also contributed to the increase with ongoing external investigations in incidents such as the Shoreham Airshow disaster and MH17 plane crash abroad.

33. In 2014 seven coroner areas had over 100 cases over 12 months old, and two areas had over 200 cases. In 2015 that number had reduced to one area with over 100 cases over 12 months old. Save for the caveat in the next paragraph, there were no coroner areas with over 100 cases over 12 months old in 2016 and only one coroner area in 2017 reported 100 cases over 12 months. In 2018 two coroner areas had over 100 cases over 12 months old; West London, which is subject to the caveat below, was one of those areas.

34. For the West London coroner area no figure was given for 2017 and in the last Annual Report it was stated that the figure provided for 2016 was subject to review. The result of the Judicial Conduct Investigations Office (JCIO) investigation into the Senior Coroner for West London was announced at the end of 2017. A staged return to work is underway. In the interim three people have undertaken the role of Acting Senior Coroner: Jeremy Chipperfield (26 October 2016 to 1 November 2017), Sarah Ormond-Walshe (2 November 2017 to 31 March 2018) and Sean Cummings (from 1 April 2018). The Chief Coroner is extremely

[1] Sections 16 and 36, Coroners and Justice Act 2009.

grateful to each of them for their leadership of the service through a difficult period.

35. There have been a number of positive developments in West London. An audit has been carried out on unresolved cases. As of 30 April 2018, there are some 355 cases over 12 months old; this figure is shown in Annex C. With the appointment of a number of new assistant coroners to the area and stable staff numbers, alongside a clear action plan going forward, it is hoped that we will continue to see improvements and a reduction in the backlog. The most recent report to the Chief Coroner from the acting Senior Coroner shows a significant increase in the numbers of inquests being held. The Chief Coroner acknowledges the increased resources made available by the consortium of local authorities in West London in an effort to address and reduce the backlog of case as well as the ongoing work. The Chief Coroner has met with each of the acting Senior Coroners for West London, representatives of the Metropolitan Police and from the London Borough of Hammersmith & Fulham (lead authority in the consortium) to monitor developments. He will continue to do so.

36. The wording of the 2009 Act and the Coroners (Inquests) Rules 2013 reflects the concern of the public and Parliament that cases had not in the past been completed by coroners in a timely fashion. Rule 8 requires that a 'coroner must complete an inquest within six months of the date on which the coroner is made aware of the death, or as soon as reasonably practicable after that date.'

37. What amounts to 'reasonably practicable' depends on the particular facts and circumstances of each case. There are often good and clear reasons why some cases are outstanding. For example, if there are ongoing police enquiries, criminal investigations and prosecutions, investigations overseas, Health and Safety Executive (HSE) or Prisons and Probation Ombudsman (PPO) inquiries, Independent Office of Police Complaints (IOPC) inquiries or investigations by one of the specialist accident investigation bodies, the coroner's inquest is put on 'hold' pending the outcome of those enquiries or investigations. In some cases, those other investigations are very lengthy. The net result can be that a coroner can only hold an inquest on a case after a period of two years or more. Homicide investigations by the police, manslaughter or health and safety investigations by the HSE and investigations by the PPO or IPOC will have a particular impact on the figures for cases over 12 months in those coroner areas covering the major cities of England and Wales where the majority of homicides take place or where the major prisons are located.

38. In some areas there has been a problem with coroner resources. Senior coroners in those areas have worked with their local authority to ensure that adequate resources are provided to ensure that cases can be dealt with as expeditiously as possible.

39. The Chief Coroner welcomes the reduction in the numbers of older cases. He is grateful to those senior coroners and local authorities who have made strenuous efforts to address issues around older cases, and to all coroners and local authorities for continuing to ensure that work is undertaken to address these cases.

40. There is more work to be done. In some areas additional resources are required so as to ensure that the number of cases over 12 months is just a handful of cases.

Average time to inquest; post-mortem examination rates

41. From the annual Ministry of Justice statistics[2], there are several matters to note. The average time of all cases from death to inquest completed rose to 21 weeks in 2017 from 18 weeks in 2016. The figure had reduced substantially over the last two years. It should be noted that the figure in 2014 was 28 weeks. This change reflects the removal of Deprivation of Liberty Safeguards (DoLS) cases. The percentage of deaths in which coroners required post-mortem examinations is now at 37% of all deaths reported to coroners. This is a small increase over 2016 (1%). By comparison the figure 10 years ago was 48%. 5 years ago it was 42%.

42. As with the last annual report, any positive changes in the statistics are welcomed, and any increases will be looked at to assess the reasons for change. In relation to the figure for post-mortem examinations, despite an increase by 1% of the proportion of deaths where post-mortems were ordered, the overall number of post mortems reduced. The Chief Coroner is keen for more work to be done to reduce further the post mortem rate and will continue to monitor the position and to look at regional variations in the percentage of cases where post mortems are ordered.

Overall figures

43. The number of registered deaths in England and Wales has been relatively static over the last few years. It has been around 500,000. In 2017 the provisional figure for registered deaths is 533,118, the highest since 2003. All deaths are registered with the local registrar of births and deaths in order to create a complete record of how people die. Most of these deaths are from natural causes, certified as such by a general practitioner or hospital doctor. But in every case where it is not clear that the death is from natural causes, it must be reported to the coroner.

44. 229,700 deaths were reported to coroners in 2017, the lowest level since 2014 and down 5% on 2016. Excluding deaths under a DoLS authorisation, there were 225,834 deaths reported to coroners in 2017, down 2% on 2016. Comparing the percentage of deaths reported to coroners over the last five years, it has been around the 45% mark. In 2017 this proportion is 43%. This is a 3% reduction on 2016 and the lowest proportion since 2003. The number of reported deaths that require a full investigation with an inquest is a small proportion of the overall numbers reported. Many cases reported to the coroner are signed off by the coroner after preliminary enquiries, with or without a post-mortem examination, as being deaths from natural causes. In these cases a formal investigation under the 2009 Act is not required and therefore there is no inquest.

45. The number of inquests opened in 2017 is 31,519, a reduction of some 18% on 2016. Inquest cases represent approximately 14% of all deaths reported to coroners in 2017, a reduction from 16% in 2016. The reduction is a direct result of the removal of the requirement to report all DoLS deaths, and that the fact that all such deaths previously required an inquest. Although the number of inquests is reducing, as has been noted in previous years, the number is very much higher than any other comparable jurisdiction internationally, and as the Chief Coroner recommends at paragraphs 167-172 below, they could be substantially reduced by a special procedure for non-contentious cases.

[2] https://www.gov.uk/government/collections/coroners-and-burials-statistics

46. In 2017 there were 501 inquests held with juries. The number of jury inquests had shown a downward trend until 2013, but then increased year on year since 2014. The figure for 2017 shows a reduction of 13% on the number for 2016 (576). The number of jury inquests is approximately 1% of all inquests. The number for 2017 mirrors the fall in the number of inquests held and the overall numbers of deaths reported to coroners. There were 528 deaths in state detention (excluding DoLS) in 2017[3]. This represents a decrease of 8% over 2016. Of the 528, many concerned deaths in prison or police custody under section 7 of the 2009 Act. Deaths in custody are of particular concern to coroners. Many coroners make reports to prevent future deaths from such cases.

Appointments

47. The appointments process for all coroners has been the subject of further work in the last year. In 2016 the Chief Coroner completed a thorough audit of all coroner areas seeking information as to all coroners within each coroner area as well as details of the sitting pattern of all assistant coroners.

48. A questionnaire was sent to each senior coroner asking them to provide details of individual coroners in their area, appointment dates, contact information and how many days each assistant coroner has sat in the last three years. Other important contact details for local authority managers were also sought.

49. A table setting out the senior and area coroners in post, along with their coroner areas, can be found at Annex C.

50. The audit had a number of aims. One aim was to provide a clearer pattern of the likely appointments to be made over the coming years. The audit should inform the potential merger issues with coroner areas as the key time to consider such a move is on the retirement of a senior coroner.

51. The Chief Coroner is keen to look into the possibility of regional recruitment of assistant coroners rather than each local authority running separate competitions to appoint. There is likely to be regional recruitment in some areas in 2018-2019 and going forward. The Chief Coroner has run a series of workshops for assistant coroners interested in seeking appointment as full-time area or senior coroners and also for those seeking a first appointment as an assistant coroner. The Chief Coroner is keen to ensure that all appointments are made from the widest pool of the most meritorious applicants.

52. The appointments pack[4] has been substantially revised in consultation with representatives of the Coroners' Society of England and Wales, the Ministry of Justice

[3] Deaths comprise 298 in prisons, 10 in police stations, 1 in an immigration removal centre, 196 Mental Heath Act detention cases, 1 in probation approved premises, 2 whilst on temporary release on licence for medical reasons, and 10 where released from custody within 7 days of death.

[4] The pack comprises: step by step guide for local authorities on recruiting a coroner; template adverts for senior, area and assistant coroner; Chief Coroner's Guidance No.6; Guide to Judicial Conduct; Guide to Equality and Diversity; and templates on recording sift scores and declarations.

and with representatives of local authorities.

53. The Chief Coroner is closely involved with each appointment process. Although local authorities make all appointments, each appointment is subject to the consent of the Chief Coroner and the Lord Chancellor. The Chief Coroner takes the view that being involved in all the stages of the recruitment process - advertising a vacancy, considering the applications, and sift or proposed shortlist of candidates, the constitution of an interview panel and with presentations and questions for final interview - provides the best picture of the process.

54. For all senior coroner and area coroner appointments the Chief Coroner or one of his nominees will be present at the final interviewing stage. Although not voting in the process of selection, his presence (or that of a nominee) ensures that the Chief Coroner can see the process is open, complete and fair, and informs his report to the Lord Chancellor for the purpose of giving his consent.

55. All appointments are announced by the relevant local authority and appear in the Chief Coroner's regular newsletters to coroners. Appointments of senior and area coroners are also published on the judiciary website. The Chief Coroner also announces the retirements of senior coroners in his regular newsletter.

56. This year there have been 7 senior coroner appointments, 5 area coroner appointments and 45 assistant coroner appointments. The senior coroners who have been appointed are Jeremy Chipperfield (County Durham & Darlington), Kevin McLoughlin (West Yorkshire (Eastern), Sarah Ormond-Walshe (South London), Kally Cheema (Cumbria), Philip Spinney (Exeter and Greater Devon), Heidi Connor (Berkshire) and Nigel Parsley (Suffolk). The Area coroners who have been appointed are Christopher Morris (Manchester South), Bina Patel (Mid Kent and Medway, James Newman (Lancashire and Blackburn with Darwen), Paul Smith (Central Lincolnshire) and Alan Blunsdon (North East Kent).

57. The Chief Coroner expresses his grateful thanks to those coroners who have retired in the last twelve months. In particular the Chief Coroner would like to thank Peter Dean (Suffolk), Peter Bedford (Berkshire), Selena Lynch (South London), Andrew Tweddle (County Durham & Darlington), David Roberts (Cumbria), David Hinchliff (West Yorkshire (Eastern)) and Elizabeth Earland (Exeter and Greater Devon) for their years of service and hard work.

Training

58. The Chief Coroner trains approximately 1,000 people in coroner work each year: 380 coroners and approximately 600 coroners' officers. This training, under the auspices of the Judicial College (which trains all judges and tribunal members), has been highly successful. Training is delivered through a combination of two-day residential courses, which are all compulsory. These include an induction course for newly appointed assistant coroners, continuation courses for all coroners and continuation courses for all coroners' officers as well as one-day events. In 2018-19 the annual continuation courses for coroners focuses on hospital deaths. The first continuation course has taken place and met with universal approval.

59. In 2016-2017 the coroners' continuation courses concentrated on disaster victim identification and preparedness for mass fatality incidents. All of the continuation

courses have taken place and met with universal approval. The plan is to have a further course on this subject in early 2019 so that those recently appointed along with some coroners who were not able to attend, are also trained on this vitally important topic.

60. Last year the coroners' officers training covered topics including death through a heart attack where issues over hospital treatment occur. This year the focus is on preparedness for a mass fatality event.

61. The feedback from all the courses is positive and shows that the training has been well received, with high levels of achievement in learning outcomes, aims and usefulness. Great emphasis is placed on work in syndicates. Through discussion participants learn how best to tackle practical problems.

62. The training is devised by the Chief Coroner's Training Committee which is comprised of the Chief Coroner, those coroners who are course directors, representatives of the Judicial College, and officials from the Chief Coroner's office. They are all supported by two experienced coroners' officers.

63. The Chief Coroner has been extremely impressed with the quality of the work and the commitment of the course directors. All course directors are appointed following an open selection process at the Judicial College. There are currently 9 course directors. There will be an expressions of interest process this year for appointments as course directors from February 2019. Unlike some judicial office holders, coroner course directors are not provided with an allowance of protected time to devise and prepare courses. The Chief Coroner and the lead course directors have submitted a joint proposal to the Judicial College to address this issue. The Chief Coroner wishes to express his grateful thanks to all the coroners who act as syndicate leaders at training events and to all the coroners involved in the Chief Coroner's Training Committee. The Chief Coroner would also like to express his gratitude to Derek Winter, Alan Wilson, Louise Hunt, Penny Schofield, Chris Dorries, Heidi Connor and Kally Cheema along with all members of the training committee for all of the time they devote to devising and running the training courses for coroners and coroner's officers.

64. In addition to the annual residential courses, there have been a number of one-day training events in the course of the year. They include the Chief Coroner's annual conference for senior coroners and a day course on medical issues. This year the Chief Coroner's annual conference focused on two key issues: the report of Bishop James Jones of his review of the experiences of the Hillsborough families and dealing with the vulnerable. The event was held at Westminster Central Hall and was led by the Chief Coroner. The Lord Chief Justice spoke about the importance of coroners being included in the wider judicial family. Mr Justice (now Lord Justice) Haddon-Cavespoke about his experiences of inquiries and inquests, Bishop James Jones spoke about his review and the recommendations made in relation to coroners. In the afternoon Angela Rafferty QC (Chair of the Criminal Bar Association) and Gillian Jones QC (Treasurer of the Criminal Bar Association) led an interactive session on the lessons to be learned for coroners from the criminal courts on the approach to the vulnerable. Dealing with the vulnerable is a topic that will be revisited during training in 2018 and 2019. The feedback on the event was all positive.

65. The first in a series of one-day course on medical issues took place in 2015-2016. The subject matter was the head and the brain. In 2016-2017 the course focused on the

heart. This year it will deal with the bowel. These medical training days have taken place at the Queen's Medical Centre in Birmingham. The Chief Coroner is extremely grateful to Louise Hunt for putting the course together, and to the medical experts who have made their time available to address coroners. The courses have been of the highest quality.

66. There will be a one-day training event for local authorities in February 2019 as well as workshops on appointments: one for those assistant and area coroners seeking appointment as an area or a senior coroner and another for those seeking a first appointment as an assistant coroner. The first of these workshops took place in October 2017 and May 2018. Demand has been strong and it is likely the workshops will repeated.

Guidance and Advice

67. To support and add to the training, and with a view to increased consistency and enhanced national standards, the Chief Coroner continues to produce written guidance for coroners (and others), all of which is published on the judiciary website[5]. There are now 28 separate pieces of written guidance.

68. In the last 12 months the Chief Coroner has issued revised guidance on the issue of organ donation, jury management and on reporting of death to the coroner: decision making and expedited decisions. This last piece of guidance was issued following the judgment of the Administrative Court in *R (Adath Yisroel Burial Society) v Senior Coroner for Inner North London* [2018] EWHC 969 (Admin) ("the AYBS Case") in which the Chief Coroner was a party.

69. In addition to formal written and published guidance, the Chief Coroner has given advice to coroners (as a group and individually) on various topics. The Chief Coroner has continued to publish a number of newsletters to update all coroners on a number of topics. Each newsletter sets out the meetings and events attended by the Chief Coroner, any new appointments made, news of any retirements of senior or area coroners as well as articles on new cases of interest. The newsletters are sent to all senior, area and assistant coroners and are made available to all coroner's officers.

Juror Notices

70. Professor Cheryl Thomas of University College London has undertaken research at the invitation of the Lord Chief Justice on the understanding of jurors as to the offences of misconduct and the warnings given in relation to potential misconduct offences whilst acting as a juror. The research follows a number of prosecutions of jurors in criminal trials for misconduct. The result of the research has been a pilot scheme in the crown court of a new Juror Notice. A document setting out the 'do's and don't's' in jury service has been provided to all serving jurors. Professor Thomas has adapted the notice for use for coroner's inquests. Guidance will be provided along with the notices for use in all coroner's inquests in England and Wales with effect from the

[5] https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/

start of September 2018.

Memoranda of understanding

71. On 29 September 2016 the Administrative Court gave judgment in the judicial review decision of R (on the application of the Secretary of State) v. Senior Coroner for Norfolk and British Airline Pilots Association [2016] EWHC 2279 (Admin). At the conclusion of the judgement the Lord Chief Justice stated: *"... It would also be desirable for the Chief Coroner to reconsider the terms of the MoU (memorandum of understanding) with the AAIB in the light of the judgments in this case and for the future be responsible for the guidance and arrangements contained within the MoU."*

72. Following that decision, the Chief Coroner has carried out a wide review encompassing all existing memoranda. This exercise has considered the wording of each document. As part of the review the Chief Coroner has liaised with the other agencies and with coroners. In due course each memorandum will be available through the judiciary website along with guidance.

Medical examiners

73. The Chief Coroner is of the view that the investigation of deaths in England and Wales will be greatly enhanced by the proper implementation of the medical examiner (ME) system as set out in the 2009 Act. The ME scheme should supplement and complement the work of the coroner service. Working alongside coroners MEs should provide a more comprehensive independent system of death investigation in England and Wales. It should mean more accurate medical certificates of the cause of death and ensure more appropriate referrals of deaths to coroners. It should also produce more accurate data about the causes of death, particularly in hospitals.

74. The Government consultation entitled *Consultation on the introduction of medical examiners and reforms to death certification* in England and Wales closed on 15 June 2016. The first Chief Coroner's response to the consultation was published on the judiciary website[6].

75. The Government's response to the consultation process was published on 11 June 2018.[7] This sets out the Government's new plans to introduce a phased system of medical examiners in England from April 2019. The Welsh Government consulted separately in Wales.

76. The ME scheme as set out for through the 2009 Act will not provide the basis for the NHS service that will operate from April 2019. However the government will draw on the 2009 Act to establish a National Medical Examiner and to introduce regulations for the notification by medical practitioners of deaths to coroners. It is understood that the proposal is that MEs will only cover hospital deaths initially and that the launch of the service next April will not cover primary care, nursing homes, mental health or community services.

[6] https://www.judiciary.gov.uk/wp-content/uploads/2016/06/chief-coroner-cp-response-medical-examiners
[7] https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Lords/2018-06-11

77. The detail of how ME implementation will work is still under discussion. The Chief Coroner sits on the Strategic Programme Board run by the Department of Health and Social Care which will be meeting regularly over the next few months. The Chief Coroner will want to be assured that MEs are independent, there will be sufficient training for coroners and that sufficient time is given to prepare for implementation.

78. Whilst he welcomes the confirmation that a form of the planned ME scheme will be in place from April 2019, the Chief Coroner remains of the view that the interlocking system of oversight for community, hospital and all other deaths by the ME, with the coroner performing a more specialist role in relation to their legal jurisdiction, as envisaged in the 2009 Act, should be the ultimate objective. Until then, the issues the ME was designed to address, as highlighted in Dame Janet Smith's third Shipman report and elsewhere, will not be fully dealt with.

Service deaths

79. The Chief Coroner has a statutory responsibility for the monitoring of and training for investigations into deaths of service personnel on active service or in preparation for active service. The Chief Coroner requires senior coroners to notify him of all such investigations and to update him on their progress and the outcome.

80. In 2013 a special cadre of coroners was created to conduct such investigations if and when necessary and special training was arranged. Specific guidance on the use and function of the cadre was provided. This cadre remains in place.

81. Since the withdrawal of many armed forces from Afghanistan there have been relatively few service deaths reported to the Chief Coroner under section 16 of the 2009 Act.

82. Since July 2013 there have been 26 relevant service death inquests. The most recent concerned training and related activities. A second inquest into the death of Private Sean Benton at Deepcut Barracks has been conducted by His Honour Peter Rook QC, a retired senior circuit judge as coroner and HH Rook QC will also conduct a fresh inquest in to the death of Private Geoff Gray, who also died at Deepcut Barracks.

Reports to prevent future deaths

83. Coroners submit reports to prevent future deaths (PFD reports). Each report is an important statement by a coroner raising a concern arising out of an investigation or inquest on action that should be taken to prevent future deaths.

84. Between July 2017 and June 2018 there were 377 PFD reports issued by coroners. All reports are published by the Chief Coroner on the judiciary website (sometimes with redaction for data protection purposes). Through this route the reports are made public and accessible to all who may have an interest in them. Email alerts are available

85. For this annual report, some work has been done on analysing the reports by reference to the coroner areas submitting the reports and the themes within the reports. My office focused on a sample of ten of the PFD reports on deaths in prison in 2016-17 in

order to identify any common themes. Whilst all PFD reports are different, because they deal with individual cases, the following themes could be identified as appearing in several reports issued concerning deaths in prison in 2016:

86. These themes include:

- Evidence of a lack of awareness amongst some staff about procedures (for example one PFD Report highlighted the lack of awareness amongst staff of the different procedures in day and night working).
- Lack of clarity amongst staff about how to trigger an emergency medical response.
- The inconsistent application of procedures (this is a common observation in reports; for example, in one report it referred to the inconsistent or incorrect application of established procedures such as for cell observation checks).
- Failure to pass on information between agencies and within institutions.
- Issues around buildings and estate (such as exposed ligature points in cells).
- Several reports also identified the need for extra or reinforced training for staff.

87. The Chief Coroner encourages all coroners to write and submit PFD reports where appropriate.

88. The Chief Coroner is keen to undertake additional work on PFD reports. The Chief Coroner will make a submission for additional resource so that the platform on which the reports are available is easier to use. It is also hoped that with some additional staff resource the trends in reports and in the responses to them can be drawn together so that the lessons from death can be more easily understood.

Faith communities

89. The Chief Coroner continues to work with faith communities, particularly Muslim and Jewish, so as to try and comply with two main religious requirements: avoidance where possible of so-called invasive post-mortem examinations; and early burial.

90. The Chief Coroner has attended a number of events hosted by faith communities. For example, he attended a conference in Cardiff at the invitation of Chaplain Ahmed and also the national conference in Bolton. Both events provided an opportunity for the Chief Coroner to speak to over 150 representatives of the Muslim community in England and Wales about the role of a coroner and the Chief Coroner and to answer questions posed by those present about the process of an investigation, issues over the release of a body and the service provided by differing coroner areas. The Chief Coroner has also met with representatives from the Board of Deputies of British Jews and the Adath Yisroel Burial Society in the course of the last year.

Post-mortem imaging

91. Post-mortem imaging by means of a computerised tomography (CT) scan as an alternative to more invasive post- mortem examination (autopsy) continues to develop but slowly. As the law stands, an autopsy ordered by a coroner is free of charge to the family and is paid for by the state. CT scanning is more expensive and there is no state funding for it at present. There are only a limited amount of post-mortem scanning facilities provided by the state although private companies have provided these services in some areas. Provision is geographically variable and in those parts of England and Wales where it is available, families may be asked to pay for it. However more facilities are becoming available – including those built and run by local authorities - and the Chief Coroner encourages the availability and use of imaging.

92. The ideal solution would, over time, for all pathology services to become regionalised in centres of excellence where body storage, conventional pathology and imaging can take place. This would provide resilience, introduce efficiency and improve the quality of the service to coroners.

Release of the body and out of hours services

93. The time taken to release a body for burial or cremation – both during working hours and out of working hours - varies depending on the circumstances of the death. There is also some variation across coroner areas as a result of resources. However early release for burial or cremation, where possible, is the aim for all. This not only benefits faith communities, but it is also of benefit to the public as a whole that bodies can be released for burial or cremation as early as possible. However it cannot always be achieved, especially in those situations where death occurs out of normal working hours.

94. In some coroner areas there are formalised out-of-hours services. In other areas there are informal services and in a few areas, there are no provisions in place at all.

95. For an out-of-hours service to operate fully, it requires not just for there to be a coroner on duty over weekends and public holidays, but also some resource from police and local authorities, as well as pathologists. For a system to work effectively there needs to be, for example, an effective rota of coroner's officers to take calls from the public or from funeral directors and to conduct any investigations on behalf of the coroner. The local registrar's office needs to be open for part of the weekend or public holiday and if there is a local public mortuary, that may also need to be open. The coroners for an area (senior coroner, area coroner (if one is in post) and assistant coroners) should be paid for being on a rota to cover these periods. Different local authorities have different views about the funding of out-of-hours services.

96. In some parts of England and Wales, the demand for a more formal out-of-hours scheme has grown. The Chief Coroner would like there to be a scheme in place across all coroner areas. The extent and resource required needs to be the subject of agreement between the senior coroner and relevant local authority and police.

Second post-mortem examinations

97. Any post-mortem examination may cause distress to a family. Additional post-mortems add to that distress. These can arise in cases where the police have arrested a suspect in relation

to causing a death or where it is believed a suspect may be arrested. Inevitably there will be some cases where there is no alternative other than a second full forensic post-mortem, but the Chief Coroner hopes that the numbers of second post-mortems can be reduced. They should only be carried out where there is a good and reasonable justification for them. In addition, the form of the examination – whether a full autopsy, or some sort of external examination of the body and of the notes of the first pathologist – should be considered very carefully by the coroner.

98. The first Chief Coroner developed some initial proposals for modernising the approach to second post-mortems in homicide cases.

99. The current Chief Coroner is developing this work and is giving consideration to other types of cases – not just homicides - where a second post-mortem may be ordered. The Chief Coroner has met with groups concerned about cases where such an order is made. The Chief Coroner has met with representatives from the Home Office in the hope that there can be a significant reduction in the number of cases where second post mortems take place. The Chief Coroner intends to issue guidance on the topic of second post-mortems later this year

Treasure

100. As set out in the third annual report, Chapter 4 of Part 1 of the 2009 Act, which provides for the appointment of a Coroner for Treasure and other provisions on treasure investigations, has not been brought into force. The provisions on treasure finds in the Coroners Act 1988 therefore remain in force. The Chief Coroner has taken steps to modernise and simplify the arrangements for treasure investigations and inquests. Treasure: A Practical Guide for Coroners which the first Chief Coroner issued on 12 November 2015 is a public document and can be read on the Chief Coroner's website.

101. The Department for Digital, Culture, Media and Sport (DCMS) is working with the British Museum and other stakeholders in preparation for a review on the code of practice published under the Treasure Act 1996 and the possible extension of the definition of treasure. September 2017 marked 20 years since the commencement of the Treasure Act. To commemorate the occasion and the ongoing success of the Act in ensuring that archaeological discoveries are acquired by public collections, the British Museum's Portable Antiquities Scheme engaged in a series of activities around the 'Treasure 20' theme. These included:

- a public vote organised by *The Telegraph* on the best Treasure find from the last 20 years. Almost 10,000 people participated and the winner was the Frome Hoard of 52,000 Roman coins discovered in 2010.

- 'Treasure 20' branded labels for museums across England and Wales to use in their display cases – over 600 finds were put on display in more than 100 museums.

- A session on Treasure at the annual Coroners' Society of England and Wales conference.

- A day-conference on Treasure at Yorkshire Museum

- A public debate/discussion at the British Museum as part of the 'Being Human' festival.

- Use of the twitter hashtag #Treasure20 throughout the year

International

102. The Chief Coroner continues to have oversight of the arrangements for major cases involving deaths overseas. Following major incidents the Chief Coroner liaises with coroners, the Foreign and Commonwealth Office (FCO), the Cabinet Office, the police and local authorities in order to ensure that the arrangements for repatriation of bodies to England and Wales and subsequent investigations are sound.

103. The Chief Coroner continues to have oversight of the arrangements made in the Leicester City and South Leicestershire coroner area following the Malaysian Airlines Flight MH17 disaster over Ukraine in July 2014, and the arrangements in the Kingston-upon-Hull and East Riding coroner area following the Lufthansa Germanwings Flight 4U9525 in the French Alps in March 2015.

104. In disaster cases a coordinated strategy is followed. The Chief Coroner works with a cadre of disaster victim identification coroners, the FCO and the police, whilst having in the forefront of any arrangements the wishes of the families who have lost loved ones. In all of the cases so far, each Senior Coroner has provided the families with written advice about the details of the coroner process.

Nomination of judge to conduct an investigation

105. The Chief Coroner has a power to request the Lord Chief Justice to nominate a judge (including himself) to conduct an investigation into a person's death. The Lord Chief Justice must consult the Lord Chancellor before making a nomination. This year the Chief Coroner has made four such requests for a nomination. In each case a judge has been nominated by the Lord Chief Justice and in each case the Lord Chief Justice has consulted the Lord Chancellor before making the nomination. The cases and the judges are set out below.

- The Chief Coroner has conducted the investigations (including inquests) into the deaths arising from the Westminster Bridge terrorist attack on 22 March 2017. Those inquests took place at the Central Criminal Court from 10 September 2018 and concluded on 12 October.

- The Chief Coroner will also deal with the investigations (including inquests) into the deaths arising from the London Bridge and Borough Market terrorist attack on 3 June 2018. The inquests will take place at the Central Criminal Court starting in 2019.

- His Honour Judge Paul Matthews was nominated to conduct the investigation (including an inquest) into the death of Barry Pring who was killed near Kiev in the Ukraine by a speeding car on 16 February 2008. There was an earlier inquest and the High Court ordered a fresh inquest on 24 April 2017.

- As at paragraph 82 above, His Honour Peter Rook QC has been appointed an Assistant coroner in Surrey to conduct the investigation (including inquest) into the death of

Private Geoff Gray who died in 2001 at Deepcut Barracks, Surrey ("Deepcut 3"). There was an earlier inquest and the High Court ordered a fresh inquest on 21 July 2017.

106. The Chief Coroner liaises closely with the judges nominated to deal with these cases.

The events of 2017

107. In the period between 22 March 2017 and 14 June 2017 there were a number of events that have resulted in mass fatalities. Westminster Bridge, the Manchester Arena, London Bridge and Borough Market were the subject of terrorist activity with the loss of many lives and numerous serious injuries. On 14 June fire broke out at Grenfell Tower. The fire developed and engulfed the tower. 71 people died as a result of the fire. Each of these horrific incidents led to the extensive involvement of the coroner service and of the local senior coroner.

108. When a mass fatality incident occurs, depending on where and how it takes place, the senior coroner with responsibility for the area will be notified by the police and will be involved in the process of the identification of the victims. The coroner will be part of the response along with the emergency services.

109. As set out in the last annual report the identification of those killed (and those injured) in any incident – whether it be a terrorist incident, a suspected terrorist incident, or a fire – can be a lengthy process. The site where the incident takes place may not be safe and where terrorist activity is the cause, there may be a live investigation to ensure there are no other devices. In other incidents the scene may well be a crime scene and the police will need to have an eye on securing evidence for any prosecution that may ensue. If the incident is an explosion or a fire it may have caused substantial damage to the fabric of the building where it has taken place as well as causing substantial disruption to the bodies of those killed.

110. The coroner and all others involved in the safe removal of bodies from a scene work to internationally agreed standards of identification.

111. Events worldwide have shown that it is important to deal with the process of identification in a clear and methodical way to make sure that the correct identifications are made. Where a plane crashes onto open land the plane manifest will provide an accurate list of those on the plane and will be a key feature of the identification of those involved. However a bomb explosion in a public space or a fire in a tower block poses many questions. There is unlikely to be any fully comprehensive manifest or list of those present. The formal identification process seeks to reconcile ante-mortem and post-mortem elements to ensure accurate identification and to arrive at an accurate number of those who have died. Where available fingerprint records, dental records and other similar records are compared to the body that has been found. The coroner and others engaged in the aftermath of events work as quickly as the conditions allow to formally identify those involved. There can be nothing worse than confirming to the family or friends of someone that their friend or family member has died only for that to be proved wrong. Once identification of a body is confirmed to the satisfaction of the coroner through trained family liaison officers (FLOs) there will be discussions with families as to the next stages.

112. The Chief Coroner has continued to work closely with each of the senior coroners in the coroner areas where these incidents have taken place.

113. As set out above the inquests arising out of the Westminster Bridge attack were heard by the Chief Coroner and held at the Central Criminal Court, starting on 10 September 2018.. They have now been completed.The inquests arising out of the London Bridge and Borough Market attack will also be heard by the Chief Coroner. They will also be held at the Central Criminal Court and are likely to start in the Spring on 2019.

114. The Chief Coroner is extremely grateful to the Recorder of London, His Honour Judge Nicolas Hilliard QC and the Corporation of the City of London for all of their work in assisting with these inquests. In particular the Chief Coroner would like to thank the Corporation for refurbishing rooms for the use of families in the course of the inquests.

115. The Chief Coroner has sought the nomination of a retired High Court Judge to deal with the inquests arising out of the Manchester Arena attack and has been in discussion with Sir Martin Moore-Bick in relation to the public inquiry into the fire at Grenfell Tower.

116. As set out in the last annual report the training programme for all coroners in 2017 to 2018 had as its focus mass fatalities, and the lessons learned from the coroner response to these incidents was included in the training programme.

117. The Chief Coroner has reformed the cadre of specialist coroners in this area of work. The cadre now has two co-chairs: Dr Fiona Wilcox and Mrs Cathie Mason. The cadre receive specialist training and there is a rota in place to ensure that for any event in England and Wales or overseas, a coroner is on call to respond.

118. The training is run by the Chief Coroner in conjunction with UK Disaster Victim Identification (DVI). The Chief Coroner wishes to express his sincere thanks to Detective Superintendent Alan Crawford and to Detective Inspector Howard Way OBE for all of their help and assistance throughout 2016, 2017 and 2018. They have both played extensive roles in the training of all coroners and coroner's officers as well as spearheading the response to incidents in the UK and throughout the world.

119. The Chief Coroner has taken part in a number of training events organised by UK DVI including training held in London for some of the Gulf States, in Rome for specialist investigators and prosecutors in Italy as well as attending the Interpol Conference on DVI in Lyon.

Northern Ireland and Scotland

120. Northern Ireland has a separate coroner service which is outside the Chief Coroner's jurisdiction. Scotland has no coroner service.

121. The Chief Coroner and his office nevertheless maintain close links with both the Coroners Service for Northern Ireland and the Lord Advocate and Crown Office and Procurator Fiscal Service in Scotland. There are regular meetings to discuss subjects of mutual interest.

Stakeholders

122. The Chief Coroner continues to meet regularly with a wide range of relevant

stakeholders. The Chief Coroner meets with coroners of all ranks, coroner's officers, Ministers (at the Ministry of Justice, Department of Health and Social Care, Home Office and elsewhere), senior judges, local authorities, senior police officers, registrars of births and deaths, pathologists, toxicologists, funeral directors (through the national associations), lawyers, the Director of Public Prosecutions, bereaved family members, the Coroners' Court Support Service, bereavement organisations and charities.

123. Over the last year, among the many meetings, he has met with senior members of the Coroners' Society of England and Wales on a wide range of topics including the reforms to appointments, appraisals and mentoring, with the Chief Inspector of Prisons on deaths in prisons and other detention, with representatives of the Air Accident investigation Branch, the Marine Accident Investigation Branch and the Rail Accident Investigations Branch on reformulating memoranda of understanding in those cases where they and coroners have roles, with the Royal College of Pathologists and others on the deaths of children including sudden infant death syndrome and sudden unexpected deaths in infancy and pathology issues generally, with Government departments about intelligence and intercept material, with the Foreign and Commonwealth Office (FCO) about deaths overseas, with the Royal College of Pathologists and others about forensic pathologists, with a number of representatives of the NHS on issues surrounding coroner investigations and inquests, with the Office of National Statistics over the ways in which coroners record inquest findings, with representatives of the Coroners' Courts Support Service on generating greater financial support for their work and expanding the service across all of England and Wales, and with various charities and other groups such as RoadPeace and the Campaign for safer births.

124. The Chief Coroner has continued to carry out an extensive schedule of speaking engagements. He has spoken at senior coroner continuation seminars and at coroner officer training. He has attended and spoken at a number of events including the Muslim Burial Conferences in Cardiff and Bolton, NHS Resolution conference in Newcastle and at the annual INQUEST seminar. He has also been a guest speaker at various law firms in England and Wales.

125. The Chief Coroner is deeply indebted to the work and support of all his team in the Chief Coroner's office. The team is ably led by James Parker (Head of the Chief Coroner's Office). The Chief Coroner values the support and assistance he has received throughout the year from James as well as from Brenda Jones (Deputy Head of the Chief Coroner's Office), Eve Naftalin (Chief Coroner's Legal Advisor), Gary McKenzie (Assistant Private Secretary) and Zara Smith (Diary Secretary).

126. In the course of the year Amy Jabbal left to take up an appointment elsewhere in the Civil Service. She was a valued member of the team and her contribution is greatly missed.

127. Brenda Jones (Deputy Head of the Chief Coroner's Office) retires in July 2018. The Chief Coroner thanks her for her fantastic contribution to the work of the office. Brenda has taken the lead on a number of difficult topics in the last few years. Her presence, experience and accumulated knowledge will be greatly missed. The Chief Coroner wishes her a long and happy retirement.

128. The Chief Coroner also wishes to express his sincere thanks for the regular working cooperation from those in the Ministry of Justice part of the Coroners, Burials, Cremations and Inquiries Policy Team in the Ministry of Justice led by Judith Bernstein OBE and Glenn Palmer, the team at the Judicial College led by Sheridan Greenland, the officers and members of the Coroners' Society of England and Wales, representatives from Local Government, the police and others, as well as all coroners and coroners' officer

129. The Chief Coroner wishes to express his particular thanks to those coroners who have assisted with devising and delivering training, those who have been consulted throughout the year on draft guidance and on outline plans and other aspects of the Chief Coroner's work. The Chief Coroner is deeply indebted to them all.

Issues of concern

130. As with previous years, there are several issues affecting the coroner service that remain unresolved. The Chief Coroner makes no apology for repeating a number of the issues from previous years' reports that remain to be considered. They are each important and deserve consideration. Some may require statutory change.

(i) Reporting deaths to the coroner

131. In the third Annual Report concern was expressed as to the lack of statutory or other clear criteria for medical practitioners reporting deaths to coroners. This has created uncertainty and inconsistency. When should a doctor report a death to a coroner? The answer to this question is not definite.

132. More than 229,000 deaths were reported to coroners in England and Wales in 2017. The vast majority of them were referred to coroners by GPs and hospital doctors. And yet there are no statutory criteria for doctors on when to report a case to the coroner.

133. The notes for doctors attached to the Medical Certificate of Cause of Death state, under the heading *When to Refer to the Coroner*: 'There is no statutory duty to report any death to a coroner.' The notes, therefore, do no more than encourage doctors to adopt the criteria for registrars and report any death which should be referred to the coroner by the registrar of births and deaths.

134. But this is no requirement or instruction. Doctors are not bound by it. There is, therefore, a lacuna in the law. Doctors need clear statutory guidance for reporting deaths to a coroner.[8] It would provide a clear framework for referrals to coroners and it would form the basis for better education and training for doctors and regular discussion with the local coroners about when a death should be reported. Doctors would develop greater confidence and accuracy about death certification, registration and referrals.

135. At the same time statutory criteria would also guide local coroners. It would preclude

[8] The Mid Staffordshire NHS Foundation Trust Public InquiryRecommendation 277.

them from promoting their own policies for reporting deaths locally. At present there is inconsistency of practice among senior coroners. Some, for example, request doctors to report all still births and all child deaths. There is no legal basis for this approach and a neighboring coroner area may have no such policy. This is confusing for doctors who travel and work in different parts of the country.

136. It is therefore a matter for Parliament in regulations to decide what types of death should be referred. Some other countries provide detailed criteria for reporting, for example in the New Zealand Coroners Act 2006 and the State of Victoria Coroners Act 2008 in Australia.

137. In England and Wales Parliament has envisaged that the Lord Chancellor could make regulations 'requiring a registered medical practitioner, in prescribed cases or circumstances, to notify a senior coroner of a death of which the practitioner is aware'. As stated in the third Annual Report this task should be completed as a matter of urgency.

138. There are two possible routes for this. If the medical examiner scheme is implemented, draft Death Certification Regulations are ready to be brought into force. Alternatively, free-standing regulations should provide the necessary criteria. The Chief Coroner understands that following the Government's announcement on medical examiners in June 2018, the most likely course is that free-standing regulations will be developed. The Chief Coroner welcomes any moves in this direction by Government.

139. Once implemented, doctors and others should routinely make referrals to coroners electronically, not orally as is often done at present, by email or other means, such as a web-based solution.

(ii) Pathology services

140. There remains considerable concern amongst coroners about the dwindling availability of pathologists to carry out post-mortem examinations at the request of coroners.

141. Not only is this problem capable causing considerable distress to families as they have to wait longer for a post-mortem but there is inconsistency with the way in which the 88 lead local authorities, who fund and administer the coroner service are managing this issue.

142. Individual authorities and their senior coroner are often driven to agree approaches to pathology which differ significantly depending on the resources they have available. Some are paying additional fees in an attempt to keep pathologists working within their area. This creates pay differential and can create supply problems in the areas unwilling or unable to pay the additional fees.

143. I am also concerned about a system which can allow sole practitioner pathologists working without the support of colleagues within an NHS Trust or organised private setting. This can lead to obvious problems if that pathologist gets behind with their reporting. If this happens, coroners often take the brunt of the blame from the bereaved family, who are rightly distressed about delay.

144. Other local authorities and senior coroners are constructing agreements which avoid

using autopsy pathologists altogether. The Lancashire and Darwen with Blackburn coroner area is looking at how to cope with a lack of pathologists available and have developed a scheme where they will use a radiologist to look at images from post mortem imaging. The Chief Coroner encourages the availability and use of post mortem imaging in general, so will be monitoring this pilot over the coming year.

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145. There are therefore worrying inconsistencies of practice across the country. These inconsistencies are symptomatic of system without properly funded and organised national foundations.

146. Section 14 of the 2009 Act permits a coroner to request a post-mortem examination (autopsy), either before or during an investigation into a death which has been reported to the coroner. Each request is a judicial decision made at the discretion of the coroner.

147. The vast majority of these autopsies are carried out by histopathologists (coroner's pathologists)[9]. Most of them are employed by health trusts or boards to carry out other pathology work (often on the living). The work for coroners is not usually conducted under their formal contracts or job plans, but independently. Their work for coroners often takes place outside their normal working hours. Arrangements vary across areas.

148. In a small number of cases, mostly suspected homicide cases, autopsies are carried out by forensic pathologists who are accredited by the Home Office and employed in private practice. In those cases their fee is paid by the police but they also act at the request of the coroner.

149. Approximately 85,600 autopsies were ordered and conducted this way in 2017. As raised in the annual report last year and the year before, despite that significant number of autopsies, the number of histopathologists available to carry out this work for coroners is decreasing. As a result, local pathology services are stretched and coroners are forced to delay releasing the body to a family for burial or cremation. Many coroners and medical examiners around the world release bodies within a timescale of approximately 24 hours. In England and Wales many coroners continue to struggle to achieve a three-day timescale and in many areas much longer than that. These delays are not acceptable.

150. As I have previously said the provision of pathology services to coroners was described by a senior pathologist as 'an already hard-pressed service on the edge of a complete meltdown'. In his Review of forensic pathology in England and Wales (March 2015)[10], Professor Peter Hutton described the immediate future of both forensic and non-forensic pathology services as 'fragile, and corrective action needs to be taken now'. A survey referred to in last two year's Annual Reports showed that of 463 consultant pathologists who conduct autopsies 26% intend to give up coroner autopsy work in the near future. Most cited 'poor remuneration' as the reason for doing so.

[9] In a small number of cases, autopsies are carried out by forensic pathologists who are accredited by the Home Office and employed in private practice.

[10] https://www.gov.uk/government/publications/review-of-forensic-pathology-in-england-and-wales

The standard statutory fee for an autopsy, set by central Government but paid by local government, has remained static for ten or more years at the rate of £96.80 per examination.

151. There is a lack of control and oversight over the provision of this service. Most pathologists who do this work have to make themselves available out of hours of their day jobs. This work is not part of their hospital trust contracts or job plans but extra work carried on outside normal working hours. Anecdotally we hear reports that this lack of support from their NHS employers discourages pathologists from taking on this vitally important public service coroner work.

152. No government department wishes to take responsibility for this service. The Department of Health and Social Care and the NHS do not consider that they have responsibility for pathologists in this work. The Home Office will, at present, only take responsibility for forensic pathologists.

153. The Chief Coroner repeats his belief that action is required in both the short term and the longer term. For the longer term he repeats the proposal that pathology services for coroners are organised regionally. Some 12 to 15 regional centres of excellence should be created, providing mortuary, post-mortem examination and post-mortem imaging (CT scanning) facilities.

154. The proposal is that each centre would be funded through local authorities and the NHS both in England and Wales. Forensic pathologists and other pathologists would be employed by the NHS at these centres. A forensic pathologist would lead the team. The employment of pathologists by the NHS to carry out coroner work would recognise that death investigation, for the benefit of the living, should be part of the NHS's core business. In the short term this would cost money. In the longer term substantial savings should be made, including the closure of small out of date local authority mortuaries which are expensive to maintain and even more expensive to replace.

155. The regional centre would have an on-duty pathologist at all times. The centre would operate a triage system. The centre would receive the body into the mortuary and (i) the pathologist would make an external examination of the body followed by imaging. (ii) The coroner's officer would receive the report of the death from the GP or hospital doctor and carry out any relevant initial inquiries including speaking to the family, especially asking if they have any concerns about the circumstances of the death. (iii) The coroner would receive information from stages (i) and (ii), discuss the pathologist's preliminary findings with the pathologist and decide whether a post-mortem examination was necessary and what further action should be taken, if any, before releasing the body to the family.

156. Under this scheme, or a variant of it, pathologists would be expected to provide a report, either preliminary or full, to the coroner within three days of the examination or earlier where possible. Training for all pathologists could be re-ordered and rationalised. The autopsy module provided by the Royal College of Pathologists would no longer be optional. It would become mandatory for all trainee pathologists, as it was before. Under this proposal further training for all pathologists should be provided by NHS England and Wales with additional skills training from the Home

Office. All pathologists would need to be on a specialist register with their level of expertise identified.

157. The Chief Coroner's proposal suggests that regional centres could in the first instance be a mixture of units developed by local authorities (and independent of NHS trusts) or units based on premises on NHS England or Wales. Ideally they would be a combined NHS and local authority resource, funded by both. Small local authority mortuaries which are out-dated would in time be closed. At present there are too many smaller mortuaries.

158. Short-term solutions are much more difficult. In the absence of any Government action the Chief Coroner continues to encourage coroners and their local authorities to nurture and support existing arrangements as best they can. That is unlikely to be enough. In the short to medium-term at least, imaging facilities are likely to develop through the private sector, and, as is current practice, although not desirable, at a cost to the families (within the range of £400 to £1,000). In due course the Chief Coroner would like the government, via the NHS, to provide post-mortem imaging for all cases. In many cases imaging will be able to replace more invasive post-mortems. Death and life are part of one continuum and we should all aim for the quality of care in death as we would in life.

159. In the short-term NHS Trusts could make autopsy work by pathologists part of the working contract for separate fees. Learning lessons from death should once more become an integral part of learning about life

160. As a result of the shortage of coroner's pathologists many coroners are facing delays in releasing bodies and taking cases to inquests. Although pathologists' reports should be provided to the coroner within three to four weeks, the dwindling numbers willing to do the work prevents this from happening. This needs to change.

(iii) Medical Examiners

161. As set out in the last Annual Report and restated at paragraph 78above, the introduction of the medical examiner (ME) system is welcomed. The Chief Coroner will work closely and constructively with Government following the announcement in June 2018. However, the Chief Coroner is disappointed that the scheme that was consulted on in 2016 which covered all deaths will not currently be implemented. He remains of the view that the interlocking system of oversight for community, hospital and all other deaths by the ME, with the coroner performing a more specialist role in relation to their legal jurisdiction, as envisaged in the 2009 Act, should be the ultimate objective. Until then, the issues the ME was designed to address, as highlighted in Dame Janet Smith's Shipman report and elsewhere, will not be fully dealt with.

162. Other concerns centre around the independence and quality of MEs. Will they be and be seen to be, sufficiently independent of those they are scrutinising? If they are (or were) hospital doctors, will they be sufficiently independent of their present and former colleagues and of hospital trusts in England and health boards in Wales? It is fundamental to the essence of the ME scheme that they must be independent in their appointment and in the execution of their functions.

163. Will they be of sufficient quality? Are there enough doctors or recently retired doctors at consultant level to provide this service? Will they be sufficiently accredited in this specialist field?

164. There is also a concern about possible delays. Increased coroner workloads without extra resources may lead to delays, both in releasing bodies and in concluding inquests. The ME service could also add delay by introducing an extra layer of investigation. And if MEs are part-time appointments will they be sufficiently available for early release of a body for burial or cremation? This issue is particularly acute for faith communities who want very early burial. Will MEs be available to make relevant decisions out-of-hours, at weekends and on bank holidays?

165. Another concern of the Chief Coroner relates to the likely increase in the workload of coroners, which may take place without any additional resources provided. Whilst it is generally believed that the involvement of MEs will produce a decrease in the number of cases referred to the coroner, it is also likely to lead to an increase in the complexity of the cases which are referred. These are cases that are likely to proceed to inquest and are likely to be the more difficult and more complex medical cases. The scale of the increase is uncertain.

166. Many coroner areas have been neglected for years in the provision of resources. They have a very modest number of coroner's officers to investigate and prepare cases for the coroner and very few administrative staff to support them. Local authorities are currently seeking to reduce their spending, as too are police authorities who employ most coroner's officers. Some local authorities and police forces are reluctant to send their coroner's officers to training as the cost of doing so is not regarded as 'essential' spending.

167. These are important considerations. A public service of death investigation which is not understood and valued by the public, particularly where a lack of planned resources could lead to delays in releasing bodies and completing inquests, will not flourish. The Chief Coroner restates the suggestion that there must be a clear resolution of these issues before the implementation of the ME scheme.

168. The ME scheme is a vital part of the death investigation reforms of the 2009 Act and the resource implications need to be carefully considered.

(iv) Salaries and fees of coroners.

169. The Chief Coroner has no statutory responsibility for the payment or level of payment to coroners. As was stated in last year's annual report in order to promote greater consistency and transparency there should be a fresh approach to the payment of salaries and fees to coroners.

170. The Chief Coroner is aware that discussions between representatives of the Coroners' Society of England and Wales and local authorities and the Local Government Association on salary levels have concluded and resulted in a joint approach. The agreement is being put into effect and salaries agreed between senior and area coroners and local authorities.

171. For future years the Chief Coroner is considering publishing a list of coroner salaries.

172. Despite this national agreement the Chief Coroner is aware that the level of fees paid to assistant coroners varies across areas. Some local authorities will pay a fee when an assistant coroner attends training – some do not. There ought to be payment to all assistant coroners to attend training. Some local authorities will reimburse travel costs to attend training, some will not. Training is compulsory and no assistant coroner should be 'out of pocket' when attending training.

Recommended law changes

173. The Chief Coroner recommends that consideration should be given to a number of changes in the law. The following recommendations were also proposed in the Chief Coroner's second annual report (2014-2015) and in last year's annual report: items (1), (2) (4) and (5). Items (3) and (6) also appeared in last year's report.

Item (1): Mergers of coroner areas

174. Under the law at present, each coroner area is to consist of the area of a local authority or the combined areas of two or more local authorities. Two coroner areas may not be merged into one area if that area will consist in total of less than the area of a local authority.

175. This has caused difficulties. For example, Kent consists of four separate coroner areas. Kent County Council, with the approval of the Chief Coroner, wishes all four areas to be combined into one coroner area, coterminous with the area of Kent County Council and Kent Police Authority. Kent would have liked to achieve this piecemeal, merging one area with another as and when a senior coroner from one of the coroner areas retires. But that is not possible under Schedule 2 to the 2009 Act in its present form. Hampshire County Council is in a similar position.

176. The provision therefore needs minor revision so as to provide greater flexibility. Whether the present position was intentional or not is not clear. It may have been oversight in the statutory drafting.

177. It is proposed that Schedule 2 be amended to permit two coroner areas to combine, by order of the Lord Chancellor, into one coroner area which consists of the area of a local authority or part of the area of the local authority. It is proposed that paragraph 1(2) of Schedule 2 to the Coroners and Justice Act 2009 be amended by the insertion of the words underlined so as to read as follows:

(2) Each coroner area is to consist of the area or part of the area of a local authority or the combined areas or parts of the area of two or more local authorities.

Item (2): Discontinuance without a post-mortem examination

178. Section 4 of the 2009 Act makes provision for the discontinuance of a coroner investigation, but only where the cause of death is revealed by a post-mortem examination. This was a new provision, not previously available to coroners.

179. In practice it allows a coroner who has commenced an investigation into a death under section 1 of the 2009 Act to bring the investigation to an end without having to hold an inquest. However, the coroner can only do so if the cause of death has been revealed by a post-mortem examination. In all other circumstances, once an investigation has been commenced, the coroner has no power to discontinue it; there must be an inquest.

180. The effect of this provision is that even if the coroner discovers the cause of death by means other than by a post-mortem examination, for example through medical records that become available at a later stage, the coroner must nevertheless proceed to inquest even though the outcome may be a foregone conclusion. This is an unnecessary step. It is time consuming, may be costly and adds to the distress of a bereaved family.

181. The solution is to amend section 4 of the 2009 Act so as to broaden the circumstances in which an investigation can be discontinued. It is proposed that the section be amended by the insertion of the words underlined so as to read:

Discontinuance where cause of death by post-mortem examination or other inquiry.

4.(1) A senior coroner who is responsible for conducting an investigation under this Part into a person's death must discontinue the investigation if-

(a) an examination under section 14 or other inquiry reveals the cause of death before the coroner has begun holding an inquest into the death, and

(b) the coroner thinks that it is not necessary to continue the investigation.

Item (3): Inquests without a hearing

182. There is no need for all inquests to be concluded with a hearing. In a case where the facts are not contentious, no witness are required to attend, the outcome is clear (at least on the balance of probabilities), the family do not want an inquest and there is no other public interest for conducting an inquest in a public hearing, the case could be concluded by a decision 'on the papers' with a written ruling.

183. A written ruling would have the advantage that it is a clear (and brief) decision with reasons, based upon the circumstances of the death, with findings of fact and a conclusion (short-form or narrative). This ruling could be handed down in open court and provided to the family for them to keep.

184. Such a ruling would be more focused than an *ex tempore* decision made at the time and more permanent. In some cases it need be no more than the completed Record of Inquest. In others, a page or two will usually suffice. There would be no need for an inquest, thereby saving court time, coroner time and other resources. Families would not need to attend court.

185. Rulings of this type are common in other jurisdictions – for example, in Australia and work well. Families appreciate the process and welcome receiving a copy of the ruling.

With the increasing use of digital technology across the mainstream Courts and Tribunals estate in England and Wales, there are fewer hearings in court, and this would lead in due course, in straightforward cases to inquests being concluded without the need for a hearing. Clearly, where an inquest must be held with a hearing or where there is a clear public interest in holding an inquest with a hearing, then a hearing will be held.

186. In most cases where there is no hearing, the public nature of the coroner's investigation and conclusion can be recognised by publication of the ruling, sometimes in a redacted form, or publication of the Record if Inquest (which is a public document).

187. The Chief Coroner therefore proposes the following amendment to the 2009 Act by the addition of a new section 6A:

6A Inquest without a hearing

(1) An inquest into a death must be conducted with a hearing, unless subsection (2) applies.

(2) An inquest into a death shall be held without a hearing, if the senior coroner is of the opinion that –
(a) the details required for the Record of Inquest are complete and not disputed,
(b) no interested person reasonably requires a hearing, and
(c) there is no public interest which requires a hearing.

Item (4): Fresh Inquests

188. The first Chief Coroner previously recommended, and a previous Secretary of State for Justice agreed in principle, that there should be a change in the law by way of amendment to section 13 of the Coroners Act 1988 (as amended) in order to give the High Court greater flexibility when it quashes an inquest.

189. Section 13 allows the High Court, on an application brought with the permission of the Attorney General, to quash an inquest and order a fresh one where it is necessary or desirable in the interests of justice to do so, for example by reason of irregularity of proceedings, insufficiency of inquiry or the submission of fresh evidence.

190. At the moment the High Court's powers are limited to quashing an inquest and ordering a fresh one, as for example happened in the case of the original Hillsborough inquests. Some section 13 cases could be sufficiently concluded without ordering a fresh inquest.

191. Applications for the exercise of the power in section 13 are still relatively common. Despite the repeal of many sections of the Coroners Act 1988, Parliament retained the section 13 provision. The power has been in existence since 1887 and continues to be a useful provision. However, the powers of the High Court seem to be unduly restricted in the way described.

192. In many cases there will undoubtedly need to be a fresh inquest and the final decision will rightly be left to be made at that inquest and not by the High Court, as for example in the Hillsborough case. In other cases there will be no such need. The amendment

proposed would mean that the High Court would not automatically be required to order a fresh inquest. The amendment proposed is by the addition of a new section 13A:

13A Where by virtue of the discovery of new facts or evidence or otherwise the High Court is satisfied that it is neither necessary nor desirable in the interests of justice that a fresh investigation or inquest should be held into the death, the High Court may direct that the particulars of the Record of the Inquest (Form 2, Schedule, Coroners (Inquests) Rules 2013) be amended as appropriate.

Item (5): Deaths at sea (body not recovered)

193. The Chief Coroner recommends that deaths at sea may be investigated by the coroner in the absence of a body, even if the death may not have occurred 'in or near the coroner's area'. As the law currently stands a death has to be 'in or near the coroner's area' for the coroner to request the Chief Coroner to direct the coroner to investigate: section 1(4)(a) of the 2009 Act. The effect of this is that if the death is beyond the reach of the coastal coroner's jurisdiction because it was not 'near' to the land, there can be no investigation or inquest.

194. In the last year the Chief Coroner has been sent 6 requests in circumstances such as this.

195. The Chief Coroner proposes that it would be preferable to adopt the approach as set out in section 6 of the Coroners Act 2009 No. 41 of New South Wales where the coroner may investigate if a death or suspected death occurred outside the State but had 'a sufficient connection with the State'.

196. Applying this kind of test to deaths at sea which are not 'near' the land of the coroner's area but are further out to sea, the coroner would be permitted to investigate the death if the deceased (or presumed deceased) had sufficient connection to the land. Taking an actual example, a retired man regularly set out to sea to fish alone on his boat. One day the boat was found with the engine on, drifting several miles out, with no sign of the man. His death was presumed after an extensive maritime investigation. It occurred too far out from the land to be 'near' the coroners' area, but he had sufficient connection' with the land because he was resident there and/or he set out to sea from his usual mooring on the land.

197. Section 1(4)(a) could therefore be amended by adding to the words 'in or near the coroner's area' words such as 'or with a close connection to the coroner's area', as follows:

1 …

(3) A senior coroner who has reason to believe that-

(4) (a) a death has occurred in or near the coroner's area or with a close connection to the coroner's area,

Item (6): Representation for families

198. In previous annual reports the Chief Coroner has asked that the Lord Chancellor gives consideration to amending the Exceptional Funding Guidance (Inquests) so as to provide exceptional funding for legal representation for the family where the state has agreed to provide separate representation for one or more interested persons.

199. The Lord Chancellor has addressed this by undertaking a review of legal aid for inquests. The Chief Coroner looks forward to reading the conclusions of the review.

Statutory powers and duties

200. Set out below is a summary of the Chief Coroner's powers and duties under the 2009 Act and the 2013 Coroners Rules and Regulations and the actions taken by the Chief Coroner since 1 July 2017.

201. Where a senior coroner exercises his or her discretion to report to the Chief Coroner under section 1(4) of the 2009 Act that he has reason to believe that a death has occurred in or near the coroner's area, that the circumstances of the death are such that there should be an investigation into it, and the duty to conduct an investigation does not arise because of the destruction, loss or absence of the body, the Chief Coroner may direct a senior coroner to conduct an investigation into the death (section 1(5)). Since 1 July 2017 there have been 47 applications and the Chief Coroner has granted 39 of them.

202. The Chief Coroner must be given notice in writing of any request made by a senior coroner for an investigation to be carried out by another coroner including the outcome of the request (section 2(5)). In the last year the Chief Coroner has received 965 notifications.

203. The Chief Coroner also has a discretionary power to direct a coroner to conduct an investigation into a person's death even though, apart from the direction, a different coroner would be under a duty to conduct it (section 3). By this power the Chief Coroner may direct transfers of investigations from one coroner area to another. The Chief Coroner has exercised this power four times in the last year.

204. The Chief Coroner may notify the Lord Advocate that it may be appropriate for the circumstances of certain deaths of service personnel abroad to be investigated in Scotland under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (section 12 of the 2009 Act). A protocol facilitating the notification process has been agreed between the Chief Coroner, the Crown Office and Procurator Fiscal Service, the Scottish Government, the Ministry of Defence and the Ministry of Justice. The Chief Coroner has not yet made any notifications to the Lord Advocate.

205. The Chief Coroner also has a power in certain circumstances to direct a senior coroner to conduct an investigation into such a death despite the body being in Scotland (section 13). It has not been necessary for the Chief Coroner to use this power yet.

206. The Chief Coroner may designate suitable practitioners to make post-mortem

examinations (section 14). The Chief Coroner has not exercised this power.

207. The Chief Coroner must keep a register of notifications by senior coroners of investigations lasting more than a year (section 156). That register was first opened on 25 July 2014, one year after the statutory provisions came into force. A summary of the number of such cases this year is set out at paragraph 32 above. Reference should also be made to the table at Annex C.

208. The Chief Coroner must monitor and train coroners for investigations into deaths of service personnel (section 17). For details see paragraph 80 above.

209. No appointment of a coroner may be made by a local authority without the consent of the Chief Coroner (and the Lord Chancellor) (section 23, Schedule 3). The Chief Coroner has given his consent to the appointment in the last year of four senior coroners, four area coroners and 20 assistant coroners.

210. The Chief Coroner has responsibility to train coroner and coroners' officers (section 37): see paragraph 59 above.

211. The Chief Coroner may carry out an investigation into a person's death (section 41, Schedule 10). The Chief Coroner has exercised this power in relation to the inquests into the tragic deaths on Westminster Bridge and the Palace of Westminster and at London Bridge and Borough Market.

212. The Chief Coroner may request the Lord Chief Justice to nominate a judge or a former judge to conduct an investigation (section 41, Schedule 10). The Chief Coroner may also request a former coroner to conduct an investigation (section 41, Schedule 10). He has made four requests to the Lord Chief Justice this year. All have been granted.

213. Senior Coroners who report to prevent future deaths under paragraph 7 of Schedule 5 to the 2009 Act and Regulation 28 of the Coroners (Investigations) Regulations 2013 (the Investigations Regulations) must send a copy of the report and any response to the Chief Coroner (regulations 28(4) and 29(6)). The Chief Coroner has received 377 such reports in the last year. The Chief Coroner may publish these documents (Regulations 28(5) and 29(7)). In practice they are all published, with redactions where necessary, on the judiciary website. The Chief Coroner seeks to publish as soon as is reasonably practicable after receipt of the reports. Email alerts are available for those who wish to subscribe on the Judiciary website.

214. Under Regulation 19 of the Investigations Regulations the Chief Coroner has power to direct the receiving local authority to bear the costs of an investigation transferred by direction under section 3 of the 2009 Act. The Chief Coroner has exercised this power once in the last year.

215. In addition, under Regulation 25 the Chief Coroner has power to require information in relation to a particular investigation or investigations. The Chief Coroner frequently requests details from coroners which are always complied with and as such has not needed to exercise this power.

216. The Chief Coroner also has the power under Regulation 27 to direct a coroner to retain

documents for a period other than 15 years. The Chief Coroner has not used this power in the last year.

Conclusions

217. This is the fifth annual report of the Chief Coroner to the Lord Chancellor. In the opinion of the Chief Coroner significant progress has continued to be made in this period. The statutory reforms and the first Chief Coroner's reforms have been effective and positive and in the public interest.

218. The Chief Coroner acknowledges the enormous contribution made by his predecessor His Honour Sir Peter Thornton QC, is setting in place many systems, guidance and training that have continued after his retirement.

219. There is still much to be done. The Chief Coroner is confident that the system will develop and improve further for the benefit of all who come into contact with the coroner system. The Chief Coroner looks forward to working further with all coroners on the plans set out in this report.

His Honour Judge Mark Lucraft QC,
Chief Coroner
June 2018

Annex A

CHIEF CORONER'S DEVELOPMENT PLAN 2018-2019

This Business Plan for 2018-2019 reflects the work of the Chief Coroner in implementing and developing the statutory reforms of the Coroners and Justice Act 2009 and the 2013 Coroners Rules and Regulations. Much of the work has been commenced and is ongoing; some of it will continue after 2019. But the purpose of this Plan is to identify the differing and evolving aspects of coroner reform and the advancement of a modern coroner system which serves the public efficiently, effectively and compassionately.

A. STRUCTURES

No	TOPIC	ACTION	TIMESCALE	COMMENTS
1	MERGERS	With Lord Chancellor (LC) to reduce the current 88 coroner areas to in the region of 75	Reduced to 88 (as of June 2018); ongoing	Purpose: to produce more effective, efficient size of coroner area with full-time senior coroner; regular discussion with Ministry of Justice and Local Authorities (LAs)
2	APPOINTMENTS	New procedures for appointments of all coroners (open competition, consent by Chief Coroner and LC).	Completed; Guidance No.6 amended Jan 2016. Revised appointments pack under development in 2018. Full audit of those in post completed in 2017.	Senior appeal judge swears in new senior coroners at RCJ with Chief Coroner;
2A	APPOINTMENTS -TRAINING	New workshops for assistant coroners wishing to be considered as area or senior coroners	Ongoing. Workshop completed in 2017 and 2018 and will be on-going as well as workshops for those seeking a first appointment.	
3	CORONER TEAMS	Advice to senior coroners	First delivered Feb 2014; ongoing	Needs organisation at local level
4	TRIANGLE OF RESPONSIBILITY	Advice to senior coroners, local authorities and police	Completed 2014; ongoing	

No	TOPIC	ACTION	TIMESCALE	COMMENTS
5	ROLE OF SENIOR CORONERS	Identified by Chief Coroner with advice to senior coroners	Completed Feb 2014; ongoing	
6	SALARIES AND FEES	Survey levels of salaries/fees of coroners; consider national scheme	Chief Coroner survey completed Feb 2015	Agreement reached between the Coroners' Society (CSEW) and Local Government Association. Agreement now being implemented
7	CORONER'S OFFICERS (1)	Identify functions and duties	Drafted 2014, in consultation	In discussion with CC's draft *Model Coroner Area*
8	CORONER'S OFFICERS (2)	Survey of numbers for coroner areas	Completed Feb 2015: CC makes requests	Purpose: to increase numbers in under-staffed areas
9	MEDICAL EXAMINERS	Discuss consequences of implementation with coroners, acting National Medical Examiner, pilot schemes, Government, LAs	Ongoing discussion since 2013; partial implementation by Government now scheduled for April 2019.	CC's response to DH consultation paper: 15 June 2016; further observations in 3rd Annual Report

B. INVESTIGATION

No	TOPIC	ACTION	TIMESCALE	COMMENTS
10	REPORTING DEATHS	Review criteria for which kind of deaths, and in what circumstances, deaths should be reported to the coroner.	Considered, discussed	Statutory list of criteria proposed in CC's 3rd Annual Report
11	TRANSFERS	Receive notice of transfers; to consider exceptional use of section 3 powers	Ongoing	For details see Annual Reports
12	'NATURAL CAUSES'	Definition: review law and practice	Discussion commenced at Chief Coroner's Conference for Senior Coroners Feb 2015; ongoing	
13	PRELIMINARY INVESTIGATIONS	Section 1(7) of Coroners and Justice Act 2009 in force; monitor use by coroners	Ongoing	Awaiting Government review of coroner service following 2015 consultation
14	STILLBIRTHS	To consider whether stillbirths/near term deaths should be reportable cases	Discussion commenced	Parliament likely to debate the issue in the near future.

No	TOPIC	ACTION	TIMESCALE	COMMENTS
15	CHILD DEATHS	One-day training for coroners	14 Sept 2016	Chief Coroner attended Child Death Overview Panels' Conference; discussion with Local Safeguarding Children Boards; meets with charities; involved in revision of Kennedy Guidelines
16	DEATHS IN PRISON	One-day training for coroners	13 May 2015	Chief Coroner attends Ministerial Board on Deaths in Custody and meetings with PPO, Chief Inspector of Prisons etc
17	POST-MORTEM EXAMINATIONS (P-Ms) (1)	Encourage coroners to avoid invasive P-Ms by reference to wider information; develop use of alternatives such as post-mortem imaging	Commenced; continuing	See Chief Coroner's Guidance No.1 on Post-Mortem Imaging (Adults); reducing P-M rates (see https://www.gov.uk/government/collections/coroners-and-burials-statistics
18	POST-MORTEM EXAMINATIONS (2)	Advice on P-Ms for deaths in prison; monitor	Advice produced 2014; ongoing monitoring	
19	POST-MORTEM EXAMINATIONS (3)	2nd P-Ms in homicide cases	Proposal drafted April 2015, in consultation; round table discussion July 2016. New guidance being developed on all aspects of 2nd P-Ms, not just homicide. .	Purpose: to reduce numbers of 2nd P-Ms

No	TOPIC	ACTION	TIMESCALE	COMMENTS
20	PATHOLOGISTS	Draft standard instructions for pathologists	By March 2016	Draft CC Guidance on coroners and hospital trusts in discussion
21	TOXICOLOGY	Draft scheme for standardised coroner/provider arrangements	Drafted March 2015, continuing consultation	
22	DISPOSAL OF ORGANS, TISSUE ETC	Advice to coroners; monitor and discuss	Advice provided 2013; continuing monitoring and discussion with Human Tissue Authority. New guidance on the coroner approach to organ donation to be prepared.	
23	FUNERAL DIRECTORS	Draft scheme for standardised coroner/funeral director arrangements	By Nov 2015; issued 8 Dec 2015	
24	OUT OF HOURS SERVICES	Consider extending scope of service	Discussion commenced; pan-London scheme proposed 2014; police and LAs agree in principle at meeting convened by Minister of Justice to London service Dec 2014, detail being considered 2015	Law and resources limited; developing interest across E & W; 'light touch approach requires on call coroner's officers and open registrar's office

No	TOPIC	ACTION	TIMESCALE	COMMENTS
25	SECTION 1(4) REPORTS: INVESTIGATIONS WITHOUT A BODY	Guidance for senior coroners; draft template for use; monitor	Completed April 2015; updated Jan 2016; monitor ongoing (working well)	167 reports received, 148 directions made by Chief Coroner (July 2013-June 2016); law change on bodies lost at sea proposed (see below)
26	DISCONTINUANCE	Monitor use; consider amendment to section 4 of Coroners and Justice Act 2009 where no P-M	Continuing	Amendment proposed: see 3rd Annual Report
27	SPECIAL CASES	Advice: Duty to Notify Chief Coroner in special cases, including mass fatality, military deaths, viral haemorrhagic fevers (eg Ebola), Regulation of Investigatory Powers Act 2000 etc	Issued Dec 2014, monitoring (working well)	Now used widely eg for MH17 (Ukraine) and Germanwings (France) air disasters and Sousse, Tunisia, killings, with special arrangements devised by Chief Coroner with coroners, police and Foreign and Commonwealth Office (FCO)
28	DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)	Guidance; discussion with coroners, Law Commission, LAs	Guidance No. 16 Dec 2014, updated Jan 2016; ongoing discussion. Revised guidance issued April 2017 in the light of the change to the definition of 'state detention'. Developments on the Law Commission plans awaited.	Definition of 'state detention' amended and the exclusion of most DoLS cases reflected in the statistics.

No	TOPIC	ACTION	TIMESCALE	COMMENTS
29	DEATHS ABROAD	Review procedures, draft scheme and guidance	By April 2016; not yet finalised, except CC advice on executions abroad July 2015	Chief Coroner has discussed with FCO, coroners and charities
30	MASS FATALITIES	Scheme for coroners and role of Chief Coroner; regular discussion with Government	Scheme completed July 2014; training conference 10 May 2016; discussion, training ongoing and the major topic for all coroners training 2017-2018.	CC heavily involved in training events both domestically and internationally. Close liaison with UK DVI.
31	ASPHYXIA RESTRAINT DEATHS	Monitor deaths in police/prison/other custody; provide advice where necessary	Ongoing	Evidence by CC to Dame Elish Angiolini's review of deaths and serious incidents in police
32	TASER DEATHS	Monitor and provide coroners with information	Assistance provided; ongoing	
33	APPOINTMENT OF JUDGE CORONERS	Draft scheme for nomination process	By August 2015; completed Sept 2015	Chief Coroner also provides advice to judge coroners on process and arrangements with LAs
34	LEGAL AID	Encourage Government to provide through Legal Aid Agency for families in appropriate cases	Completed: generally and on some individual cases; letter to Minister sent	LC reconsidered his guidance in light of High Court decision in *Letts*
35	BEREAVED FAMILIES	Meet with families, organisations; discuss issues, concerns	Ongoing	NB Chief Coroner cannot overturn judicial decisions of coroners

No	TOPIC	ACTION	TIMESCALE	COMMENTS
35A	MOUs	Memoranda of understanding between various agencies and coroners being revised and updated and devised to be between the Chief Coroner and the agency.	Ongoing. Various meetings with the AAIB, RAIB and MAIB, FCO, Care Quality Commission, CPS and others to deal with drafts.	

C. INQUESTS

36	SETTING DATES	Encouragement to set dates for all hearings as early as possible	Completed; ongoing monitoring and encouragement	
37	DISCLOSURE	To produce Guidance	By August 2016; incomplete	
38	ARTICLE 2 INQUESTS	To produce Guidance	By August 2015; still in draft form (awaiting decision in *Tyrell*)	
39	EXPERT EVIDENCE	Review; devise scheme for use of, instructions for, and receipt of expert evidence	12-18 months; delegated to coroners for first draft (awaiting)	
40	PRE-INQUEST REVIEW HEARINGS	To produce Guidance	By end of 2015; completed Jan 2016	

No	TOPIC	ACTIONS	TIMESCALE	COMMENTS
41	INQUESTS WITHOUT HEARINGS	To consider whether (i) appropriate and (ii) law change required	By June 2016; proposal in 3rd Annual Report July 2016 and restated in 4th Annual Report July 2017.	Written judgment without a hearing where (a) facts are uncontroversial, (b) there is no special public interest, and (c) family agree
42	TIMELINESS	Monitor cases of over 12 months; reduce backlogs	Annual figures from coroners commenced 2014, second return due May 2015; continuing with advice and training. 4th Annual report includes a schedule with all of the figures as returned by coroner areas.	In 3 years, number of cases over 12 months has reduced by 52%; nearly half of areas have less than 10 cases outstanding
43	USE OF FINDINGS IN FAMILY COURT PROCEEDINGS	Guidance; monitoring	Guidance No.13 April 2014 (working well); discussion with senior family law judges April 2015	
44	CONCLUSIONS	Guidance; training for all coroners	Guidance No.17 Jan 2015, updated Jan 2016; continuation training for all coroners 2015-2016	

No	TOPIC	ACTION	TIMESCALE	COMMENTS
45	RECORD OF INQUEST	Guidance on completion of Form 2 and public nature of document	Completed in Guidance No.17 above; part of training 2015-2016	Considering proposal to publish Records of Inquest
46	JURY INQUESTS	Draft directions for coroners	Completed April 2015	In new Bench Book (see below)
47	MEDIA	Guidance	Completed September 2016	
48	RETENTION OF RECORDS	Direction to retain longer than 15 years	2 cases 2015-2016	

D. REPORTS TO PREVENT FUTURE DEATHS

49	CORONERS' REPORTS TO PREVENT FUTURE DEATHS (PFD)	(1) Encourage more reports (2) monitor reports (3) publish reports on judiciary website (4) Chief Coroner to follow-up certain reports (5) set up alerts for monitoring agencies		All PFD reports are published on the judiciary website (subject to occasional redaction), with email alerts

E. HIGH COURT

50	APPLICATIONS FOR FRESH INQUEST (1)	Chief Coroner sits in High Court on most section 13 Coroners Act 1988 cases		

No	TOPIC	ACTION	TIMESCALE	COMMENTS
51	APPLICATIONS FOR FRESH INQUEST (2)	Further amend section 13 of Coroners Act 1988 so that High Court has discretion in uncontentious cases to amend Record of Inquest and not require further inquest	Proposal for amendment made: 2nd and 3rd Annual reports	MoJ has agreed in principle to change Dec 2013 but 'no Parliamentary time yet available'
52	JUDICIAL REVIEW	Chief Coroner is notified of all JR applications and sits in High Court on many hearings		

F. CHANGES IN THE LAW

No	TOPIC	TOPIC	ACTION	TIMESCALES
53	POSSIBLE CHANGES	Consider and recommend changes, including • merger of coroner areas into part of LA area • section 4 discontinuance without P-M • section 13 applications (above) • stillbirths • suicide standard of proof • revocation of assistant coroner appointments • registration of deaths of British nationals who die abroad. • bodies lost at sea	Discussion and consideration ongoing – dependent on Parliamentary time	Proposals of some changes in 2nd, 3rd ,4th and 5th Annual Reports

G. TREASURE

No	TOPIC	ACTION	TIMESCALES	COMMENTS
54	TREASURE	Rationalise treasure work, create step by step process and standard forms	Complete by October 2015; completed November 2015	Without implementation of Chapter 4 of Coroners and Justice Act 2009 existing procedures continue; new *Practical Guide for Coroners* with standard letters

H. TRAINING

55	CHIEF CORONER'S TRAINING COMMITTEE	Regular meetings with Judicial College (JC) and course directors. Chief Coroner is lead course director for all coroner training	CC held committee 3 meetings between July 2017 and June 2018; ongoing	Chief Coroner also attends JC Courts Committee
56	COURSE DIRECTORS	Appoint through JC	Completed; ongoing for fresh appointments	EOI to be run this autumn for, the period from February 2019
57	SYNDICATE LEADERS	Appoint through JC	Completed;	
58	INDUCTION TRAINING	Devise, produce, deliver (with JC) for newly appointed coroners	New course completed, delivered; two courses p.a. continuing	Last course Spring 2018; next course Winter 2018

No	TOPIC	ACTION	TIMESCALES	COMMENT
59	CONTINUATION TRAINING	Devise, produce, deliver (with JC) for all coroners	2016- 2017 course focused on mental health, 2017-2018 on mass fatalities and 2018-2019 on hospital deaths.	New course each year
60	CORONER'S OFFICERS TRAINING	Devise, produce, deliver regionally (with JC) for all coroners' officers	Created 2014-2015; delivery commenced April 2015 and on-going.	New course each year
61	SPECIAL ONE-DAY TRAINING	Devise, produce, deliver	Military cadre 2013; Deaths in prison May 2015; Child deaths Sept 2016; plus one day medical courses, mass fatality training May 2016	Other courses being discussed with course directors and JC
62	CHIEF CORONER'S CONFERENCES FOR SENIOR CORONERS	Devise, produce, deliver	Leadership, management and organisation Feb 2014; natural causes, DoLS etc Feb 2015; media issues Feb 2016, leadership and ethical issues Feb 2017, the vulnerable 2018.	Continuing on annual basis; opportunity for senior coroners to meet and discuss coroner issues; area coroners to attend from Feb 16

63	CHIEF CORONER'S SPECIAL TRAINING DAYS	Devise, produce, deliver	Bereavement organisations June 2014; LAs Dec 2014, July 2016, October 2017, February 2019	Further days to be considered
No	**TOPIC**	**ACTIONS**	**TIMESCALES**	**COMMENTS**
64	CHIEF CORONER'S INTERNATIONAL CONFERENCE	Devise, produce, deliver conference for overseas Chief Coroners (or equivalent)	3 day event in London May 2016	Follow-up email group

I. GUIDANCE ETC

65	CHIEF CORONER'S GUIDANCE	Produce, circulate to all coroners, publish on judicial intranet and judiciary website	Guidance Nos.1-22 completed and published, with updates in Jan 2016. Guidance on juror notices, jury questions and organ donation and prioritisation 2017-2018, paper inquests and second post-mortems in preparation.	Further possible Guidance to include an introduction to Article 2, dealing with the media, deaths overseas, hospital trusts and coroners, disclosure etc Email alert scheme to be implemented

66	CHIEF CORONER'S LAW SHEETS	Produce, circulate to all coroners, publish on judicial intranet and judiciary website	Law Sheets Nos.1-5 completed and published, updated Jan 2016	Further Law Sheets to be considered
67	CHIEF CORONER'S ADVICE	Produce, circulate to all coroners, publish on judicial intranet	Various completed;	
No	**TOPIC**	**ACTION**	**TIMESCALES**	**COMMENTS**
68	WELFARE ADVICE	Access to judges' helpline	By July 2015; completed 29 July 2015	
69	JOINT GUIDANCE	Produce, circulate to all coroners, publish on judicial intranet and judiciary website	Joint Guidance with British Heart Foundation etc completed	Further Joint Guidance with Health and Safety Executive in development
70	NEW CORONER'S BENCH BOOK	Produce in sections, publish on judicial intranet	Section on jury inquests completed April 2015; further sections to	Written and produced by Chief Coroner with two coroners
71	CHIEF CORONER'S NEWSLETTER	Occasional publication for coroners, with news, events, dates, announcements, discussion	First edition published on judicial intranet February 2015, further editions in 2016, 2017 and 2018.	Further editions in due course

J. SPEECHES, MEETINGS, VISITS

72	SPEECHES, TALKS, MEETINGS, VISITS	To coroners, coroners' officers, organisations, agencies, police, LAs, charities, faith groups, judges, lawyers etc	Ongoing	To explain coroner service, role of Chief Coroner and reforms; to discuss issues, concerns, reorganisation, progress etc

73	MINSTRY OF JUSTICE	Regular contact with LC, relevant Ministers and Head of Coroners, Burials, Cremation and Inquiries Policy Team	Ongoing	
74	JUDICIAL EXECUTIVE BOARD (JEB)	Regular updates to senior judges at JEB	Ongoing	
No	**TOPIC**	**ACTION**	**TIMESCALES**	**COMMENTS**
75	CORONERS' SOCIETY OF ENGLAND AND WALES (CSEW)	Regular meetings to discuss coroner issues	Ongoing	Chief Coroner also speaks at local CSEW meetings

K. COMPLAINTS

76	Judicial Conduct Investigations Office	Chief Coroner has no role in investigation and adjudication of complaints, but occasionally provides pastoral advice	Ongoing	

L. ANNUAL REPORT

77	ANNUAL REPORT TO LORD CHANCELLOR	Chief Coroner reports annually to LC	2nd annual report due July 2015, completed	3rd Annual Report June 2016, 4th Annual Report July 2017, 5th Annual Report July 2018..

22 April 2015 and 29 June 2016 HH JUDGE MARK LUCRAFT QC CHIEF CORONER
Revised 29 June 2018

Annex B

A MODEL CORONER AREA

THE CHIEF CORONER'S RECOMMENDED MODEL

This document is intended to assist senior coroners, local authorities and police authorities as to the nature, scope and organisation of a model coroner area. All should work together to try and achieve, wherever possible, the aspirations of this model.

Size of coroner area; mergers

1. Approximately 225,000 deaths are reported to coroners in England and Wales each year.

2. The size of a coroner area should be such that the senior coroner receives approximately 3,000 to 6,000 reports of deaths each year. Areas which receive less than 2,500 reported deaths should consider merging with another area. Smaller, part-time jurisdictions may sometimes be less efficient and effective.

3. Applications to merge two or more coroner areas are considered by the Lord Chancellor. If two or more local authorities wish to merge their coroner areas into one combined area, they should apply to the Lord Chancellor through the Ministry of Justice (MoJ). The MoJ will ask the authorities to complete a business case for the merger in standard form before the Lord Chancellor formally consults relevant stakeholders.[11] The Chief Coroner is always available to discuss mergers.

Coroners

4. Each coroner area should have a senior coroner supported by assistant coroners. In some larger areas there will also be an area coroner.

5. Where there is an area coroner, the senior coroner's administrative workload should be shared with the area coroner by agreement.

6. The senior coroner, with the agreement of the local authority, must allocate the area coroner (if there is one) or an assistant coroner as the senior coroner's deputy. This is not a formal statutory post; the deputy should deputise for the senior coroner in their absence for leave or sickness.

7. New coroners should be appointed by the local authority following an open and transparent competition.[12]

[11] See Chief Coroner's Guidance No.14 *Mergers of Coroner Areas.*

[12] See Chief Coroner's Guidance No.6 *The Appointment of Coroners.*

8. The role of the senior coroner, a post which came into force for the first time with the implementation in 2013 of the Coroners and Justice Act 2009, embraces the following. The senior coroner:

    - stands at the head of the local coroner service
    - provides collaborative leadership
    - leads on coroner work and manages the caseload
    - organises and supports the coroner team locally
    - works closely with the local authority and the police
    - manages the expectations of the public and bereaved people
    - is on call all the time (or on a rota basis) for urgent matters and for making decisions about organ and tissue donation, and
    - is prepared for a mass fatality disaster.

9. Senior coroners and area coroners are entitled to a salary. Assistant coroners are entitled to fees. Fees for assistant coroners should be paid at a daily (or half daily) rate for preparation and court casework as well as office work. The basis of all payments should be clearly agreed in advance.

10. Salaries and fees (and other terms and conditions) should be agreed from time to time between coroner and local authority. It is the Chief Coroner's view that an independent assessor (such as the Senior Salaries Review Body) should recommend levels of salaries and fees.

11. In the Chief Coroner's view the JNC Agreement on coroners' pay as set out in Circular No.51 (latest version 14 April 2011) lapsed in July 2013. The Coroners' Society of England and Wales and the Local Government Association, who entered into the JNC Agreement, both accept that it has lapsed. The agreement referred to terminology in an Act of Parliament which was been repealed. Accordingly, new agreements between coroners and local authorities should not include terms such as long inquest payments, county loading and assessment of 11.5% of annual caseload for payment of a deputy. Senior coroners should not be required to pay for any other coroner or pay for any expenses out of their salary.

12. Senior coroners should be expected to have and take an annual leave entitlement of 30 days.

13. Assistant coroners should be given a minimum of 15 days work a year (either sitting and/or office coroner work). They must first be assessed as competent and ready to work on their own.[13]

14. There is a mentoring scheme for assistant coroners (and other coroners) who require additional assistance or advice and an appraisal scheme is to be piloted and launched across all areas in due course.[14]

15. Where possible, senior coroners should provide 'shadowing' opportunities for aspiring assistant coroners.

16. Area coroners and assistant coroners should be appraised annually by the senior coroner. An appraisal scheme needs to be developed.

[13] In accordance with the Chief Coroner's Guidance No.20 *Core Competencies for Assistant Coroners.*

[14] See Chief Coroner's Guidance No.19 *Mentors for Coroners.*

17. The senior coroner should hold regular (possibly monthly) meetings with the coroner team to discuss relevant coroner issues and work. There should also be regular meetings with the relevant local authority and the police, as well as local registrars. The senior coroner should also hold meetings with hospitals and GPs, and with community and faith groups.

18. Meetings of senior coroners within a region are encouraged.

19. The senior coroner should present a brief annual report to the local authority. The report, which should be published on the local authority website, should include relevant statistics on current and concluded cases (with comparison figures for previous years), an update on coroner work and relevant issues, a summary of the coroner team and staffing arrangements, and any plans for the future.

20. Coroners (including senior coroners) should be computer competent and therefore able to deal with correspondence and other necessary documentation themselves, if required. That is not to say that coroners should not be provided with necessary administrative support whether by a personal assistant or other staff (see below).

Coroners' officers

21. Coroners' officers are employed by the police authority or local authority. For their functions and duties as coroners' officers see the Chief Coroner's note on *The Functions and Duties of Coroners' Officers*.

22. In order that coroners can carry out their functions, there should be a minimum of one coroner's officer for every 350-450 reported deaths. In complex jurisdictions, particularly those with prisons, more should be provided.

23. Those employing coroners' officers, whether police or local authority, should maintain a full complement of officers at all times. Arrangements should be in place so that proficient temporary cover is available whenever officers are absent through long-term sickness or suspension.

24. Employers of coroners' officers and councillors are encouraged to visit the coroner's office (by appointment) to discuss the work of coroners' officers and the issues raised by them.

Administrative support staff; the telephone system

25. Coroners and coroners' officers should be supported by administrative support staff employed by the local authority. The minimum ratio of coroners' officers to administrative staff should be approximately 3:1.

26. The work of administrative support staff employed by the local authority should be of a purely administrative nature. Administrative staff should not usually be carrying out the work of coroners' officers; their role is to support coroners and coroners' officers.

27. Administrative support staff should carry out the following functions: answer the telephone; copy documents (which cannot be scanned); distribute disclosure; deal with jurors and juries; manage invoices in connection with post-mortem examinations, toxicology and body removal/storage, as well as witnesses and jurors etc; collate management data; manage the computer system (ALS or another system); and deal with insurance companies and others.

28. Administrative staff, through a telephonist receptionist or other system, should answer all incoming telephone calls in the first instance. In doing so they should provide basic general information and information on specific cases, taken from a centralised computer system. In this way calls to coroners' officers should be greatly reduced.

29. The telephone system should be operated during working hours, ordinarily from 9am - 5pm (or 8am - 4.30pm), Monday to Friday, including the lunch hour. Calls should be answered promptly, ideally within 30 seconds. Where necessary, staff working hours should be staggered in order to permit good access to the coroner service. It is vital that all stakeholders, including doctors, pathologists, toxicologists, registrars, funeral directors and insurance companies, as well as members of the public, should have prompt access to the coroner service. Appropriate answering messages should be given for calls out of normal hours with appropriate emergency numbers. Telephone systems should not have complex 'menus'.

Accommodation

30. The local authority should provide office accommodation for all coroners, coroners' officers and administrative support staff. Ideally, all personnel should be close together in one building. The coroner's court should be in the same premises where possible. Where the local court is not large enough for jury inquests, courts should be made available to the coroner for jury inquests on a regular basis. Coroner areas should actively work towards these arrangements.

31. Where the police employ coroners' officers, the police authority may share some of the necessary cost of accommodation. Coroners' officers should not be in different parts of the county or in police stations, but working together in one place with the coroner and administrative staff. This produces greater resilience, efficiency and effectiveness of working. It serves the public better.

32. The coroner's premises should, where possible, be close to the registration services and other relevant local authority staff (and Medical Examiner service when implemented).

33. In a busy jurisdiction there should be more than one coroner's courtroom in the premises: a larger court capable of holding jury inquests, and a smaller court for everyday work.

34. Senior coroners should not routinely use their home as an office. The local authority should provide them with an office.

35. The use of private email addresses for judicial work should be discouraged. The local authority should provide coroners with a secure email address. There should also be secure storage for documents.

Investigations and inquests

36. Coroners must act independently in making judicial decisions, including (but not exclusively) on the following issues:

- deciding whether to commence an investigation or to complete Forms 100A and 100B
- requesting a post-mortem examination
- releasing a body for burial or cremation
- issuing interim death certificates
- discontinuing an investigation
- conducting hearings
- completing inquests
- making Out of England orders, and
- writing reports to prevent future deaths

37. Coroners are expected in most cases to follow the Chief Coroners Guidance on practice and procedure. Coroners may depart from guidance, however, where there are good reasons to do so, but they should provide their reasons either in open court or in correspondence. As independent judicial office holders, coroners must make their own

judicial decisions. The Chief Coroner may not interfere with those decisions, nor amend or reverse them, except when he sits in the High Court.

38. Doctors should have a statutory duty to report deaths to coroners in specified circumstances. In the current absence of statutory regulation, doctors should comply with the recommended reporting requirements set out in the notes for doctors on the Medical Certificate of Cause of Death.[15] Coroners should not require doctors to make reports (referrals) in any other circumstances.

39. Deaths should be reported (referred) to the coroner immediately (at the latest within 24 hours) and electronically, by email or other means, such as a web-based solution, in standard form. Doctors should not be paid by the coroner for referral reports.

40. All bodies should be released for burial or cremation within three days of the report of the death to the coroner, or where possible earlier.

41. Most inquests should be completed within six months of the death being reported. Coroners should aim to complete 40% (or more) of all inquests within one month and a further 20-25% (or more) within one to three months.

42. In some cases, such as deaths overseas, deaths in custody, or where the police or other agency have ongoing investigations, this timescale may not be possible. But coroners should keep a close watch on such cases to ensure that they are completed within a reasonable time.

43. In cases where the death occurs overseas the coroner should take a realistic view when no useful purpose would be served in deferring further the inquest. Similarly, where the body has been lost at sea or in a river and may never be recovered, the coroner should not delay unreasonably in making a section 1(4) request to the Chief Coroner to hold an inquest in the absence of the body. Some such cases in the past have been deferred almost indefinitely. Earlier inquests may be needed, even though information may be limited.

44. A coroner area should avoid a backlog of cases. There should be no more than a handful of cases which are not completed or discontinued within 12 months of the report of the death. Coroners must report annually to the Chief Coroner with details of all cases not concluded within 12 months.

45. All inquests should be opened in open court, in a local courtroom. Open court means a court arranged in a building in such a way that any member of the public can drop in to observe the hearing (any hearing) unannounced.

46. At the opening hearing a date should be fixed either for the inquest itself or, in more complex cases, for a pre-inquest review hearing. Normally, the name of the coroner who will be hearing the case should be announced. The coroner should not as a matter of course fix review hearing dates instead of inquest dates at the opening hearing.

47. Reports, including, post-mortem reports should be required from pathologists within three to four weeks, except where further reports from toxicologists or other experts are required. Timescales should be announced at the opening hearing.[16]

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[15] Paragraph 5.3.

[16] See Chief Coroner's draft Guidance *Coroners and Healthcare Providers.*

48. All hearings should be recorded. Coroners should usually avoid obtaining a transcript of a hearing.

49. Interim hearings and final hearings should be notified to the public by notice on the coroner's or local authority website.[17]

50. In non-contentious cases, where no witness is required, the family have no concerns and there is no particular public interest, inquests should be concluded with brief paper rulings. This proposal will require a change in the law.

51. In more complex cases, coroners should hold pre-inquest review hearings (PIRs). The coroner should set an agenda in advance and give rulings either at the hearing or shortly afterwards. All rulings should be reduced to writing (in brief) and distributed to Interested Persons. Topics for a PIR agenda may include:

    - identity of Interested Persons
    - representation
    - scope of inquest
    - whether Article 2 is engaged
    - whether jury is required
    - venue
    - timescale
    - list of witnesses
    - disclosure
    - jury bundle
    - other outstanding issues

52. Where a person dies in a care home or hospital subject to a Deprivation of Liberty Safeguard authorisation (DoLS), the coroner may proceed to a brief paper inquest, preferably within two weeks of the death, in the following circumstances: the coroner obtains (i) a copy of the authorisation and (ii) a medical report indicating that the death was from natural causes, and (iii) the coroner checks with the family that they have no particular concerns about the death.

53. Coroners, through their officers, should check with all families in all cases to see whether they have any particular concerns about the death.

54. Coroners, through their officers, should provide families with early information and early explanation about the forthcoming coroner process. Officers should keep families and other interested persons informed of the progress of the investigation including the reason for any delay.

55. Coroners' officers should not normally be required to remain at court during an inquest.

56. In due course, Records of Inquests should be published (subject to any necessary redaction) on the coroner's or local authority's website. Similarly, where inquests are permitted to take place without a hearing (see paragraph 50 above), the final rulings should also be published.

Reports to prevent future deaths

57. All coroners are encouraged to write reports to prevent future deaths in appropriate cases. They are of value to the family concerned and the wider public.

[17] See Chief Coroner's Guidance No.9 *Opening Inquests.*

58. Reports should be completed using the standard template. A copy of the report and any response must be forwarded to the Chief Coroner's office by email.[18] The report and any response will usually be published on the judiciary website (sometimes with redactions).

Out of hours services

59. The senior coroner, in collaboration with the police and the local authority, should provide an out of hours coroner service.

60. In view of current financial limitations, an out of hours service (overnight, weekends and bank holidays) should be arranged on a 'light touch' basis. This should require as a minimum the availability of one or more coroners' officers on a rota system, in the first instance answering calls and having access to case records on a centralised local computer system. It should also require an on call rota of coroners, special opening hours for registrar's offices and occasional access to local authority mortuaries.

61. A local coroner should always be available for emergencies such as homicide cases, mass fatalities and decisions on organ and tissue donation. In some areas an out of hours service will require more, particularly in order to assist families who seek early burial for their loved ones or Out of England orders.

62. The registrar's office should be open for a limited period at the weekend and on bank holidays for the registration of deaths and the provision of death certificates. This will complement out of hours arrangements in the coroner service and provide a more coordinated system for death investigation and registration.

63. Since the coroner service continues to be funded locally, the cost of providing an out of hours service will fall on the local authority and local police authority.

Mortuary and pathology services

64. Mortuary and pathology services should be arranged on a regional basis. Local authorities and NHS England and NHS Wales should combine to provide regional medical centres of excellence. These should include mortuary services, a hierarchy of pathologists (with forensic pathologists at the highest level), CT scanning and ideally other facilities such as toxicology and other forensic testing.

65. The Chief Coroner will be working actively with NHS England, NHS Wales, the Department of Health, as well as coroners, local authorities and others, to encourage developments in this direction.

66. Until regional centres are available, coroners should have access to CT scanning facilities (although this may be a facility which requires payment of a fee by families).

67. Coroners should aim towards a post-mortem examination (autopsy) rate of 30% of reported deaths or below. (Current post-mortem rates in coroner areas across England and Wales vary from 22% to 62%.) Coroners are encouraged, as in other jurisdictions, to judicially manage resources proportionately, allocating to any one case an appropriate share of resources, while taking into account the need to allot resources to other cases.

Tendering

68. Tendering for services from external providers should be undertaken every three or four years. Relevant providers include toxicology and funeral directors.

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[18] See Chief Coroner's Guidance Nos.5 and 5A *Reports to Prevent Future Deaths* and *Practical Guidance: PFD Reports.*

69. The precise process of tendering is a matter for each relevant authority in discussion with the senior coroner.

70. Tendering criteria should always focus on more than just cost. Quality and delivery of service are essential.

71. Funeral directors who have a contract with the coroner and local authority for 'coroner's removals' (removal of a deceased person on the authority of the coroner from the place of death to the coroner's mortuary) should not solicit bereaved families for business at the time of removal. They may, however, leave behind with the family a Notice of Transfer (or similar document) in the terms suggested by the Chief Coroner.[19]

Local authorities

72. The relevant local authority should discuss issues including financial issues with the senior coroner and staff on a regular basis. Good, frequent and collaborative contact is essential.

73. Local authorities should understand that coroners are independent judicial officers and that the local authority may not interfere in matters within the exclusive jurisdiction of the coroner. This does not, however, mean that coroners have exclusive rights over all things coronial. Much needs to be the subject of sensible discussion and agreement. Senior coroners are not chief officers of the local authority, although in some cases there may be useful analogies from the way chief officers and other council departments operate.

74. When the senior coroner is approaching retirement (ideally at least a year in advance), local authorities should consider succession planning and, if a small jurisdiction, possible future merger with another coroner area or areas.

75. Local authorities should provide the senior coroner with a dedicated website or a page of the local authority website, so that information about the coroner service and details of forthcoming inquests (and, in due course, outcomes) may be posted.

Training

76. Compulsory training is provided for all coroners (380) and coroners' officers (590), from basic learning to continuing development, as part of the modern requirement for a professional public service. Training is devised, arranged and delivered by the Chief Coroner together with the Chief Coroner's course directors (selected by competition). Training is provided under the auspices of the Judicial College which trains all judges, magistrates and tribunal members. The College funds and administers the training.

77. Newly appointed assistant coroners receive compulsory residential induction training.

78. Newly appointed assistant coroners should also receive local in-house training at the coroner's premises. They must satisfy the core competencies for assistant coroners (see paragraph 13 above).

79. In order to ensure that assistant coroners are sufficiently skilled in coroner work for the benefit of local people, local authorities should remunerate assistant coroners for attendance at training (by way of daily rate for lost working time) and pay their reasonable expenses. Where assistant coroners hold posts in more than one jurisdiction, these costs should be shared between relevant local authorities. The training, accommodation and meals are provided by the Judicial College free of charge.

[19] See Chief Coroner's Advice *Contracts for Coroners' Removals.*

80. All coroners receive compulsory residential training each year (which is similarly arranged by the Chief Coroner).

81. In addition, the Chief Coroner provides one-day courses on specific topics such as deaths in prison, deaths of children, mass fatality events, medical topics, as well as special training for his cadre of coroners for military deaths.

82. Coroners' officers also receive (as of 2015) compulsory residential training from the Chief Coroner (as above) each year. They should also receive extensive in-house training while learning in post, both from the coroner and coroners' officer manager. Local registrars should also be invited in to help train coroners' officers.

83. Where possible, senior coroners (or a member of the local coroner team) should make themselves available to instruct GPs and hospital doctors about the coroner service and requirements for reporting deaths and contents of MCCDs.

Discipline

84. Coroners' officers and administrative support staff are line-managed and disciplined where necessary by their employers (police or local authority) and not by the senior coroner. Police and local authorities should, however, discuss with the senior coroner the implications of enforcing discipline.

85. Coroners are appointed (but not employed) by local authorities. As independent judicial office holders, they cannot be dismissed or removed from office by local authorities. By statute, a coroner (like other judges) may only be removed from office by the Lord Chancellor, with the agreement of the Lord Chief Justice, for 'incapacity or misbehaviour'.

86. In practice complaints against coroners over personal conduct should be made to the Judicial Conduct Investigations Office which investigates and makes recommendations to the Lord Chancellor. Complaints about judicial decisions by coroners should be made through the High Court.

87. The Chief Coroner has no role, statutory or otherwise, in the disciplinary process of coroners.

HH JUDGE MARK LUCRAFT QC
CHIEF CORONER

Revised 30 June 2017

Annex C

Cases over 12 months old reported to the Chief Coroner (information correct as at April 2018)

Coroner Area	Senior Coroner	Area Coroner	Number of cases over 12 months old (2015)	Number of cases over 12 months old (2016)	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of reported deaths in 2017
Avon	Maria Voisin		11	12	8	12	4300
Bedfordshire & Luton	Ian Pears (Acting)		12	15	12	18	2230
Berkshire	Peter Bedford		13	13	13	27	2333
Birmingham & Solihull	Louise Hunt	Emma Brown	14	10	18	19	5090
Black Country	Zafar Siddique		5	5	6	9	4731
Blackpool & Fylde	Alan Wilson		5	2	3	2	1483
Brighton & Hove	Veronica Hamilton-Deeley		1	1	0	5	1272
Buckinghamshire	Crispin Butler		3	1	4	11	1404
Cambridge & Peterborough	David Hemming		21	25	53	60	4094
Carmathenshire & Pembrokeshire	Mark Layton		11	13	12	13	1518
Central & South East Kent	Patricia Harding (Acting)		13	8	1	4	1690
Central Hampshire	Grahame Short		5	3	4	6	1494

Coroner Area	Senior Coroner	Area Coroner	Number of cases over 12 months old (2015)	Number of cases over 12 months old (2016)	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of reported deaths in 2017
Ceredigion	Peter Brunton		0	0	1	2	318
Cheshire	Alan Moore	Claire Hammod	12	22	19	28	4138
City of London	Alison Hewitt		1	1	1	4	255
Cornwall & Isles of Scilly	Emma Carlyon		30	28	32	32	2814
County Durham and Darlington	Jeremy Chipperfield		6	5	11	17	2906
Coventry	Sean McGovern		4	1	5	7	1792
Cumbria	Kally Cheema		11	16	24	20	2082
Derby & Derbyshire	Robert Hunter		73	69	55	47	4732
Dorset	Rachael Griffin		7	13	22	22	3742
East London	Nadia Persaud		86	39	51	84	2300
East Riding & Hull	Paul Marks (Prof)	Rosemary Baxter	2	7	15	11	3012
East Sussex	Alan Craze		11	6	9	20	2248
Essex	Caroline Beasley-Murray	Eleanor McGann	20	10	21	9	7372

Coroner Area	Senior Coroner	Area Coroner	Number of cases over 12 months old (2015)	Number of cases over 12 months old (2016)	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of reported deaths in 2017
Exeter & Greater Devon	Philp Spinney		25	29	21	45	2834
Gateshead & South Tyneside	Terence Carney		10	20	17	10	1911
Gloucestershire	Katy Skerrett		20	7	3	7	2264
Gwent	David Bowen		5	7	6	6	2901
Hartlepool	Clare Bailey (Acting)		0	0	1	0	246
Herefordshire	Mark Bricknell		3	5	5	5	827
Hertfordshire	Geoffrey Sullivan		32	31	33	22	3021
Inner North London	Mary Hassell		13	11	15	21	2505
Inner South London	Andrew Harris		106	29	54	84	3612
Inner West London	Fiona Wilcox		24	32	14	27	2359
Isle of Wight	Caroline Sumeray		8	12	13	9	738
Lancashire and Blackburn with Darwen	James Adeley		*	*	*	29	3950
Leicester City & South Leicestershire	Catherine Mason		17	15	4	8	2489
Lincolnshire	Stuart Fisher		*	*	*	24	3389
Liverpool and Wirral	André Rebello	Anita Bhardwaj	16	21	9	10	3919

Coroner Area	Senior Coroner	Area Coroner	Number of cases over 12 months old (2015)	Number of cases over 12 months old (2016)	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of reported deaths in 2017
Manchester North	Joanne Kearsley	Lisa Hashmi	27	29	50	53	2699
Manchester South	Alison Mutch	Christopher Morris	17	8	12	18	2876
Manchester West	Jennifer Leeming	Alan Walsh	8	6	15	15	4336
Mid Kent & Medway	Patricia Harding		32	21	12	13	2164
Milton Keynes	Tom Osborne		6	5	21	9	819
Newcastle upon Tyne	Karen Dilks		8	9	6	24	1928
Norfolk	Jacqueline Lake	Yvonne Blake	25	18	14	20	4209
North East Hampshire	Andrew Bradley		0	1	7	3	1458
North East Kent	Patricia Harding		23	27	22	24	2150
North Lincolnshire & Grimsby	Paul Kelly		4	4	6	8	1759
North London	Andrew Walker		24	10	13	17	3182
North Northumberland	Tony Brown		2	15	14	9	600
North Tyneside	Eric Armstrong		3	3	5	1	655
North Wales (East & Central) & Gogledd	John Gittins		19	25	29	18	2710
North West Kent	Roger Hatch		5	2	3	7	2045

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North Yorkshire (Eastern)	Michael Oakley		1	0	1	2	1155
North Yorkshire (Western)	Robert Turnbull		6	5	7	12	1053
Northamptonshire	Anne Pember		16	17	21	20	2669
Nottinghamshire & Nottingham	Maírín Casey		10	17	15	16	6709
Oxfordshire	Darren Salter		3	3	11	9	2343
Plymouth Torbay & South Devon	Ian Arrow		6	10	7	21	3362
Portsmouth & South East Hampshire	David Horsley		15	14	14	14	2676
Rutland & North Leicestershire	Trevor Kirkman		8	9	20	22	1221
Sefton, St Helens & Knowsley	Christopher Sumner		10	7	6	15	2491
Shropshire, Telford & Wrekin	John Ellery		3	2	4	6	1764
Somerset	Tony Williams		13	14	15	27	2681
South London	Selena Lynch		17	20	35	37	2377
South Northumberland	Eric Armstrong		2	2	1	2	1131
Staffordshire South	Andrew Haigh		7	6	12	8	2390
South Wales Central	Andrew Barkley		16	9	20	30	3665

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South Yorkshire (West)	Christopher Dorries		7	15	26	40	3472
Southampton & New Forest	Grahame Short		2	3	4	6	2205
Stoke on Trent & North Staffordshire	Ian Smith		4	17	12	36	3842
Suffolk	Peter Dean		37	56	67	72	2588
Sunderland	Derek Winter		0	2	2	3	1454
Surrey	Richard Travers	Simon Wickens	31	24	17	44	4418
Swansea & North Port Talbot / Abertawe	Colin Phillips (Acting)		61	59	36	36	2195
Teesside	Clare Bailey		3	7	8	8	2599
Warwickshire	Sean McGovern		3	3	4	4	1630
West London	Sean Cummings		69	17	*	355	3631
West Sussex	Penelope Schofield		8	6	14	32	3290
West Yorkshire (Eastern)	Kevin McLoughlin	Jonathan Leach	63	36	39	44	4231
West Yorkshire (Western)	Martin Fleming		27	20	22	38	3433
Wiltshire & Swindon	David Ridley		5	3	6	9	2600
Worcestershire	Geraint Williams		7	13	8	10	2617

York	Robert Turnbull (Acting)		3	3	5	3	869

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