Ministry of Justice

Published 9 May 2019

Coroners Statistics Annual 2018

England and Wales

Main points

The removal of the requirement to report Deprivation of Liberty Safeguard (DoLs) deaths to coroners, in April 2017, has had an impact on key statistics in this publication, when comparing 2018 to recent previous years (2014-2017). Key findings are summarised below:

Decrease in deaths reported to coroners in 2018	220,600 deaths were reported to coroners in 2018, the lowest level since 2000 – down 4% (9,100) compared to 2017. This mainly reflects the removal of DoLs cases being reported to Coroners.
41% of all registered deaths were reported to coroners in 2018	The proportion of registered deaths in England and Wales reported to coroners has decreased by two percentage points compared to 2017, the lowest proportion since 2000.
Deaths in state detention (excluding DoLS) down 3%	513 deaths in state detention were reported to coroners in 2018 (down from 528 in 2017), the decline is driven by a 13% fall in deaths of individuals under the Mental Health Act 1983.
Post-mortem examinations were carried out on 39% of all deaths reported to coroners	There were 85,600 post-mortem examinations ordered by coroners in 2018, remaining stable compared to 2017. However, the proportion of reported deaths requiring a post-mortem is up two percentage points since 2017.
8% fewer inquests were opened in 2018, as DoLS deaths are no longer reported	29,100 inquests were opened in 2018, down 8% compared to 2017, driven by DoLS deaths no longer being reported to coroners, which prior to the 2009 Act amendment, required an inquest, as all state detention deaths do.
Inquest conclusions down 9%, driven by fall in natural cause conclusions	In 2018, 30,700 inquest conclusions were recorded in total, down 9% on 2017. Natural causes conclusion was the main driver in the decline, down 56% on 2017, to 4,000 inquest conclusions in 2018, likely due to the removal of DoLS.
Average time taken to process an inquest rises by five weeks	The estimated average time taken to process an inquest increased from 21 weeks in 2017 to 26 weeks in 2018. The increase is largely due to DoLS cases no longer automatically requiring an inquest.

This annual bulletin presents statistics on deaths reported to coroners in England and Wales in 2018. Information is provided on the number of deaths reported to coroners, post-mortem examinations and inquests held, and conclusions recorded at inquests. For previous editions of this report please see: www.gov.uk/government/collections/coroners-and-burials-statistics.

1. Deaths Reported

4% decrease in the number of deaths reported to coroners in 2018

220,648 deaths were reported to coroners in 2018, the lowest level since 2000. This shows a decrease of 4% (9,138) compared to 2017, reflecting how deaths under DoLS authorisations are no longer reported to coroners.

41% of all registered deaths were reported to coroners in 2018

The proportion of registered deaths in England and Wales reported to coroners has decreased by two percentage points compared to 2017, the lowest proportion since 2000.

All deaths in England and Wales must be registered with the Registrar of Births and Deaths; statistics on all registered deaths are published by the Office for National Statistics (ONS). The ONS mortality statistics, based on death registrations, report the number of deaths registered in England and Wales in a particular year irrespective of whether a coroner has investigated the death. The Ministry of Justice's coroner statistics provide the number of deaths which are reported to coroners in England and Wales. Further background information is provided in the Guide to Coroners Statistics published alongside this bulletin.

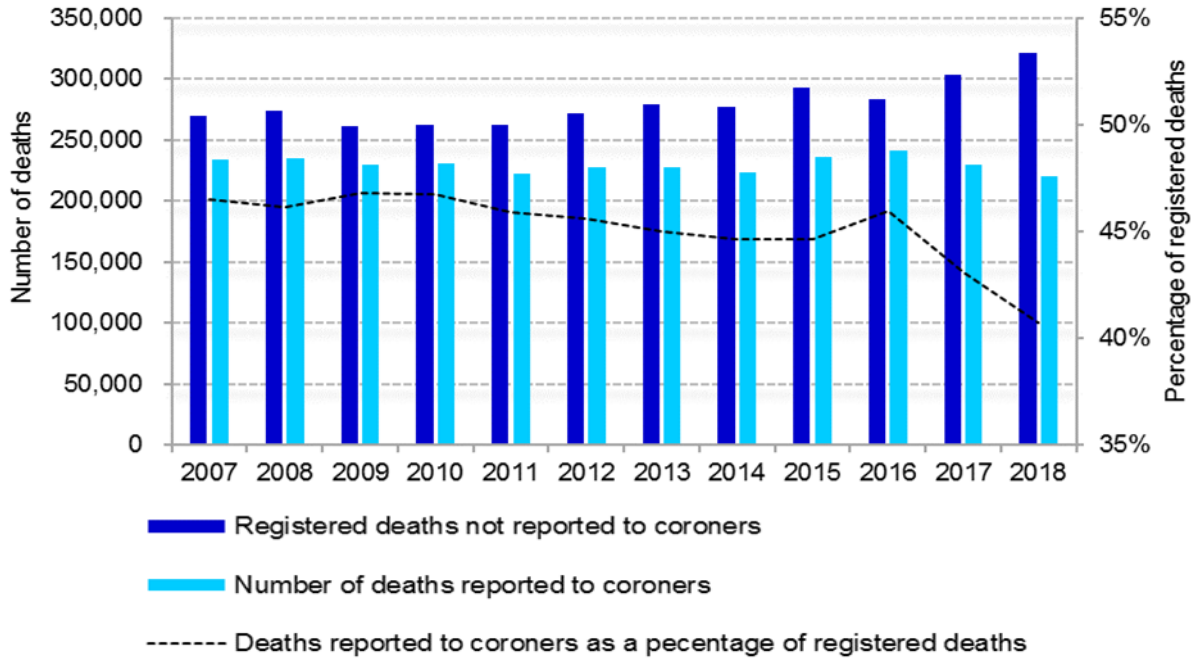
The number of deaths reported to coroners in 2018 fell by 4% (9,138) to 220,648, in contrast to ONS registered deaths which rose by 8,374 in 2018 (up 2%)[1]. Consequently, the proportion of registered deaths in 2018 reported to coroners fell by two percentage points, to 41%, compared with 2017. This reflects how deaths of individuals under DoLS authorisations are no longer reported to coroners (following the removal of DoLS deaths from the 'otherwise in state detention' category in April 2017 – see section 2).

The number of registered deaths in England and Wales has been broadly increasing, from a low of 484,367 in 2011 before gradually rising to 533,253 in 2017. Provisional figures for 2018 show a further increase to 541,627, the highest since 1999. The number of deaths reported to coroners has followed a similar trend, from a low of 222,371 deaths reported in 2011 and then rising to a high of 241,211 in 2016. However, in contrast to deaths registered in 2017 and 2018, deaths reported to coroners over these two years have fallen, as shown in figure 1. This shows a reversal to similar broadly stable levels seen prior to 2015, before the impact of DoLS on 2015, 2016 and 2017 figures.

[1] Provisional figure based on ONS monthly death registration figures for 2018: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/monthlyfiguresondeathsregisteredbyareaofusualresidence

Figure 1: ONS registered deaths and deaths reported to coroners, England and Wales, 2007-2018

(Source: Table 2)



Out of England and Wales Orders

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

Coroners issued 5,861 Out of England and Wales orders in 2018, an increase of 163 cases on 2017 (3%). The number of orders issued represented 2.7% of the total number of deaths reported to coroners, (see Table 5).

Deaths Abroad

Of the 220,648 deaths reported to coroners in 2018, around 1.0% (2,145) were reports of deaths that had occurred outside England and Wales. This proportion has remained stable since 2011.

2. Deaths in State Detention

Deaths in state detention, excluding DoLS, down 3% in the last year

Excluding DoLS, deaths in state detention decreased from 528 deaths in 2017 to 513 in 2018, driven by a fall in number of deaths of individuals detained under the Mental Health Act 1983 (as amended).

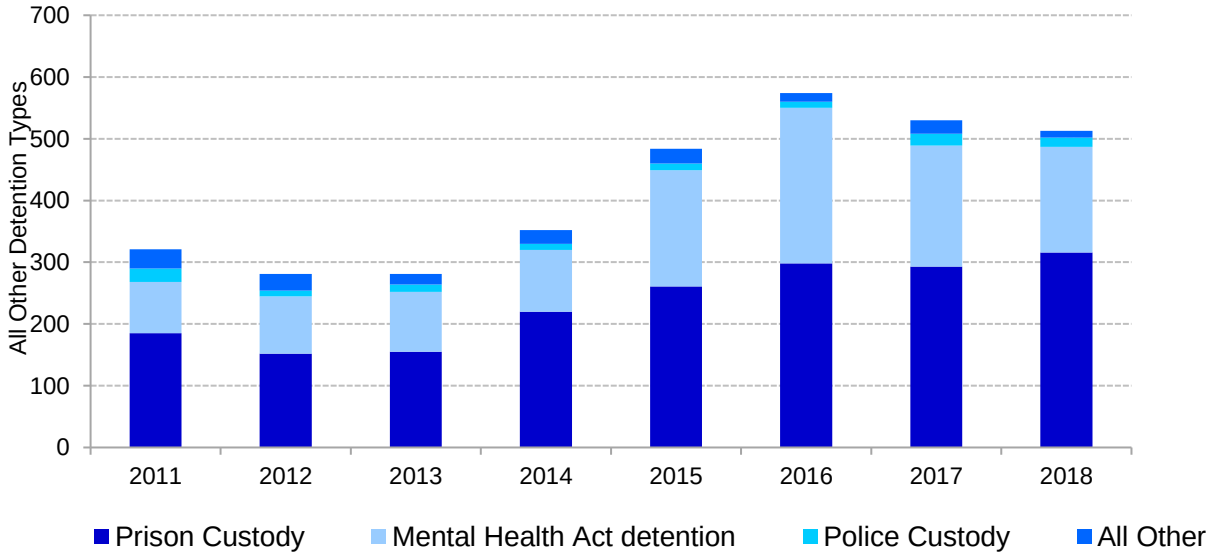
In 2018, 513 deaths in state detention were reported to coroners[2], a decrease of 3,927 deaths (88%) on the previous year and representing less than 1% of all deaths reported to coroners.

In 2018, no deaths of individuals subject to DoLS authorisations were reported to the coroner (down from 3,912 in 2017), as a result of the amendment to the Coroners and Justice Act 2009 which removed the requirement to report a DoLS death to the coroner as 'otherwise in state detention' with effect from 3 April 2017.

Figure 2 below shows the state detention deaths reported to coroners, excluding the DoLS deaths. There has been a general rise in deaths in state detention since 2011, although the number has decreased in the last two years.

Figure 2: Number of deaths in state detention (excluding DoLS), by type of detention, 2011-2018

(Source: Table 6)



Excluding DoLS deaths, the number of deaths in state detention fell by 3% compared with 2017 – continuing the 8% decrease seen between 2016 and 2017. The decrease has been driven by a fall in the number of deaths while under Mental Health Act detention, with 171 deaths reported to Coroners in 2018 (down 13% on 2017). In comparison the Care Quality Commission reported 247 deaths under the Mental Health Act 1983 (as amended)[3] in financial year 2017/18, the same number they reported in 2016/17. Prison custody deaths increased by 8% over the same period, to 316 deaths being reported to coroners in 2018.

[2] These data only represent deaths in custody which were referred to a coroner and subsequently reported to the Ministry of Justice in the coroner's annual return.

[3] For further detail please see Figure 12 of 'Monitoring the Mental Health Act in 2017/18', available at the following link: https://www.cqc.org.uk/sites/default/files/20190320_mhareport1718_report.pdf

3. Post-mortem Examinations Held

Post-mortem examinations were carried out on 39% of all deaths reported in 2018 (2 percentage points higher than 2017)

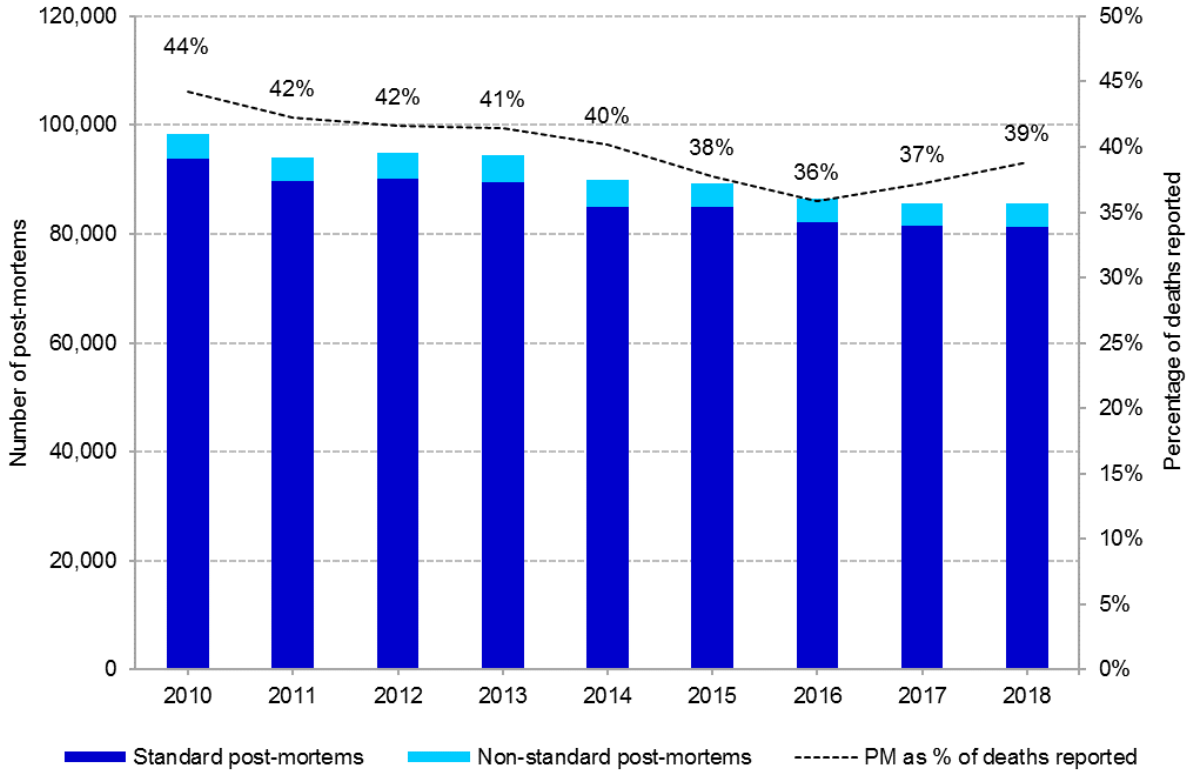
There were 85,593 post-mortem examinations ordered by coroners in 2018, remaining stable compared to 2017.

Post-mortem examinations were held for 85,593 deaths reported to coroners in 2018, up 20 (less than 1%) from 2017. This represents 39% of all deaths reported to coroners in 2018, up from 37% in 2017. This continues the rise from 2016, prior to this is had steadily decreased from 61% in 1995 to 36% in 2016 (see Table 3).

Figure 1 of the supporting guidance document provides an overview of the possible outcomes when a death is reported to a coroner, including circumstances involving a post-mortem.

Figure 3: The number of post-mortems and as a percentage of deaths reported to coroners, England and Wales, 2010-2018

(Source: Tables 3-4)

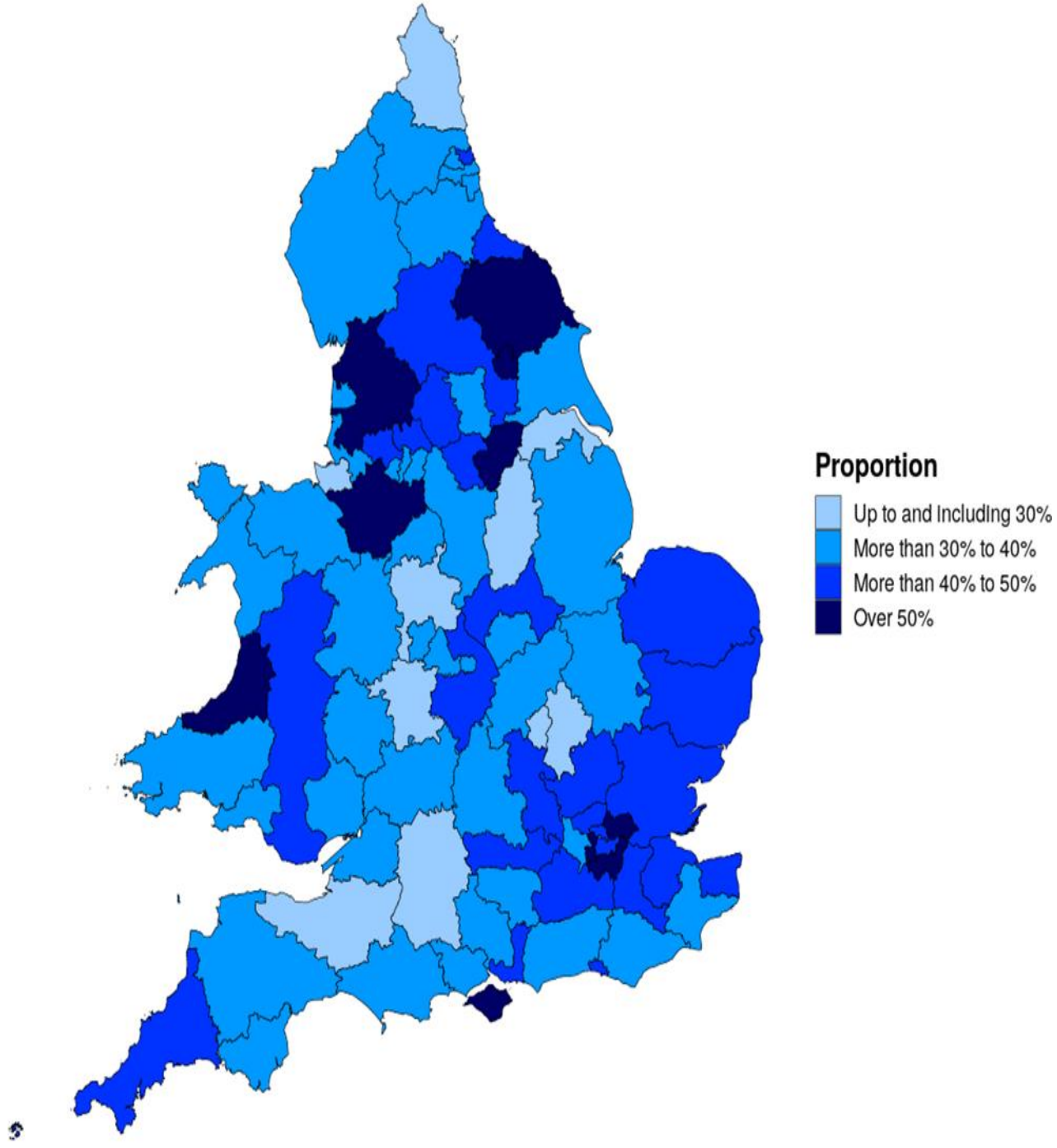


Post-mortem examinations are classified as either standard or non-standard, depending on the cost of the examination. A non-standard post-mortem is charged at a higher rate than a standard post-mortem and is defined as a post-mortem which requires specialist skills, for example, paediatric or specialist pathologist. In 2018, almost all (95%) of post-mortems were ordered at a standard rate - this proportion has remained at the same level since collection began in 2010.

The proportion of post-mortems carried out by coroners varies from 22% of deaths reported in North Lincolnshire and Grimsby to 63% in North Yorkshire (Eastern), as shown in Map 1 below.

Map 1: Post-mortems held as a proportion of deaths reported to coroners, England and Wales, 2018

(Source: Table 11)



Post-mortem examinations in inquest cases

When an inquest is opened, a post-mortem examination is often ordered. In 2018, just under two-thirds (62%) of inquest cases involved a post-mortem, up 8 percentage points on 2017. The increase in this proportion is due to DoLS deaths no longer being reported, all of which required an inquest - the majority also recorded an inquest conclusion of natural causes and so a post-mortem examination was unlikely.

Post-mortem examinations in non-inquest cases

In the majority (83%) of deaths referred to coroners, there is no inquest. In 2018, there were 61,346 non-inquest cases where a post-mortem was held – 34% of all non-inquest cases. This percentage has risen one percentage point in the last year, continuing the rise started in 2017, after a constant downward trend seen since the beginning of the time series (56% in 1995 to 32% in 2016).

Post-mortem examinations in potential inquest cases

Prior to July 2013 (when the Coroners and Justice Act 2009 and the suite of Rules and Regulations to underpin the Act were implemented), cases were either categorised as ‘inquest’ or ‘non-inquest’ cases. Changes in the way coroners are able to conduct an investigation mean that there is now a third category of ‘potential inquest’ cases. This means that the coroner is investigating the death, but has not yet decided whether it is necessary to hold an inquest. In 2018, there were 9,308 potential inquest cases being dealt with by coroners in England and Wales, with 65% of these cases requiring a post-mortem. The number of potential inquest cases has been steadily rising since the category was introduced in 2013, up 8% in the last year.

Cases requiring neither a post-mortem nor inquest

There were 120,900 cases reported to coroners where there was neither a post-mortem nor an inquest. This type of case has generally been increasing in number over time, from 81,701 in 1995 to 133,101 in 2016, before decreasing to 127,601 (down 4%) in 2017 and decreasing again to 120,900 (down 5%) in 2018. However, as a proportion of all reported deaths, this has remained fairly constant around 55% and is still the most common outcome when a death is reported to a coroner.

Post-mortems involving histology, toxicology and less-invasive techniques

In 2018, 22% (19,012) of all post-mortems included histology, remaining stable compared to 2017. Post-mortems including toxicology increased over the same period to 18,315 (up 8%), with 21% of all post-mortems held in 2018 including toxicology. This follows the steady rising trend seen since 2011.

There were 3,326 post-mortems conducted using less-invasive techniques (such as Computerised Tomography (CT) scans) in 2018, up from 1,671 cases in 2017. 64 of the 88 coroner areas in England and Wales carried out at least one less-invasive post-mortem. Lancashire and Blackburn with Darwen conducted over a half (55%) of all their post-mortems using less-invasive techniques, Black Country, Leicester City and South Leicestershire and South Yorkshire (Western) conducted over a quarter of all their post-mortems using less-invasive techniques (42%, 34% and 29% respectively).

4. Inquests Opened

8% fewer inquests opened in 2018 due to removal of DoLS requirements

The number of inquests opened in 2018 decreased by 2,465 to 29,094, driven by the removal of the requirement to report DoLS deaths to coroners - all such cases previously required an inquest.

There were 29,094 inquests opened in 2018, down 8% on 2017, driven by the removal of the requirement to report DoLS deaths to coroners – all of which previously required an inquest[4]. The number of inquests opened is the lowest since 2014, the last reporting year before DoLS investigation requirements were introduced.

Inquest cases represented 13% of all deaths reported to coroners in 2018, down from 14% in 2017. The number of inquests opened as a proportion of deaths reported in 2018 varied across coroner areas, from 6% in both Nottinghamshire and Gwent to 24% in Inner North London. However, most coroner areas held inquests for between 10% and 20% of all deaths reported (74 of the 88 coroner areas).

Map 2 shows the inquests opened as a proportion of deaths reported in 2018 for all coroner areas in England and Wales.

Inquests with juries and adjourned inquests

There were 423 inquests held with juries in 2018 (representing 1% of all inquests), a decrease of 78 (16%) compared to 2017.

The number of inquests held with juries showed a downward trend until 2014, but then increased year on year to 576 in 2016, the highest level since 2003. Whilst there has been a decrease to 423 in 2018, this mirrors the fall in the number of inquests held and the overall number of deaths reported to coroners. The proportion of inquests held with juries has however remained stable between 1% and 2% over the last decade (see Table 9).

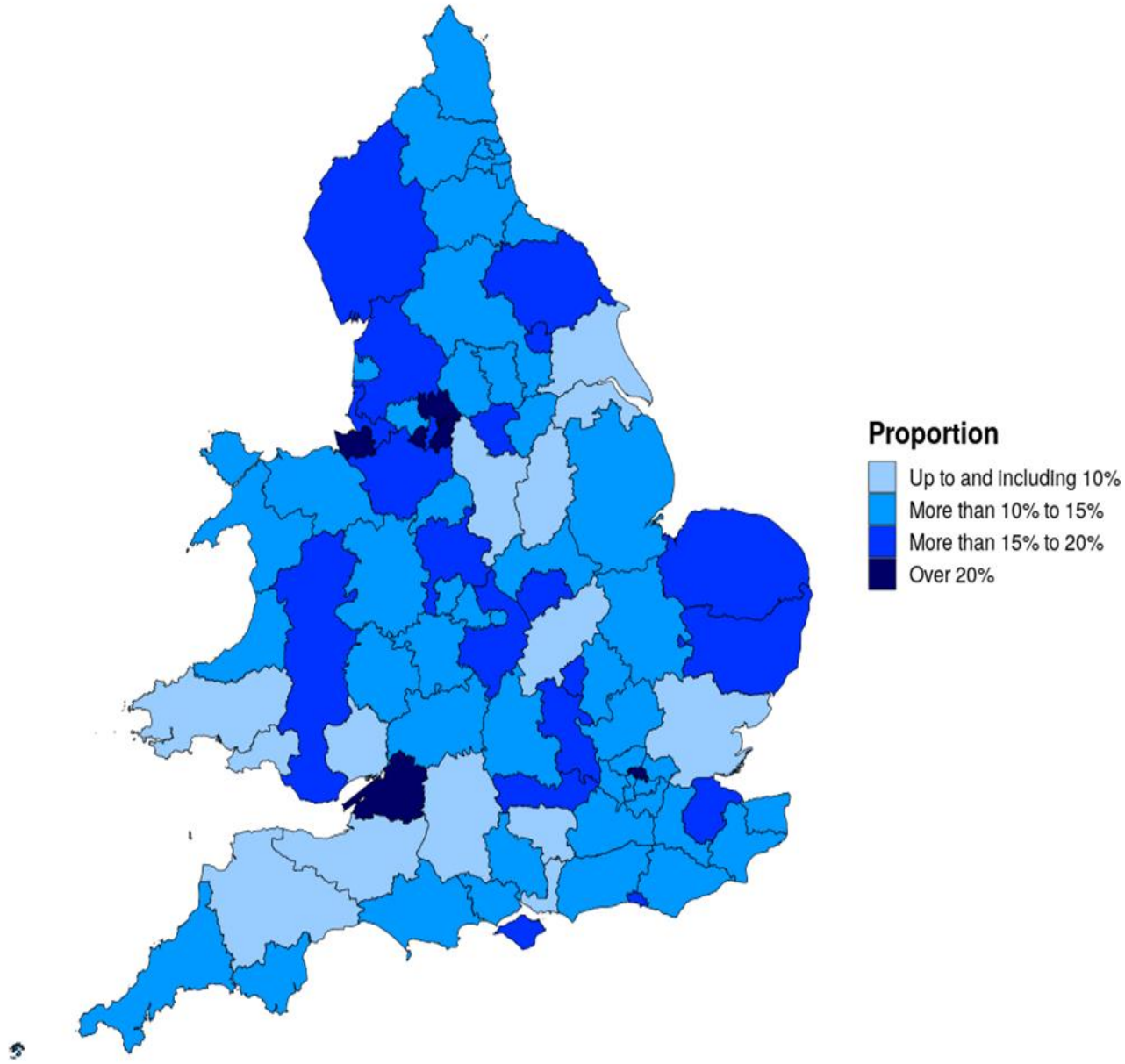
In 2018, 834 inquests were adjourned (and not resumed) by the coroner under Schedule 1[5] of the Coroners and Justice Act 2009, down 11% on 2017. This represents 3% of all inquests concluded, the same as in 2017.

[4] More information on DoLS can be found in the Guide to Coroners Statistics published alongside this bulletin.

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

Map 2: Inquests opened as a proportion of deaths reported to coroners, England and Wales, 2018

(Source: Table 11)



5. Inquest Conclusions

9% fall in inquest conclusions driven by natural cause conclusions

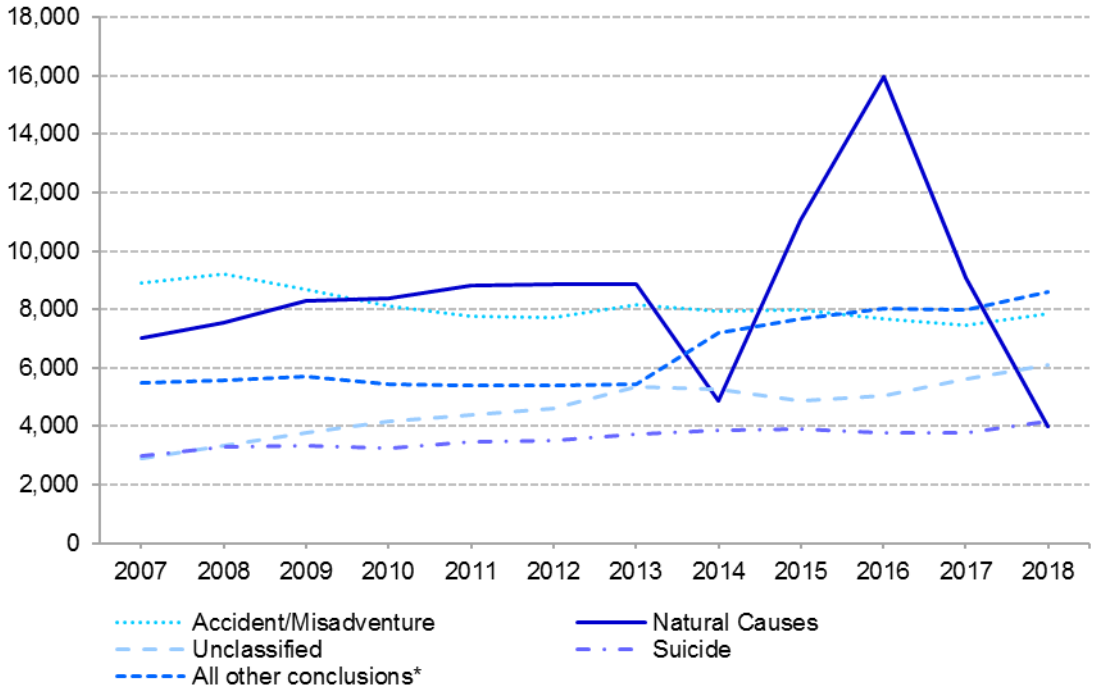
In 2018, 30,732 inquest conclusions were recorded (down 9%), reflecting the decrease in the number of inquests opened. Inquest conclusions of natural causes were down 56% on 2017 to 3,980, continuing the fall driven by DoLS deaths no longer being reported.

There were 30,732 inquests conclusions recorded in 2018, down by 3,213 (9%) from 2017, directly reflecting the fall in the number of inquests opened, which has fallen due to the removal of the requirement to investigate deaths under DoLS from April 2017 onwards (see section 4). This is the lowest number of inquest conclusions since 2014 and indicates a return towards pre-DoLS inquest levels. Background information on inquest conclusions is provided in Chapter 1 of the supporting guidance document.

Two of the inquest short form conclusions accounted for over one-third (39%) of all conclusions in 2018 – suicide and deaths by accident or misadventure. These were the two most common short form conclusions (by order of frequency) making up 14% and 26% of all inquests conclusions in 2018, respectively.

Figure 4: Number of conclusions recorded at inquests, England and Wales, 2007-2018

(Source: Table 7)



*Includes Killed unlawfully, Killed lawfully, Attempted or self-induced abortion, Cause of death aggravated by lack of care, or self-neglect, Want of attention at birth, Stillborn, Disasters, Open, Industrial Diseases, Drugs/Alcohol Related[6], and Road traffic collision

In 2015 and 2016, there were significant increases seen in natural causes conclusions, driven by deaths of individuals subject to DoLS authorisations where the majority (94%) had an inquest conclusion of natural causes. In line with the falls seen in the number of inquests opened and

[6] For years 2007-2013, this includes the previously used conclusions “Dependence on Drugs” and “Non-dependence on Drugs”

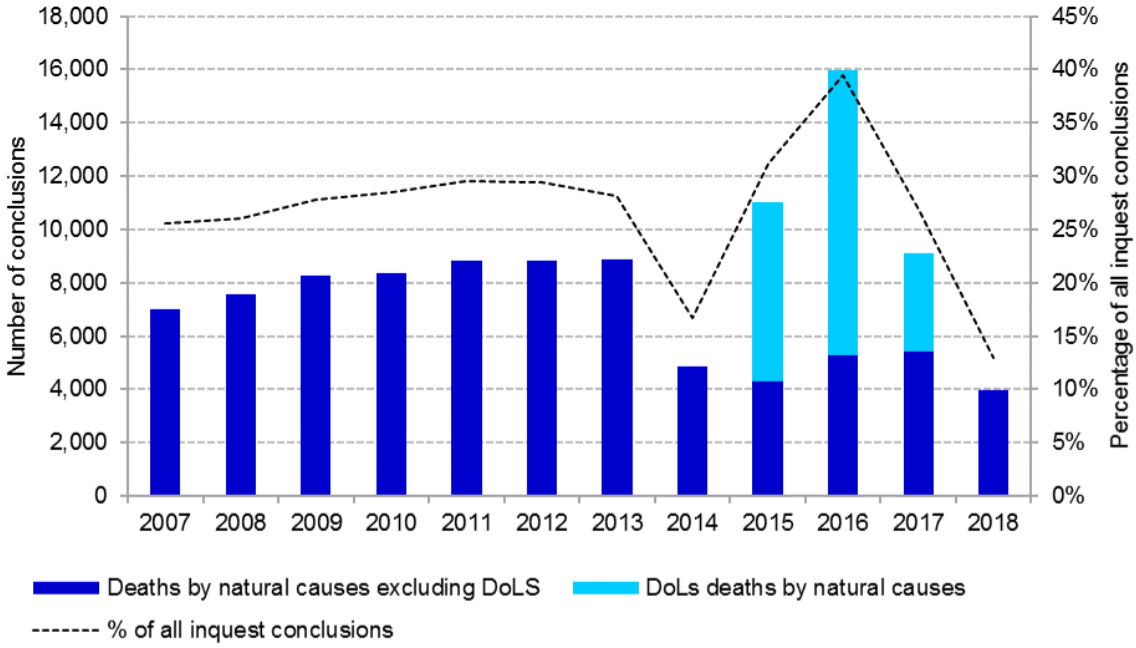
inquest conclusions following the removal of the requirement to report DoLS deaths, there has also been a corresponding decrease in the number of natural cause conclusions in 2017 and 2018 (down 43% and 56% respectively).

Historically, natural cause conclusions had been gradually increasing to a peak of 8,881 in 2013, and as a proportion, accounted for 25-30% of all inquest conclusions (between 2006 and 2013). However, since 2014 (excluding DoLS cases) there has been a drop of around 50% in such conclusions. This decline followed the Coroners Act 2009 coming into effect in July 2013, which meant a coroner could now issue a death certificate without holding an inquest when it was known that a death has occurred naturally.

Figure 5 below shows the time series of natural cause inquest conclusions when including or excluding DoLS. In 2018, natural cause conclusions made up 13% of conclusions, down from 27% of all inquest conclusions in 2017. However, when DoLS cases are excluded, natural causes only made up 16% of all inquest conclusions in 2017, suggesting the continued impact of the Coroner Act 2009 reforms as above.

Figure 5: Number of natural cause conclusions recorded at inquests, England and Wales, 2007-2018

(Source: Tables 6-7)



In 2018, the number of unclassified conclusions increased by 464 cases (up 8%) to 6,094, continuing the increasing trend since 2015 despite the decrease in overall inquest conclusions in 2018. Unclassified conclusions made up 20% of all conclusions in 2018 and can fluctuate due to the use of what are known as 'narrative conclusions' by some coroners. In these cases, the conclusion is recorded as unclassified. As well as narrative conclusions, this category includes short non-standard conclusions which a coroner or jury might return when the circumstances do not easily fit any of the standard conclusions[7].

The proportion of conclusions recorded as suicide has remained broadly constant over the past ten years, generally at around 11-12%. However, in 2018, it accounted for 14% of all inquest

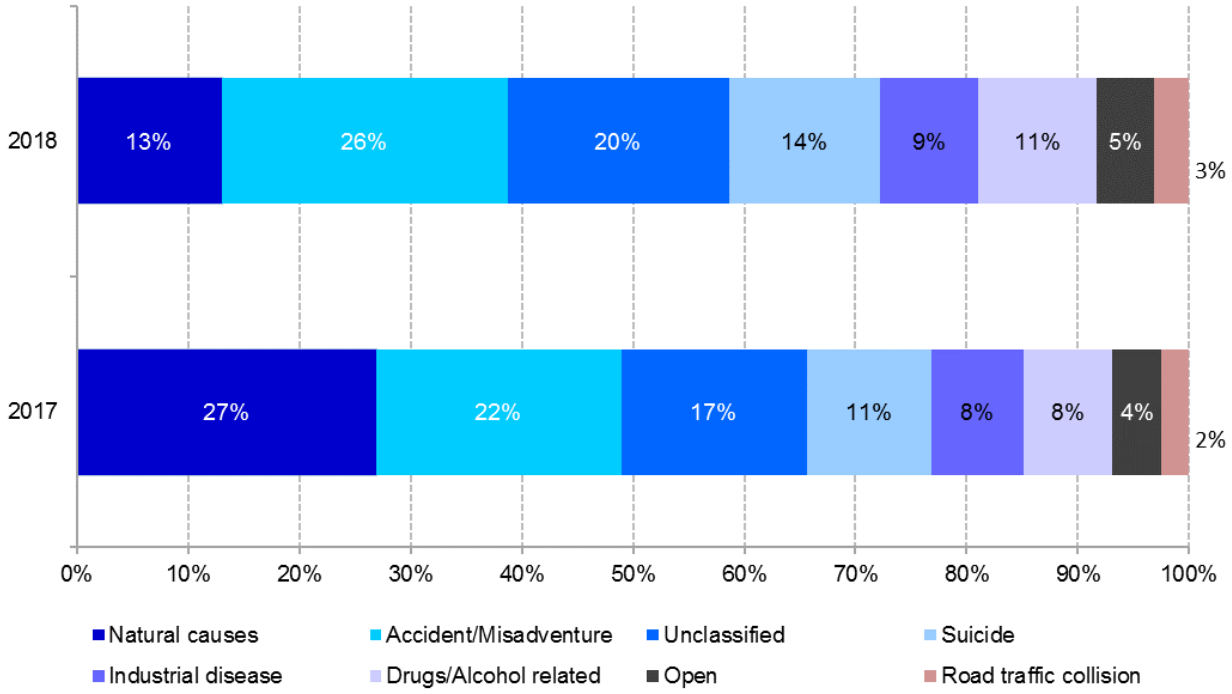
[7] An analysis on unclassified conclusions can be found in the Coroners Statistics 2012 publication (Annex A), available at: www.gov.uk/government/statistics/coroners-statistics

conclusions, up from 11% of all conclusions in 2017. This proportion in 2018 varies from 3% in Portsmouth and South East Hampshire area to 34% in East Sussex[8].

For the remaining main conclusion types, drugs and alcohol related cases increased by 533 cases (up 20%) to 3,237 and road traffic collisions increased by 118 cases (up 14%) to 962. Open conclusions have increased by 98 cases (up 7%) to 1,595.

Figure 6 shows the proportion changes in inquest conclusions between 2017 and 2018. The natural cause inquest conclusion has had the largest shift, decreasing its share by 14 percentage points compared to 2017, reflecting the reduction in the number of natural causes conclusions, likely due to the removal of DoLS. Both accident and misadventure and unclassified inquest conclusions showed increases when compared to 2017, up four and three percentage points respectively.

Figure 6: Conclusions recorded at inquest, by category and as a proportion of all conclusions, England and Wales, 2017 and 2018[9] [10] (Source: Table 7)



[8] Note that Ceredigion has been excluded from this analysis due to a disproportionately low number of inquest conclusions (26) distorting the trend.

[9] Total percentages may not equal 100% due to rounding.

[10] All other conclusions (including Killed unlawfully, Killed lawfully, Attempted or self-induced abortion, Cause of death aggravated by lack of care, or self-neglect, Stillborn) were not included in the chart as they represented less than 1% of the short-form conclusions

6. Inquest Conclusions by Sex

Conclusions recorded at inquests by sex[11]

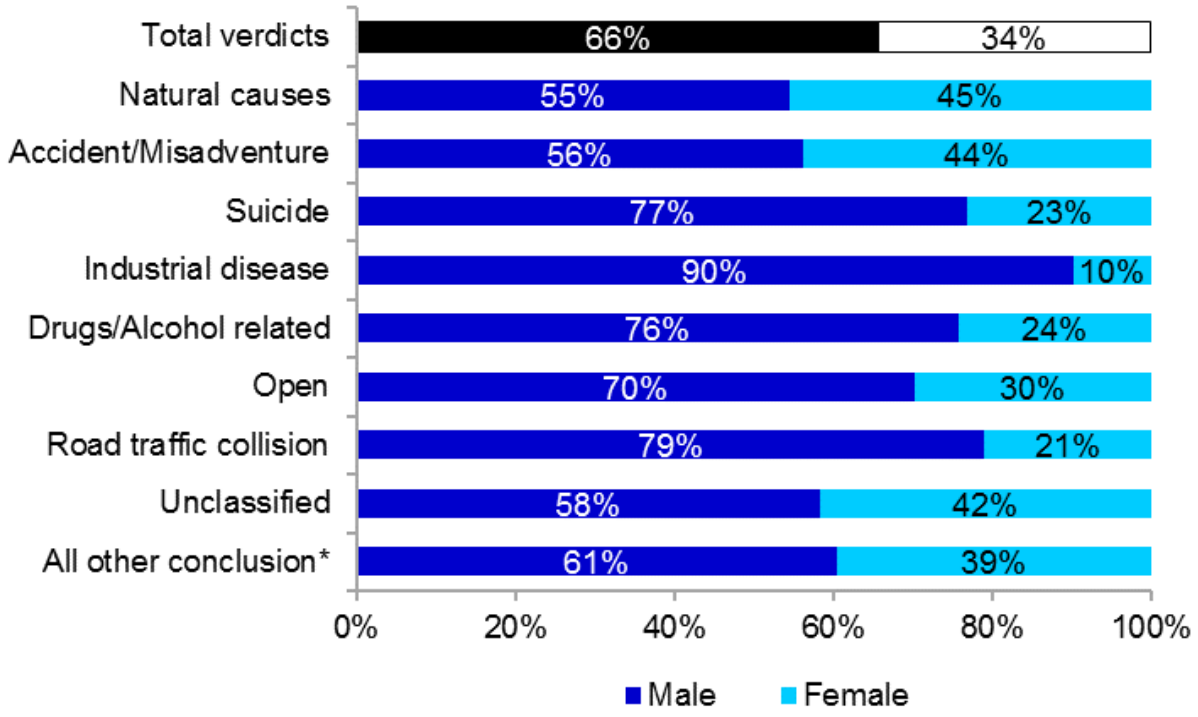
Male deaths accounted for 66% of all conclusions recorded in 2018 while female deaths accounted for 34%. In 2017, the percentages were 61% and 39% respectively.

The pattern of inquest conclusions recorded differs between males and females. Male deaths accounted for 66% of all conclusions recorded in 2018, however they accounted for 56% of deaths reported; this suggests that males are more likely to die in circumstances that lead to an inquest. Correspondingly, female deaths accounted for 34% of all conclusions recorded in 2018 (and 44% of all deaths reported to coroners).

Figure 7 shows the variation in proportions by sex for each inquest conclusion. Industrial disease had the highest proportion of males, at 90%, and natural causes had the highest proportion of females[12], at 45%.

Figure 7: Proportion of inquest conclusions recorded by sex of deceased, England and Wales, 2018

(Source: Table 7)



*Category includes Killed unlawfully, Killed lawfully, Attempted or self-induced abortion, Stillborn, Lack of care or self-neglect, Want of Attention at Birth, and Disaster

[11] The sex of the deceased is based on the 'registrable particulars' which coroners have a duty to record. Death certificates only give two options, 'male' and 'female', and these will normally be completed by the registrar based on the information given to them by the informant. Under normal circumstances there would not be an investigation to ascertain whether what the informant says corresponds to biological sex or DNA of the deceased.

[12] Lack of care or self-neglect had a higher proportion of females, with 57%, however, it was excluded from above, as there was only 21 such inquest conclusions in total in 2018.

7. Inquest Conclusions by Age

The majority of inquests concluded were for those aged 65 years and over

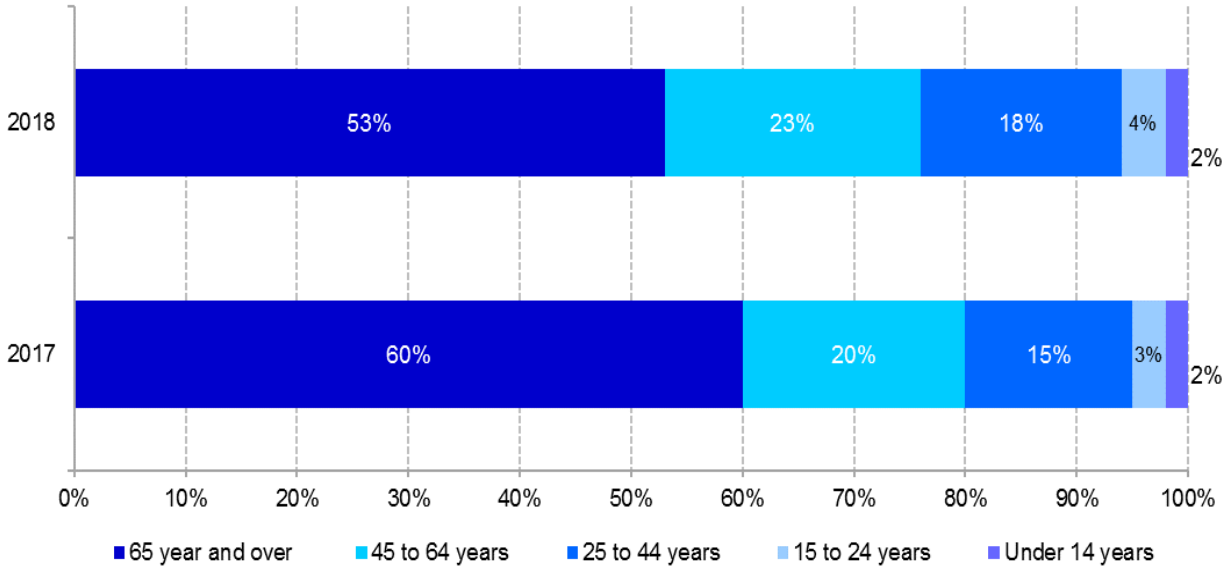
Of the inquests completed in 2018, 53% related to persons who were aged 65 years or over at time of death, compared with 6% related to persons under 25 years of age.

The profile of the age of deceased at inquests in 2018 has changed slightly from 2017. The percentage of inquests completed relating to persons aged 65 or over has fallen from 60% to 53%, while the percentage of those between 25 and 65 years has increased from 35% to 41%. This is likely due to the removal of the requirement to report DoLS deaths to the coroner from April 2017 as these will have predominantly related to the older population.

Although an age breakdown of registered deaths in England and Wales in 2018 is not yet available, ONS figures for 2017[13] show that 85% of registered deaths in England and Wales were persons aged 65 or over, with only 1% aged under 25 years old.

Figure 8: Proportion of inquest conclusions by age of deceased, England and Wales, 2017 and 2018[14]

(Source: Table 8)



[13] ONS data is available online at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsregisteredinenglandandwalesseriesdrreferencetables

[14] The 'age not known' category has been excluded from the chart due to small numbers (less than 0.5%). Totals may not add up to 100% due to rounding.

8. Time Taken to Process an Inquest

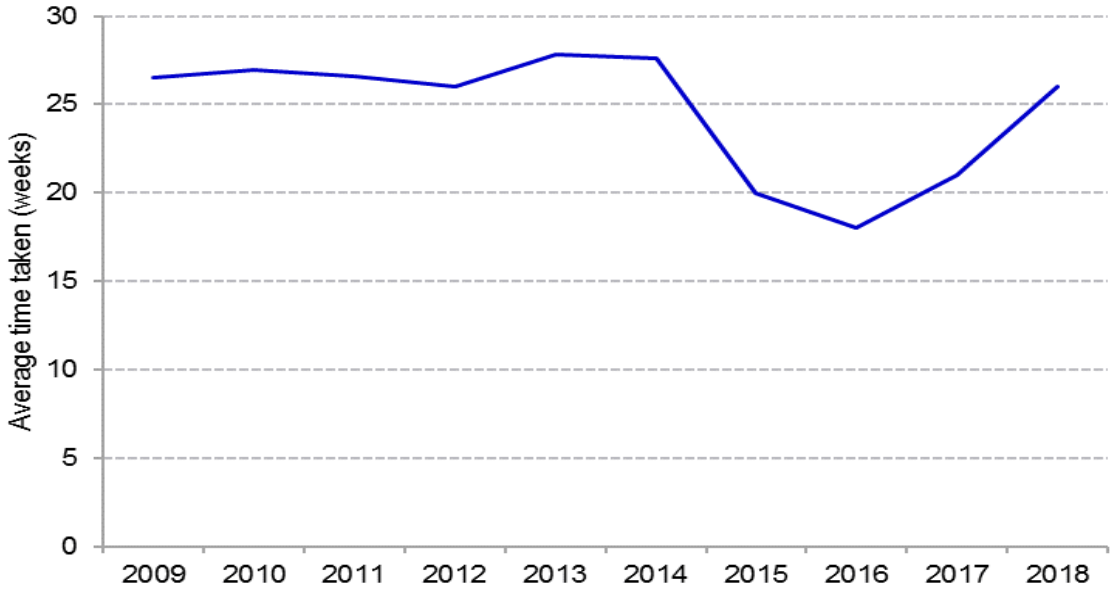
Average time taken to process an inquest rises by five weeks

The estimated average time taken to process an inquest increased from 21 weeks in 2017 to 26 weeks in 2018.

The estimated[15] average time taken to process an inquest in 2018 (defined as being from the date the death was reported until the conclusion of the inquest) was 26 weeks (see Table 13)[16], an increase of five weeks compared to 2017. This can largely be attributed to DoLS deaths where, in accordance with the Chief Coroner's guidance, in uncontroversial cases, there could be a 'paper inquest', i.e. not decided in open court but on papers without the need for witnesses or a post-mortem – such cases took less time to process and as a result, reduced the average time to process inquests overall. Following the removal of the requirement to report DoLS deaths to coroners in April 2017, there has been an increase in the average time to process an inquest, reversing the downward trend seen in the last few years when there were many DoLS cases.

Figure 9: Average time taken to process an inquest (in weeks), 2009-2018

(Source: Table 13)



The time taken to process an inquest varies by coroner area - the maximum average time taken to process an inquest in 2018 was 50 weeks in West London, and the minimum was 8 weeks in Liverpool and the Wirral. The large range of average time (42 weeks – based on 8 and 50 weeks as above) may be because of considerable variations in the profile of coroners' caseloads and a direct comparison between coroner areas is therefore not advised. Map 3 provides an overview of average times taken across England and Wales.

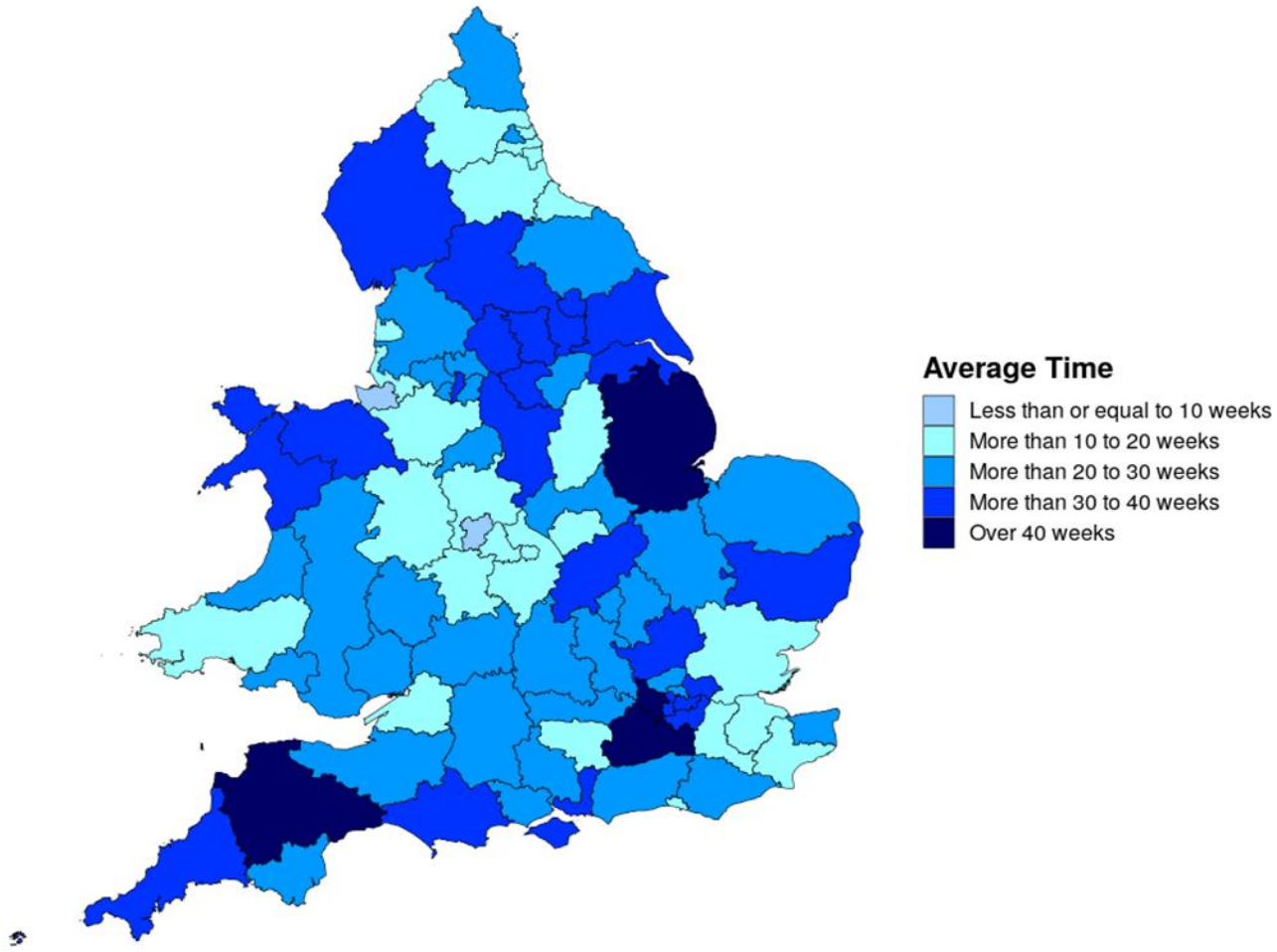
More information about how the average time taken has been estimated can be found in the Guide to Coroners statistics published alongside this report.

[15] A direct average of the time taken to process an inquest cannot be calculated from the summary data collected; an estimate has been made instead. Please see the Guide to Coroners statistics published alongside this report.

[16] Only deaths occurring within England and Wales are included in this estimation.

Map 3: Estimated average time taken to process inquests at coroner area level, England and Wales, 2018

(Source: Table 13)



9. Treasure

Treasure finds[17] down by 6% in 2018 compared to the previous year

999 finds were reported to coroners in 2018, 60 less than in 2017. 425 inquests were concluded into finds. Of these, 89% (380) returned a verdict of treasure, three percentage points lower than in 2017.

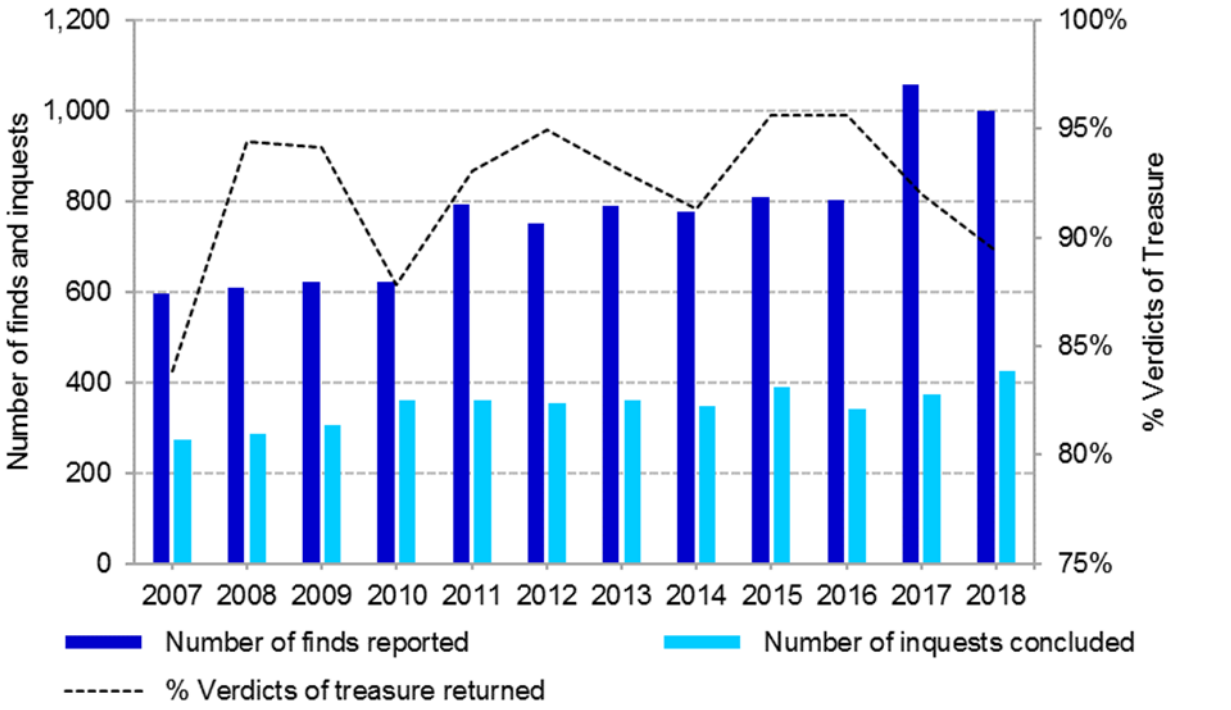
In 2018, there were 999 treasure finds reported to coroner, 6% less than in 2017. The number of finds reported has steadily increased since the commencement of the 1996 Act in September 1997, from 54 finds in 1997 to 1,059 in 2017, before decreasing to 999 in 2018.

Of the 425 inquests concluded in 2018, 89% (380) returned a verdict of treasure, a decrease of three percentage points when compared to 2017.

There were no inquests held into Treasure Trove in 2018 (relating to finds made before the Treasure Act 1996 came into force), however it is likely that a few such inquests will continue to be held from time to time.

Figure 10: Finds reported to coroners, treasure inquests held under the Treasure Act, and proportion of treasure verdicts returned, 2007-2018[18]

(Source: Table 10)



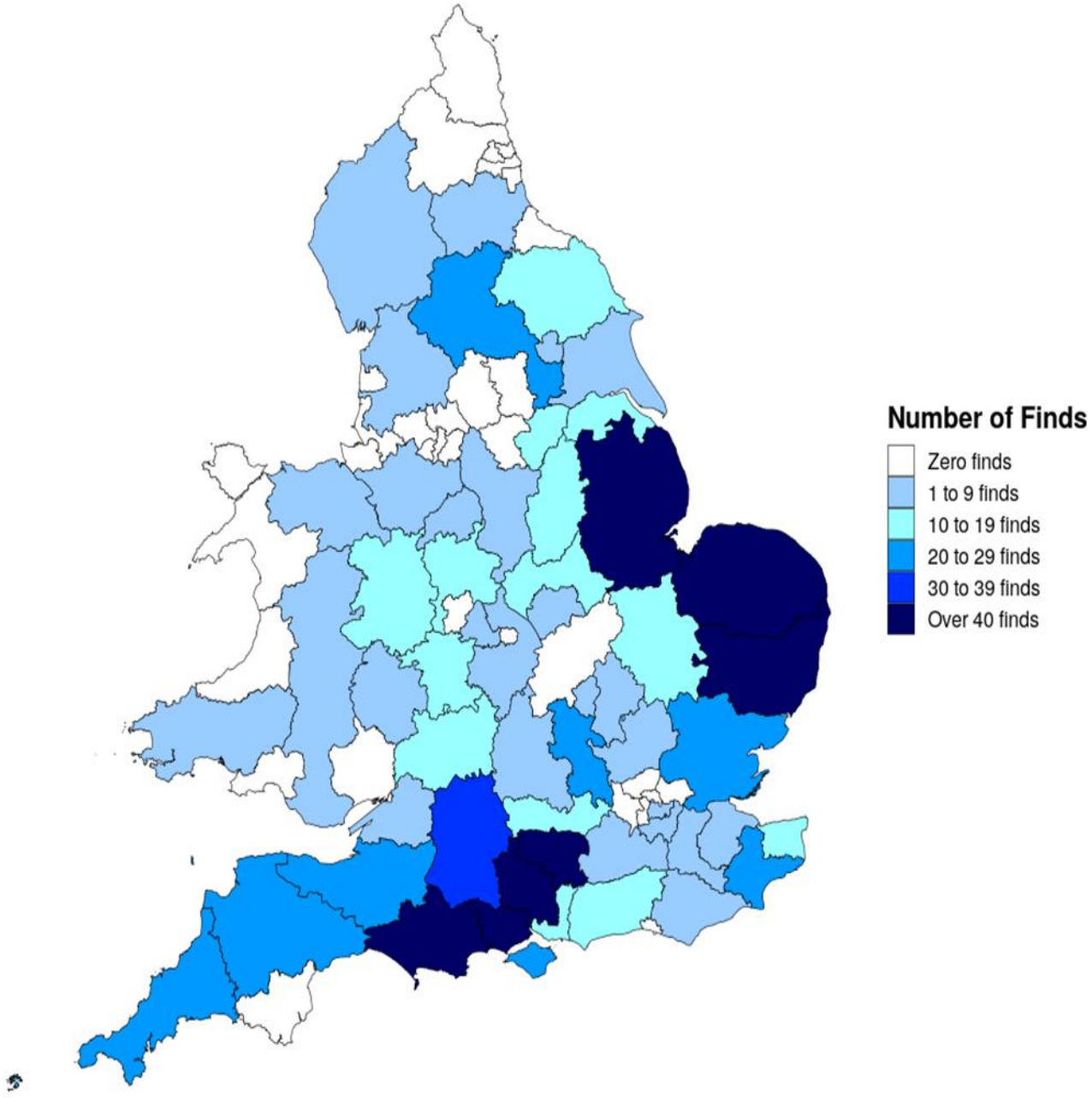
The number of finds and inquests held varies greatly across the country, most likely due to geographical and historical differences between areas. In 2018, 32 coroner areas had no treasure finds reported to them, whilst Norfolk had the highest number of treasure finds at 102. Map 4 shows treasure finds across England and Wales in 2018. More information about the duties of coroners to investigate treasure found within their jurisdiction and the provisions of the 1996 Act (and the previous Treasure Trove provisions) can be found in the supporting guidance document.

[17] The latest Department for Digital, Culture, Media & Sport (DCMS) figures are for 2017 and showed there were 1,266 finds reported in England and Wales, in line with the 1,059 treasure finds reported to Coroner Areas in 2017. These figures can be found at: https://www.gov.uk/government/statistics/statistical-release-for-reported-treasure-finds-2016-and-2017

[18] This chart does not include reported findings under “Treasure Trove”

Map 4: Number of treasure finds reported to coroners, England and Wales, 2018

(Source: CSV)



Annex A: Details of recent coroner area amalgamations

The following table summarises the coroner area amalgamations that have occurred during 2017 and 2018. For a list of all historical amalgamations and changes to coroner areas, please refer to the supporting guidance document.

Date effective	Previous coroner area	New coroner area	Nature of merge
01-Apr-17	Central Lincolnshire; South Lincolnshire	Lincolnshire	2 into 1
01-Dec-17	Blackburn, Hyndburn and Ribble Valley; East Lancashire; Preston and West Lancashire	Lancashire and Blackburn with Darwen	3 into 1
01-Aug-18	Hartlepool; Teesside	Teesside and Hartlepool	2 into 1

Annex B: Further analysis of deaths reported to coroners

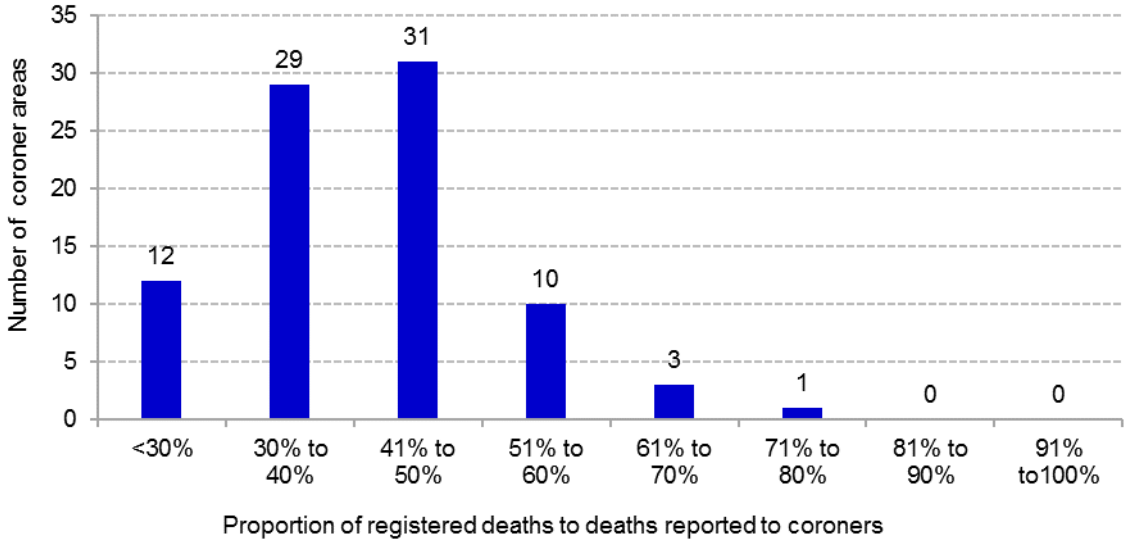
In 2018, the number of deaths reported to coroners as a proportion of registered deaths varied widely across coroner areas, from 22% in North Yorkshire (Western) District to 75% in Newcastle upon Tyne

The number of deaths reported to coroners in 2018 varied by coroner area – from 293 in City of London to 6,914 in Essex. The number of deaths reported in each area will be affected by the area's size, population and demographic breakdown so comparisons of deaths reported to the coroner across coroner areas should be treated with caution.

When looking at the number of deaths reported to coroners in 2018 as a proportion of registered deaths[19], which allow for some differences in population characteristics, there is still a wide variation across coroner areas (e.g. 22% in North Yorkshire (Western) compared to 75% in Newcastle upon Tyne). However, caution should be taken when using these figures as other local area factors can influence these proportions. For example, large hospitals near boundary lines can impact the proportion, due to the difference between the coroners deaths reported figures being based on the place of death and the ONS death registered figures being based on the place of residence.

Figure 11: Deaths reported to coroners in 2018 as a proportion of registered deaths[20,21]

(Source: Table 11 & ONS[20])



[19] As the ONS death registration figures are based on area of usual residence whereas the coroners' figures are based on the area where a person died, these figures should be used with caution. For example, the coroner office for the City of London and Manchester City show distorted figures (of 792% and 104% respectively), due to the low levels of residence and high level of commuters.

[20] Provisional figure based on ONS monthly death registration figures for 2018

[21] City of London and Manchester City have been excluded from this analysis due to the percentage of deaths being greater than 100% - please see footnote 18 above for further information. So only 86 coroner areas have been included in this analysis.

Further information

Revisions to statistics for previous years

The estimated figure for the number of registered deaths in 2017 which was derived from monthly data for the purposes of Table 2 in last year's edition of this bulletin has now been replaced by the annual figure published by the Office for National Statistics. The 2017 number of deaths reported and number of inquests opened figures have been revised in this edition, as an error was found in Hartlepool's 2017 figures (which would also affect the national figures), after the publication of the Coroner Statistics 2017.

Symbols and rounding convention

Within the 'Key Findings' sections, figures greater than 1,000 are rounded to the nearest 100. The following symbols have been used throughout the tables in this bulletin:

n/a	=	Not applicable
-	=	Zero
..	=	No data available
r	=	Revised
p	=	Provisional

Accompanying files

- This publication should be read alongside the statistical tables which accompany it
- There is also a supporting comma-separated values file (CSV) to allow users to carry out their own analysis
- In addition to the bulletin and tables, we have published a coroners' statistical tool. The tool provides easier access to local level data and allows the user to compare up to four areas of interest, for example, it is possible to compare a coroner area with a geographical region, England and/or Wales.
- The accompanying guide to coroner statistics provides a more detailed overview of coroners; including the functions of coroners and the chief coroner, policy background and changes, statistical revision policies, and data sources and quality. It also includes a map reference of coroner areas in England and Wales, as well as a glossary with brief definitions for some commonly used terms.

National Statistics status

National Statistics status means that official statistics meet the highest standards of trustworthiness, quality and public value.

All official statistics should comply with all aspects of the Code of Practice for Official Statistics. They are awarded National Statistics status following an assessment by the Authority's regulatory arm. The Authority considers whether the statistics meet the highest standards of Code compliance, including the value they add to public decisions and debate.

It is the Ministry of Justice's responsibility to maintain compliance with the standards expected for National Statistics. If we become concerned about whether these statistics are still meeting the appropriate standards, we will discuss any concerns with the Authority promptly. National Statistics status can be removed at any point when the highest standards are not maintained, and reinstated when standards are restored.

Contact

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Next update: 14 May 2020
URL: https://www.gov.uk/government/collections/coroners-and-burials-statistics

Produced by the Ministry of Justice

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