CHIEF CORONER

Report of the Chief Coroner to the Lord Chancellor

Sixth Annual Report: 2018–2019

Seventh Annual Report: 2019–2020

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Presented to Parliament Pursuant to Section 36(6) of the Coroners and Justice Act 2009

Contents

Introduction

1. This is the Chief Coroner's annual report to the Lord Chancellor. It combines both the sixth and seventh such reports. It is the third and fourth reports from His Honour Judge Mark Lucraft QC, who is the second holder of the post of Chief Coroner. In these combined reports, the Chief Coroner will provide an assessment of the current state of the coroner service over the last two years 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. Although a report for 2018-19 had been provided to the Lord Chancellor, the Model Coroner Area blueprint had not been finalised and the report with its annexes had not been published before the outbreak of the COVID-19 pandemic; the report for 2019-20 is provided with the plan that both be published in this joint report.

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. The Chief Coroner is the judicial head of the coroner system, providing national leadership for coroners in England and Wales.

6. His Honour Sir Peter Thornton QC took up the post with effect from September 2012. Sir Peter completed his term as Chief Coroner on 30 September 2016 and retired as a Senior Circuit Judge on 18 October 2016.

7. His Honour Judge Mark Lucraft QC, The Recorder of London, was appointed as the second Chief Coroner of England and Wales with effect from 1 October 2016 for a three-year term. In June 2019, his term of office was extended for up to two years, to 30 September 2021. On 8 April 2020, it was announced that following the election by the Court of Aldermen of the City of London, Her Majesty The Queen had appointed the Chief Coroner as the next Recorder of London, the lead judge at the Central Criminal Court.

It was stated that Judge Lucraft QC would take on some of the responsibilities of leadership at the Central Criminal Court with immediate effect. However, in the light of pressures on the coronial system as a result of the COVID-19 pandemic, it was agreed that Judge Lucraft QC would remain in post as the Chief Coroner. An exercise to recruit a new Chief Coroner has been launched and appointment will be made in due course.

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

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). He also hears some high-profile inquests at first instance.

The coroner service in 2018-19 and 2019-20

10. 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.

11. 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.

12. However, in the absence of a national service the Chief Coroner, working with coroners, local authorities, the police and other stakeholders, continues to make progress on reducing inconsistency through training, guidance and other interventions. In addition, he held a further Local Authority conference in early 2019 in which many of these issues were discussed.

13. Many of the topics raised below expand on these issues.

Statistics

14. The Ministry of Justice publish coroner statistics annually and the latest figures can be found at https://www.gov.uk/government/collections/coroners-and-burials-statistics.

2018

15. In 2018, the number of registered deaths in England and Wales rose by 2% to 541,600, which was the highest recorded since 1999. Most deaths recorded are from natural causes certified as such by a general practitioner or a hospital doctor. Where it is not clear that a death is from natural causes it must be reported to the coroner. There were 220,600 deaths reported to the coroner in 2018, which accounts for 41% of all deaths in England and Wales. This is a decrease of 4% on the number of deaths reported in 2017 and can mainly be attributed to the removal of the requirement to report Deprivation of Liberty Safeguards (DoLS) deaths to the coroner.

16. Many cases reported to the coroner are signed off after preliminary enquiries 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. This can be either with or without a post-mortem examination. In 2018 there were 85,600 post-mortem examinations ordered by coroners which equates to 39% of the deaths reported to the coroner. 29,100 inquests were opened in 2018, a decrease of 8%. This can again be directly linked to DoLS cases, all of which previously proceeded automatically to an inquest, no longer being reported to the coroner.

17. Deaths in state detention (excluding DoLS) fell from 528 in 2017 to 514 in 2018, a reduction of 3%. The decline is driven by a 13% fall in reported deaths of individuals detained under the Mental Health Act 1983. In 2018 there were 423 inquests held with juries. This is down from 501 jury inquests held in 2017 but still equates to 1%-2% of all inquests. Deaths in state detention remain of particular concern to coroners and many generate prevention of future death reports where a coroner has a duty to make reports to a person, agency, government department or local authority where they believe action should be taken to prevent future deaths.

2019

18. In 2019, the number of registered deaths in England and Wales rose by 2% on the 2018 figures to 530,857. There were 210,900 deaths reported to the coroner in 2019, which accounts for 40% of all deaths in England and Wales. This is a decrease of 4% on the number of deaths reported in 2018 and can mainly be attributed to the removal of the requirement to report DoLS deaths to the coroner.

19. In 2019, there were 82,100 post-mortem examinations ordered by coroners, a reduction of 4% on the previous year. Overall, the figure equates to 39% of the deaths reported to the coroner. 30,000 inquests were opened in 2019, an increase of 3%.

20. Deaths in state detention (excluding DoLS) fell from 514 in 2018 to 478 in 2019, a reduction of 7%. The decline is driven by a 16% and 5% fall in reported deaths of individuals detained under the Mental Health Act 1983 and in prison custody respectively. In 2019 there were 527 inquests held with juries. This is up from 423 jury inquests held in 2018 but still only equates to 1%-2% of all inquests.

Cases over 12 months

21. The Chief Coroner has a statutory duty to report to the Lord Chancellor on these cases. Set out in Annex B 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 2016 through to 2020. In total, there were 2,278 cases in England and Wales not completed within 12 months of being reported to the coroner as at 2019. This is in the context of 220,600 deaths reported to the coroner in 2018 and 29,100 inquests being opened. The figures for 2020 are set out where they have been provided. With the impact of coroners dealing with COVID-19 issues, this data is not yet complete.

22. 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 IOPC 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.

23. 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.

24. The impact of the COVID-19 pandemic is likely to mean that there will be a significant increase in the numbers of over 12-month cases. As is set out below (see paragraph 30), there has, anecdotally, been a significant increase in the numbers of death referrals to coroners since March 2020 and also a reduction in the ability of coroners to hold inquest hearings.

25. The Chief Coroner carefully monitors these figures and discusses them with senior coroners in an effort to understand the reasons for delay and to address any practical, resourcing or other issues.

Highlighted topics for 2018–19 and 2019–20

26. I wish to bring the following issues and developments to the attention of the Lord Chancellor.

COVID-19 – coroner response to the pandemic

27. On 5 March 2020, the first death in England reported to be from COVID-19 was recorded. Through March, April, May and June the figure has risen in England and Wales. In most instances, a death through this virus will be a natural cause death and not be referred to coroners. Some deaths have been reported to coroners and have been considered by the coroner in the same way as any other reported death.

28. The period from 23 March 2020 when the Prime Minister announced measures described as a 'lockdown' had a significant impact on the running of coroner's offices and courts. The Chief Coroner set up regular meetings of a group of coroners representing all regions of England and Wales to monitor the coroner response to death reports and the on-going work on inquest hearings. This group met initially twice weekly, then weekly before moving to fortnightly intervals and has been an invaluable source of information to the Chief Coroner and has fed into the issuing of Guidance to coroners on topics connected with the pandemic.

29. Coroners and their staff have made a significant public service contribution to managing the effects of the pandemic, not least through their tireless work as members of Local Resilience Forums to plan, act and adapt to ensure death management, certification and investigation was (and is) in a position to deal with the excess deaths brought about by the pandemic. They have done this in difficult circumstances and the Chief Coroner thanks them all for their effort and dedication.

30. Analysis of the annual death registrations shows that, on average, there are some 10,000 or so deaths each week of the year. There are seasonal variations and with a harsh winter, or a flu epidemic, a rise in the number of deaths that occur. One of the features of the COVID-19 pandemic has been (anecdotally) a significant rise in the numbers of deaths referred to coroners across England and Wales. It has also led to a rise in the numbers of deaths referred to the coroner where COVID-19 does not appear to be involved. Clearly, the full picture will not be known for some time, until official ONS data on coroner cases becomes available in 2021. These additional death referrals will add to the pressures on the coroner service.

31. The period of lockdown has meant that many inquests have had to be adjourned or postponed. For as long as it remains a requirement, social distancing will require the coroner service to adapt its practices. Some court rooms will not be suitable for holding anything but the most straightforward of inquest hearings because they are too small. The Chief Coroner has issued guidance to assist with the holding of remote hearings, but there will be some large or complex inquests that can only be held with all participants present. Jury inquests are a vital part of the armoury of the coroner and public involvement in the examination of the circumstances surrounding

some deaths. Anecdotally, many jury inquests have had to be postponed Sufficient resource will need to be provided by local authorities to coroners to enable them to carry out this part of their statutory functions and coroners will have ensured their local authority is aware of these impacts of COVID-19 (and Local Authorities are likely to have added them to their risk register).

32. The Chief Coroner stresses the proposals set out below in statutory changes by the addition of section 6A to the 2009 Act as such a change would obviate the need for even a paper inquest.

Statutory framework

33. The view expressed in previous Reports that the structure set out in the 2009 Act has worked well, remains to be the case.

34. The Government's promised review of the implementation of the 2009 Act is still awaited.

Mergers: reduction in number of coroner areas

35. There are currently 85 coroner areas in England and Wales and the long-term joint target with the Ministry of Justice is to reduce the number to around 75. Mergers are always considered when the opportunity arises, invariably when a senior coroner retires. The merging of coroner areas has many benefits as combining areas leads to greater consistency and uniformity of approach within the coroner service, as well as potential savings for the local authorities concerned. A reduction in the number of coroner areas over the last few years has been of considerable benefit, leading to more areas that are of similar size. All mergers that have taken place have been achieved through consensus and agreement.

36. There are several coroner areas where there is ongoing work in regard to potential mergers taking place in the future. The Chief Coroner is keen to ensure that there is adequate coroner cover to provide resilience during times where merger discussions are ongoing.

37. In 2019 and 2020, the following merger took place: Central Hampshire, North East Hampshire, Southampton and the New Forest and Portsmouth and South East Hampshire were merged to form the new Hampshire, Portsmouth and Southampton coroner area.

Appointments

38. The Chief Coroner conducted an audit of appointments in 2018-2019 to confirm the names of all coroners in post and in which area they are appointed. This has been useful as it revealed that some coroners are appointed in areas but have not sat for some time.

39. There has been considerable interest in assistant coroner posts throughout the last 24 months. The Chief Coroner runs a workshop for aspiring assistant coroners and there have been a large number of enquiries to attend the workshops, so additional workshops are planned.

40. Whilst this has been a busy twenty-four months for coroner appointments, the Chief Coroner has ensured that he has been involved in each local authority appointment campaign. The appointment process is run by the local authority and it is their appointment, but each coroner appointment requires the consent of the Chief Coroner and the Lord Chancellor. By engaging with local authorities during the appointment campaign, the Chief Coroner is fully informed about whether to provide consent or not. Involvement in the process entails approving the advert prior to it being published by the relevant local authority, approving the application sift and advising on technical questions before making the final determination as to whether to provide consent to the proposed appointee or not.

41. For area and senior coroner appointments, the Chief Coroner or one of his nominees attends the interviews. This is to ensure that the process is fair and open. The nominee does not have a 'vote' in the choice of candidate but reports back to the Chief Coroner and Lord Chancellor on the interview process. The Chief Coroner would like to thank his nominees for their hard work (which is voluntary) in ensuring appointments can run effectively and with good oversight.

42. The application guidance that the Chief Coroner issues to local authorities has been revised in 2020. The guidance is provided to local authorities to provide direction on the process and notify local authorities the stages at which the Chief Coroner is involved. The aim of the guidance is to create more consistency in the appointment process.

43. There were 104 assistant coroner appointments in the 2018-2019 and 112 in 2019-2020.[1] A number of appointment campaigns have attracted large numbers of applicants.

44. There has been a rise in the number of area coroners who have been appointed; there were eight in 2018-19 both full and part-time appointments. These were Jacqueline Devonish (Suffolk), Graeme Hughes (South Wales Central), Kirsty Gomersal (Cumbria), Peter Nieto (Derby and Derbyshire), Catherine McKenna (Greater Manchester North), James Bennett (Birmingham and Solihull), Graeme

1 Please note that this number includes "cross" appointments made for the purposes of providing resilience in coroner areas.

Irvine (East London) and Peter Harrowing (Avon). In 2019-20, there have been 10 area coroner appointments both full-time and part-time appointments. These are Joanne Andrews (North East Kent), Katrina Hepburn (Central and South East Kent), Joanne Lees (Black Country), Zak Golombeck (Manchester City), Rosamund Rhodes-Kemp (Hampshire, Portsmouth and Southampton), Jason Pegg (Hampshire, Portsmouth and Southampton), Lincoln Brookes (Essex), Jan Alam (West Yorkshire (East)), Ivan Cartwright (Leicestershire and Leicester City) and Ian Singleton (Wiltshire and Swindon). Area coroner appointments greatly add to the resilience within coroner areas and the Chief Coroner supports all local authorities in giving consideration to appointment at this level. As at the date of this report, there are 30 area coroners in post. These posts cover 24 coroner areas. The recruitment process for the area coroner for Leicestershire and Leicester City was the first process carried out by remote interviews for all short-listed candidates.

45. There were five senior coroner appointments in 2018-19. These were Emma Whitting (Bedfordshire and Luton), Timothy Brennand (Lincolnshire), Andrew Barkley (Stoke on Trent and North Staffordshire), David Reid (Worcestershire) and Caroline Saunders (Gwent). In 2019-20 there have been four senior coroner appointments. These are Christopher Wilkinson (Hampshire, Portsmouth and Southampton), Timothy Brennand (Manchester West), Graeme Hughes (South Wales Central) and Julie Goulding (Sefton Knowsley and St Helens).

46. The Chief Coroner is grateful to those coroners who have retired in the last 24 months. In particular, he would like to thank David Bowen (Gwent), Christopher Sumner (Sefton, Knowsley and St Helen's), Stuart Fisher (Lincolnshire), Paul Kelly (North East Lincolnshire), Michael Oakley (North Yorkshire East), Ian Smith (Stoke on Trent and North Staffordshire),Geraint Williams (Worcestershire), Andrew Bradley (North East Hampshire), Eric Armstrong (South Northumberland and North Tyneside), Grahame Short (Central Hampshire), David Horsley (Portsmouth and South East Hampshire) and Christopher Dorries (South Yorkshire (West).

47. On 3 January 2019, the Chief Coroner was greatly saddened to hear the news that Professor Jennifer Leeming, the Senior Coroner for Manchester West had died in service. Jennifer was appointed Senior Coroner for Manchester West, based in Bolton, in September 2001. She was an outstanding coroner and she is greatly missed by all of her coronial colleagues, those from all stakeholder groups, faith communities as well as her many friends. Jennifer had been a fantastic role model for many, and she took great pride in seeing many of her assistant coroners move on to become full-time area and senior coroners across England and Wales. She is simply irreplaceable and the thoughts of all are with her husband Mike and all the family.

Deputy Chief Coroner Appointments

48. Two Deputy Chief Coroner's were appointed in January 2019. These are Derek Winter, who is the senior coroner in Sunderland, and Her Honour Judge Alexia Durran, who sits as a Circuit Judge at Guildford Crown Court and in the Mental Health Tribunal.

49. Deputy Chief Coroners support the role of the Chief Coroner in his wide range of duties and provide cover during periods of annual leave or other absence. This may include providing resilience in responding to any mass fatality incidents (in which the Chief Coroner has a national coordinating role). Along with the role of Chief Coroner, the post of Deputy Chief Coroner was created by the 2009 Act and this is the first time appointments to the role have been made since the Act came into force in 2013.

50. The Chief Coroner is extremely grateful for the support and assistance provided by the Deputy Chief Coroners; their continued hard work and dedication is invaluable.

Extension of term of office

51. The Chief Coroner is grateful for the extension to his term of this office up to October 2021. As set out above, now that he has been appointed as the Recorder of London, a selection process for the appointment of a successor is in progress.

Coroner Appraisals

52. In April 2019, the Chief Coroner launched the system of appraisal for assistant coroners. This is the first year that the appraisal scheme has run, and the Chief Coroner will be reviewing the scheme at the end of 2020. The scheme means that every assistant coroner is appraised by their senior coroner. The aim is to identify any areas of learning and development for assistant coroners. The completed appraisal forms received to date show that senior coroners and the assistants they have appraised have fully engaged in a constructive process.

53. The Chief Coroner is working on the structure for the appraisal for senior and area coroners. A small pilot scheme has been set up and the Chief Coroner will monitor progress with a view to introducing a scheme in the near future.

Coroner Salaries

54. Senior and area coroners are paid salaries by their relevant local authority who have the responsibility for the coroner service within their local area. The salary is stated on the advert for any new senior or area coroner appointment and the coroner can negotiate their salary with the relevant local authority from time to time.

55. The Chief Coroner ensures that the salary advertised for senior and area coroner posts is in line with the Joint Negotiation Committee (JNC) Coroners' Circular 63 which provides levels of salary payments according to the level of complexity of the coroner area.[2]

56. The Chief Coroner has undertaken to collect details from all senior and area coroners and from local authorities to confirm what the senior and area coroners earn. This has been completed within all areas of the judiciary and the Chief Coroner is keen to ensure that transparency is created in relation to coroner earnings. The details of each senior coroner and area coroner's salary as of July 2020 are provided at Annex C to this report.

57. Assistant coroners are fee paid judicial roles and the Chief Coroner ensures that new posts for assistant coroners are advertised with a fee that is determined in line with the JNC Coroners' Circular 63.

Model Coroner Area

58. The latest and revised version of the blueprint 'A model Coroner Area' is appended at Annex A to this Report.

59. 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 and the infrastructure required to deliver coroner services, including court accommodation.

60. 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 as well as working with the medical examiner.

Training

61. The Chief Coroner trains approximately 1,000 people in coronial 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.

2 https://www.coronersociety.org.uk/announcements/coroners-remuneration-jnc-circulars--/

62. The 2019-2020 continuation course for coroners focused on the inquest. Scenes from a fictionalised inquest were filmed and formed the basis for work in syndicates with the action being stopped at various stages and group discussion along the lines, "this has taken place, what would you do?" This was complemented by a series of talks on how you should best prioritise death referrals, dealing with the vulnerable in coroner's courts and transgender issues., For 2020/2021 the plan is that the courses will look at conclusions to inquests and prevention of future death reports, as well as a refresher on issues around disaster victim identification (DVI). Professor Peter Brennan has agreed to speak on human factors. He spoke to all senior and area coroners in February 2019 and the Chief Coroner decided that all coroners would benefit from his talk.

63. As a consequence of the COVID-19 pandemic, the Chief Coroner and the coroner course directors have been adapting training for delivery on-line. As the shape of in person training remains uncertain, it is very likely that continuation training will be delivered on-line.

64. In 2018-2019, coroners' officers' training covered preparedness for a mass fatality event. This complemented the training of all coroners in that area in 2016-17. In 2019-20 coroners' officers will have received training about deaths in police custody and in residential care home settings for the older population. The theme of the 2020/21 cycle of training for Coroner's Officers will be the quality of explanations provided to bereaved families about a range of issues including pathology, medical complications arising in a hospital setting, toxicology and medical terminology so as to ensure families have a clear understanding of the coronial investigation. As set out above with coroner training the course director with primary responsibility for leading officer training (Alan Wilson) is adapting the materials for on-line delivery.

65. Underpinning all of the training is the careful use of language and equal treatment with particular reference to the Equal Treatment Bench Book and dealing with the vulnerable.

66. 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.

67. 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.

68. The Chief Coroner supports the use of technology for the promotion and delivery of training. For example, in 2019 the Chief Coroner made a short promotional video about the coroner and coroners' officer training for 2019-20 which was sent out by the Judicial College to encourage early bookings. In addition, the Course Directors have introduced the use of other teaching apps to encourage participation especially in plenary or larger group sessions.

69. 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 nine Course Directors. Expressions of interest for the appointment of additional Course Directors drew significant interest, and six new Course Directors have now been appointed and tasked to specific areas of training.

70. The Chief Coroner wishes to express his grateful thanks to all the coroners and coroner's officers who act as syndicate leaders at training events and to all the coroners involved in the Chief Coroner's training committee.

71. The Chief Coroner would also like to express his particular 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 the time they devote to devising and running the training courses for coroners and coroners' officers.

    The current lead Course Directors are:

    Coroner continuation training: Zafar Siddique

    Induction and one-day training: Kally Cheema

    Coroners' Officers continuation training: Alan Wilson

72. 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 and area coroners and a course on medical issues. In 2019 the Chief Coroner's one-day conference was held at Westminster Central Hall led by the Chief Coroner. His Honour Peter Rook QC, Bridget Dolan QC, Lord Justice Singh, Professor Peter Brennan and Charles DeLacey all gave excellent presentations on topics of great interest to coroners. Due to the COVID-19 pandemic the event planned for March 2020 had to be cancelled.

73. In addition, all coroners and coroners' officers will see at their training or view on the Judicial College Learning Management System (LMS) an interview by Deputy Chief Coroner Derek Winter with Dame Elish Angiolini DBE QC FRSA FRSE who conducted an independent review of deaths and serious incidents in police custody.

74. The first in a series of one-day courses 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, and then in 2018 – the bowel. In 2019 the one-day training dealt with the care of the older population. 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 courses together, and to the medical experts who have made their time available to address coroners. The courses have been of the highest quality and in common with all the coroner and coroners' officer training the speakers are filmed and those films are catalogued onto Learning Management System for further viewing by way of Induction or refresher.

75. There was to be a one-day training event for local authorities in February 2020, but this had to be cancelled due to the issues around the then emerging COVID-19 pandemic. The Chief Coroner has held workshops on appointments: one for those assistant and area coroners seeking appointment as an area or a senior coroner, and another for those seeking the first appointment as an assistant coroner. Demand has been particularly strong for those seeking a first appointment and it is likely the workshops will be repeated. As at the date of this report over 100 lawyers have expressed an interest in attending these workshops and the Chief Coroner is developing this course for delivery on-line.

76. The Chief Coroner is aware of training initiatives by local Coroners' Societies and the commitment of many coroners to training with their local NHS Health Trusts, GPs and other stakeholders.

77. In April 2019, a non-statutory Medical Examiner scheme was introduced within NHS Hospital Trusts in England. The Chief Coroner has a regular dialogue with the National Medical Examiner Dr Alan Fletcher. Plans were put in place for the Chief Coroner with the assistance of the Royal College of Pathologists and the National Medical Examiner to run eight regional training days for coroners and medical examiners. Due to the COVID-19 pandemic these plans had to be put on hold. This issue will be addressed when circumstances allow.

78. Finally, the Chief Coroner is very proud of the training delivered, especially in response to observations made in recent reports about the work of coroners and coroners' officers, and he encourages those organisations, with whom coroners work, to attend the training (by arrangement) to see for themselves the interest and commitment of coroners and coroners' officers to it.

Chief Coroner Guidance

79. A key role of the Chief Coroner is to provide non-statutory Guidance to coroners. A substantial amount of work on Guidance and refreshing existing Guidance has been undertaken over the last two years. The Chief Coroner is very grateful in particular to Eve Naftalin, his former legal adviser (now legal adviser to the Lord Chief Justice), for her role in supporting and advising him on Guidance.

Guidance 29 – Documentary inquest guidance

80. The Chief Coroner issued new Guidance in November 2018 (Guidance No. 29) on the recommended process and procedures for dealing with Documentary Inquests (also known as Short form or Rule 23 inquests). This followed the judgment of the High Court in Simon Mueller v HM Area Coroner for Manchester West [2017] EWHC 3000 27, which was a case concerning a suicide. At the inquest the suicide note was not read out and a summary from a police report was used instead, which misinterpreted the suicide note. Rule 23 of the Coroners (Inquests) Rules 2013 states that where certain conditions are met it is permissible to hold a documentary inquest. This can be a useful and proportionate method to conclude an inquest for

certain cases and if the family and other interested persons consent. There are many cases which coroners deal with that are straightforward and do not require witnesses to be called to give evidence. Broadly speaking, documentary inquests can arise in one of two ways. Firstly, cases that can be opened and completed in one hearing, sometimes called a "fast track" inquest; secondly, an inquest that has been opened and adjourned and is later deemed suitable for a documentary inquest after receipt and consideration of evidence.

Guidance 30 – Judge-led inquests

81. The Chief Coroner issued new Guidance in January 2019 (Guidance No. 30) on Judge-led inquests. In recent years, there has been an increase in the complexity of investigations and inquests. The Guidance gives practical advice on the way in which coroners should handle inquests which may involve security-sensitive material and in what circumstances it is appropriate to request the Chief Coroner either to nominate a judge under Schedule 10 of the 2009 Act to sit as a coroner (and therefore able to see security-sensitive material – see also paragraph 73 below) or by appointment to sit as an assistant coroner if there is an exceptional reason to do so. The Guidance covered a number of related issues including bias and conflict of interest, recusal, physical security and disclosure of security-sensitive evidence. It is the Chief Coroner's view that once the duty under section 1 of the 2009 Act has been triggered, the senior coroner of the relevant jurisdiction is and remains seized of the matter and is under the corresponding duty to conduct the investigation, including inquest, unless there are exceptional reasons for transferring the case. The nomination of a judge under Schedule 10 should be a rarity as the Chief Coroner hopes that most inquests which involve sensitive material can be heard by the coroner using the assistance of Developed Vetting (DV) cleared counsel and/or by gisting the relevant sensitive material.

Guidance 31 – Death Referrals and Medical Examiners

82. The Chief Coroner issued new Guidance in September 2019 to coincide with the coming into force on 1 October 2019 of the Notification of Deaths Regulations 2019. The regulations make clear that a registered medical practitioner must notify the relevant senior coroner (the senior coroner appointed for the coroner area in which the body of the deceased person lies) of a person's death if they come to know of the death, in certain types of cases. Prior to these regulations, there had been no such provisions and the circumstances of the reporting of deaths by medical practitioners to coroners had varied across coroner areas. The regulations are part of the roll-out of medical examiners as an important part of the death investigation system as provided for within the Coroners and Justice Act 2009.

Guidance 32 – Post-Mortem Examinations including Second Forensic Post-Mortem Examinations

83. The Chief Coroner published new Guidance on post-mortem examinations including second post-mortem examinations. This Guidance will assist coroners with decisions as to when to allow second post-mortem examinations and is intended to be a practical guide for decision making and to promote broad consistency in coronial practice. The accurate determination of the cause of death can sometimes only be identified by a post-mortem examination and the coroner has a specific statutory power, exercised under section 14 of the 2009 Act to order such an examination. However, there is no legal definition of a post-mortem examination and practice amongst coroners varies quite widely. This Guidance supersedes the twenty-year-old Home Office Circular (No.30/1999) which is now out of date. The Chief Coroner has long been concerned with the high number of post-mortem examinations carried out in England and Wales. He commends the downward trend to order a post-mortem examination which in 2019 was 39% of all deaths reported, although that is still higher than in other comparable international jurisdictions. The Guidance also seeks to give clarity to coroners on what circumstances it is appropriate to order a second post-mortem examination. The Chief Coroner wishes to thank Elaine Gordon and Lucy Harrison from RoadPeace for their work on this issue in memory of Gina Johnson and Peter Price. The Chief Coroner is particularly grateful for their work flagging the inconsistency of approach across the coroner areas. He hopes this Guidance will address those concerns.

Guidance 33 – Suspension, Adjournment and Resumption of Investigations and Inquests

84. The Chief Coroner published new Guidance on suspension, adjournment and resumption of investigations and inquests in October 2019. This Guidance will assist coroners on the law and practice on suspending investigations and adjourning inquests, on resumptions and on when a coroner becomes functus officio, with a view to achieving greater consistency of approach between senior, area and assistant coroners across all of England and Wales. The Guidance includes a section on resumption of historic inquests, and the particular issues as to the scope of inquest that may arise in such situations.

Guidance 34 to 39 – COVID-19

85. In the period between March and June 2020, the Chief Coroner published new Guidance to coroners on various aspects of their work. This included Chief Coroner's Guidance for Coroners on Covid-19, Hearings during the pandemic, Summary of the Coronavirus Act 2020 and provisions relevant to coroners, COVID-19 deaths and possible exposure in the workplace and Remote participation in coronial proceedings via video and audio broadcast.

86. The Chief Coroner is working on three additional pieces of Guidance. One concerns the use of counsel or solicitor to an inquest, another the use of pen portrait material and thirdly, revised guidance on prevention of future death reports. Each of these pieces of work are at an advanced stage of preparation but have been delayed by the additional work the COVID-19 pandemic has brought with it. Work is also underway in related areas. For example, work is underway on a revision to the coroner's Bench Book and for a Toolkit for lawyers working in the coroner jurisdiction, which is a joint project with the Solicitors Regulation Authority, the Bar Standards Board and others. The Chief Coroner also spoke at the Ministry of Justice conference for inquest lawyers in early 2020.

Judge-led inquests

87. The Chief Coroner has a power under Schedule 10 of the 2009 Act to request the Lord Chief Justice to nominate a judge (including himself) to conduct an investigation into a person's death. The Schedule 10 process will be suitable for cases in which national security sensitive material is in scope and the coroner has not been able to discharge his statutory functions because statute prevents disclosure of some security sensitive material to the coroner himself. The Lord Chief Justice must consult the Lord Chancellor before making a nomination. Over the last two years, the Chief Coroner has made five 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.

88. Very occasionally, it may be the case that for particular, case-specific reasons, it is prudent for a sitting or retired judge to sit as a coroner. This may be because the investigation and inquest is very controversial or sensitive, or it has a difficult history which means that, looking at the case as a whole, the Chief Coroner decides to invite the relevant local authority to appoint a judge to sit as an assistant coroner. Over the last two years, five such appointments have been made.

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

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

- The Chief Coroner conducted the investigations (including inquests) into the deaths arising from the London Bridge and Borough Market terrorist attack on 3 June 2017. The inquests into the victims started at the Central Criminal Court on 7 May 2019 and concluded on 28 June 2019. The inquests into the death of the three attackers took place and concluded in July 2019 at the Central Criminal Court.

- Sir John Saunders, a retired High Court judge, was nominated to conduct the investigations (including the inquests) into the deaths arising from the Manchester Arena terror attack on 22 May 2017. On 22 October 2019 it was determined that the inquests would become a public inquiry with Sir John Saunders as the Chairman. The hearings in the inquiry are likely to be heard in September 2020.

- His Honour Judge Patrick Field QC was nominated to conduct the investigation (including the inquest) into the death of Jamal Uddin who was murdered in February 2016. The inquest was suspended due to the criminal trial of his assailant who was convicted of murder and sentenced to life imprisonment with a minimum term of 24 years.

- His Honour Clement Goldstone QC was nominated to conduct the investigation (including the inquest) into the death of Jermaine Baker was shot and killed by a firearms officer on 11 December 2015 when armed police were engaged in an operation to prevent an attempt to free a prisoner on route to the Crown Court in Wood Green, North London. On 13 February 2020, the Home Secretary announced that the inquest would become a public inquiry under the Chairmanship of His Honour Clement Goldstone QC.

- Her Honour Judge Angela Rafferty QC, sitting as an assistant coroner for South London, will hold the inquest into the death of Sabrina Rivzi. Sabrina Rivzi was shot in 2003 when collecting her boyfriend from a police station.

- His Honour Judge Paul Matthews was nominated on 31 October 2017 to hold a fresh inquest into the death of Barry Pring who died following a road traffic collision in February 2008 in Kiev, Ukraine. An inquest had been held in January 2017 and a conclusion of unlawful killing had been given. On 24 April 2017, by consent, the High Court quashed the inquest and ordered a fresh inquest be opened.

- Her Honour Judge Sarah Munro QC, sitting as an Assistant Coroner for East London, will hold the inquests into the deaths of Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor. Stephen Port was convicted of their murders. The four deaths took place between June 2014 and September 2015. Inquests for two of the men were held and open conclusions recorded. In November 2017 the High Court ordered that the two inquests should be quashed and ordered fresh inquests. It was also decided that inquests for the two other deaths should be heard before the same coroner. The inquest hearing with a jury is due to commence on Monday 4 January 2021.

- His Honour Judge Philip Katz QC, sitting as an assistant coroner for Hertfordshire, held the inquest into the death of Daniel Cuffe. Daniel Cuffe died following contact with the police in Hertfordshire when a drugs warrant was executed at his address in Cheshunt. In the course of the search, whilst under restraint, Mr Cuffe informed officers he had swallowed a significant quantity of cocaine. An ambulance was called. He died in hospital two days later. The inquest was heard at the Central Criminal Court starting on 6 January 2020. The inquest concluded on 14 January 2020. The conclusion was misadventure.

- The Deputy Chief Coroner, HHJ Alexia Durran, is responsible for holding the inquest into the death of William Smith who was shot by police officers on 1 May 2016. The inquest is currently listed to take place at Maidstone Crown Court on 2 November 2020.

- The Chief Coroner, HHJ Mark Lucraft QC, is responsible for holding the inquests into the deaths of the two individuals killed as well as the attacker in the attack on 29 November 2019 at Fishmongers' Hall. The inquests are provisionally fixed to take place at the Central Criminal Court as from 4 April 2021. The Chief Coroner has given an initial ruling and directions (dated 5 June 2020) following written submissions from Interested Persons. Copies of the ruling and the draft directions can be read online.

- His Honour Judge Nigel Lickley QC was nominated on 29 April 2020 to take on and conclude inquests into the deaths of two fishermen Yves Gloaguen and Pascal le Floch, who died when a trawler, the Bugaled Breizh sank off the Lizard, in Cornwall, in 2004.

- Mr Justice Hilliard was nominated on 29 April 2020 to hold an inquest into the death of Sudesh Amman who was shot on 2 February 2020 after he had stabbed two people in a terror attack.

90. The Chief Coroner was very saddened to hear of the death of Siân Jones on 11 June 2020. Siân was a partner with BDB Pitmans and had many years of experience. She undertook the role of solicitor to the inquests into the deaths of the 30 British nationals killed in the terror attack at the beach resort of Sousse, Tunisia in June 2015, as well as undertaking the same role with the inquests into the deaths as a result of the terror attacks in March 2017 on Westminster Bridge and the Palace of Westminster, and in June 2017 on London Bridge and at Borough Market. In 2020, she was working on the investigation and inquests into the deaths at Fishmongers' Hall. Words cannot adequately cover the impact she had in those cases. She was intelligent, warm, engaging, delightful to work with and brought to each a whole host of skills. All her work was done with care and concern for those involved in these incidents. She will be greatly missed. The Chief Coroner extends his condolences to her family, friends and colleagues.

Memoranda of understanding

91. 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 judgment 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 [Air Accident Investigation Branch] in the light of the judgment in this case and for the future be responsible for the guidance and arrangements contained within the MoU."

92. 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.

Juror Notices

93. 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'ts' in jury service has been provided to all serving jurors. Professor Thomas has adapted the notice for use for coroner's inquests and these have been circulated amongst all coroners and are now in use at all inquests with juries.

Stillbirths

94. The Government consultation on the coronial investigation of stillbirths closed on 18 June 2019. The Chief Coroner provided a response to this consultation which is published at www.judiciary.uk.

Medical examiners

95. As at paragraph 66 above, in April 2019 the Department of Health and Social Care launched a non-statutory version of the Medical Examiner scheme set out in the 2009 Act. This scheme is gathering pace rapidly and medical examiners are being appointed to work within NHS Trusts in England at an expanding rate. The Chief Coroner's view is that coroners should give the scheme their support.

96. The Chief Coroner is delighted that Dr Alan Fletcher, a consultant in Emergency Medicine, has been appointed as the National Medical Examiner. The Chief Coroner has worked closely with Dr Fletcher and with others in the Ministry of Justice and in the Department of Health and Social Care on the development of the non-statutory scheme and will continued to do so. Some of this includes the work on the statutory criteria for doctors reporting deaths to coroners, which the Chief Coroner is pleased went ahead in 2019.

97. As above, part of the Chief Coroner's training plans for 2019-20 included joint regional training so that coroners and medical examiners can explore issues of practice and common interest side-by-side. The COVID-19 pandemic has led to the postponement of this as 'in person' training, but the delivery of this training remains on the Chief Coroner's agenda.

98. The scheme currently only covers hospital deaths but in due course will extend to deaths in the community and the proposed statutory reforms will be enacted.

99. The Chief Coroner remains of the view that the interlocking system of oversight for community, hospital and all other deaths by the medical examiner, 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.

Pathology services

100. The Chief Coroner remains very concerned about the pathology service to coroners. There are a dwindling number of pathologists prepared to carry out post-mortem examinations requested by a coroner and the service is severely under-funded.

101. A post-mortem examination is not a requirement of death investigation by the coroner although the accurate determination of the cause of death (how the deceased came by his death) can sometimes only be identified by a post-mortem examination. The general trend over the last twenty years has been a decrease in first post-mortem examinations requested by coroners, from 59% in 1997 to 39% in 2019 of all deaths reported to coroners.[3] The Chief Coroner commends the nature of this trend. In considering the statistics it is important to register a note of caution. If as the pilot schemes show, once there are medical examiners in place, there may be a reduction in the number of deaths reported to coroners, as well as a reduction in the number of post-mortem examinations requested by coroners, but as a result, the percentage of post-mortem examinations to reported deaths may rise.

102. Post-mortem examinations are carried out, for the most part, by consultant histopathologists or consultant Home Office registered forensic pathologists.

103. Local pathology services are seriously stretched with the result that coroners are sometimes forced to wait for a post-mortem examination to be performed. This in turn delays the release of the body to the family for burial or cremation as well as having an adverse impact on mortuary capacity. There is a lack of control and oversight of the pathology provision partly as no government department, or the NHS, considers it has responsibility for this vital service. The proper recording of the cause of death leads to better mortality statistics and the lessons to be learned from all deaths.

104. Professor Peter Hutton, in his March 2015 Report,[4] described the immediate future of both forensic and non-forensic pathology services as 'fragile, and corrective action needs to be taken now'. 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.

3 Coroners statistics published in May 2020 by the Ministry of Justice. https://www.gov.uk/government/statistics/coroners-statistics-2019

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

105. 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.

106. 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.

107. 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.

108. The Chief Coroner continues to work with the Royal College of Pathologists and others on these issues.

Service deaths

109. 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.

110. 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.

111. 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.

112. Recent high-profile cases to note include a second inquest into the death in 1995 of Private Sean Benton at Deepcut Barracks which was conducted by His Honour Peter Rook QC, a retired senior circuit judge, as coroner and concluded in July 2018. His Honour Peter Rook QC also conducted a fresh inquest into the death in 2001 of Private Geoff Gray, who also died at Deepcut Barracks. That inquest concluded in June 2019. The Senior Coroner for Birmingham and Solihull conducted the inquest into the death of Corporal Joshua Hoole in October 2019. An inquest was opened into the death of Royal Marine Ethan Jones in January 2020.

Deaths in Custody Leaflet

113. The Chief Coroner has worked with the Home Office, the IOPC, the Ministry of Justice and INQUEST to produce a joint leaflet for families following a death in custody. This has been circulated to all coroners and to coroners' officers. Please see https://www.gov.uk/government/publications/deaths-in-police-custody-leaflet-for-families.

Standard of Proof in Inquests

114. An important case has been proceeding through the courts concerning the standard of proof, in particular in conclusions of suicide. The case of Maughan was heard in the Supreme Court in February 2020 and, as in previous stages, the Chief Coroner had interested party (or equivalent) status. He (a) made submissions on the legal background to inquest conclusions and the practicalities of inquests; (b) set out the arguments for and against each possible outcome of the case; and (c) addressed the issue of the unlawful killing conclusion, which arises indirectly. The Chief Coroner has no agenda or intention to pursue any particular outcome to the appeal. However, he considers the issues important and is keen to ensure that any guidance given is clear and practicable for coroners and service users. As at the date of preparation of this report, the decision of the Supreme Court is awaited.

Reports to prevent future deaths

115. 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.

116. Between July 2018 and June 2019, there were 505 PFD reports issued by coroners. Between July 2019 and June 2020, the number is 386. This reduction is likely to be accounted for by the three-month period of lockdown from late March to late June, which significantly reduced the number of inquests being held (the inquest itself is the process via which most PFD reports are produced). All reports, and responses to them, 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.

117. The Chief Coroner encourages all coroners to write and submit PFD reports where appropriate and as mentioned above in the section on Guidance, Guidance on Reports will be refreshed and re-published in 2020. In addition, the Chief Coroner is exploring ways in which publication of the reports may be enhanced and made easier to research and digest.

Treasure

118. The Chief Coroner's document 'Treasure: A Practical Guide' which is a guide for coroners on how to investigate and conduct treasure inquests can be found on the Chief Coroner's website.

119. A consultation was launched in February 2019 by the Department for Digital, Culture, Media and Sport with the British Museum and other stakeholders about the Revision of the definition of treasure in the Treasure Act 1996 and revising the latest codes of practice under the Treasure Act 1996. The Chief Coroner fed into this consultation and continues to work with the British Museum on treasure matters.

120. In 2017, to mark 20 years since the launch of the Treasure Act 1996 the Portable Antiques Scheme engaged in a number of activities around the #Treasure20 theme.

Disaster Victim Identification (DVI) and International Incidents

121. The Chief Coroner continues to have oversight of the arrangements for major cases involving mass fatalities, terrorist incidents with loss of life and other deaths overseas. Following major incidents, the Chief Coroner liaises with coroners, the Foreign, Commonwealth and Development Office, the Ministry of Justice, 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.

122. Within England and Wales, in the period between 22 March 2017 and 14 June 2017 there were three terror incidents that 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. Regrettably, other mass fatality incidents have occurred. On 14 June 2017, fire broke out at Grenfell Tower. The fire developed and engulfed the tower. 71 people died as a result of the fire. In February 2018, an explosion in Leicester resulted in five deaths and in October 2018 the helicopter crash that killed the five people on board including the pilot and four passengers including the owner of Leicester City football club Vichai Srivaddhanaprabha. In October 2019, the bodies of 39 Vietnamese nationals were found in the trailer of an articulated refrigerator lorry in Grays, Essex. In November 2019, there was the terror attack at Fishmongers' Hall and, in February 2020, a terror-related knife attack occurred in Streatham Hill. Each of these horrific incidents led to the extensive involvement of the coroner service and of the local senior coroner.

123. 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. 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.

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

125. Events worldwide have continued to show 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 fingerprint, dental, DNA and other similar records are available, they 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. The importance of accurate identification, for families and for the process of justice cannot be overemphasised. Once identification of a body is confirmed to the satisfaction of the coroner through trained police family liaison officers, there will be discussions with families as to the next stages.

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

127. In 2017, the Chief Coroner reformed the cadre of specialist coroners in this area of work and a generic set of DVI documents has been developed. The cadre now has two co-chairs: Dr Fiona Wilcox and Professor 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. The training is run by the Chief Coroner in conjunction with UKDVI. The Chief Coroner wishes to express his sincere thanks to Detective Superintendent Alan Crawford (now retired) and to Detective Inspector Howard Way OBE for all of their help and ongoing assistance. He is delighted that Detective Chief Inspector Pete Sparks has taken the lead role with UKDVI and that he will work with DI Way to ensure the excellent work of the unit continues. UKDVI has played an extensive role in the training of all coroners and coroners' officers as well as spearheading the response to incidents in the UK and throughout the world. The DVI skills developed by coroners have played a key role in enabling coroners to plan and advise on excess death planning as part of the COVID-19 pandemic, with Local Resilience Forums and other partners.

Northern Ireland and Scotland

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

129. 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

130. The Chief Coroner continues to meet regularly with a wide range of stakeholders. As well as ongoing interaction with various government departments at the highest ministerial level, including meeting with the Minister responsible for coroners, he continues to cultivate relationships with a diverse range of stakeholder groups who have direct interaction with the coroner service.

131. In the course of his duties to lead the coroner service of England and Wales, the Chief Coroner over the last two years has met with amongst others the Lord Chief Justice, the Director of Public Prosecutions, the Prisons and Probation Ombudsman, the Chief Investigator of Healthcare Safety Investigation Branch, the National Director of Patient Safety, the Deputy Registrar General, and the President of the Royal College of Pathologists and chair of their death investigation group to discuss issues of concern and best working practice. He has met with the Victims Commissioner, representatives from INQUEST, Empathy Training Ltd, Dignity for the Deceased, the Samaritans and the IOPC to discuss putting families of the bereaved at the heart of the inquest process and continues to use feedback to drive training and guidance for coroners and their teams.

132. The Chief Coroner continues to speak at a variety of engagements, including at the Faculty of Forensic and Legal Medicine Conference, the Local Registration Association Year Ahead Conference and the National Suicide Prevention Strategy event as part of his involvement as a member of the working party. The Chief Coroner was interviewed by Dame Joan Bakewell for BBC Radio 4's programme on 23 January 2019 "We Need to Talk about Death" which sought to inform about the coronial process and was very well received. He took part in a series of talks presented by the Dean and Chapter of Ely Cathedral on the topic of 'doing justice'. He has also attended the National DVI training courses in Oxford, the Addenbrooke's Hospital working party on organ donation and both the coroner and coroners' officers' training this year where he has addressed the delegates. The Chief Coroner has also engaged in talks and meetings with faith groups.

133. As above, the Chief Coroner hosted the senior and area coroners' conference and the Local Authority Conference. He also hosted the inaugural meeting of the retired coroners' group.

134. The Chief Coroner is fully engaged with the Ministry of Justice Coroner Services Committee and Stakeholder Forum and has regular meetings with the officers of the Coroners' Society of England and Wales.

135. The Chief Coroner is very grateful for the dedication, industry and hard work of all his team based at the Royal Courts of Justice. The team is very ably led by James Parker, Head of the Chief Coroner's Office and Private Secretary to the Chief Coroner. Eve Naftalin undertook the role of legal adviser to the Chief Coroner until her promotion to the role of Legal Adviser to the Lord Chief Justice in October 2019. At the outbreak of the COVID-19 pandemic, she returned to assist the Chief Coroner alongside whilst retaining her role with the Lord Chief Justice. Anne Marie Aherne joined the team as Deputy Head of the Chief Coroner's Office and Deputy Private Secretary in January 2019. Laura Walters and Emma Myers are both Assistant Private Secretaries to the Chief Coroner and Zara Smith the Diary Secretary. Since the last report, Gary McKenzie left the Chief Coroner's office to take a new position within the National Crime Agency. The Chief Coroner would not be able to do what he does without the support of all those within the office and he expresses his sincere thanks to each of them.

Recommended law changes

136. The Chief Coroner recommends that consideration should be given to a number of changes in the law. The following recommendations were also proposed in previous Chief Coroner annual reports.

Item 1: Mergers of coroner areas

137. 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.

138. 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.

139. 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 an oversight in the statutory drafting.

140. 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 2009 Act 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

141. 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.

142. 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.

143. 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.

144. 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

145. 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.

146. 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.

147. 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.

148. 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.

149. 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 of Inquest (which is a public document). There would be significant advantages to the coroner service if this change were to be implemented, given the backlogs created by the COVID-19 pandemic.

150. 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

151. 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.

152. 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.

153. 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.

154. 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.

155. 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)

156. 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.

157. In the last two years the Chief Coroner has been sent six requests in circumstances such as this.

158. 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'.

159. 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 coroner's 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. 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

160. 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.

161. The Ministry of Justice published the Final Report of its Review of Legal Aid for Inquests in February 2019 and the Chief Coroner notes its contents. Clearly, the future nature of Legal Aid funding for inquests is a matter for Government and Parliament.

Statutory powers and duties

162. 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 2018.

163. 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) of the 2009 Act). Between 30 June 2018 and 1 July 2019, there have been 62 applications and the Chief Coroner has granted 58 of them and between 30 June 2019 and 1 July 2020 there have been 33 and the Chief Coroner has granted all of them.

164. 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 of the 2009 Act). By this power the Chief Coroner may direct transfers of investigations from one coroner area to another. The Chief Coroner has exercised this power once in the year to 30 June 2019 and once in the year to 30 June 2020.

165. 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 year to 30 June 2019 the Chief Coroner received 1,051 notifications and in the last year the Chief Coroner has received 989 notifications.

166. 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.

167. 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 of the 2009 Act). It has not been necessary for the Chief Coroner to use this power yet.

168. The Chief Coroner may designate suitable practitioners to make post-mortem examinations (section 14 of the 2009 Act). The Chief Coroner has not exercised this power.

169. The Chief Coroner must keep a register of notifications by senior coroners of investigations lasting more than a year (section 156 of the 2009 Act). That register was first opened on 25 July 2014, one year after the statutory provisions came into force. Reference should be made to the table at Annex B.

170. The Chief Coroner must monitor and train coroners for investigations into deaths of service personnel (section 17 of the 2009 Act). The Chief Coroner was notified of 8 deaths in this category in the last two years.

171. 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 to the 2009 Act). For details see above.

172. The Chief Coroner has responsibility to train coroner and coroners' officers (section 37 of the 2009 Act): for details see above.

173. The Chief Coroner may carry out an investigation into a person's death (section 41, Schedule 10 to the 2009 Act). The Chief Coroner has exercised this power in relation to the inquests into the tragic deaths on Westminster Bridge and the Palace of Westminster, at London Bridge and Borough Market and is to do so in relation to the tragic deaths at Fishmongers' Hall.

174. The Chief Coroner may request the Lord Chief Justice to nominate a judge or a former judge to conduct an investigation; the Chief Coroner may also request a former coroner to conduct an investigation (section 41, Schedule 10 to the 2009 Act). He has made five requests to the Lord Chief Justice in the year to 30 June 2019 and two requests this year. All have been granted.

175. 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 received 505 reports in the year to 30 June 2019 and has received 386 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.

176. In addition, under Regulation 25 of the Investigations Regulations 2013 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.

177. The Chief Coroner also has the power under Regulation 27 of the Investigations Regulations 2013 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 two years.

Conclusions

178. This is the combined sixth and seventh 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.

179. The Chief Coroner continues to acknowledge the enormous contribution made by his predecessor His Honour Sir Peter Thornton QC, in setting in place many systems, guidance and training that have continued long after his retirement.

180. The Chief Coroner is sincerely grateful to all coroners in post in the course of his tenure, for all of their hard work and support. Many coroners work with limited resources in the most difficult of situations and often their work goes unacknowledged. As with any other area of human life, we do not always get everything right, and we need to acknowledge that and work to learn and improve.

181. 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 and other stakeholders on the plans set out in this report in the course of the remainder of his time in post and to observing the further developments in the hands of his successors.

His Honour Judge Mark Lucraft QC,
Chief Coroner
1 July 2020

Annex A

CHIEF CORONER

A MODEL CORONER AREA
2nd Edition July 2020

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 (referred to as 'Areas' in the remainder of this document) should be such that the senior coroner receives approximately 2,000 to 6,000 reports of deaths each year, with some caveats (see below).

3. There can be very few grounds for Areas of less than 1,000 reported deaths a year continuing to exist as stand-alone jurisdictions (although there may be particular arguments unique to an Area).

4. For Areas between 1,000 and 2,000 deaths, it is the Chief Coroner's view that these should actively consider merging if the circumstances are right, although factors which should be considered include: geographical area, complexity of work, effect of medical examiner implementation.

5. There are a small number of Areas where the number of reports of death are higher than 6,000. These large Areas can be effective especially where they are coterminal with a (typically also large) local authority area. In these Areas, it will be necessary to ensure that the senior coroner has sufficient numbers of area and assistant coroners to ensure the smooth running of the area.

6. As the Medical Examiner (ME) service is implemented, the number of deaths reported to the coroner service locally is likely to reduce, although indications are that the nature of additional reports from the ME may be more complex. The nature and demands of the Area caseload should be carefully monitored over the coming years, and additional resources made available as necessary.

7. 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. The Chief Coroner is always available to discuss mergers.

Coroners

8. Each coroner Area should have a senior coroner supported by assistant coroners. In many areas there will also need to be an area coroner. It is a minimum statutory requirement for there to be at least one assistant coroner appointed alongside the senior coroner.

9. Where there is an area coroner, the senior coroner's administrative workload should be shared with the area coroner by agreement. The appointment of an area coroner provides considerable additional resilience to an area. Over the last five years, far more coroner Areas have appointed a full-time or part-time area coroner. Whether a post is full or part-time should be the subject of discussion between the senior coroner and the relevant authority and should fit the needs of the Area. The requirements of the successful candidate may also need to be taken in to account, especially if the Area wishes to attract the ablest candidates. The Chief Coroner is always available to discuss the options with such appointments.

10. 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.

11. New coroners should be appointed by the local authority following an open and transparent competition.

12. 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, provides both judicial leadership on reports of death and investigations and inquests (typically dealing with the most complex inquests as well as dealing with the full range of judicial work in the Area) as well as significant judicial-administrative responsibilities, including listing and deployment as well as involvement with myriad administrative and leadership matters, working with the relevant authority in a constructive way.

13. The role 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 and directs listing
- 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 as required in statute (or on a rota basis with an area/assistant coroner)
- is prepared for a mass fatality disaster including with a disaster victim identification (DVI) component, as well as other events such as a terrorist related incident or pandemic scenarios. This function includes senior participation in the Local Resilience Forum (LRF) on DVI and terror incidents, mass fatalities and excess deaths.

14. Senior coroners and area coroners are entitled to a salary with pension. Assistant coroners are entitled to fees. Assistant coroners are eligible for a Local Government Pension Scheme pension. Fees for assistant coroners should be paid at a daily (or half daily) rate and there should be no differential in fee for the type of work, since all forms of work involve judicial decision-making.

15. In line with the rest of the judiciary, daily fees already incorporate payment for preparatory work. This should be the routine position; normally, additional fees should not be paid for preparation. The basis of all payments should be clearly agreed in advance.

16. There are to be no arrangements for an assistant coroner to be engaged solely for 'signings only' (i.e. where the only work the assistant coroner is permitted to do is office-based signing work). They must be exposed to the full range of coroner work in the Area.

17. 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 in the long-term, an independent assessor (such as the Senior Salaries Review Body) should recommend levels of salaries and fees. In the meantime, the framework provided by JNC Agreement No.63 dated 30th November 2018 prevails and should be followed.

18. Senior coroners and area coroners should be expected to have and take an annual leave entitlement of at least 30 days, and additional leave in lieu of statutory holidays, when on-call.

19. Except in exceptional circumstances, assistant coroners should be given a minimum of 20 sitting days per year (to include a continuous calendar week of sitting days). They must first be assessed as competent and ready to work on their own.

20. 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.

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

22. Assistant coroners should be appraised annually by the senior coroner. An appraisal scheme has been developed. Area coroners and senior coroners are to be appraised, and a pilot project is underway.

23. The senior coroner for each coroner Area should present a brief annual report to the Chief Coroner and their relevant local authority in July of each year. 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.

24. 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).

The Local Authority (including the relationship between the Senior Coroner and the Local Authority)

25. A well-functioning coroner Area requires a constructive relationship based on mutual understanding, trust and respect between the senior coroner and the relevant authority.

26. It is the statutory responsibility of the relevant local authority to provide "staff and accommodation" as set out under section 24 of the Coroners and Justice Act 2009. In practice, the role of the local authority extends beyond that of the simply providing some staff and buildings; the infrastructure required to run the service (implicit in the term 'accommodation') includes, amongst other things, security, administrative and IT provision, a public facing website, adequate office and courtroom accommodation, access to case law resources including text books, legal and HR support where necessary and so on.

27. Where the police provide coroners' officers they should, in the same spirit, provide the requisite level of staff support.

28. The senior coroner has judicial functions, including judicial-administrative responsibilities, as set out above. Coroners have a wide judicial discretion to conduct investigations into a death and they may make whatever enquiries seem necessary. They have wide powers to investigate at pre-investigation, investigation and inquest stages. When a member of coronial staff (coroners' officers, local authority staff, police staff or others) is carrying out activities in pursuit of the coroner's wide statutory powers and responsibilities, this is also judicial activity. This is because the coroner's judicial authority cannot be delegated, even though the coroner may direct the coroners' officers or other staff to carry out certain tasks on their behalf.

29. Local authorities should therefore understand that coroners are independent judicial office holders, and not employees or a department of the local authority and as such the local authority may not interfere in matters within the exclusive jurisdiction of the coroner.

30. The Forrest case (Forrest v Lord Chancellor & Anor [2011] EWHC 142 (Admin)) is the classic statement of the position.[5]

31. As Laws LJ says at paragraph 27 of the judgment: "Certain things are beyond contention. The Coroner is a judge; and neither BCC nor anyone else, save a properly constituted court of appeal or review, has the least business interfering with his judgments or how he arrives at them. His independence as a judge is a matter of constitutional guarantee. Nothing could be more elementary."

32. 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. The relevant authority has (properly) a duty to manage public finances and a legitimate interest (including a reputational interest) in maintaining public confidence in the effective administration of the local justice it is required to help deliver.

33. Dorries[6] says in his commentary on the judgment in Forrest that "the Coroner as a guardian of public money must not act in a profligate or insensitive manner."

34. Regulation 7 of the Coroners (Investigations) Regulations 2013 encodes this principle in statute: whilst expenditure is a matter for the coroner and the coroner does not need the permission of the relevant authority to incur costs, it states that the coroner must notify the relevant authority of any unusual expenditure before it is incurred.

5 https://www.bailii.org/ew/cases/EWHC/Admin/2011/142.html

6 Dorries. C. (2014) Coroners' Courts: A Guide to Law and Practice 3rd ed. OUP

35. It is impossible in this document to set out the proper minutiae of every interaction between the senior coroner and the relevant authority save to say that it is very important that all parties understand the nature of the respective roles and of their relationships and that they calibrate the nature of their engagement carefully and with respect. As part of that process of calibration, the relevant authority should respect the seniority and status of the coroner as a judge (and the leader of the coroner service locally) and the relevant authority will inevitably be required to accept they do not have the same level of direct control over the work of the local coroner service as they would over another local authority department. This is axiomatic and should be accepted as the settled position of parliament.

36. However, in the same spirit, the senior coroner should not (to quote Forrest) "harbour an idée fixe of the scope" of his or her role and domain. They should accept and respect the proper role of the relevant authority in their shared task of delivering justice locally for the bereaved. A senior coroner who is flexible and who is willing to work constructively with a relevant authority which in turn respects the coroner's judicial independence will find significant advantages in doing so. Any differences of view about arrangements for the running of the service should be aired constructively and resolved quickly; a good relationship will make this possible.

37. When the senior coroner is approaching retirement (ideally at least a year in advance), local authorities should consider succession planning and, if a smaller Area, possible future merger with another coroner Area or Areas.

Accommodation

38. The relevant (local) authority should (and is required by law) to provide suitable accommodation for all coroners, coroners' officers and administrative support staff. Whilst 'suitable' is not defined in statute, in the opinion of the Chief Coroner, and in an ideal world, 'suitable' should mean, amongst other things, that it should be appropriate in terms of the dignity of the deceased and their families and should be of a good and safe standard physically. It would include (for example) adequate private rooms for the bereaved family to use during the course of an inquest. Security arrangements for staff, judiciary and the public is an important factor. In terms of an efficient coroner's office, 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.

39. Where the police employ coroners' officers, they should not be in different parts of the Coroner Area or in police stations but working together in one place with the coroner and other staff. This produces greater resilience, efficiency and effectiveness of working. It serves the public better. Police stations in particular are entirely unsuitable places from which the independent judicial activity of the coroner should be conducted (even if it is only ever in the sense of members of staff working from that location). Staff, including coroners' officers, should not be based in police stations.

40. 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).

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

42. Save in exceptional circumstances, senior coroners must not use their home as an office. The local authority should provide them with an office.

43. All Coroners have eJudiciary email addresses which can be used alongside Local Authority email addresses. The use of private email addresses such as Hotmail or Gmail for judicial work is not acceptable.

Coroners' officers and other staff

44. Coroners' officers are employed by the police authority or local authority. Other staff are usually employed by the local authority (although there are no fixed rules on this matter). The functions and duties of coroners' officers are set out in the Chief Coroner's note on *The Functions and Duties of Coroners' Officers*.

45. Coroners' officers and other staff are not employed by the senior coroner. The senior coroner is not the line manager of those members of staff in the sense that that term is normally used. However, the senior coroner (and the coroners in the Area more widely) are entitled to direct the work of the coroners' officers' and other staff because the role of those members of staff is, amongst other things, to carry out tasks in pursuit of the coroner's judicial function. The service could not work unless this was so. See paragraph 28 above. Reasonable directions and instructions made by coroners appointed to the coroner Area should be followed by coroners' officers and staff.

46. Coroners' officers and other staff should not purport to make judicial decisions themselves (for example, the decision to order a post-mortem examination) and coroners should not expect members of staff to do so.

47. In order that coroners can carry out their functions, there should be appropriate staffing levels. In complex jurisdictions, more should be provided.

48. Those employing coroners' officers, whether police or local authority, should maintain a full complement of officers at all times. It is reasonable for the senior coroner to expect that if a member of staff is on (for example) maternity leave or shared parental leave, their role should be covered in a way so as to maintain a full complement. Arrangements should also be in place so that proficient temporary cover is available whenever officers are absent.

49. Employers of coroners' officers and local authority councilors are encouraged to visit the coroner's office to discuss the work of coroners' officers and the issues raised by them.

50. Whilst different coroner Areas deploy officers and other staff in different ways, where coroners' officers or other staff manage inquest caseloads (i.e. files for cases which are proceeding to inquest) the case load for each officer or member of staff should be approximately 25 inquest files, having regards to the complexity of the particular cases.

51. Coroners should be supported by administrative support staff (which will typically be employed by the local authority). Administrative support staff should carry out administrative functions as directed by the Coroner or the Coroner Service Manager.

Investigations and inquests (including preliminary matters such as release of the body)

52. It is not the purpose of this document to rehearse the statutory functions of coroners in relation to death investigation, save to say that the Chief Coroner expects that coroners should (of course) approach their work professionally, with due regard to statute, case law and Chief Coroner Guidance and in a way which upholds their judicial oath and judicial independence.

53. It is important that the coroner Area works in such a way (including in the level of resource provided by the relevant authority and the efficiency of its organisation) so as to maximise the likelihood of the right outcomes and to reduce error, including prompt decision-making for the bereaved. In particular:

- Reports of death should be capable of being made electronically.
- Bodies should be released for burial or cremation as soon as reasonably practicable. The coroner service should focus on release within a few days of the report of death rather than on a longer timescale, although in some cases it will be not possible to release a body that quickly.
- Most inquests should be completed within six months of the death being reported, in line with rule 8 of the Coroners (Inquests) Rules 2013 (accepting that in complex cases this may not be possible).
- A coroner Area should avoid a backlog of cases. Coroners must report annually to the Chief Coroner with details of all cases not concluded within 12 months. Senior Coroners should alert the relevant local authority and/or the police force, if they are unable to progress investigations and inquests in a timely way, so that additional resources may be deployed.
- All inquests should be opened in open court and all hearings should take place in open court. All hearings should be recorded.

- 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.
- Pre-inquest review hearings and inquest hearings should be notified to the public by notice on the coroner's or local authority website.
- In all cases coroners, through their officers, should check with all families to see whether they have any particular concerns about the death.
- 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.
- The coroner's office should be staffed during normal working hours and the telephone system should also be operated during normal working hours, including the lunch hour. Calls should be answered promptly. 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.
- Save in very exceptional circumstances, coroners' courts should not sit outside of standard sitting hours. Coroners, as judges, should consider their obligations in particular to legal practitioners (but also bereaved families and other Interested Persons and witnesses) in terms of these hours. It is unreasonable to expect professionals to routinely appear in court for extended hours or at unusual times and such practices are at odds with norms within the wider judiciary and the legal profession. Such practices are inconsistent with (for example) the caring responsibilities of practitioners and others involved in the process and routinely sitting lengthy hours in court creates risk in terms of the quality of decision-making by the coroner and the long-term resilience of the service.
- Except in complex cases, coroners' officers should not normally be required to remain at court during an inquest, and a member of support staff can act as a Court Usher and operate the recording equipment.

Reports to prevent future deaths

54. 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.

55. 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. The report and any response will usually be published on the judiciary website (sometimes with redactions).

Out of hours services

56. It is the position of the Chief Coroner that the senior coroner, in collaboration with the relevant local authority and the police (where the police fund coroners' officers), should provide an out of hours, including weekend and bank holiday service. The nature of this service is a matter for detailed discussion and agreement between those parties.

57. An out of hours service should be organised fairly and rationally, with a rota system in place to avoid the senior coroner being routinely exposed to all out of hours duties. Out of hours work should be paid, whether via fees or as an agreed component of a salary. It is widely understood that 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 be required to do more, particularly in order to assist families who seek early burial for their loved ones or Out of England orders.

58. 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 in some cases local police authority.

Mortuary and pathology services

59. The Chief Coroner's long-term aspiration is that mortuary and pathology services should be arranged on a regional basis in line with the principles set out in the report of Professor Hutton.[7] 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.

60. Coroner pathology remains a significant concern for the Chief Coroner (as he has highlighted in successive Annual Reports).

61. Because of the problems with the availability of pathologists and the complexities around the fee (including its low level), good cooperation between the senior coroner and the relevant authority in planning and managing pathology services is extremely important.

62. Mortuaries are also significant strategic resources for the coroner and the relevant authority in dealing with mass fatalities, DVI incidents, terrorism and excess death scenarios.

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

63. The Chief Coroner invites senior coroners and local authorities to consider the following:

- Provide access to CT scanning facilities as a way (a) to take some pressure from conventional autopsy provision; and (b) to provide a robust form of post-mortem evidence capture including for DVI, mass fatality and other special cases.
- Set clear standards for post-mortem reports, including, that they should be required from pathologists within a prompt timescale. Post-mortem fees should be paid upon receipt of the full report, not before.
- Following the Chief Coroner's Guidance,[8] avoid unnecessary post-mortem examinations. Post-mortem examinations should not be a 'reflex' response of the coroner service, but a targeted tool to be used in the right circumstances.
- Ensure that disaster mortuary (and related) plans are up to date.

Tendering for services (e.g. body removal, toxicology)

64. Tendering for services should be the norm. The precise process of tendering is a matter for each relevant authority in discussion with the senior coroner. Tendering criteria should always focus on more than just cost. Quality and delivery of service are essential. Tendering for coroner services should be undertaken with an appropriate level of frequency.

65. 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.

Training

66. Compulsory training is provided for all coroners and coroners' officers, from basic learning to continuing development, as part of the modern requirement for a professional public service. Any cost (for example, travel expenses or a day's sitting fee) that falls on to the relevant authority or the police in terms of supporting training should be consider an important investment in a quality service for the bereaved.

67. 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.

8 https://www.judiciary.uk/wp-content/uploads/2019/09/Guidance-No.-32-Post-Mortem-Examinations-including-Second-Post-Mortem-Examinations.pdf

68. Newly appointed assistant coroners receive compulsory induction training, including cross-jurisdictional induction training.

69. 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.

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

71. 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 without charge.

72. In addition, the Chief Coroner provides ad hoc one-day courses on specific topics.

73. Coroners' officers also receive 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. Employers of coroners' officers should meet their reasonable travel expenses. If an officer cannot get to the training venue by setting off from home after 7am on the first day of training, then their employer should meet their reasonable accommodation and subsistence costs for the night before the first day of training.

74. Where possible, senior coroners (or a member of the local coroner team) should make themselves available to educate GPs and hospital doctors about the coroner service and requirements for reporting deaths and contents of medical certificates of cause of death.

75. In the immediate aftermath of the COVID-19 pandemic, training is likely to be primarily virtual. It remains compulsory.

Discipline

76. 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.

77. Coroners are appointed (but not employed) by local authorities. As independent judicial office holders, or put more simply, judges, 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'.

78. 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.

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

Welfare

80. The relevant local authority should provide at their expense independent counselling and other services, requested by a coroner, in connection with a coroner's welfare. All coroners have access to the Judicial Helpline.

His Honour Judge Mark Lucraft QC,
Chief Coroner
1 July 2020

Annex B

Cases over 12 months old reported to the Chief Coroner (information correct as at April 2020)

Coroner Area	Senior Coronerw	Area Coroner	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of cases over 12 months old (2019)	Number of cases over 12 months old (2020)	Number of reported deaths in 2019
Avon	Maria Voisin	Peter Harrowing	8	12	21	32	4045
Bedfordshire & Luton	Emma Whitting		12	18	11	23	2191
Berkshire	Heidi Connor		13	27	40	55	1943
Birmingham & Solihull	Louise Hunt	Emma Brown	18	19	23	29	5196
Black Country	Zafar Siddique		6	9	11	18	5183
Blackpool & Fylde	Alan Wilson		3	2	3	22	1197
Brighton & Hove	Veronica Hamilton-Deeley		0	5	5	5	1151
Buckinghamshire	Crispin Butler		4	11	11	10	1231
Cambridgeshire & Peterborough	David Hemming		53	60	86	113	3923
Carmathenshire & Pembrokeshire	Paul Bennett (Acting)		12	13	12		1502

Coroner Area	Senior Coronerw	Area Coroner	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of cases over 12 months old (2019)	Number of cases over 12 months old (2020)	Number of reported deaths in 2019
Central & South East Kent	Patricia Harding (Acting)		1	4	7	5	1261
Ceredigion	Peter Brunton		1	2	1	4	328
Cheshire	Alan Moore	Claire Welsh	19	28	29		2949
City of London	Alison Hewitt		1	4	4	11	277
Cornwall & Isles of Scilly	Andrew Cox (Acting)		32	32	40	45	2693
County Durham & Darlington	Jeremy Chipperfield		11	17	20	24	3013
Coventry	Sean McGovern		5	7	9	16	1594
Cumbria	Kally Cheema	Kirsty Gomersal	24	20	25	27	1982
Derby & Derbyshire	Robert Hunter	Peter Nieto	55	47	60		4660
Dorset	Rachael Griffin		22	22	24	37	3476
East London	Nadia Persaud	Graham Irvine	51	84	91	91	2111
East Riding & Hull	Prof Paul Marks	Rosemary Baxter	15	11	47		2932

Coroner Area	Senior Coronerw	Area Coroner	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of cases over 12 months old (2019)	Number of cases over 12 months old (2020)	Number of reported deaths in 2019
East Sussex	Alan Craze		9	20	18		2362
Essex	Caroline Beasley-Murray	Lincoln Brookes	21	9	40	33	5860
Exeter & Greater Devon	Philip Spinney		21	45	49	69	2425
Gateshead & South Tyneside	Terence Carney		17	10	13		1777
Gloucestershire	Katy Skerrett		3	7	11	13	2180
Gwent	Caroline Saunders		6	6	11	28	2648
Hampshire, Portsmouth & Southampton	Christopher Wilkinson	Jason Pegg Rosamund Rhodes-Kemp	*	*	*	56	*
Hartlepool	See Teesside		1	0	See Teesside	See Teesside	See Teesside
Herefordshire	Mark Bricknell		5	5	7	6	855
Hertfordshire	Geoffrey Sullivan		33	22	49	39	2800
Inner North London	Mary Hassell		15	21	22	12	2340
Inner South London	Dr Andrew Harris		54	84	76	71	3402

Coroner Area	Senior Coronerw	Area Coroner	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of cases over 12 months old (2019)	Number of cases over 12 months old (2020)	Number of reported deaths in 2019
Inner West London	Dr Fiona Wilcox		14	27	40		2158
Isle of Wight	Caroline Sumeray		13	9	11	27	832
Lancashire and Blackburn with Darwen	Dr James Adeley	James Newman Richard Taylor	*	29	58	64	3677
Leicester City & South Leicestershire	Catherine Mason	Ivan Matthew Cartwright	4	8	12	30	2031
Lincolnshire	Paul Smith (acting)	Paul Smith	*	24	17	50	3243
Liverpool and Wirral	André Rebello	Anita Bhardwaj	9	10	24	41	3444
Manchester City	Nigel Meadows	Fiona Borill	124	113	78		3338
Manchester North	Joanne Kearsley	Catherine McKenna	50	53	43	54	2181
Manchester South	Alison Mutch	Christopher Morris	12	18	17	20	2575
Manchester West	Timothy Brennand		15	15	23	43	3891
Mid Kent & Medway	Patricia Harding	Bina Patel	12	13	36	28	2036
Milton Keynes	Tom Osborne		21	9	8	12	840

Coroner Area	Senior Coronerw	Area Coroner	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of cases over 12 months old (2019)	Number of cases over 12 months old (2020)	Number of reported deaths in 2019
Newcastle upon Tyne	Karen Dilks		6	24	8		1878
Norfolk	Jacqueline Lake	Yvonne Blake	14	20	23	34	2923
North East Kent	Patricia Harding (Acting)	Alan Blunsdon	22	24	19	12	1500
North Lincolnshire & Grimsby	Mark Kendall (Acting)		6	8	8	10	1741
North London	Andrew Walker		13	17	14	42	3188
North Northumberland	Tony Brown		14	9	8		630
North Tyneside	Karen Dilks (Acting)		5	1	0		734
North Wales (East & Central)	John Gittins		29	18	16	28	2721
North West Kent	Roger Hatch		3	7	3		1777
North West Wales	Dewi Pritchard-Jones		8	17	15	5	935
North Yorkshire (Eastern)	Robert Turnbull (Acting)		1	2	4	6	714
North Yorkshire (Western)	Robert Turnbull		7	12	10	20	830

Coroner Area	Senior Coronerw	Area Coroner	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of cases over 12 months old (2019)	Number of cases over 12 months old (2020)	Number of reported deaths in 2019
Northamptonshire	Anne Pember		21	20	24	33	2543
Nottinghamshire & Nottingham	Maírín Casey		15	16	24		6781
Oxfordshire	Darren Salter		11	9	10	13	2034
Plymouth Torbay & South Devon	Ian Arrow		7	21	14	19	3069
Rutland & North Leicestershire	Trevor Kirkman		20	22	24		1318
Sefton, St Helens & Knowsley	Julie Goulding		6	15	33	87	2126
Shropshire, Telford & Wrekin	John Ellery		4	6	9	6	1661
Somerset	Tony Williams		15	27	25	34	2527
South London	Sarah Ormond-Walshe		35	37	29	39	2353
South Northumberland	Tony Brown (Acting)		1	2	3		1097
South Staffordshire	Andrew Haigh		12	8	9	14	2327
South Wales Central	Graeme Hughes		20	30	33	51	3270

Coroner Area	Senior Coronerw	Area Coroner	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of cases over 12 months old (2019)	Number of cases over 12 months old (2020)	Number of reported deaths in 2019
South Yorkshire (East)	Nicola Mundy		18	15	22		2466
South Yorkshire (West)	David Urpeth (Acting)		26	40	27	30	3356
Stoke on Trent & North Staffordshire	Andrew Barkley		12	36	42	51	2562
Suffolk	Nigel Parsley	Jacqueline Devonish	67	72	64	43	2064
Sunderland	Derek Winter		2	3	7	8	1397
Surrey	Richard Travers	Simon Wickens	17	44	124	118	3509
Swansea & North Port Talbot / Abertawe	Colin Phillips (Acting)		36	36	37	51	1902
Teesside & Hartlepool	Clare Bailey		8	8	4	56	3013
Warwickshire	Sean McGovern		4	4	4	11	1693
West London	Chinyere Inyama		*	355	96		3504
West Sussex	Penelope Schofield		14	32	53	44	3316
West Yorkshire (Eastern)	Kevin McLoughlin	Jan Alam	39	44	58	55	3648

Coroner Area	Senior Coronerw	Area Coroner	Number of cases over 12 months old (2017)	Number of cases over 12 months old (2018)	Number of cases over 12 months old (2019)	Number of cases over 12 months old (2020)	Number of reported deaths in 2019
West Yorkshire (Western)	Martin Fleming		22	38	59		3240
Wiltshire & Swindon	David Ridley		6	9	12	15	2536
Worcestershire	David Reid		8	10	12		2476
York	Jonathan Heath (Acting)		5	3	8	8	556

Annex C

Senior and area coroner salaries as of July 2020

Full-time senior coroner salary table

According to statute, the Chief Coroner must be either a Circuit Judge, a Senior Circuit Judge or a High Court Judge and is remunerated on that basis.

The Coroners and Justice Act 2009 states that all senior coroners are entitled to a salary (paragraph 15 of Schedule 3 to the Coroners and Justice Act 2009). The Chief Coroner's position is that for all new coroner appointments the salary should be set according to latest JNC Coroner's Circular.[9] The JNC Coroner's Circular states that the salary for a senior coroner is be determined according to the complexity of the coroner area. The salary figures detailed in the table below have been supplied upon request from each senior coroner or acting senior coroner and are correct as of July 2020.

Some senior coroners are paid additional allowances which can include a payment for out of hours work or allowances. These have been included in the figures provided and have been indicated in the footnotes.

Senior Coroner Annual Gross Salary Band (£) (July 2020)	Coroner Area
180,000-184,999	North London[10]
165,000-169,999	Plymouth Torbay and South Devon
160,000-164,999	Inner West London[11]
	Manchester West[12]
155,000-159,999	Lancashire with Blackburn and Darwen[13]
	Manchester City[14]
	West Yorkshire (Western)[15]
150,000-154,999	Mid Kent and Medway (including North East Kent and Central and South East Kent)[16]

9 https://www.coronersociety.org.uk/announcements/coroners-remuneration-jnc-circulars--/

10 This figure includes an additional payment for allowances including an out of hours payment.

11 This figure includes an out of hours payment.

12 This figure includes an out of hours payment.

13 This figure includes a payment for allowances.

14 This figure includes an out of hours payment.

15 This figure includes an out of hours payment.

16 The senior coroner in the Mid Kent and Medway area is the acting senior coroner for Central and South East Kent and North East Kent so receives one salary covering all three areas.

Senior Coroner Annual Gross Salary Band (£) (July 2020)	Coroner Area
145,000-149,999	Leicester and South Leicestershire
	Manchester North[17]
140,000-144,999	South Yorkshire (East)[18]
	South Yorkshire (West)[19]
135,000-139,999	Avon
	Cheshire
	County Durham and Darlington
	Cumbria
	Dorset
	Essex and Thurrock
	Hampshire, Portsmouth and Southampton
	Inner North London
	Isle of Wight
	Liverpool and Wirral
	Manchester South[20]
	North Wales (East and Central)
	Nottinghamshire and Nottingham[21]
	South London
	South Wales Central
	Sunderland
	Surrey[22]
	Teesside and Hartlepool
	West London
	West Yorkshire (Eastern)

17 This figure includes an out of hours payment.
18 This figure includes an additional payment for allowances which may include payment for out of hours work.
19 This figure includes an additional payment for allowances which may include payment for out of hours work.
20 This figure includes a payment for out of hours work.
21 This figure includes a payment for out of hours work.
22 The payment for allowances is still being negotiated.

Senior Coroner Annual Gross Salary Band (£) (July 2020)	Coroner Area
130,000-134,999	Birmingham and Solihull
	Black Country
	Cambridgeshire and Peterborough
	Cornwall and Isles of Scilly
	Coventry (and Warwickshire)[23]
	East Riding and Hull
	Exeter and Greater Devon
	Gloucestershire
	Hertfordshire
	Newcastle Upon Tyne
	Norfolk
	North Northumberland (including South Northumberland)[24]
	Oxfordshire
	Somerset
	Staffordshire South
	Stoke-on-Trent and North Staffordshire
	Swansea and Neath Port Talbot
	Warwickshire (and Coventry)[25]
	Wiltshire and Swindon
125,000-129,999	Berkshire
	Gateshead and South Tyneside
	Lincolnshire
	Milton Keynes
	North West Kent
	Shropshire, Telford and Wrekin
	West Sussex
	Worcestershire

23 The senior coroner in the Coventry coroner area is also appointed as the senior coroner in Warwickshire; one salary figure has been provided which covers both areas.

24 The senior coroner in North Northumberland is the acting senior coroner in South Northumberland and receives one salary covering both areas.

25 The payment for allowances is still being negotiated.

Senior Coroner Annual Gross Salary Band (£) (July 2020)	Coroner Area
120,000-124,999	Bedfordshire and Luton
	Blackpool and Fylde
	Brighton and Hove
	Buckinghamshire
	East London
	Gwent
	Northamptonshire[26]
	Sefton, Knowsley and St Helens
	Suffolk
115,000-119,999	Derby and Derbyshire
	Inner South London

26 The salary figure is still being negotiated in this coroner area.

Full-time area coroner salary table

The appointment of an area coroner is made by the local authority according to the needs of that coroner area. Not all coroner areas have an area coroner and some have more than one area coroner. Area coroners are paid a salary from the local authority. The amount paid is agreed between the coroner and the local authority. The JNC Coroner's Circular states that the amount paid to an area coroner should be set in accordance with the complexity of the coroner area.

Area Coroner Annual Gross Salary Band (£) (July 2020)	Coroner Area
105,000-109,999	Manchester North[27]
	Lancashire with Blackburn and Darwin*
100,000-104,999	Birmingham and Solihull*
	Central and South East Kent
	Cheshire
	Hampshire, Portsmouth and Southampton*
	Leicestershire and South Leicestershire
	Liverpool and the Wirral
	Manchester City
	Manchester South[28]
	Manchester West
	Mid Kent and Medway
	Norfolk
	North East Kent
	South Wales Central
	Surrey
	West Yorkshire (East)
95,000-99,999	Black Country
	Derby and Derbyshire
	Essex and Thurrock*
	Lincolnshire
	Wiltshire and Swindon
90,000-94,999	Cumbria
85,000-89,999	East Riding and Hull

*these coroner areas have two full-time area coroners.

27 This figure includes payment for out of hours work.

28 This figure includes payment for allowances including out of hours work.

Part-time senior coroner salary table

Whether a coroner area is categorised as a full-time or part-time area is determined by the local authority according to the needs of that particular coroner area. A part-time coroner area can still be classed as a complex area as the level of complexity assessment is not only linked to numbers of reported deaths. Complexity is also determined by factors like the number and type of prisons, other places of detention, hospitals and so on in the area (JNC Coroner's Circular 61).

The Coroners and Justice Act 2009 states that all senior coroners whether they are appointed in a coroner area that is determined to be a full-time or part-time area are entitled to a salary (paragraph 15 of Schedule 3 to the Coroners and Justice Act 2009). The Chief Coroner's position is that for all new coroner appointments the salary should be set according to latest JNC Coroner's Circular.

In a part-time area, the JNC Coroner's Circular 61 states that the senior coroner is paid a basic salary of £20,000 and then a set fee paid at a daily rate according to the number of days they work. The daily rate is set according to the complexity of that coroner area. The Coroner's JNC Circular 61 states that the salary for a senior coroner in a part-time area should then be capped at the salary level for a full-time senior coroner working in a coroner area of similar complexity.

The table below shows the gross salary for senior coroners appointed in part-time areas. The fact that a coroner area is determined to be a part-time area does not in itself determine what days or hours the senior coroner works. The working patterns of part-time senior coroners vary and are agreed between the local authority and the senior coroner according to the needs of that coroner area. It is difficult therefore to properly compare the salaries listed below as working patterns will differ from coroner area to coroner area.

Senior Coroner Annual Gross Salary Band (£) July 2020	**Coroner area**
105,000-109,999	North Yorkshire (Western) (and North Yorkshire (Eastern)[29]
100,000- 104,999	Carmarthenshire and Pembrokeshire
70,000-74,999	North West Wales
65,000-69,999	East Sussex
	Herefordshire
	North Lincolnshire and Grimsby
60,000-64,999	City of London
	North Tyneside
	York
40,000-45,999	Rutland and North Leicestershire
35,000-39,999	Ceredigion[30]

29 The senior coroner for North Yorkshire (Western) is also the acting senior coroner in North Yorkshire (Eastern) and receives a salary which includes both areas.

30 This figure includes a payment for allowances.

Part-time area coroner salary table

Coroner areas can appoint area coroners who work on a part-time basis depending on the needs of that coroner area. The working patterns of part-time area coroners vary and are determined by the needs of the area. The working pattern of the area coroner is agreed between the local authority and the area coroner. It is difficult therefore to properly compare the salaries listed below as working patterns will differ from coroner area to coroner area. Some areas have both a full-time area coroner and a part-time area coroner.

Area coroner Annual Gross Salary Band (£) July 2020	**Coroner area**
80,000-84,999	Avon
70,000-74,999	Suffolk
65,000-69,999	East London
50,000-54,999	Manchester City

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