Chief Coroner

Report of the Chief Coroner to the Lord Chancellor

Combined Annual Reports for 2021 and 2022

December 2023

Chief Coroner

His Honour Judge Thomas Teague KC, Chief Coroner of England and Wales

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1. Introduction

1.1 This annual report is a combined annual report which covers the years 2021 and 2022. In part, this approach is being taken in order properly to align the publication schedule of the Annual Report of the Chief Coroner with the precise statutory wording of the Coroners and Justice Act 2009 (the 2009 Act), which requires the production of an annual report by 1 July each year, to cover the previous calendar year. Since 2014, when the first Chief Coroner Annual Report was published, legacy practice has been for each report to cover the period 1 July to 31 June. This approach was initially implemented to enable the first Chief Coroner to rapidly issue his first report. However, as the reporting framework is now well established, it is appropriate that the process for publication should be aligned with the precise statutory requirement.

1.2 Secondly, the July–June approach put the Annual Report out of synchronisation with other important publications in the death management system, including the annual MOJ coroner statistics, which are published each May covering the previous calendar year. Going forward, therefore, I hope that this new schedule will provide information which is clearer to understand and easier to assess and place in context.

1.3 The office of Chief Coroner was created by the 2009 Act as part of the far-reaching statutory reforms to the coronial system contained in that Act and implemented in July 2013. The Chief Coroner, who must be a High Court or Circuit Judge under the age of 70, is appointed by the Lord Chief Justice in consultation with the Lord Chancellor. The appointee is required to combine their responsibilities as Chief Coroner with their existing judicial duties. In my case, I spend part of my time sitting as a Circuit Judge in the Crown Court at Liverpool.

1.4 I am supported by my private office and by two Deputy Chief Coroners – HHJ Alexia Durran (who is a senior Circuit Judge at the Central Criminal Court) and Derek Winter DL (who is the Sunderland Senior Coroner).

1.5 The Chief Coroner's jurisdiction covers England and Wales and includes a range of formal powers and duties:

(a) approving ('consenting to' in the language of the 2009 Act) the appointments of all coroners, alongside the Lord Chancellor;

(b) directing an inquest to be held in the absence of a body;

(c) global case management powers, such as directing transfers of inquests between coroner areas and appointing judges to deal with certain high-profile or unusually complex inquests;

(d) receiving notifications of investigations taking longer than a year and maintaining a register;

(e) monitoring investigations into service deaths and ensuring that coroners conducting such investigations are suitably trained; and

(f) reporting annually to the Lord Chancellor, who must lay the report before Parliament.

1.6 By convention, the Chief Coroner also sits in the Divisional Court hearing judicial and statutory review cases concerning coroners, and from time to time may also conduct inquests personally, either by virtue of his office or as a nominated judge.

1.7 A bare recital of those formal functions cannot provide a complete picture of the Chief Coroner's role, for they represent only the tip of a large iceberg. Much of the work involves leadership of an informal kind. The Chief Coroner seeks to promote consistency and good practice in coroners' courts by organising training for coroners and coroners' officers (delivered through the Judicial College), encouraging constructive collaboration between coroners and their relevant authorities (i.e. the lead local authority in each coroner area), working closely with the Ministry of Justice (MOJ) and local authorities to facilitate coroner area mergers, issuing written guidance on coronial law and practice, and providing judicial leadership and pastoral supervision. The Chief Coroner also has an important co-ordinating role in the event of a mass fatality, terrorist attack or other incident having Disaster Victim Identification (DVI) aspects in England and Wales (or a similar event overseas involving UK nationals). Unsurprisingly, because of the decentralised nature of the coroner service, much of the Chief Coroner's work takes place in the interstices between the statutory provisions and day-to-day operational practice, and requires the exercise of diplomacy, patience and good communication.

1.8 As Chief Coroner, one of my functions is to communicate the views and interests of coroners to central government. In addition to the report submitted annually to the Lord Chancellor, I meet regularly with the Justice Minister responsible for the coroner service, as well other ministers. My office engages with the MOJ and other government departments on my behalf (and on behalf of coroners) on a range of issues, including new legislation, government consultations and policy initiatives, and such operational matters as may have a practical impact on the administration of justice. My officials also sit on committees and working groups where a technical perspective on the coroner system is needed.

1.9 In summary, my role is to provide judicial leadership to coroners in promoting and sustaining a consistently efficient and proportionate system of death investigation that keeps the deceased and bereaved families at the heart of the process. In no sense am I a 'Chief Executive' of the coroner service – the bricks and mortar and most other operational aspects (such as staff, IT systems, courtrooms and so on) are provided by local authorities. And since every coroner is an independent judicial decision-maker, it is quite right that I have no power to issue binding edicts or instructions in individual cases. Instead, I seek to provide leadership through a combination of guidance, training, informal advice and pastoral governance.

1.10 By contrast to the Chief Coroner's post, the office of coroner is of great antiquity, dating back at least as far as the 12th century. Over the course of its long history, it has developed a character and ethos of its own. To this day there remain two respects in which coroners differ conspicuously from other judges in England and Wales. In the first place, the specialist jurisdiction they exercise is inquisitorial rather than adversarial; in other words, their function is not so much to adjudicate as to investigate. Second, they do not form part of the unified national system of courts and tribunals now administered by HM Courts and Tribunals Service. They are, and always have been, locally appointed and resourced judges, divided into 83 independent coroner areas as at the end of 2022.

1.11 Although the office of coroner is an ancient one, it retains considerable contemporary significance. Its proper function of investigating deaths serves the welfare of the bereaved and the interests of society at large. A coroner must investigate a reported death if he or she has reason to suspect that the deceased person died a violent or unnatural death, or the cause of death is unknown, or the deceased died while in custody or other state detention. In many cases, the coroner's investigation will culminate in a court hearing known as an inquest.

1.12 A coronial investigation is a form of efficient summary justice that provides answers to four statutory questions, namely who the deceased was and when, where and how (usually confined to meaning "by what means") the deceased came by his or her death. The investigation must be a swift one. The coroner, who must conduct his or her investigation "as soon as practicable",[1] is under a duty to open an inquest "as soon as reasonably practicable"[2] and, if possible, to complete any inquest within six months of the date on which the death is reported.[3] The investigation must, of course, be sufficient but it is not meant to be exhaustive. Even where the enhanced duty of investigation arises under Article 2 of the European Convention on Human Rights, the coroner or jury is not permitted to express an opinion on any topic other than the four statutory matters to be ascertained. Nor may an inquest's determination be framed in such a way as to appear to determine any question of civil liability or any question of criminal liability on the part of a named person.

1.13 These are the characteristics I have in mind when I describe the coroner's investigation as "a form of efficient summary justice". It is a process that has its roots in the inquisitorial method and makes an invaluable contribution to the administration of justice in England and Wales. It combines a process of fact-finding, in collaboration with interested persons and witnesses, with the legal rigour that comes from exposure to scrutiny and challenge by way of Judicial Review proceedings.

1.14 My predecessors repeatedly emphasised that the deceased, and by extension the bereaved, should be at the very heart of the coronial process. That is a core principle that I fully endorse. But we should not forget that it is precisely the inquisitorial nature of the coroner's investigation that guarantees the centrality of the bereaved. Where proceedings acquire a more adversarial character, the focus is liable to be diverted away from the bereaved, where it properly belongs, and channelled instead into a debate between competing disputants, who will not necessarily include the family of the deceased. In the process, the important distinction in principle between the role of an interested person and a party to proceedings can become blurred to the point where a coroner may even find that he or she has, without intending to, ceded a measure of control of the investigation to interested persons or their lawyers. In short, there is a risk that the inquest might end up as yet another form of litigation, with the coroner becoming complicit, albeit unwittingly, in the marginalisation of the bereaved.

1 Coroners and Justice Act 2009 (legislation.gov.uk)

2 Coroners (Inquests) Rules 2013, rule 5(1) (legislation.gov.uk)

3 Coroners (Inquests) Rules 2013, rule 8 (legislation.gov.uk)

1.15 Of course, some inquests are unavoidably high-profile or contentious. But even a contentious inquest should not descend into an adversarial confrontation. It is not the function of a coronial investigation to resolve disputes or to serve as a vehicle for those who wish to air extraneous grievances.

2. Coroner statistics 2021 and 2022

2.1 All deaths in England and Wales must be registered with the Registrar of Births and Deaths. From the information provided for registration, the Office for National Statistics (ONS) collates and publishes statistics on all deaths – its mortality statistics report the total number of deaths registered in England and Wales in a particular year, irrespective of whether coroners have investigated them.

2.2 The MOJ publishes separate coroner statistics annually in May. The latest figures (for the calendar year 2022) and those for preceding years can be found at www.gov.uk/government/collections/coroners-and-burials-statistics. These statistics provide detail on a range of metrics including inquest conclusions broken down by type, the number of deaths in state detention, the number and type of post-mortem examinations undertaken, and data on timeliness. This data can also be broken down by individual coroner area. I do not propose to repeat all that data, but I will provide a summary of high-level information here on the total number of reported deaths in England and Wales, as well as on timeliness.

2.3 In addition, I provide my own figures (which relate to my statutory responsibilities as Chief Coroner) on cases over 12 months old, service deaths and Prevention of Future Death Reports.

MOJ / ONS data

2.4 195,200 deaths were reported to coroners in 2021, the lowest amount since 1995. This figure represents 33% of the 586,334 deaths registered in England and Wales in 2021.[4]

2.5 The relatively low proportion of deaths reported to a coroner (as opposed to the sum total of all registered deaths in 2021) is likely to be a function of the number of excess deaths caused by COVID-19 infection. As COVID-19 is a naturally occurring disease, it will have meant that a greater proportion than usual of all deaths in England and Wales would have arisen from natural causes and therefore did not require a report to the coroner.

4 It is important to make clear that the number of deaths registered in a calendar year and the number of deaths reported to a coroner in each calendar year are not necessarily composed of the same cohort of deaths. A minority of deaths registered in 2021 will have occurred in 2020 or in earlier years; typically these are deaths which will have required an inquest and for a number of reasons the inquest will not have been held in the same year as the death.

2.6 In 2022, 208,400 deaths were reported to the coroner – a 7% increase compared with 2021, and 36% of the 577,160 deaths registered in England and Wales in 2022.

2.7 The average time taken to complete an inquest increased from 27 weeks in 2020 to 31 weeks in 2021. In 2022, the average time to complete an inquest was 30 weeks; a modest but encouraging improvement.

2.8 The sharp increase in time taken to complete an inquest in 2021 (and its after-effects in to 2022) are a matter of real concern to me, and tackling delay is a priority for me and my office. A primary cause of delay in 2021 was the COVID-19 pandemic. During the initial period of lockdown from March to June 2020, many jury and non-jury complex inquests were halted. Of course, many coroners continued to hear routine inquests, either on the papers or in court using audio and videoconferencing.

2.9 The effect of lockdown on timeliness was not instantaneous. The significant backlog created by lockdown fed forward into 2021, because most coroners' courts did not have the capacity to clear the backlog created during the remainder of 2020 (not least because social distancing and other factors continued to slow the throughput of cases after the return to hearing cases in court from June 2020 onwards). Of course, new deaths continue to be reported to coroners all the time. As I will set out later in this report, I am taking forward several measures to tackle delay.

Cases over 12 months old

2.10 As Chief Coroner, I have a statutory duty to report to the Lord Chancellor on cases over 12 months old. Set out in **Annex A** is a table for 2021 and 2022 (as well as preceding years), broken down by coroner area, showing the number of cases that have been in the system for over 12 months, and the percentage these represent of the number of cases reported in each area. This data represents a snapshot, in April each year, of the number of cases older than 12 months old in the system. It is important to make clear that this data is collected separately from the MOJ and ONS statistics.

2.11 In any normal year, there are good reasons why some cases are outstanding beyond 12 months – for example, where there are ongoing police enquiries, criminal investigations and prosecutions, or investigations by other state bodies. The coroner's inquest will be adjourned pending the outcome of these enquiries or investigations which can, in some circumstances, be very lengthy. In certain areas, there have also been problems with coroner resources. Senior Coroners in these areas have worked with their local authorities to ensure that adequate resources are provided to enable cases to be dealt with as expeditiously as possible.

2.12 However, it is concerning that the number of cases over 12 months within the system has increased during the period covered by this report. In April 2021, there were 5,013 cases in England and Wales that were not completed within 12 months of being reported to the coroner. For comparison, in 2019 (incomplete data exists for 2020), there were 2,278 such cases. The impact of the pandemic on case progression is therefore clearly visible.

2.13 In April 2022, there was a reduction in the number of cases over 12 months old, down to 4,568, which is a welcome improvement, although there is much still to do.

2.14 This picture is symptomatic of the backlog of cases created by the COVID-19 pandemic, not least because of the wholesale adjournment of cases which occurred across the justice system during the first lockdown in March–June 2020 which I refer to above. I discuss the response to and recovery from the pandemic below; one of my priorities as Chief Coroner is to tackle and eliminate backlogs wherever possible. I work with Senior Coroners and local authorities to deal with any particular local backlogs, and to concentrate efforts and local resources on the recovery.

Service deaths

2.15 In the whole period covering 2021 and 2022, I received reports of three deaths of service personnel within the meaning of section 17 of the 2009 Act. I am satisfied that these coroner investigations and inquests are being progressed by the relevant Senior Coroners in an entirely satisfactory way.

Prevention of Future Death Reports

2.16 During a coroner investigation and inquest, the coroner's primary focus will be on identifying and formulating the answers to the four statutory questions, but coroners also have a duty, in certain circumstances, to make a report to prevent future deaths (a 'PFD' report).

2.17 However, although the duty to make a report may be an important aspect of the outcome of an investigation, it is ancillary to the primary purpose of an inquest which is to make the statutory determinations, findings and conclusions relating to the death.

2.18 The statutory obligation to make a PFD report arises where the evidence obtained during an investigation or inquest gives rise to a concern that future deaths will occur, and the investigating coroner is of the opinion that action should be taken to reduce the risk of death.

2.19 Chief Coroner Guidance on PFD Reports is published on the judiciary website.[5]

2.20 440 and 403 PFD Reports were issued by coroners in 2021 and 2022 respectively. Much more information can be found at the judiciary website where there is a section dedicated to the publication of PFD Reports.[6] Useful information can also be found in the academic community, especially at the Preventable Death Tracker led by Dr Georgia Richards at Oxford University.[7]

5 Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths[i] – Courts and Tribunals Judiciary

6 Reports to Prevent Future Deaths – Courts and Tribunals Judiciary

7 The Database – Preventable Deaths Tracker

3. Training

3.1 As Chief Coroner, I exercise my responsibilities for training Senior Coroners, Area Coroners, Assistant Coroners and coroners' officers under the auspices of the Judicial College. I remain very grateful to all the course directors, syndicate leaders and the college (particularly HHJ Jeremy Richards) for their support in devising and providing our programme of training.

3.2 The judicial training year runs from April to March so this report (covering both 2021 and 2022) includes information relating to three training cycles.[8]

3.3 Due to the severe restrictions and disruption imposed by the pandemic, coroner continuation and coroner officer training had to be suspended in the training year March 2020–21. Coroner induction training went ahead digitally.

3.4 For the training year April 2021 to March 2022, coroner continuation training was delivered digitally as a one-day course, focusing on a number of issues for coroners arising from the experience of the pandemic. Coroner induction training was also delivered digitally, as it was in 2020–21. In addition, one-day medical training was paused in 2021–22.

3.5 Bearing in mind the disproportionately intense levels of pressure to which coroners' officers were subjected during the pandemic, training was paused for the 2021–22 cycle (although some desktop learning material was provided).

3.6 During late 2021 and early 2022, pursuant to a joint arrangement between the Judicial College, Chief Coroner's Office and Royal College of Pathologists, all coroners and medical examiners were offered the chance to attend a one-day digital course on the interface between Medical Examiners and coroners. Feedback confirms that this was a very successful course, designed to ensure that coroners and Medical Examiners gained a broad understanding of each other's roles and responsibilities. It was delivered to delegates via a number of online sessions. I am very grateful for the support of the National Medical Examiner, Dr Alan Fletcher, and the Royal College of Pathologists, including Dr Suzy Lishman, in developing this important training.

3.7 From April 2022 onwards, training returned to 'in-person' residential or one-day training for all coroner and coroners' officers courses.

8 April 2020 – March 2021, April 2021 – March 2022 and April 2022 – March 2023.

3.8 Finally, work on the new coroners' bench book, which has been developed under the leadership of Deputy Chief Coroner HHJ Alexia Durran, is now substantially complete and the text is undergoing a thorough review process prior to publication, which is expected before the end of 2023.

4. Appointments

4.1 While coroner appointments are made by the relevant local authority for the respective coroner area, as Chief Coroner I have a statutory responsibility to consent, along with the Lord Chancellor, to all coroner appointments in England and Wales. In practice, my involvement goes further; I provide detailed guidance to coroners and local authorities and oversee individual competitions.[9]

4.2 I am particularly pleased to see the growth in the appointment of Area Coroners which has taken place during the period of this report.

4.3 As of 1 July 2023,[10] the number of coronial appointments[11] are:

- Senior Coroners – 77
- Area Coroners – 46
- Assistant Coroners – 391

4.4 At any one time, a number of judge-led inquests are in progress within the coroner system. Further information about judge-led inquests can be found at www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/

9 Chief Coroner's Guidance No.6 The appointment of coroners – Courts and Tribunals Judiciary

10 Although this report covers the period until the end of the calendar year 2022, I hope it will be considered more useful for the most-up-to-date figure to be provided.

11 That is the number of extant judicial posts currently held.

5. The coroner system in 2021 and 2022

COVID-19 and the recovery

5.1 Although the COVID-19 pandemic is receding into the distance, it has had a significant effect on the administration of justice across all jurisdictions, and its effects remain. My predecessor, HHJ Mark Lucraft KC, set out the impact of the initial stages of the pandemic on the coroner service in England and Wales in the previous annual report.[12]

5.2 During the initial period of lockdown, from March to June 2020, many inquests were unavoidably adjourned, although urgent hearings did go ahead. Coroners did not, of course, stop working, even if many court hearings had to be suspended. Much of their work involved making judicial decisions with respect to reports of death, as well as engaging in the pandemic response as part of the wider civil contingencies community. I remain extremely grateful to coroners, coroners' officers and all other staff for their steadfast service and commitment during this protracted period of national emergency.

5.3 After the initial lockdowns of 2020 and early 2021, coroners resumed conducting hearings, striving to navigate the unpredictable course of the pandemic and associated restrictions. I am grateful for the imaginative and effective way in which they, their teams, and local authorities adapted working practices to ensure that coroner services could continue to function.

5.4 As we can see above, the 'long tail' effect of the pandemic restrictions, as well as the general pressure of excess deaths on the wider system of death management, continues to exert pressure on timeliness in the coroner system.

5.5 I continue to monitor the situation carefully, using my limited resources to provide the framework, through training and guidance, to enable local coroner services to address backlogs, as well as targeting support and intervention in those areas that are in greatest need of help.

12 www.gov.uk/government/publications/chief-coroners-combined-annual-report-2018-to-2019-and-2019-to-2020

Welfare and morale and the 'tour'

5.6 In 2022, I conducted a nationwide 'tour' of all coroner areas in England and Wales, to assess the state of welfare and morale among coroners and their officers and staff. I am grateful to the Senior Presiding Judge for facilitating my release from Crown Court business for that purpose. The tour has been a significant logistical undertaking and has occupied a significant amount of my time throughout 2022. But I believe it has been time very well spent. My tour has involved visiting the physical premises where the staff and coroners work, and where inquests are held. I typically met the Senior Coroner and other coroners and, usually, representatives of the funding local authority. Most importantly, on each visit I spent time talking to coroners' officers and other staff to understand how they were coping and the pressures they may have been under, particularly in the light of the pandemic but also due to the general pressure of work. As I always say, being a coroner's officer is a true vocation and their contribution to the administration of justice and the support they provide to bereaved people is inspirational. It is, in my view, something that deserves far greater public recognition than it has hitherto received.

5.7 My tour was completed in early 2023. I can report that, despite the significant pressures those working in the system faced during the pandemic and in its aftermath, morale remains high. Coroners and their staff are dedicated public servants who do not want to let the bereaved down.

5.8 Welfare is something I distinguish from morale. The picture is mixed. In some coroner areas, the pressure felt by both coroners and their staff is significant, not least because of the demands of emerging from the COVID-19 pandemic and dealing with backlogs which, in some areas, are especially large. In some areas, too, welfare suffers because of a lack of material resources or a lack of resilience in the cadre of coroners available to undertake work. In addition, my group of Regional Lead Coroners, who cover the major regions of England with Wales represented in its own right, has the core function of monitoring, and assisting me to address, welfare concerns.

5.9 In some areas I remain concerned, as did my predecessors, about the level of resources provided by the funding authority, as well as the understanding some funding authorities have for judicial independence. Many local authorities provide a good level of funding and high levels of support. Even where a local authority is under real financial pressure, the difference is often that the level of engagement, support and understanding shown by the local authority is decisive. On my tour, however, I also encountered some regrettable examples of authorities failing to provide an acceptable level of funding. Where such failures are accompanied – as all too often they are – by a lack of interest in, or understanding of, the important public service the coroner system provides, they manifest themselves in court offices that lack the necessary organisation and resources to thrive, and that suffer from staff retention problems and a lack of overall capability. I continue to work with a number of areas to resolve these serious problems.

New legislation and revisions to Chief Coroner guidance

5.10 Significant changes to coroner legislation took place in 2022. The Police, Crime, Sentencing and Courts Act 2022, the Judicial Review and Courts Act 2022, and the Remote Observation and Recording (Courts and Tribunals) Regulations 2022 all took effect in June 2022. These provisions:

- enable the coroner, in line with the rest of the judiciary in England and Wales, to permit the public and/or press to join hearings remotely via video/audio transmission (s85A Courts Act 2003 and the above-mentioned regulations)
- enable the coroner to discontinue an investigation when a death from natural causes becomes clear before inquest, even where there has been no post-mortem examination (s4 Coroners and Justice Act 2009)
- enable the coroner to conduct inquests in writing without sitting in a courtroom (s9C Coroners and Justice Act 2009)
- enable rules to be made to allow coroners and juries to attend hearings remotely (s45 of the Coroners and Justice Act 2009)
- disapply the coroner's obligation to hold an inquest with a jury in relation to COVID-19 deaths, replicating and replacing, for a period of two years subject to review, the previous provision in the Coronavirus Act 2020

- enable coroner areas within a local authority area to be merged, where the new coroner area would not cover the entire local authority area (Schedule 22, para.1A Coroners and Justice Act 2009)

5.11 More generally, during 2021 and 2022 I put in place a process to review and consolidate Chief Coroner guidance. Guidance is a major strand of Chief Coroner work and represents a significant investment of time and resource in providing accurate, helpful and relevant guidance to coroners and others.

5.12 This process continues, in tandem with the work on the forthcoming coroner bench book. With publication of that important resource, much existing formal guidance will become redundant or obsolete. My intention is that the bench book should cover all matters relating to the conduct of inquest and other coronial hearings. Areas not covered by the bench book will continue to be the subject of separate written guidance, but such guidance will be slimmed down as far as possible so as to make it rapidly accessible and easy to navigate.

5.13 In 2021 and 2022, I issued new or amended guidance notes on the judiciary website in order to assist coroners in applying the new legislative provisions and for other purposes:

Guidance No. 29 Inquests in Writing and Rule 23 Evidence

Guidance No. 41 Use of Pen Portrait material

Guidance No. 42 Remote Hearings

Guidance No. 43 Discontinuing an Investigation

Guidance No. 44 Disclosure

5.14 Amendments to Guidance No. 14 Mergers of Coroner Areas, and Guidance No. 34 COVID-19 (to remove the references in the latter note to remote hearings and provide other necessary updates) were also published in July 2022.

Medical Examiner system

5.15 The development of the Medical Examiner system in England and Wales continues at pace. The Health and Care Act 2022 received Royal Assent on 28 April 2022 and a written ministerial statement was made on 9 June 2022 referencing the timing, and the model for funding, of the statutory Medical Examiner system. The introduction of the non-statutory Medical Examiner system in non-hospital (community) settings continued in 2022. I continue to work closely with the National Medical Examiner, Dr Alan Fletcher, and others, to support Medical Examiners and the roll-out of the new system, including the delivery of joint training for coroners and Medical Examiners.

5.16 I should like to record one particular observation. I am concerned that early indications that the Medical Examiner system is proving effective in diverting the right cases to coroners may be masked by other problems within the system. Anecdotal evidence from coroners and others suggests that the number of referrals of deaths outside hospital settings has noticeably increased since March 2022. At least some of these referrals relate to deaths from natural causes where some entirely avoidable problem prevents proper completion of the medical certificate of cause of death (MCCD). That is something that can arise where a break in continuity of care in the GP surgery means that the MCCD can only be partially completed, or where no GP has seen the patient within the 28-day window before death, or where the GP declines to see the deceased after death. This is generating unnecessary work for hard-pressed coroners and their staff, and it is also increasing costs for local authorities. Our system of death management, certification and investigation is a highly integrated and sensitive one that can only operate efficiently where all participants strictly fulfil their statutory and other obligations. I note that the government has consulted on potential changes to the circumstances in which a medical practitioner can complete an MCCD and I welcome this. I encourage the government to continue to monitor the situation and address the root causes of this emerging and potentially serious problem.

Wider working with the judicial family

5.17 I am grateful to both Deputy Chief Coroners, HHJ Alexia Durran and Derek Winter, for their work in engaging with the wider judicial family. In particular, HHJ Durran led work on my behalf with the senior judiciary on the redesign of the judiciary.uk website, ensuring that the needs of coroners were properly represented, while Derek Winter represented me and, more importantly, all coroners in the work to develop Lord Chief Justice guidance on remote proceedings and the transmission of proceedings to the public and press. Their presence ensured that the needs of coroners and the coroner system were firmly in the mind of the ultimate decision-makers on these projects.

Pathology services

5.18 The crisis in the delivery of coronial pathology services has been well documented elsewhere and I do not propose to recite all the issues here, save to emphasise that the situation remains acute.[13] There are not enough autopsy pathologists in England and Wales, particularly those who deal with non-forensic work. Coroners, as well as other court jurisdictions (such as the family courts), are experiencing severe difficulties in accessing niche sub-specialisms of pathology. The President of the Family Division has raised the issue in a judgment.[14]

5.19 I am grateful to the Ministry of Justice and to Minister Freer for taking steps to tackle this problem, including establishing an interdepartmental working group on coronial pathology. I continue to urge wider government to resolve this situation, not least by taking a comprehensive overview of the value to the common public good of those NHS pathologists who undertake coronial work but who all too often find themselves under pressure to fit such work into the margins around their NHS contracts. The current system constitutes a significant obstruction to pathologists, deterring them from undertaking the conduct of post-mortem examinations on behalf of coroners. I urge the government to take immediate steps to address these issues, including ensuring that the NHS, as an employer and provider of services, can structure job plans so as to make it easier, rather than more difficult, for pathologists to undertake coronial work.

13 Review of forensic pathology in England and Wales – GOV.UK

14 Re G (Child Post-Mortem Report: Delays) [2022] EWFC 55 (14 June 2022) (bailii.org)

Work with the Bar Standards Board (BSB) and the Solicitors Regulation Authority (SRA)

5.20 Since the early part of 2020, my office has worked with the BSB and SRA on a project, led by them but with contributions from many representatives including the MOJ, INQUEST, the Coroners' Courts Support Service and others, to produce a 'toolkit' to improve standards of advocacy in coroners' courts. This toolkit was published in September 2021 and represents a significant resource for legal practitioners and coroners in ensuring that inquests retain their inquisitorial ethos and that the examination of witnesses by advocates is conducted properly. My view is that it has been well received by practitioners and coroners and I look forward to continuing my work with the regulators and the professions in this area.

Disaster Victim Identification (DVI) and Mass Fatality investigations

5.21 The coronial system continues to make provision for the effective management of DVI and other related events in the coronial world. The coroner DVI cadre is co-chaired by Senior Coroners Darren Salter (Oxfordshire) and Joanne Kearsley (Manchester North). Special provision has been made for investigations into the deaths of British residents who have died in the war in Ukraine and are repatriated to England and Wales (which is how the coronial jurisdiction arises), including post-mortem arrangements and liaison with the bereaved family. The Oxfordshire Senior Coroner is the nominated 'incident coroner', and my intention is that all inquests in England and Wales into deaths from the war in Ukraine will be conducted by him in due course. This work has been led by HHJ Alexia Durran and Darren Salter, alongside UKDVI policing leads, for which I am very grateful.

Stakeholders

5.22 My practice is to hold meetings with as many key stakeholder representatives as possible in order to build relationships and maintain those already developed by my predecessors. I have held meetings with the Lord Chief Justice and other senior judges, the Justice Minister responsible for coroner service, the Chief Rabbi of the United Hebrew Congregations of the Commonwealth, the National Medical Examiner, the President of the Royal College of Pathologists, the Victims' Commissioner, and representatives of the legal regulatory organisations. Among others, I have met the Chief Inspector of Prisons and the Chief Inspector of the Health and Safety Investigation Board, other stakeholders including INQUEST, and representatives of faith communities. I also participate in the Ministerial Board on Deaths in Custody and work with the Independent Advisory Panel on Deaths in Custody.

6. Conclusion

6.1 Significantly, the period covered by this report covers the aftermath of the COVID-19 pandemic as well as my post-pandemic tour of all coroner areas in England and Wales. It was my predecessor, HHJ Mark Lucraft KC, who steered the coroner service through the first half of turbulent pandemic period. Since assuming the role of Chief Coroner at the end of 2020, I have benefited greatly from his wise and freely given advice, for which I extend my sincere thanks. I know that he shares my sense of profound gratitude to the coroners and coroners' officers of England and Wales for their dedicated and tireless work in managing the effects of the pandemic and its aftermath.

6.2 Pandemic restrictions have, of course, all but disappeared and society has returned to something resembling normality, but a significant aftershock remains. The size of the backlogs of inquests remains too high, despite the strenuous efforts of coroners and their staff. Tackling them remains my priority. The coroner service is also not immune from wider pressures in society, including the ability to recruit and retain sufficient staff, the pressure on wages and the impact of the energy and cost-of-living crisis on local authority budgets.

6.3 Besides doing what I can to tackle and eliminate backlogs, my other priority continues to be to prevent any erosion of the inquisitorial character of coronial proceedings. Both aims are intimately connected, for no investigation can be conducted with the degree of expedition we should all like to see when, in some circumstances, proceedings are frustrated by the unrealistic attempts to expand their remit to embrace issues that have no true relevance to the coroner's inquiry. That is why I insist on the need to uphold the distinctively inquisitorial ethos of the coronial jurisdiction in England and Wales.

6.4 I should like to conclude by acknowledging the outstanding contributions of my two predecessors, HH Sir Peter Thornton KC and HHJ Mark Lucraft KC, as well as the two Deputy Chief Coroners, HHJ Alexia Durran and Derek Winter DL, and all members of the team at the Chief Coroner's Office. Their combined efforts have laid a secure foundation for the future. While I take sole responsibility for the opinions expressed in this report, I am confident that we all share the same commitment to maintaining and defending the position of the bereaved at the heart of the coronial process.

Annex A

Cases over 12 months old reported to the Chief Coroner – 2021 and 2022

Coroner Area	Number of cases over 12 months old (2021)	Number of reported deaths in 2021	Number of cases over 12 months old (2022)	Number of reported deaths in 2022
Avon	61	3748	56	4041
Bedfordshire and Luton	20	1907	16	2104
Berkshire	68	2057	32	2257
Birmingham and Solihull	39	5716	56	5851
Black Country	16	4676	24	4587
Blackpool and Fylde	32	1159	27	1226
Brighton and Hove	17	1219	18	1139
Buckinghamshire	25	1312	34	1346
Cambridgeshire and Peterborough	256	2907	34	3197
Carmarthenshire and Pembrokeshire	22	1293	29	1695
Central and South East Kent	17	1272	13	1232
Ceredigion	2	293	2	378
Cheshire	194	2670	154	3107
City of London	11	247	11	255
Cornwall and Isles of Scilly	93	2041	50	2304
County Durham and Darlington	14	2802	18	3323
Coventry	17	1363	14	1509
Cumbria	22	1767	17	2069
Derby & Derbyshire	182	4456	165	4420
Dorset	46	2176	49	2481
East London	100	2620	80	2771
East Riding & Hull	87	2579	85	2889

Coroner Area	Number of cases over 12 months old (2021)	Number of reported deaths in 2021	Number of cases over 12 months old (2022)	Number of reported deaths in 2022
East Sussex	30	2168	28	2345
Essex	120	5774	112	6050
Exeter & Greater Devon	113	1857	145	1967
Gateshead & South Tyneside	39	1725	47	1591
Gloucestershire	23	1764	23	1892
Gwent	52	2414	84	2636
Hampshire, Portsmouth & Southampton	120	5984	169	6612
Hartlepool	See Teesside	See Teesside	See Teesside	See Teesside
Herefordshire	11	590	7	702
Hertfordshire	70	2354	80	3001
Inner North London	42	2547	60	2627
Inner South London	235	3292	235	3313
Inner West London	51	2231	68	2163
Isle of Wight	68	769	81	747
Lancashire and Blackburn with Darwen	103	3709	92	4315
Leicester City & South Leicestershire	42	2243	31	2360
Lincolnshire	66	2953	89	3229
Liverpool and Wirral	47	3056	40	2883
Manchester City	304	2786	235	2682
Manchester North	58	2042	42	2144
Manchester South	24	2350	26	2375
Manchester West	109	3255	104	3636
Mid Kent & Medway	29	1852	15	2034
Milton Keynes	14	845	7	961
Newcastle upon Tyne	57	2112	46	1977
Norfolk	41	2976	38	3304
North East Kent	18	1289	11	1340
North Lincolnshire & Grimsby	69	1213	113	1392

Coroner Area	Number of cases over 12 months old (2021)	Number of reported deaths in 2021	Number of cases over 12 months old (2022)	Number of reported deaths in 2022
North London	17	2850	17	3193
North Northumberland	17	667	4	800
North Tyneside	See Newcastle upon Tyne	963	9	960
North Wales (East & Central) & Gogledd	58	2633	50	2681
North West Kent	7	1617	6	1765
North West Wales	9	874	23	876
North Yorkshire (Eastern)	60	686	65	2136
North Yorkshire (Western)	See above	607	See North Yorkshire (East)	See North Yorkshire (East)
Northamptonshire	56	2330	54	2518
Nottinghamshire & Nottingham	32	4305	22	4584
Oxfordshire	25	1904	22	2119
Plymouth Torbay & South Devon	19	2458	52	2685
Rutland & North Leicestershire	26	1347	21	1369
Sefton, Knowsley & St Helens	131	2069	65	2205
Shropshire, Telford & Wrekin	5	1689	8	1964
Somerset	60	2346	66	2448
South London	100	2623	117	2892
South Northumberland	27	1251	1	1228
South Staffordshire	13	2376	15	2404
South Wales Central	158	3530	194	4147
South Yorkshire (East)	44	2213	50	2308
South Yorkshire (West)	27	3354	21	3501
Stoke on Trent & North Staffordshire	29	2477	4	2497
Suffolk	31	2013	21	2219

Coroner Area	Number of cases over 12 months old (2021)	Number of reported deaths in 2021	Number of cases over 12 months old (2022)	Number of reported deaths in 2022
Sunderland	17	1203	12	1084
Surrey	72	3419	32	3538
Swansea & North Port Talbot / Abertawe	64	1881	68	2015
Teesside & Hartlepool	78	2975	110	3155
Warwickshire	13	1838	16	1820
West London	110	3626	90	3787
West Sussex	58	2949	36	3268
West Yorkshire (Eastern)	67	3538	68	3733
West Yorkshire (Western)	217	3082	159	3142
Wiltshire & Swindon	37	2347	42	2446
Worcestershire	33	2296	16	2484
York	See North Yorkshire (Eastern)	504	See North Yorkshire (Eastern)	See North Yorkshire (Eastern)

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