Chief Coroner

Report of the Chief Coroner to the Lord Chancellor

Annual Report for 2023

May 2024

Chief Coroner

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

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Annual Report for 2023

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Correction:

Page 19 Para 3.11 Area Coroner for Cheshire

Text currently reads:

Alex Frodham

Text should read:

Victoria Davies

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Contents

1. Introduction

1.1 This annual report covers the 2023 calendar year and will be my last report as Chief Coroner, as my term of office ends on 24 May 2024.

1.2 The office of Chief Coroner was created by the Coroners and Justice Act 2009 (the 2009 Act) to be the judicial head of the coroner system, providing national leadership for coroners in England and Wales.

1.3 The Chief Coroner's primary responsibilities include:

- providing support, leadership, and guidance for around 500 coroners throughout England and Wales
- representing the interests of coroners to Ministers and Parliament
- working with the Judicial College to provide coroner training
- consenting to coroner appointments
- providing an annual report to the Lord Chancellor

1.4 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 and chair public inquiries that arise out of inquests.

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

1.6 When I was appointed as Chief Coroner, the expectation was that I would dedicate 50% of my time to the role and continue to sit as a Circuit Judge at Liverpool Crown Court for the other 50%. However, during my period of office I was given permission to prioritise my leadership responsibilities. It has now been agreed that future Chief Coroners, including my successor, will be appointed on the basis that they will devote most of their time to leading the coroner service, enabling them to provide the focus that the service needs.

The role of the coroner service

1.7 The primary role of the coroner service is to investigate deaths that are violent, unnatural, of unknown cause or that have occurred in custody or otherwise in state detention. However, it also fulfils other important functions, including:

- providing bereaved families with answers as to how their loved ones died with the assurance that an independent judicial process has investigated any relevant concerns
- contributing to the accurate registration of deaths, thereby enabling more secure analysis of trends in public health
- carrying out an enhanced investigation where the state's responsibilities under Article 2 of the European Convention on Human Rights (ECHR) (the right to life) are engaged
- considering whether any circumstances revealed by an investigation give rise to a risk of future deaths and alerting those who might be able to mitigate or eliminate such risks
- investigating treasure finds, allowing museums to acquire treasure and appropriate rewards to be paid

1.8 A coronial death investigation is a form of summary justice designed to provide 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. Where the enhanced duty of investigation arises under Article 2 of the ECHR, the coroner or jury must examine the wider circumstances in which the death occurred, but still cannot express an opinion on any topic other than the four statutory matters to be ascertained. The 2009 Act expressly prevents inquest determinations from being 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.

1.9 Coronial investigations are inquisitorial, with the coroner (assisted by Interested Persons) examining evidence to discover the truth about how the deceased died, rather than adjudicating between competing versions of events.

The intellectual foundation of the service

1.10 The modern history of the coroner service has exposed a long-latent tension at its heart as to what the service is aiming to achieve. Either the inquest is a summary medico-legal investigation into the immediate cause of an unnatural death, or it is a more exhaustive exploration of the wider circumstances, seeking to explain not just how each deceased person died, but why.

1.11 The 2009 Act provides for the former. It explicitly sets out the four questions that a coronial death investigation must answer, which do not include 'why' the person died. It also specifically prevents the coroner from attributing blame for the death. It is therefore clear from the statutory framework that the coroner's role is to investigate, not to adjudicate. These principles were reinforced in October 2022 by Lord Burnett, then Lord Chief Justice, in the case of *Morahan*[1]:

> "An inquest remains an inquisitorial and relatively summary process. It is not a surrogate public inquiry. The range of coroners' cases that have come before the High Court and Court of Appeal in recent years indicate that those features are being lost in some instances and that the expectation of the House of Lords in Middleton of short conclusions in Article 2 cases is sometimes overlooked. This has led to lengthy delays in the hearing of inquests, a substantial increase in their length with associated escalation in the cost of involvement in coronial proceedings. These features are undesirable unless necessary to comply with the statutory scheme."

1.12 Over the past three years, like my predecessors, I have aimed to reinforce this approach, but there is constant pressure on coroners to expand the scope of their investigations. It seems to me that the time has come for me to offer a more thoughtful response as to why an inquest should remain a hearing that is narrowly focused on establishing a person's immediate cause of a death, as opposed to in effect becoming a surrogate public inquiry.

1.13 The office of coroner is known to have existed since the 12th century and was created to ensure that justice was administered in matters in which the Crown had a financial interest. The reason coroners investigated unnatural deaths was because the instruments of such deaths were forfeit to the Crown. However, over the course of centuries, the institution has developed into something more principled, with the deceased person, and by extension their family, at the heart of the inquest process.

1 *R (Morahan) v West London Assistant Coroner [2022] EWCA Civ 1410*

1.14 Care for the dead is one of the most deeply rooted human impulses and has long been recognised as possessing a moral, and not merely utilitarian, dimension. As William Gladstone famously said:

"Show me the manner in which a nation cares for its dead and I will measure with mathematical exactness the tender mercies of its people, their respect for the laws of the land, and their loyalty to high ideals."

1.15 This care for the dead, which goes beyond mere respect, is not just the result of collective intuition, and acceptance of it as a moral imperative does not depend on a belief in the afterlife. It has its roots in right reason, in what some refer to as the natural law – that unwritten system of universal ethical norms recognised by all civilised peoples.

1.16 The earliest reference to a specific norm of natural law of which I am aware relates to the care and disposal of the dead. It dates back to the 5th century BC and is to be found in the play Antigone by the Greek tragedian Sophocles. Antigone was a Theban princess who preferred to die rather than yield to King Creon's decree forbidding her to bury the body of her disgraced brother. Addressing the King, and referring to his unjust edict, she said:

"...these laws were not ordained of Zeus;
And she who sits enthroned with gods below,
Justice, enacted not these human laws.
Nor did I deem that thou, a mortal man,
Could'st by a breath annul and override
The immutable unwritten laws of Heaven.
They were not born today nor yesterday;
They die not; and none knoweth whence they sprang".

1.17 It is clear from those lines that Antigone is appealing to a higher law that transcends laws posited by the state. It is not simply a matter of decency or hygiene. It is a moral duty owed by the living to the dead. It binds Antigone in conscience to the extent that she must disobey any state law that conflicts with it.

1.18 Applying this principle to the modern world, I believe that there is a deep truth in the idea that bereaved families owe a posthumous duty to care for their deceased relatives and that the state in turn, is under an obligation do what it reasonably can to enable them to discharge that duty. This not a new idea; it has long been at least implicitly recognised. For example, in 2006, the Commons Select Committee for Constitutional Affairs said:

"The death certification and investigation systems have essential roles, providing each person who dies with a last, posthumous service from the State; they serve families and friends by clarifying the causes and

circumstances of the death; and they contribute to the health and safety of the public as a whole by providing information on mortality and preventable risks to life."

1.19 This leads me to draw the following conclusions:

(a) The purpose of a coroner's investigation is not simply defined by the statutory rules and regulations that coroners must apply. The death investigation process has a profound human significance and there is a clear moral basis for placing the deceased at its heart.

(b) The existence of a posthumous duty to the dead lends an enhanced dignity to the right of the bereaved to be involved in coronial investigations, but it also defines the limits of their involvement. My predecessors and I have repeatedly spoken of a duty to put families at the heart of the investigation process. However, as I pointed out in my 2023 lecture celebrating the 10-year anniversary of the 2013 reforms, that duty is based on principle.[2] It does not confer a free-standing right to explore whatever issues families may decide to raise for their own purposes. It presupposes the existence of a prior duty owed by the living to the dead. The ultimate reason for the centrality of families in the coroner's inquest is to enable them to discharge that duty and to speak on behalf of their loved one, whose voice would not otherwise be heard. That is why I have always preferred to say that it is the deceased, and by extension the bereaved, who should be at the heart of the process.

(c) It is this posthumous duty owed to the deceased by the family and the state that ultimately explains and justifies the need for the focus of each investigation to be on the deceased person, not on the wider issues that are explored during a public inquiry. If a coroner's investigation is a summary, inquisitorial process, the centrality of the deceased and their families is guaranteed, and they are protected from being marginalised.

1.20 This analysis leads me to the following practical conclusions about the coroner service:

(a) **The scope of inquests should be narrowly focused on the death of the deceased** – the coroner's investigation should not be conducted as a surrogate public inquiry to examine extraneous issues of concern.

(b) **The inquisitorial nature of the coroner service should be protected** – an inquest should not be a forum for individuals and organisations intent on avoiding reputational or financial damage to present competing

2 www.judiciary.uk/speech-by-the-chief-coroner-death-and-taxes

versions of events. It should be an investigation controlled by the coroner and focused on discovering the truth about the death of the person at its heart.

(c) **Issuing prevention of future death (PFD) reports is an ancillary duty** – PFD reports provide a way for the coroner to draw attention, without recommending any specific solution, to the existence of matters on which action could be taken to prevent future deaths. PFDs are very important and can achieve a great deal when properly used, but the prevention of future deaths is not the primary function of a coroner's investigation, which is to focus on the death of the deceased person. As judges, coroners cannot make changes to avoid future deaths; their role is simply to point out risks.

(d) **Coroner cases should be conducted without delay** – the posthumous duty of the family to the deceased includes ensuring that the body is disposed of with dignity and in accordance with the deceased person's beliefs, that the death is registered, and that the estate is dealt with as the deceased person would have wanted. Where a death has been reported to a coroner, the family cannot arrange for their loved one to be buried or cremated until the coroner has released the body. The registration of the death is also delayed until the coroner's investigation concludes. There is therefore a tension between the coroner's duty to investigate and the family's need to fulfil their obligations to their loved one. This tension is particularly acute where the deceased person held religious beliefs that are incompatible with delayed burial. Delays within the coroner service not only prevent some families from complying with their loved one's beliefs, but also compound families' grief and impact on the reliability of the evidence available to coronial investigations. Avoiding unnecessary delay must therefore be a key priority for the coroner service.

1.21 During my time in office, I have placed great emphasis on protecting the narrow inquisitorial approach of the coroner's investigation and inquest, and on focusing on providing a quick and efficient service with the deceased at its heart. Unfortunately, there is still much work to be done to ensure that the role of the service is properly understood, and that all coroner areas are funded and resourced sufficiently to make achieving those aims attainable.

2. Coroner statistics

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 collates and publishes mortality statistics. These statistics relate to the total number of deaths registered in England and Wales in a particular year, whether or not there has been a coronial investigation.

2.2 The Ministry of Justice publishes separate coroner statistics annually in May, which 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. Some data is also broken down by individual coroner area.

2.3 In addition, in accordance with my statutory responsibilities as Chief Coroner, I provide figures on:

- cases over 12 months old
- service deaths
- PFD Reports

Cases over 12 months old

2.4 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 2023 showing the number of cases that have been in the system for over 12 months, broken down by coroner area. The table also includes the previously published figures for 2022, to provide a comparison. These data provide a snapshot taken in April. It should be noted that there is fluctuation in the figures throughout the year, and that my data are collected separately from the data published by the Ministry of Justice and the Office for National Statistics.

2.5 Having reduced between 2021 and 2022, the total number of cases not concluded within 12 months has risen from 4,812 in 2022 to 6,149 in 2023. This is disappointing, but in the context of the factors to which I have drawn attention in my Extraordinary Report (see Annex B) – including the residual effects of the COVID-19 pandemic, the chronic underfunding of the coroner service, the increase in the quantity and complexity of referrals, and the ongoing shortage of pathologists – it is not unexpected.

2.6 As I explained in my Extraordinary Report, there are many external factors affecting case progression which are outside the coroner's control. These include the need to await charging decisions by the Crown Prosecution Service, the outcome of criminal proceedings, reports arising out of complex specialist investigations by organisations such as the Health and Safety Executive or the Accident Investigation Branches, evidence from investigations taking place overseas, and specialist reports commissioned by coroners themselves (including post-mortem examination reports, which can take many months to obtain because of a national shortage of pathologists). In such cases, the coroner's inquest has to be delayed, sometimes for years, depending on how quickly the linked investigations are completed.

2.7 Investigations by the police, the Health and Safety Executive, Prisons and Probation Ombudsman and Independent Office for Police Conduct 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 most homicides take place and where large prisons are located.

2.8 The social distancing requirements during the COVID-19 pandemic meant that greater backlogs of jury cases built up in areas without large enough court accommodation, and the under-funding in many areas has meant that reducing those backlogs has been challenging. The adequacy of court provision during the pandemic therefore continues to affect performance in some areas.

2.9 I carefully monitor 12-month case data and offer support to areas with high numbers to try to address any practical issues. In 2021 and 2022, I identified 13 coroner areas that had particularly worrying backlogs, with a view to conducting interventions to bring about some improvement in performance. The figures indicate that between 2021 and 2022, the areas I targeted saw a net overall reduction that was significantly greater than the reduction in the other areas. While there might be many factors involved, I am cautiously optimistic that the deployment by the Chief Coroner of support and persuasion in a particular local area can bring about a tangible improvement. I am, however, limited in terms of my capacity to intervene and by the ability of local authorities in the current financial climate to respond positively to my requests.

2.10 Although delays can never be completely eradicated because of the need for coroners to wait for external investigations and processes to conclude, I must report that there is currently an unacceptable level of avoidable delay within the coroner service. While there is some potential for improving efficiency, the impact coroners – including the Chief Coroner – can have on this is limited. Policymakers need to consider how to address the fundamental problem of resourcing within the coroner service.

Service deaths

2.11 Happily, in 2023 I received no reports of the death of 'service personnel' within the meaning of section 17 of the 2009 Act.

2.12 I am satisfied that coroners have access to sufficient training, information and support to enable them to manage investigations into deaths of service personnel in an appropriate manner, should they occur.

PFD reports

2.13 In 2023, 550 PFD reports were issued by coroners, which is an increase of 132 in comparison with 2022.

2.14 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.

2.15 Since 2013, the Chief Coroner has published PFD reports online. My publication policy and a link to the reports themselves is available here: www.judiciary.uk/courts-and-tribunals/coroners-courts/reports-to-prevent-future-deaths/.

2.16 The publication of PFD reports enables public scrutiny, making them a vital tool in ensuring that steps are taken to reduce the risk of future harm. However, it must not be forgotten that the duty to issue a PFD report is ancillary to the investigation process, so a report will only be made if a risk is revealed by the evidence that falls within the scope of the death investigation. It must also be remembered that coroners have no legal power or authority to recommend specific remedial measures in PFD reports. PFD reports should only highlight risks; they should not contain recommendations.

2.17 In 2023, I changed the way in which PFD reports are published to enhance their searchability. All PFD reports published since 1 January 2023 have been published directly onto webpages, making the text fully searchable (previously, searches could only be run on the metadata associated with reports). While this may appear to be a small technical change, it has considerably increased the ease with which reports can be analysed and themes identified, thereby benefiting public learning.

2.18 I continued to work closely throughout the year with researchers at Oxford University in relation to their Preventable Death Tracker project, which uses sophisticated web-scraping techniques to aggregate data from PFD reports and produce academic analysis, including undertaking data cleansing exercises to facilitate their research. I also invited Dr Georgia Richards (who leads the project) to speak about PFD reports at my Senior and Area Coroner Conference and my Local Authority Conference in March 2023, and at Coroner Continuation training throughout the 2022/23 training year (attendance at which is mandatory for all coroners).

2.19 In addition, I continued to work with other organisations, including the Ministerial Board on Deaths in Custody and the Independent Advisory Panel on Deaths in Custody (IAPCD), to explore how the impact of PFD reports can be enhanced, including considering the IAPDC's report entitled: "More than a paper exercise" – Enhancing the impact of Prevention of Future Death Reports.

2.20 The recipients of PFD reports have a legal obligation to respond within 56 days (unless the coroner grants an extension), either explaining why no action is needed or providing details of any action taken or proposed, and the timescales involved.

2.21 Individual coroners occasionally come under pressure from Interested Persons or others to monitor the outcome of their PFD reports. In my view, this pressure is generated by the absence of any system or mechanism to oversee responses. The position in law is that once a PFD report has been issued, the coroner is 'functus officio' and has no legal power to take any further steps (other than determining any application by the report's recipient for an extension of time in which to respond). That is as it should be, for coroners are judges, not regulators. However, the lack of an enforcement mechanism means that PFD responses are not always provided. Responses that are sent to me are published alongside the relevant PFD report on my website in accordance with my PFD publication policy.

3. The coroner service in 2023

3.1 In March 2023, I completed my tour of all coroner areas in England and Wales and subsequently prepared an Extraordinary Report setting out my findings, which was published on 11 January 2024. That report provides my detailed views on the state of the coroner service in 2023.

Training and Chief Coroner guidance

3.2 The new training year commences in April, so this document reports on the training year from April 2023 to March 2024. During that period, in conjunction with the Judicial College and with hard work from the coroners who are course directors, I delivered residential 'continuation' training for all coroners and coroners' officers and induction courses for coroners who have been newly appointed.

3.3 Work on my comprehensive bench guidance has continued, under the leadership of Deputy Chief Coroner Her Honour Judge Alexia Durran. I am currently in the process of reviewing and approving each of the finished chapters ready for publication. This has been a long and exacting task, but I am confident that it will prove to be an invaluable resource for all coroners.

3.4 Although I primarily focused on the bench guidance, which will replace all of my current guidance notes that relate to the work coroners do in court, I also issued or updated the following guidance notes in 2023:

- Guidance No. 3 on Oaths and Robes
- Guidance No. 4 on Recordings
- Guidance No. 26 on Organ and Tissue Donation
- Guidance No. 45 on Stillbirth, and Live Birth Following Termination of Pregnancy

Mergers: reduction in number of coroner areas

3.5 In 2023, the following mergers took place:

- Newcastle upon Tyne and North Tyneside merged to form Newcastle and North Tyneside

- Brighton & Hove and West Sussex merged to form West Sussex, Brighton and Hove
- North Staffordshire and Stoke on Trent and South Staffordshire merged to form Staffordshire and Stoke on Trent

3.6 Following these mergers, there were 80 coroner areas in England and Wales. The Ministry of Justice's long-term target since the 2009 Act reforms has been to reduce the number of coroner areas to around 75, so we are getting close to that figure.

3.7 All mergers that took place in 2023 were achieved through consensus and agreement.

3.8 Mergers are always considered when the opportunity arises, which is usually when a senior coroner retires. The merger of coroner areas generally leads to greater consistency and provides savings for local authorities. However, it is important that the structure, governance and management of the new area is rationalised to take into account the changes in the area's size and geography. It is not enough for funding authorities to persevere with what amounts, in effect, to a slightly modified version of the system that was in place when coroner areas were much smaller.

Appointments and retirements

3.9 Coroners are appointed by local authorities, but since the 2009 Act came into effect all appointments are subject to the Chief Coroner's and Lord Chancellor's consent. My predecessors and I have therefore taken an active interest in recruitment, checking that fair processes are followed and that candidates are of good character (as is required for appointment to any judicial office within England and Wales). However, when a Chief Coroner, or a Chief Coroner's nominee, attends an interview, it is purely as an observer.

3.10 There was considerable interest in assistant coroner posts during 2023, which I encouraged through the provision of online sessions to inform aspiring coroners about the role and appointment process. These were well attended and recruitment campaigns attracted many applicants. There were 23 assistant coroner appointments in 2023 and I am pleased to report that the calibre of the appointees was extremely high.

3.11 During my time as Chief Coroner, I have encouraged the appointment of additional area coroners to improve the balance of fee paid to salaried coroners. Appointing area coroners provides senior coroners with greater support in managing coroner areas, improves the level of experience within the service and increases resilience. In 2023, I arranged aspiring area coroner workshops to encourage experienced candidates to apply, and over the year there were many successful competitions leading to the appointment of 13 area coroners. These were:

- Alexander Frodsham (Cheshire)
- Catherine Bisset (Lancashire and Blackburn with Darwen)
- Jayne Wilkes (Lincolnshire)
- Nicholas Graham (Oxfordshire)
- Hannah Godfrey (Berkshire)
- Daniel Howe (Staffordshire and Stoke-on-Trent)
- Roland Wooderson (Gloucestershire)
- Tony Murphy (North London)
- Jacques Howell (Hertfordshire)
- Susan Evans (Derby and Derbyshire)
- Paul Appleton (Manchester City)
- Samantha Goward (Norfolk)
- Alison Longhorn (Plymouth, Torbay and South Devon)

3.12 There were five senior coroner appointments in 2023. These were: Paul Smith (Lincolnshire); Kate Robertson (North West Wales); Peter Nieto (Derby and Derbyshire); Julian Morris (Inner South London); and Lydia Brown (West London).

3.13 For area and senior coroner appointments, either I or one of my nominees attended each of the interviews conducted in 2023. I would like to thank my nominees for their hard work in ensuring appropriate oversight of the appointment process.

3.14 As I explained in my Extraordinary Report, I am concerned about the robustness of the process that is used to select senior coroners. While the coroner service has so far been fortunate in those selected for the roles, I think that the process needs to be reformed to ensure that the most meritorious candidates are selected to these senior judicial posts.

3.15 In 2023, the appointments of the two Deputy Chief Coroners, Derek Winter DL (Senior Coroner of Sunderland) and Her Honour Judge Alexia Durran (a Senior Circuit Judge at Central London Criminal Court) were extended to 31 December 2024. My own appointment was also extended, enabling me to retire on 24 May 2024 instead of leaving office in December 2023. These extensions have provided the coroner service with continuity of leadership and will ensure that when my successor takes over in May, he or she will be able to benefit from the support of experienced Deputy Chief Coroners.

3.16 I am extremely grateful to the Deputies for their invaluable advice, support and dedication. Their excellent work improves the leadership of the coroner service and I am indebted to them.

3.17 I would also like to express my gratitude to those coroners who retired in 2023 having dedicated many years to public service. In particular, I would like to thank: Karen Dilks (Newcastle and North Tyneside), Ian Arrow (Plymouth, Torbay and South Devon), Robert Hunter (Derby and Derbyshire), and Andrew Harris (Inner South London) for their expertise, hard work and commitment.

Security

3.18 As I explained in my Extraordinary Report, the local organisation of the coroner service means there is no central organisation equivalent to His Majesty's Courts and Tribunals Service to develop and implement security standards. Arrangements must be made and funded by local authorities, most of which have no wider experience of judicial security requirements. During my tour of coroner areas in England and Wales, I was concerned to see that security arrangements around the country are rarely adequate.

3.19 In March 2023, Matthew Braham, Head of Security and Safety at His Majesty's Courts and Tribunals Service, attended my Local Authority Conference to give a presentation to local authority representatives on judicial security. I have urged senior coroners to raise any deficiencies in court security with their funding authorities and to contact my office should they require support, and I periodically remind them to do so. I am limited, however, to using persuasion and education to try to drive up standards in this very important area of provision.

3.20 In May 2023, there was a serious security incident at Essex Coroner's Court. Thankfully, no-one was seriously injured, but it was an extremely traumatic experience for those involved. This incident starkly highlighted the risk generated by inadequate security arrangements. It is vital that the government considers how to improve security arrangements for coroners.

Judge-led inquests

3.21 A 'judge-led' inquest is an inquest conducted by a judge borrowed from another jurisdiction (for example, from the Crown Court). Judge-led inquests are unusual, but are sometimes arranged because the profile or complexity of a case means a coroner area does not have the judicial resources to conduct the inquest, or because there is particularly sensitive material that cannot be disclosed to a coroner by reason of the law protecting national security.

3.22 In 2023, the following inquests had a judge nominated to conduct them:

- **Inquests into the deaths of the patients of Ian Paterson** – His Honour Judge Richard Foster was nominated to conduct the investigations and inquests into the deaths of patients of breast surgeon Mr Ian Paterson.
- **Inquests into the deaths of James Furlong, Joseph Ritchie-Bennett and David Wails** – Sir Adrian Fulford was nominated to conduct the investigations and inquests into the deaths of James Furlong, Joseph Ritchie-Bennett and David Wails, who died following a terror attack at Forbury Gardens, Reading on 20 June 2020.
- **Inquest into the death of Rhianan Rudd** – Her Honour Judge Alexia Durran was nominated to conduct the investigation and inquest into the death of Rhianan Rudd.

3.23 As I explained in my Extraordinary Report, I am concerned about the way in which judge-led inquests are funded. Some judge-led inquests are so immense in scale that they necessarily take years to investigate and conclude (for example, the inquests relating to the deaths of many patients of Ian Paterson). The local funding model of the coroner service means that the cost of such investigations falls on the local authority responsible for funding the coroner area that has jurisdiction over the deaths in question. The government has no formal policy in relation to providing centralised funding for such inquests. When local authorities fund a complex judge-led inquest, it can have a detrimental effect on their ability to fund the routine work of the area.

Disaster victim identification

3.24 On 6 December 2023, I published my response to the Right Reverend James Jones KBE's Report on the Experiences of the Hillsborough Families (link: www.judiciary.uk/wp-content/uploads/2023/06/Chief-Coroner_Response-to-the-Bishop-James-Jones-report_final_061223_2311-1.pdf).

3.25 In that report, I set out how mass fatality events and other serious incidents are now managed and the work that has been done, and continues to be done, to ensure that the experiences of the Hillsborough families are never repeated.

Public understanding of the coroner service

3.26 During 2023, important work was done to help the public understand the role of the coroner service. The second series of 'Cause of Death' aired on Channel 5 towards the end of the year, enabling viewers to watch the development and conclusions of selected death investigations conducted by the Senior Coroner of Lancashire and Blackburn with Darwen, Dr James Adeley. These programmes have been extremely valuable both in explaining how coroners' investigations work and in highlighting why they are important to bereaved families and the wider public. I am grateful to Dr Adeley and his team for the effort and skill they put into the series, and to Channel 5 for their interest and professionalism in properly reflecting our work.

3.27 I also sought opportunities to raise the profile of coroners and the coroner service, including being interviewed by The Times in July 2023[3] and delivering a public lecture in November 2023[4] which was livestreamed and then reported in the media.

3 www.thetimes.co.uk/article/grief-compounded-for-years-as-inquest-delays-soar-mjv20075c

4 www.judiciary.uk/speech-by-the-chief-coroner-death-and-taxes-the-past-present-and-future-of-the-coronial-service/

Treasure

3.28 As well as conducting death investigations, coroners are responsible for conducting treasure inquests. The purpose of a treasure inquest is to establish whether a find is treasure, who found it, and when and where it was found. If an item is deemed to be treasure it becomes the property of the Crown. If it is not deemed to be treasure, it is returned to the landowner where the item was found.

3.29 On 30 July 2023, changes to the Treasure (Designation) Order 2002 came into force that widened the definition of what constitutes treasure. The definition now includes any object at least 200 years old of a class designated by the Secretary of State as being of outstanding historical, archaeological or cultural importance. Prior to that change, only items over 300 years old, that were not a single coin, and that contained at least 10% precious metal constituted treasure.

3.30 The change means that more finds can be acquired by museums to be put on display for the public.

3.31 So far, to my knowledge there have been no cases where a find has fallen within the new class of treasure, so the impact on the coroner service of the amended legislation has been low. The change will, however, enable a case of this type to be considered at a treasure inquest when the next significant find arises.

4. Future changes

Medical examiner system

4.1 One of the most significant areas of work for my office and me during 2023 was advising the government on the impact on the coroner service of the forthcoming implementation of the statutory medical examiner scheme, so that the practicalities can be properly considered as operational decisions are made. The draft Medical Certificate of Cause of Death Regulations were published on 14 December 2023 and implementation is expected in 2024.

4.2 Over the years, coroners have assumed various non-statutory duties within the death certification system in order to enable the system to function. When the 2009 Act was implemented in 2013, many historic practices were carried over from old ways of working. The implementation of the statutory medical examiner scheme has provided an opportunity for the government to consider where the line between medical certification and judicial certification should be drawn and to structure the corresponding duties on a principled basis. The implementation of the scheme will therefore bring about wide-ranging changes to coronial processes.

Recommended law changes

4.3 I recommend that the government considers making the following legal changes to improve the functioning of the coroner service:

(a) Amending section 13 of the Coroners Act 1988 – I would like to see two amendments: (i) to enable the High Court, where appropriate and subject to the bereaved family's consent, to amend the Record of Inquest without ordering a fresh investigation when it quashes an inquest; and (ii) to enable a coroner to apply to the High Court to quash an inquest and hold a fresh investigation (for instance, where further evidence has come to light) without the preliminary need to seek authority from the Attorney General to make such an application.

(b) Enabling a British Sign Language (BSL) interpreter to assist deaf jurors serving on an inquest jury – section 196 of the Police, Crime, Sentencing and Courts Act 2022 makes provision for a BSL interpreter to assist deaf jurors serving on a jury in the criminal or civil court. An amendment to the 2009 Act, and the underpinning secondary legislation, could make similar provision in the coroner's court.

(c) Clarifying statutory arrangements for the provision of coroner's officers and other staff – I would like section 24 of the 2009 Act to be amended to define the division of responsibility between the local policing body and the relevant local authority for the coroner area.

(d) Holding treasure inquests in writing – section 9C of the 2009 Act enables the coroner to hold a non-contentious inquest in writing, where the interested persons have no reasonable objection, and the coroner considers that no public interest would be served by a hearing. However, that section only relates to death investigations. Because of the transitional provisions that have been in effect since the 2009 Act came into force, treasure inquests are still governed by the Coroners Act 1988 and the Coroners Rules 1984. I would like the relevant provisions to be amended to extend the ability to conduct inquests in writing to treasure inquests.

(e) Putting coroners' oaths on a statutory footing – I would like Schedule 3 to the 2009 Act to be amended to make it a statutory requirement for coroners to take the judicial oath. It is set out in Chief Coroner guidance that all new coroners should take the judicial oath, but they are currently not bound to do so. Making the oath a statutory requirement would emphasise the importance of the principles it protects and make coroners subject to the same requirement as their judicial colleagues in most other jurisdictions.

(f) Amending section 39 of the of the Children and Young Person's Act 1933 – this provision currently allows judges (including coroners) to prohibit the publication of information relating to a child concerned in proceedings, but is not wide enough to cover children within a bereaved family who are not witnesses in the proceedings. The nature of coronial proceedings make it more likely than in most other jurisdictions that there will be children not directly concerned in the proceedings who are particularly vulnerable and for whom additional protection might be warranted.

(g) Enabling retired Circuit Judges to be nominated to conduct judge-led inquests – at the moment, paragraph 3(2)(c) of Schedule 10 to the Coroners and Justice Act 2009 only allows a sitting Circuit Judge to be nominated to conduct an investigation into a person's death, whereas a sitting or retired High Court Judge can be nominated. I would like a person who has held office as a Circuit Judge (but no longer does so) to be eligible for nomination, to remove that anomaly and widen the pool of judges who can be considered for judge-led inquests involving security-sensitive material.

5. Conclusion

5.1 2023 was a difficult year for the coroner service. Many coroner areas were still struggling to eradicate the backlogs that built up during the COVID-19 pandemic, and all areas were affected by the changes to medical practice that have led to greater numbers of natural deaths being reported to coroners. At the same time, the financial crisis severely affected the ability of many local authorities and police services to resource the coroner service appropriately. Under-funding of the service remains a serious and pervasive problem.

5.2 However, there were many positive developments. The professionalism of the coroner service continues to increase, and coroners' status as judges is becoming more widely recognised. The most senior leadership judges have begun looking for ways to include coroners in judicial initiatives, including the One Judiciary project, which aims to achieve a more cohesive judiciary. The Judge's Council (a body that is constituted to be broadly representative of the judiciary for the purpose of informing and advising the Lady Chief Justice) accepted its first coroner as a member last summer. I am grateful to André Rebello for taking on that role and am impressed by the impact his membership has already made. Extensive work was also done to prepare for the implementation of the statutory medical examiner scheme, so as to ensure a smooth transition when those changes take effect.

5.3 It has been a great privilege to serve as Chief Coroner of England and Wales. I wish to thank all of the coroners, coroners' officers and staff throughout England and Wales for their hard work and dedication to the service. The enterprise on which we have been jointly engaged is one of the profoundest human significance. It is a shared vocation in which we can all take legitimate pride.

Annex A

Cases over 12 months old

Coroner Area	Number of cases over 12 months old (2022)	Number of cases over 12 months old (2023)
Avon	56	77
Bedfordshire and Luton	16	24
Berkshire	32	52
Birmingham and Solihull	56	60
Black Country	24	50
Blackpool and Fylde	27	30
Brighton and Hove	18	17
Buckinghamshire	34	30
Cambridgeshire and Peterborough	278[5]	282
Carmarthenshire and Pembrokeshire	29	30
Central and South East Kent	13	12
Ceredigion	2	10
Cheshire	154	215
City of London	11	6
Cornwall and Isles of Scilly	50	48
County Durham and Darlington	18	15
Coventry	14	29
Cumbria	17	50
Derby & Derbyshire	165	116
Dorset	49	53
East London	80	80
East Riding & Hull	85	70
East Sussex	28	38
Essex	112	188

5 The figure of 34 was incorrectly published in my Annual Report for 2021/2022, so this is a correction.

Coroner Area	Number of cases over 12 months old (2022)	Number of cases over 12 months old (2023)
Exeter & Greater Devon	145	178
Gateshead & South Tyneside	47	51
Gloucestershire	23	36
Gwent	84	49
Hampshire, Portsmouth & Southampton	169	265
Herefordshire	7	4
Hertfordshire	80	161
Inner North London	60	61
Inner South London	235	435
Inner West London	68	71
Isle of Wight	81	117
Lancashire and Blackburn with Darwen	92	109
Leicester City & South Leicestershire	31	30
Lincolnshire	89	85
Liverpool and Wirral	40	40
Manchester City	235	206
Manchester North	42	36
Manchester South	26	22
Manchester West	104	80
Mid Kent & Medway	15	24
Milton Keynes	7	10
Newcastle upon Tyne	46	46
Norfolk	38	54
North East Kent	11	15
North Lincolnshire & Grimsby	113	266
North London	17	65
North Northumberland	4	1
North Tyneside	9	See Newcastle upon Tyne
North Wales (East & Central) & Gogledd	50	64
North West Kent	6	17

Coroner Area	Number of cases over 12 months old (2022)	Number of cases over 12 months old (2023)
North West Wales	23	32
North Yorkshire (Eastern)	65	95
Northamptonshire	54	87
Nottinghamshire & Nottingham	22	35
Oxfordshire	22	37
Plymouth Torbay & South Devon	52	113
Rutland & North Leicestershire	21	11
Sefton, Knowsley & St Helens	65	55
Shropshire, Telford & Wrekin	8	13
Somerset	66	64
South London	117	210
South Northumberland	1	0
South Staffordshire	15	18
South Wales Central	194	360
South Yorkshire (East)	50	42
South Yorkshire (West)	21	26
Stoke on Trent & North Staffordshire	4	37
Suffolk	21	18
Sunderland	12	9
Surrey	32	33
Swansea & North Port Talbot / Abertawe	68	65
Teesside & Hartlepool	110	115
Warwickshire	16	18
West London	90	123
West Sussex	36	31
West Yorkshire (Eastern)	68	60
West Yorkshire (Western)	159	158
Wiltshire & Swindon	42	82
Worcestershire	16	22
Total	**4,812**[6]	**6,149**

6 This figure takes into account the corrected figure for Cambridgeshire and Peterborough.

Annex B

Extraordinary Report of the Chief Coroner: The coroner service 10 years post-reform

11 January 2024

Introduction

I was appointed as Chief Coroner on 24 December 2020 and am the third incumbent in the role since it was created by the Coroners and Justice Act 2009 (the 2009 Act). Most of the reforms introduced by the 2009 Act came into force 10 years ago, on 25 July 2013, so it seems an appropriate time to offer some reflections on their impact.

Between January 2022 and March 2023, I personally visited every coroner area in England and Wales with a view to investigating the state of welfare and morale within the coroner service in the immediate aftermath of the Covid-19 pandemic. As the first Chief Coroner ever to have conducted such a tour, I consider that I am uniquely placed to provide the assessment contained in this extraordinary report.

The purpose of the coroner service

The coroner service in England and Wales is a small but important part of the justice system. Its primary purpose is to investigate deaths that are violent, unnatural, unexplained or that have occurred in custody or otherwise in state detention. However, it also fulfils other important functions, including:

- providing bereaved families with answers as to how their loved ones died with the assurance that an independent judicial process has investigated any relevant concerns;
- contributing to the accurate registration of deaths, thereby enabling more secure analysis of trends in public health;
- carrying out an enhanced investigation where the state's responsibilities under Article 2 of the European Convention on Human Rights ('ECHR') (the right to life) are engaged;
- considering whether any circumstances revealed by an investigation give rise to a risk of future deaths and alerting those who might be able to mitigate or eliminate such risks; and
- investigating treasure finds, allowing museums to acquire treasure and appropriate rewards to be paid.

A coronial death investigation is a form of summary justice, providing 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. Where the enhanced duty of investigation arises under Article 2 of the ECHR, the coroner or jury must examine the wider circumstances in which the death occurred, but still cannot express an opinion on any topic other than the four

statutory matters to be ascertained. The attribution of blame forms no part of the coroner's role. The 2009 Act expressly prevents inquest determinations from being 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.

Coronial investigations are inquisitorial, with the coroner (in collaboration with interested persons) examining evidence to discover the truth about how the deceased died, rather than adjudicating between competing versions of events. As Lord Lane said in 1982[1]:

> "It should not be forgotten that an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the reins, whichever metaphor one chooses to use."

As the Commons Select Committee on Constitutional Affairs observed in 2006, the death certification and investigation systems provide each person who dies with "a last, posthumous service from the State". In their discharge of that service, coroners are under an obligation to place the deceased and, by extension, bereaved families at the very heart of the process. I put it in that way because a duty to the bereaved seems to me to presuppose a prior duty to the deceased, a posthumous imperative rooted in that unwritten system of universal norms to which the Theban princess Antigone appealed when she chose to defy a royal edict that would have denied decent burial to her disgraced brother[2]. The right of the bereaved to participate in the inquest process is a right to participate on behalf of the deceased, whom they represent. Even in the most contentious cases, it is only by keeping the deceased at the heart of the investigation that we can protect their families against the risk of being marginalised. And it is the inquisitorial method, upon which the higher courts have so often insisted[3], that provides the ultimate guarantee of the centrality of the deceased and, therefore, of the bereaved.

1 In R v South London Coroner Ex p. Thompson (1982) 126 S.J. 625

2 Sophocles, Antigone, lines 450-459.

3 See for example, ***R (on the application of Police Officer B50) v HM Assistant Coroner for East Yorkshire and Kingston Upon Hull*** [2023] EWHC 81 (Admin), at §94.

That is why I have made it a priority of my term as Chief Coroner to defend the inquisitorial method and ethos of the inquest against erosion by those who would turn it into a form of surrogate litigation.

The local funding model

The office of coroner is known to have existed since the 12th Century and was created to ensure that justice was administered in matters in which the Crown had a financial interest (hence the wide mix of work, which still includes death and treasure). Historically, it was a locally appointed and funded role, with coroners originally being elected as officers of the Crown by the freeholders of land in their county and subsequently being appointed by local authorities. These long-standing arrangements did not change with the introduction of the 2009 Act, so that local authorities continue to have responsibility for appointing coroners and for funding the service.

Local police forces have also long played a key role in resourcing the coroner service through the provision of coroners' officers (i.e. staff who make enquiries on a coroner's behalf and prepare cases for inquest). Although some policing bodies have transferred coroners' officers to the employment of local authorities, many forces still retain responsibility for providing and managing coroners' officers.

The 2009 Act explicitly states[4] that it is the duty of the relevant local authority for each coroner area:

- to secure the provision of whatever officers and other staff are needed by the coroners for that area to carry out their functions (except where the necessary officers and staff are provided by a policing body);
- to provide, or secure the provision of, accommodation that is appropriate to the needs of those coroners in carrying out their functions; and
- to maintain, or secure the maintenance of, such accommodation.

4 Coroners and Justice Act 2009, section 24.

The 2009 Act reforms

During the last century, concerns about failure to detect secret homicide led to growing calls for reform of the coroner service and the wider death certification system. These concerns culminated in the Government commissioning the Shipman Inquiry and the Luce Review. The resulting reports, published in 2003, suggested that the problems were structural, and that to rectify them systems needed to be rationalised, professionalised and more appropriately resourced.

The ensuing reform of the coroner service took effect in July 2013 and included the creation of the role of Chief Coroner to provide overarching leadership across England and Wales, set new national standards in the coroner system, develop a national framework in which coroners would operate, and develop and implement coroner reforms. At the time of the appointment of the first Chief Coroner (His Honour Judge Peter Thornton QC), Kenneth Clarke MP, then Lord Chancellor and Secretary of State for Justice, said:

> "Everyone is agreed that the priority is to ensure coroners provide a high standard of service at what can be a difficult time for bereaved families. I am therefore giving the Chief Coroner the full range of powers to drive up standards, including thorough coroner training, and to tackle delays within the system."

Other notable changes made by the 2009 Act included:

- permitting inquests and post-mortem examinations to be conducted anywhere in England and Wales;
- creating the role of Area Coroner (a salaried judge who can deputise for the Senior Coroner and assist with running the coroner area);
- requiring that all coroners must be legally qualified;
- introducing a retirement date for coroners in common with other judicial posts;
- bringing all coroners within the judicial disciplinary arrangements; and
- introducing a process for conducting mergers, with the intention of moving towards a smaller number of larger coroner areas.

In summary, the 2009 Act changes allowed central oversight of the coroner service, improved some aspects of its organisation and subjected coroners to the same professional standards as their judicial colleagues in other jurisdictions.

The aim of all Chief Coroners has been to use this reformed structure to create a more modern, open, just and consistent coroner service, to reduce unnecessary delays, and to put bereaved families at the heart of the process. In the past 10 years, despite the unprecedented difficulties caused by the Covid-19 pandemic, there have been many positive steps towards achieving these goals. In this report, before considering the challenges that remain, I would like to summarise some of those achievements.

The positive impacts of reform

Since the 2009 Act came into force, there have been significant improvements in the following areas:

The professional standing of coroners

Coroner roles have been harmonised with the roles of judges in other jurisdictions as follows:

- Applicants for coroner appointments must fulfil the same judicial eligibility conditions as other first instance judges.
- Appointments are subject to consent from the Chief Coroner and Lord Chancellor, allowing some oversight of recruitment processes and monitoring of good character requirements.
- All coroners are subject to the same standard of conduct and to the same disciplinary procedures as other judges.
- Coroners take the judicial oath following appointment.
- Coroners are subject to the same mandatory retirement age as other judges.
- High-quality training and guidance is provided to all coroners by the Chief Coroner and Judicial College.

Previously, coroners had been subject to less robust requirements in relation to eligibility, conduct and training than their judicial colleagues. The 2009 Act framework made it clear that coroners are judges and that they will be held to the same high standards as the rest of the judiciary.

The distribution of coronial work

Many of the 109 old coroner 'districts' have been merged. There are now 80 coroner areas, with future mergers anticipated. Larger areas support a greater number of coroners, allowing a collegiate approach, improving 'out of hours' cover, and introducing economies of scale for local authorities.

The power of the Chief Coroner to transfer cases between coroner areas under section 3 of the 2009 Act has enabled some limited global case management, although in practice the circumstances in which the power can be used are restricted by funding, resourcing and geographical considerations.

Consistency

Chief Coroner guidance has been issued on a wide variety of topics[5] and successive Chief Coroners have provided direction through regular communications and training events, all of which have improved consistency of practice between coroner areas as well as ending some unsatisfactory practices (for example, the use of pre-signed forms that delegated judicial decisions to staff). Consistency has also been increased through the introduction of new legislation, such as the Notification of Deaths Regulations 2019, which eliminated the need for local death reporting criteria.

The move towards a smaller number of coroner areas has also reduced local variation in working practices, as fewer coroners are now determining the direction of the service.

Use of technology

As technology has developed there has been significant modernisation of the coroner service, with advances including the ability to undertake remote hearings, the increased use of CT scanning in place of invasive autopsy in appropriate cases and the digitisation of coroners' work flows and processes. Access to and use of technology varies between coroner areas but, in general, IT advances have made a significant impact on the way the service is managed and delivered.

Enhanced capability in respect of serious national incidents, including mass fatalities and terrorism

In my response to the report of Bishop James Jones into the experiences of the Hillsborough families, I described the significant improvements in the preparedness, capability and sensitivity to the bereaved that have taken place since 2013 in respect of coronial investigations into mass fatality and terrorist incidents[6].

5 https://www.judiciary.uk/courts-and-tribunals/coroners-courts/coroners-legislation-guidance-and-advice/coroners-guidance/

6 Chief Coroner response to the Bishop James Jones report - Hillsborough - Courts and Tribunals Judiciary

Collaboration

The provision of national leadership has meant that, in addition to the excellent support that the Coroners Society for England and Wales has for many years provided, coroners have had new opportunities to collaborate and share best practice through regular training events, conferences and communications. The appointment of regional leadership coroners has improved regional collaboration and is helping to provide greater welfare support. At a local level, the introduction of the role of Area Coroner, and my policy over the past 18 months or so of encouraging Area Coroner appointments, has promoted greater collaboration within individual coroner areas.

The current state of the coroner service

While the 2009 Act has led to improvements within the coroner service, there remain significant problems which need to be addressed. Between January 2022 and March 2023, I visited every coroner area in England and Wales and was able to assess first-hand the current state of the service.

Tour findings

The overarching findings from my tour were as follows:

The service has insufficient personnel

In all but a handful of areas, teams of coroners' officers are understaffed and overworked, resulting in avoidable delays to cases and a conspicuous lack of resilience, as well as adversely affecting officers' welfare.

The Chief Coroner's Model Coroner Area (July 2020) advises that the caseload for each coroner's officer should be approximately 25 inquest files, subject to the complexity of the cases. I am not aware of any coroner area that meets this expectation. Although the number of files allocated to an individual officer does not provide a precise measure of workload, I encountered areas on my tour where the caseload per officer was well into three figures. The consistent picture across England and Wales is that current staffing levels are far too low. Recruitment processes within police forces and some local authorities are often so cumbersome that even where there is a recognition that more officers or administrative staff are needed, it can take an excessive length of time to fill vacant posts.

In many areas there are not enough coroners or there is a sub-optimal ratio of salaried to fee paid coroners. This places Senior Coroners under excessive pressure, which negatively affects their welfare and the performance of the service.

There is an unacceptably wide variation in the provision by local authorities of material resources

Although the resourcing needs of coroner areas vary because of differences in size, geography and work profiles, the dramatic contrast between areas, particularly in relation to court and office accommodation, does not correlate with their differing needs. In some areas, the irreducible minimum requirements of a coroner area of any sort are not being met.

The primary concerns I have identified are as follows:

1. Dilapidated buildings

   Some coroner areas are being accommodated in buildings that are not sufficiently modern or well-maintained. In one area, for example, the courtroom ceiling leaks, the jury room has had to be abandoned because of the presence of black mould, the coroner's officers cannot be co-located with the coroners and there is no disabled access for members of the public or staff.

2. Insensitively sited accommodation

   In more than one area, the coroner service is accommodated in a large, multi-occupancy civic building and is not properly insulated from local authority departments. For example:

   - in one area, the space occupied by the coroner's officers serves as a thoroughfare between adjacent offices. In another, the coroner's officers work in part of a large, shared, open-plan office with nothing more than a portable screen to divide them from other services. Coroners' officers should not have to conduct sensitive and confidential telephone conversations with bereaved relatives against an audible background of chatter and laughter from staff who are working in the same open-plan space, or who are passing through on their way elsewhere.

   - in a few areas, coroners' courtrooms are situated next to offices where births are registered. This means that bereaved families attending inquests into baby deaths have to share common areas with newborn babies.

   - in more than one coroner area, the courtroom is regularly exposed to interruption by the audible rejoicing and applause of members of the public celebrating civil weddings. This disrupts court proceedings and aggravates the distress experienced by bereaved families.

3. A lack of dedicated courtrooms

   Some coroner areas have no dedicated courtrooms and are obliged to negotiate access to committee rooms or council chambers, or to courtrooms managed by His Majesty's Courts and Tribunals Service, whenever they need to hold an inquest. This is not the situation in most coroner areas, but where it occurs it creates significant operational difficulty.

There remains a general need for more salaried Area Coroners

While there has been some rebalancing of the ratio of fee-paid to salaried coroners, there is still work to do to improve the composition of the service. Many areas rely exclusively on Assistant Coroners to support the Senior Coroner, even though most

Assistant Coroners have other professional commitments which prevent them from providing the flexible support that is needed.

The benefits of appointing an Area Coroner include:

- increasing the expertise routinely available within the local service;
- increasing efficiency because of the Area Coroner's experience and familiarity with the area and his or her ability to cover for the Senior Coroner at short notice (for example, enabling the swapping of lists in the event of an unforeseen conflict);
- enabling a collegiate approach, by giving the Senior Coroner an experienced colleague with whom to discuss difficulties and share ideas;
- protecting the Senior Coroner's welfare by providing experienced cover so that the Senior Coroner can take leave;
- releasing the Senior Coroner to do important external work (including outreach within the local community) and project work (for example relating to IT or business continuity planning);
- building the resilience of the area; and
- improving continuity when a Senior Coroner has a long-term absence or a Senior Coroner role becomes vacant.

The 'triangle of responsibility' creates operational difficulties

The involvement of both police forces and local authorities in resourcing most coroner areas creates a 'triangle of responsibility', with the senior coroner, relevant local authority and police force having to agree many aspects of how the service will function. In addition, although each coroner area has one 'relevant authority' that is responsible under s24 of the 2009 Act for providing its funding, that authority will often have collateral agreements with neighbouring local authorities to share the cost. In effect, this means that more than one local authority (in some coroner areas it can be three or more) must agree to a coroner's funding requests. These complicated arrangements often delay key decision-making and provide greater opportunity for disagreement, to the detriment of the service and its performance.

The fact that coroner's officers and other staff work to the direction of the coroner, yet are formally employed and line-managed by either the local authority or police force, causes confusion and conflict. There are frequent misunderstandings about the boundary between independent direction by the coroner and legitimate line management by the employer, with disagreements affecting the proper functioning of the service.

Judicial independence is impacted by the current resourcing structure

For local authorities and police forces, supporting a small part of the judiciary is but one of their many responsibilities. This means that they often lack the expertise to recognise the practical implications of protecting judicial independence, and they may not appropriately allocate funding in the face of competing priorities, especially when their financial situation happens to be precarious.

Problems I have recently encountered include:

1. The inappropriate treatment of coroners on long-term sick leave

   Local authorities often misunderstand their duties when it comes to managing coroners who are on long-term sick leave. The principle that judges have security of tenure and that their salaries cannot be reduced must be respected, because those protections are there to safeguard judicial independence and the rule of law.

2. Inappropriate action in relation to capability concerns

   Local authorities occasionally worry that a coroner's capability has been compromised and try to take action to prevent 'mistakes', either by interfering with listing or by implementing processes to 'check' coroners' work. However, coroners' judicial decisions must be respected unless they are challenged through a court process; not even the Chief Coroner can overrule another coroner's decision. This important constitutional safeguard is necessary to protect coroners from external pressures, thereby safeguarding their impartiality.

3. Disagreement over staff direction

   I have already pointed out that the 'triangle of responsibility' can lead to operational difficulty. In some areas, local authorities and police forces have directed their employees in a way that interferes directly with coroners' judicial decision-making, thereby undermining judicial independence.

4. Inability to provide appropriate funding

   The precarious financial position of some local authorities can affect listing decisions inappropriately. For example, I am aware of one area where the local authority asked a coroner to delay cases across financial years.

Court security arrangements vary considerably and are rarely adequate

The local organisation of the coroner service means there is no central organisation equivalent to His Majesty's Courts and Tribunal Service to develop and implement security standards. Arrangements must be made and funded by local authorities, most of which have no wider experience of judicial security requirements.

In response to the Coroner Attitude Survey of 2020[7], almost half of all coroners said that they were concerned about their personal safety in court. That these were valid concerns was corroborated by my own experience, as I rarely found adequate security measures in place at the coroners' courts I visited.

As a minimum, coroners' courts should have the following:

- a secure area for coroners and staff that remains closed to the public;
- a door for the coroner to use that provides direct access from the court to the secure area;
- a raised dais where the coroner sits, separated from the main body of the court by some physical barrier;
- a 'panic button' that the coroner can use to summon help in case of need; and
- public-facing staff to greet and discreetly check people entering the building, and to respond to the activation of the panic button.

The need for proper security measures was clearly evidenced shortly after the conclusion of my tour when a coroner's court was invaded during an inquest, causing immense distress and disruption.

Recent work increases are likely to be permanent

The additional pressure that the coroner service has experienced since 2020 is not a temporary result of the pandemic. Anecdotal evidence from my tour - corroborated in some respects by statistics published by the Ministry of Justice[8] - suggests that (i) the numbers of reported deaths are rising and will continue to do so and (ii) the complexity of coronial investigations is on the increase.

The primary reason for the observed rise in the number of reported deaths is that changes in medical practice have meant that more people are dying from natural causes without having recently been seen by a medical practitioner, with the result that there is no-one to provide a medical certificate of cause of death. When such

7 https://www.judiciary.uk/wp-content/uploads/2023/03/Coroner-Attitude-Survey-2020.pdf

8 https://www.gov.uk/government/statistics/coroners-statistics-2022/coroners-statistics-2022-england-and-wales

a certificate cannot be issued, the patient's death must be reported to the coroner. Because many such cases turn out to involve natural deaths, they artificially inflate the number of referrals to coroners.

This increase in workload has been compounded by a corresponding increase in case complexity, which appears to have resulted from a combination of factors:

- the past decade has witnessed increasing technical, organisational, procedural and legal complexity in many aspects of modern life. There are, concomitantly, greater expectations on the coroner system to provide explanations about deaths. This is a particular factor in healthcare deaths (albeit not confined to such cases), with the result that coroners often have to deal with factually complicated investigations that generate significantly greater volumes of material than would have been expected previously.
- interested persons and others have become more inclined to apply pressure on coroners to expand the scope of their investigations in the more contentious inquests. In particular, the limited availability of state funding for bereaved families except where it is required under the ECHR has fuelled persistent demands for coroners to decide that Article 2 is engaged.
- the increased professionalisation of the coroner service has subjected coroners to more stringent processes and demands.
- the introduction of the medical examiner system has meant that complex cases where reportable factors might previously have been missed are now being identified and reported to coroners for investigation.

Delay

One of the aims of the 2009 Act reforms was to reduce delays. Unfortunately, delay remains a significant challenge for the coroner service.

Although delayed cases represent a very small proportion of the total number of reported deaths and inquests handled by the coroner system each year, it is important to recognise their impact. It is well understood across the justice system that delays can affect the quality of evidence, and that being able to deal with cases within a reasonable time frame is an essential element of achieving a just outcome. Delays to death investigations mean that grieving families must wait for answers about the death of their loved ones, as well as delaying the grant of a final death certificate. As I have said on many occasions, it is my aim to ensure that the deceased and, by extension, the bereaved are kept at the heart of the process. Avoiding unnecessary delay is, in my view, the single most important element in achieving that goal. Delays can also impact on public learning, which in the worst circumstances could result in the risk of future deaths not being identified in time to prevent further fatalities.

Given the chronic under-resourcing of the service, the recent rise in reported deaths, the increase in case complexity and, in some areas, the continued existence of backlogs from the pandemic, it is not surprising that avoidable delays persist. The varying degree of delay between coroner areas reflects wide differences in local circumstances, including available resources, numbers of reported deaths and the presence of facilities such as hospitals and prisons and natural features like cliffs and coastlines. Some areas were also more seriously affected than others by the pandemic. For example, areas without a courtroom large enough to enable social distancing for jury inquests inevitably built up greater backlogs of such cases. Because the local funding structure means that cases and resources cannot be redistributed in the same way as is possible with a unified service, there remains a wide disparity in performance between areas.

Even in areas where under-resourcing is less pronounced, external complications can delay coroners' investigations. One of the most frequent sources of such delay is the difficulty in obtaining post-mortem examination reports, particularly where specialist evidence is needed. This problem was comprehensively explored and diagnosed by Professor Hutton as long ago as 2015[9], and it is something that coroners and their officers repeatedly raised with me during my tour. In some areas, specialist pathologists are so scarce that it can take more than 12 months to obtain a report.

Delays can never be completely eradicated. There will always be cases where coroners need to wait for external investigations to be completed, or other processes (for example, criminal trials) to conclude. Some investigations may reasonably be delayed whilst efforts are made to identify related deaths so that all linked inquests can proceed together (for example where there has been a systems failure at a hospital that might have contributed to deaths of patients of a particular clinician). In my opinion, however, there is currently an unacceptable level of avoidable delay within the coroner service, much of it resulting from matters outside coroners' control.

Judge-led inquests

Although the expression 'judge-led inquest' might appear to imply that coroners are not themselves judges, that is a misleading impression. 'Judge-led' in this context simply refers to an inquest conducted by a judge borrowed from another jurisdiction, in the same way that judges from the courts can sit by request in the tribunals.

Judge-led inquests are unusual, as coroners are well-qualified to conduct investigations within their own jurisdiction. Sometimes, however, a judge-led inquest is necessary when the profile or complexity of a case means a coroner area does not have the judicial resources to conduct a particular inquest, or where there is

9 A review of forensic pathology in England and Wales, March 2015. Link: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/477013/Hutton_Review_2015__2_.pdf

particularly sensitive material that cannot be disclosed to a coroner because of the law protecting national security.

Judge-led inquests require different funding from the usual work of a coroner area. They tend to be cases that are complex and necessitate lengthy hearings. A judge will usually conduct the investigation while sitting in retirement, so will be paid a fee by the local authority commensurate with the fee he or she would receive from the Ministry of Justice in other sitting-in-retirement roles. The local authority must fund a legal team chosen by the judge, including counsel to the inquest and often solicitors to the inquest, and must cover any other costs. For example, it is sometimes necessary to rent a large hearing venue that will accommodate many interested persons and members of the media. On occasion, additional infrastructure is also needed (for example, specialist IT software to manage the workload of complex cases involving numerous deaths).

Some judge-led inquests are so immense in scale that they necessarily take years to investigate and conclude (for example, the inquests relating to the deaths of patients of the convicted breast surgeon, Ian Paterson[10]). The local funding model of the coroner service means than the cost of such investigations falls on the local authority responsible for funding the coroner area that has jurisdiction over the deaths in question. The Government has no formal policy in relation to providing centralised funding for such inquests. When local authorities fund a complex judge-led inquest, it can have a detrimental effect on their ability to fund the routine work of the area.

The appointment of coroners

Local authorities are responsible for appointing coroners.

Since the 2009 Act introduced a requirement that local authorities obtain the Chief Coroner's and Lord Chancellor's consent to coroner appointments, my predecessors and I have taken an active interest in recruitment, checking that fair processes are followed and that candidates are of good character (as is required for appointment to any judicial office within England and Wales). However, the Chief Coroner plays no part in interviewing coroners or making appointment decisions. When a Chief Coroner, or a Chief Coroner's nominee, attends an interview, it is purely as an observer.

10 https://coronerspatersoninvestigation.org/

During my time in office, I have personally attended Senior Coroner interviews in a variety of different coroner areas. Although we have so far been fortunate in those selected for the roles, I have a number of concerns about the robustness of the process that is used to select senior members of the judiciary:

- There is no judge on the interview panel and usually no-one with a detailed knowledge of coronial law. The Deputy Chief Coroners do an excellent job of providing suitable questions for the panel to use, but unfortunately this does not guarantee that interviews will be properly conducted. I have witnessed interviews where the panel missed a question's significance, so formulated it incorrectly or omitted key details, preventing important points from being tested. Even where the interview questions are accurately delivered, panels may not have sufficient knowledge to score the answers appropriately.

- The local authority's interests do not always align with those of the coroner service. The local funding model means that it is important for coroners to maintain a good relationship with their local authorities. At the same time, a coroner must be willing to challenge the views of the local authority where it is necessary to do so in order to defend the needs of the service or uphold judicial independence. There is an obvious danger that those making appointments on behalf of a local authority will naturally tend to favour candidates whom they perceive to be more compliant, and I have witnessed competitions in which I believe this may have influenced the scoring of candidates. Such tractability cannot be a valid criterion for the appointment of an independent judge.

- Local authorities do not always conduct appointment processes with the same rigorous fairness that I would expect from specialist bodies like the Judicial Appointments Commission. My office and the Deputy Chief Coroners work closely with local authorities and often feel obliged to intervene on procedural grounds in relation to the sifting and selection of candidates. For example, in one case, a local authority wanted to offer a role to the second-highest-scoring candidate. Whilst my power to refuse consent (as I did on that occasion) enables me to prevent obvious instances of injustice, I consider it likely that there are occurrences of unfairness that do not become apparent from my limited involvement in the recruitment process.

The role of Senior Coroner is an important leadership position. He or she is responsible for the management and effective operation of a coroner area and for working with the local authority and police to ensure that the area receives the resourcing it needs. However, it is also a judicial post; the Senior Coroner is the most senior judge in the area and must have the legal knowledge, judgement and skills necessary to deal with the most challenging cases. I am concerned that the current recruitment process is not able to test those requirements as effectively as it should.

With regard to the recruitment of Area and Assistant coroners, I tend to have less significant involvement, as the numbers involved mean my team only has the capacity to scrutinise most competitions on the papers. During my term of office, with my team of six civil servants and two Deputy Chief Coroners, and with help from a small group of nominees who can attend interviews on my behalf, my records suggest that I have so far overseen the following numbers of competitions:

- 12 for Senior Coroners;
- 36 for Area Coroners; and
- 64 for Assistant Coroners.

That is a total of 112 recruitment competitions. The level of assurance I am able to provide in respect of coroner recruitment is therefore limited.

Coroner support

The local appointment and funding of coroners means that they receive limited specialist support. I have already mentioned the impact this has on judicial security, but its effects are far wider. Coroners do not receive the same press support, or Human Resources support as their judicial colleagues in other jurisdictions and are not included in many of the national policies that apply to their judicial colleagues. Their unique position as judges appointed, but not employed, by local authorities means that local authority policies also often do not apply to them (nor would it be appropriate for them to apply).

While coroners often have access to local press and welfare support, local authorities do not have the same understanding of constitutional principles relating to judges as His Majesty's Courts and Tribunals Service or the Judicial Office, with the result that they cannot provide equivalent specialist support. Where a dispute arises between a coroner and a local authority, the coroner may not be able to access any press or HR support at all in relation to that matter.

The future of the service

It is my responsibility to exert my influence as Chief Coroner to try to tackle the challenges that I have identified in this report and to use the existing legal framework to optimise the functioning of the service.

Current and prospective action

There is scope, in some coroner areas, for partial relief of resourcing pressures through adopting more efficient working practices. In areas where that applies, I have engaged with the Senior Coroner and relevant local authority to try to encourage improvement. I have also provided opportunities for coroners to share best practice in news items in my regular newsletters and through training events, including advice on how to operate a successful coroner area with minimal funding. However, my influence in this regard is limited, as the lack of sufficient resourcing is something that is pervasive.

During my recent tour, I challenged many local authority representatives about inadequate office and court accommodation and I continue to press individual authorities in those cases where the problems are especially severe. I am also maintaining my policy of identifying and targeting those areas where delays are particularly acute and offering them and their local authorities advice and support with regard to resourcing and supportive measures. This policy has already achieved a measure of success, with senior representatives of some authorities accepting that current resourcing is inadequate and agreeing to work towards improving it. However, the process of bringing about change is so slow and resource-intensive that it can only be selectively attempted in a few of the worst-affected areas. The time and effort required prevent me and my small team from replicating it across 80 individual coroner areas.

As I have previously mentioned, it is my policy to encourage individual funding authorities to reconsider their balance of fee-paid to salaried coroners, and we have begun to see an increase in Area Coroner appointments. I continue to support this development through a series of well-attended online workshops for aspiring Area Coroners.

I am encouraging local authorities and police forces to consider simplifying the funding model in their coroner areas by arranging for the relevant local authority to assume responsibility for providing and line-managing the coroner's officers. In practice, this can only be achieved by agreement, with all three components in the 'triangle of responsibility' negotiating a satisfactory outcome in each individual area. However, I am taking steps to provide additional information to local authorities and police forces who would like to pursue this option.

In those areas where I consider that aspects of judicial independence have been endangered, I have spoken to local authorities, police forces and coroners, explaining this vital constitutional principle and encouraging them to comply with it. I also provide general education on constitutional matters of particular relevance to coroners. For example, I asked constitutional law expert Dr John Sorabji to give a speech on judicial independence at my annual conference for local authorities and police forces in March 2023.

I have liaised with the Government about the increased number of natural deaths now being reported to coroners as a result of changes in medical practice during and following the Covid-19 pandemic. On 14 December 2023, the Government published details of its plans to implement the statutory medical examiner scheme and reform the death certification system with effect from April 2024[11], a development which I hope will resolve this problem.

To educate local authorities on security considerations, Matthew Braham, Head of Security and Safety at His Majesty's Courts and Tribunals Service, attended my March 2023 conference to give a presentation on judicial security. I have also urged senior coroners to raise any deficiencies in court security with their funding authorities and to contact my office should they require support.

I am considering how I can improve the weaknesses I have identified in the recruitment of coroners and will be exploring with local authorities the possibility of introducing judicial members into recruitment panels. The current statutory provisions, however, make it clear that it is for local authorities to appoint coroners, so my role in this regard is necessarily limited.

My team, and the panel of regional leadership coroners that I appointed, provide individual coroners with welfare support and assistance with resolving disputes. I am exploring what options might be available to increase specialist support for coroners.

I am also taking steps to raise the profile of the challenges faced by the coroner service (for example, through my public lecture on 23 November 2023, which was well attended both in-person and online[12]).

11 https://www.gov.uk/government/publications/changes-to-the-death-certification-process/an-overview-of-the-death-certification-reforms

12 https://www.judiciary.uk/speech-by-the-chief-coroner-death-and-taxes-the-past-present-and-future-of-the-coronial-service/

Defining the coroner's role in the administration of justice

One issue that I think needs to be considered at a policy level is what the Government and Parliament wants the coroner service to deliver. The current statutory framework provides for a relatively summary investigation, which focuses quite narrowly on a particular person's death. There is pressure, however, on coroners to provide a much more in-depth investigation with a wider focus. There are often proposals and requests - from Government, stakeholders and interested persons - for coroners to investigate in a way that will provide better information to society on a variety of risks, such as gambling, coercive behaviour, social media and particular types of drug. The coroner's jurisdiction is limited and if it is extended, this should be done on a principled basis with consideration being given to how all coronial cases will be affected.

In my view, it would be beneficial for the role of the coroner service to be better understood and, where necessary, more clearly defined, so that policymakers can give informed consideration to how it should be structured and resourced to make its purpose achievable.

Conclusion

The past decade has seen much welcome progress in modernising the coroner service through a combination of area mergers and national guidance, training and oversight provided by successive Chief Coroners. However, the structure of many coroner areas has not yet been modernised to reflect the deeper implications of those national reforms. My tour exposed the need for structural change to simplify and streamline the governance and management of individual coroner areas. It is not enough for funding authorities to persevere with what amounts, in effect, to a slightly modified version of the old system, relying on the provision of a few extra coroners' officers, administrative staff and fee-paid assistant coroners to supply the necessary resilience. Measures that fail to address the underlying systemic problems will afford, at best, only brief temporary respite. There is little point, for example, in appointing more coroners if there are no courtrooms for them to use or insufficient officers to support their investigations.

As a minimum, it is necessary for the coroner service to complete and consolidate its professionalisation by replicating the best working practices of other jurisdictions. There are some measures that local authorities can take now to streamline and modernise the service they provide, for example through the appointment of more salaried coroners to reduce the excessive reliance on fee-paid assistants, by improving recruitment practices, and by moving away from the outdated 'triangle of responsibility' to adopt a simpler and more efficient system of governance.

There is an urgent need for action to tackle the shortage of pathologists throughout England and Wales. This problem is not confined to death investigation and inquests, but causes delays in other court proceedings where post-mortem examination evidence is required.

As a judge, I cannot make recommendations on matters of policy. The structure and purpose of the coroner service and its funding model are matters for the Government and Parliament to consider. In my view, however, there is a limit to what can be practically achieved within the framework of the 2009 Act, so the service will continue to face significant challenges in the future.

Despite the concerns I have set out in this report, I take vicarious pride in what coroners and their staff have managed to achieve since 2013. They are hardworking, dedicated people for whom service to the public, and above all the deceased and the bereaved, is a true vocation. The work they do is important to those who seek answers about the deaths of their loved ones, as well as to society at large. They continue to provide the best service they can under very difficult circumstances, and I am confident that they will show the same dedication in the years that lie ahead.

HHJ Thomas Teague KC
Chief Coroner

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