Chief Coroner

Report of the Chief Coroner to the Lord Chancellor

Annual Report for 2024

September 2025

Chief Coroner

Her Honour Judge Alexia Durran, Chief Coroner of England and Wales

Report of the Chief Coroner to the Lord Chancellor

Annual Report for 2024

Presented to Parliament pursuant to section 36(6) of the Coroners and Justice Act 2009

September 2025

This publication is available at www.gov.uk/official-documents.

Any enquiries regarding the content of this report should be sent to us at coroners@justice.gov.uk

ISBN 978-1-5286-5965-9

E03437144 09/25

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

Contents

1. Introduction

1.1 This annual report is made pursuant to section 36(6) of the Coroners and Justice Act 2009 ('the 2009 Act') and is my first since becoming Chief Coroner. As is required it will cover the calendar year 2024 as the reporting period and must be given to the Lord Chancellor by 1 July 2025. The Lord Chancellor must then publish and lay a copy before each House of Parliament.

1.2 I am the fourth Chief Coroner, having been appointed by the Lady Chief Justice after consultation with the Lord Chancellor on 25 May 2024, pursuant to section 35 of and Schedule 8 to the 2009 Act. I am the first Chief Coroner to have held the role of Deputy Chief Coroner, having done so since 14 January 2019.

1.3 Section 36 of the 2009 Act outlines the statutory requirements of the Chief Coroner that must be covered in this report which I will address alongside the more general activities of the office.

1.4 The Chief Coroner's statutory and primary responsibilities, in addition to providing an annual report, include:

- providing support, leadership and guidance for all salaried and fee-paid coroners in England and Wales
- providing training to coroners and coroners' officers, delivered by the Judicial College
- representing the interests of coroners to the wider judiciary, government and those with a vested interest in the Coroner Service

1.5 I am supported by a Private Office and, until his retirement on 31 December 2024, I was supported by Derek Winter DL (the then Senior Coroner for Sunderland) as my Deputy Chief Coroner, who had also served as my fellow Deputy Chief Coroner since 2019. I would like to take this opportunity to express my sincere gratitude to Derek Winter for his support in office, and also for his work for the coronial jurisdiction over the last 21 years.

1.6 The recruitment of two new Deputy Chief Coroners took place in the reporting period, and on 4 December 2024 it was announced that Her Honour Judge Georgina Sharkey and Senior Coroner Joanne Kearsley would take up appointment on 1 January 2025 for a three-year term.

1.7 A significant part of the reporting period was under the leadership of my predecessor His Honour Thomas Teague KC. I would like to conclude my introduction by acknowledging his tenure as Chief Coroner and express my appreciation of his commitment to maintaining and defending the position of the bereaved at the heart of the coronial process, something I will be continuing.

2. Coroner statistics

2.1 The Ministry of Justice is responsible for publishing annual coroner statistics that cover a range of metrics, including:

- the number of deaths reported to a coroner area
- inquests and post-mortems held
- inquest conclusions recorded
- finds reported to coroners under treasure legislation

2.2 The latest figures were published on 8 May 2025.[1]

2.3 In 2024 there was a decrease in deaths reported to a coroner. 174,900 deaths were reported, a 10% reduction from the previous reporting year and the lowest level reported since 1995. While the number of deaths may have decreased, it can be reasoned that the complexity of cases being reported is growing, given that the number of deaths reported that required a post-mortem increased.[2]

1 Coroners statistics 2024 - GOV.UK, available at: https://www.gov.uk/government/statistics/coroners-statistics-2024

2 Coroners statistics 2024: England and Wales - GOV.UK, available at: https://www.gov.uk/government/statistics/coroners-statistics-2024/coroners-statistics-2024-england-and-wales

3. Cases over 12 months

3.1 The Chief Coroner has a statutory duty to provide in their report a summary of cases lasting more than a year, 'within a year'. This means within the period of 12 months beginning with the day on which the coroner was made aware that the person's body was within the coroner's area. Alongside the number of cases, each coroner area provides the reasons for the length of each investigation and the measures taken to keep them from being unnecessarily lengthy.

3.2 Successive Chief Coroners have outlined that there are often good and clear reasons why a coroner area may have cases outstanding over a 12-month period. Since taking up appointment I have visited a number of coroner areas where the figures in 2023 had remained high or had risen from previous years. On these visits it was clear that the factors impacting the ability for cases to be dealt with within a year were largely outside of the coroner's control.

3.3 It continues to remain the case that a significant proportion of cases are reliant on external investigations over which the coroner has no control, such as ongoing criminal investigations and prosecutions, Health and Safety Executive (HSE) or Prisons and Probation Ombudsman (PPO) inquiries, Independent Office of Police Complaints (IOPC) inquiries or investigations by one of the specialist accident investigation bodies. The coroners' investigations are rightly paused (suspended) pending the outcome of such external enquiries or investigations. This suspension is necessary under the 2009 Act in occurrences of criminal proceedings. The external investigations have always been cited as 'very lengthy'. Through my discussions I think it is clear the coroner services are becoming increasingly dependent on an external department or agency's ability to progress their own workload.

3.4 The under-funding in many local authority areas who provide coroner services continues to provide a challenge and impacts on the ability of senior coroners to hear cases.

3.5 Annexed to this report is a table showing the number of cases that have taken over 12 months as of 31 December 2024, the statutory reporting period I am required to summarise. For the reporting period 2025, I intend to ask all jurisdictions to provide, as a discrete figure, the estimated number of cases that they expect to take over 12 months to conclude. Due to the geographical and demographical location of facilities such as prisons, teaching hospitals and other specialist facilities, the expectation of the number of cases that will take over 12 months to conclude will be different for each area. This will inform my engagement with these areas to ensure that it is targeted and specific to the circumstances and challenges of that individual area. Next year, I plan to approach this from a different angle to ensure engagement with those who may have a higher number of cases, excluding the influence of prisons and hospitals, or local nuances and challenges.

4. Reports to prevent future deaths

4.1 Paragraph 7 of Schedule 5 to the 2009 Act provides coroners with the duty to make a report to a "person, organisation, local authority or government department or agency", 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.

4.2 As expressed by my predecessor in his written evidence to the Justice Select Committee and Chief Coroner reports, this duty is "ancillary" to the inquest procedure.[3] A coroner also has no legal power or authority to recommend specific remedial measures; a coroner can only raise concerns with the recipient of the report if they believe action should be taken to prevent future deaths.

4.3 Unfortunately, this is not well understood and is regularly misreported by the press and others who have a vested interest in the Coroner Service. Media reports often erroneously refer to 'recommendations' by coroners, thereby contributing to the raising of unrealistic expectations in the minds of members of the public.

4.4 In 2024, 713 Prevention of Future Deaths (PFD) reports were issued, compared to 569 in 2023. Regulations 28 and 29, Coroners (Investigations) Regulations 2013 provide the procedures that apply to reports and responses, namely that the coroner must send a copy of a report and subsequent responses to the Chief Coroner. Since 2013, the Chief Coroner has published PFD reports online, together with a publication policy and a link to the reports themselves. These are available on the Courts and Tribunals Judiciary website.[4]

4.5 There is a statutory obligation on those who receive PFD reports 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.

3 Re Kelly (deceased) (1996) 161 JP 417.

4 Courts and Tribunals Judiciary, 'Reports to Prevent Future Deaths', available at: www.judiciary.uk/courts-and-tribunals/coroners-courts/reports-to-prevent-future-deaths

4.6 On 31 December 2024 I published a list of organisations and departments that had not provided a response to the relevant coroner's report issued in 2024 within the statutory time limit. The list captures those responses that were due by 13 December 2024. Before the publication of the list all coroner areas were contacted to ensure that either responses had not been received by the coroner, or an extension had been granted. Since the list was published, I have received responses from organisations or institutions that were overdue, but as of the date of publication there are still 16 reports issued in 2024 that have at least one or more responses outstanding (without an extension).

4.7 It is a known factor that occasionally coroners or the Chief Coroner's Office come under pressure from the public to monitor the outcome of 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.

4.8 I have also circulated to coroners an updated list of contact details for governmental departments, should they be named on a report; this will be updated as and when details change. The Ministry of Justice, as the department responsible for coroner policy, has supported my office with this work and I hope will continue to do so.

5. Deaths of service personnel: ‘service deaths’

5.1 In the reporting period, I received reports of three deaths of service personnel within the meaning of section 17 of the 2009 Act. I am aware that my predecessor was satisfied with the level of training, information and support available to coroners to appropriately manage investigations into the deaths of service personnel.

5.2 Having served as Chief Coroner for six months during the reporting period of this report, I will ensure that this focus is maintained in my 2025 report. By the time of publication, I will have refreshed the Chief Coroner’s cadre with responsibility for military deaths and initiated a review of the relevant guidance. This review will ensure that the scope covers statutory responsibilities and appropriately reflects public perception of the armed forces and the honour of having served one’s country.

6. The Coroner Service in 2024

Reflections on Parliamentary scrutiny of the Coroner Service: Justice Committee Inquiry 2024

6.1 On 30 January 2024, the House of Commons Justice Committee convened a session to scrutinise the Coroner Service in England and Wales as part of a follow-up inquiry to the 2021 report. This session represented a timely and welcome opportunity to assess progress made since the previous inquiry and to identify persistent and emerging challenges facing the service.

6.2 Oral evidence was provided by the then Chief Coroner HHJ Thomas Teague KC and both myself and Derek Winter as Deputy Chief Coroners. The evidence presented during this session painted a frank and comprehensive picture of the state of the Coroner Service across the 80 coroner areas (as they then were).

6.3 HHJ Thomas Teague KC reflected upon his tour to all coroner areas, highlighting the significant and deeply concerning disparities in both the quality of service and allocation of resources. He raised concerns about staffing shortages and high caseloads for coroners' officers: conditions that, if left unaddressed, risk compromising the fair and timely administration of justice and the broader rule of law.

6.4 Deputy Chief Coroner Derek Winter, in his dual capacity as senior coroner for Sunderland, reinforced these concerns, particularly the systemic inequities in funding and staffing. He stressed that such inconsistencies hamper the delivery of a uniformly fair service and contribute to delays in inquests, which in turn intensify the distress of bereaved families. His evidence highlighted the urgent need for a more consistent and equitable national framework.

6.5 In my own contribution, I emphasised the necessity of standardisation across coroner practices, advocating for unified training, clear guidance and consistent application of procedures. I expressed the importance of transparency across the Coroner Service, which is essential for maintaining public confidence. When asked about media coverage of inquests, I outlined how the principles of open justice play a vital function in informing the public and highlighting systematic issues that may require attention. There is a balance between the public's right to know and the need to protect the privacy of the bereaved.

6.6 The session also explored the responsiveness of the Coroner Service to the needs of bereaved families, especially regarding delays and the handling of faith-based burial requirements. HHJ Thomas Teague KC highlighted the critical importance of both timeliness and cultural sensitivity in maintaining public confidence in the Coroner Service.

6.7 Following the session, HHJ Thomas Teague KC submitted a letter to the Justice Committee, dated 15 March 2024, reiterating the pressing need for increased funding and structural reforms. While acknowledging some progress since the 2021 inquiry, the letter stressed that substantial challenges remain which warrant immediate policy attention.

6.8 Regrettably, the Justice Committee's inquiry was discontinued following the dissolution of Parliament ahead of the July 2024 general election. As a result, no final report or formal recommendations were published. Nonetheless, the then Chair of the Committee, Sir Robert Neill KC MP, issued a letter to the previous Minister for Courts and Legal Services summarising the committee's preliminary findings and expressing serious concern about the continuing deficiencies within the Coroner Service.

6.9 As Chief Coroner, I remain committed to working collaboratively with government departments, local authorities and fellow coroners to address these longstanding issues. The insights gained from the 2024 inquiry, though cut short, remain valuable and will continue to inform the strategic priorities of this office in the months and years ahead.

Evidence to the Work and Pensions Select Committee

6.10 On 11 March 2024 the Work and Pensions Select Committee sought evidence from the Chief Coroner regarding their inquiry into safeguarding vulnerable claimants, particularly in the context of deaths involving individuals who were receiving benefits.[5] The committee asked for the following information which was provided by a written statement by HHJ Thomas Teague KC:

- what triggers the undertaking of an inquest
- who can request that an inquest be carried out
- the stages and processes involved in conducting an inquest
- the conditions under which a Prevention of Future Deaths (PFD) report is issued

Evidence to the UK Covid-19 Inquiry

6.11 HHJ Thomas Teague KC provided a witness statement to the UK Covid-19 Inquiry dated 23 May 2024 as part of their Module 3 enquiries. This evidence was published on the Inquiry's website on 26 November 2024.[6]

6.12 Judge Teague detailed the challenges faced by coroners amid the pandemic, including increased caseloads and the need to adapt procedures to ensure safety and compliance with public health guidance.

6.13 The statement highlighted how coroners' dedication and professionalism during the pandemic and their ability to adapt to unprecedented change, including the swift implementation of remote hearings, aided in maintaining the continuity of inquest proceedings, and it emphasised the importance of supporting bereaved families during this period.

5 'Written evidence to the Work and Pensions Select Committee inquiry into safeguarding vulnerable claimants', available at: https://committees.parliament.uk/publications/44444/documents/220845/default/

6 UK Covid-19 Inquiry, 'INQ000479888 – Witness Statement provided by HHJ Thomas Teague KC, Chief Coroner of England and Wales, dated 23/05/2024', available at: https://covid19.public-inquiry.uk/documents/inq000479888-witness-statement-provided-by-hhj-thomas-teague-kc-on-behalf-of-hm-courts-and-tribunals-service-dated-23-05-2024/

6.14 Judge Teague outlined the collaborative efforts between the Coroner Service and other agencies to manage the surge in deaths and subsequent impact on mortuary capacity. He explained that significant lessons were learnt during this time that should be reflected on, to help shape future responses to public health emergencies.

Statutory medical examiners scheme

6.15 On 9 September 2024 the statutory medical examiners scheme and the related rationalisation and reform of the death certification system were introduced, having remained largely unchanged for over 50 years.

6.16 The changes introduced a robust system in England and Wales whereby all deaths will be subject to mandatory scrutiny by a medical examiner where a death is natural, if not subject to an investigation by a coroner where section 1 of the 2009 Act is engaged.

6.17 The underpinning primary legislation is:

- section 21 of the 2009 Act, which was commenced in June 2018
- sections 19 and 20 of the 2009 Act, which were commenced on 1 October 2023
- section 169 of the Health and Care Act 2022, which was commenced on 1 October 2023

6.18 In response to the changes in legislation I issued Chief Coroner's 'Guidance Note No 47: The Death Certification Reforms' to support coroners' understanding of the reforms and to encourage consistency with its implementation.[7]

6.19 Official Ministry of Justice statistics (referred to above) show a slight decline in the number of cases reported to a coroner. On the anecdotal evidence I have heard I am optimistic that this may be associated with the new statutory scheme. However, as the statistics reporting period is the calendar year January to December 2024, I hope the 2025 statistics will provide us with more evidence on the impact.

7 Courts and Tribunals Judiciary, 'Guidance No 47: The Death Certification Reforms', available at: https://www.judiciary.uk/guidance-and-resources/guidance-no-47-the-death-certification-reforms/

Fuller Inquiry

6.20 In October 2024 I and Deputy Chief Coroner Derek Winter attended a meeting with the chair of the independent inquiry into the issues raised by the David Fuller case. This meeting followed previous correspondence between my predecessor and the inquiry. At the meeting it was emphasised that coroners in England and Wales rely on the provision of external mortuary facilities funded by hospitals and local authorities and have no responsibility in the oversight mechanisms. We expressed the critical importance of mortuaries to be properly safeguarded to ensure the security and dignity of the deceased.

Consistency of standards between coroner areas

6.21 The Chief Coroner advocates for national standards for all coroners and their services, especially in the absence of a national service to administer the Coroner Service.

6.22 Chief Coroner guidance is published on the Courts and Tribunals Judiciary website. In my 6 months in office, I have started work on reviewing and updating all previously issued Chief Coroner guidance.

6.23 During my tenure as a Deputy Chief Coroner, I was asked by the then Chief Coroner, His Honour Judge Mark Lucraft KC, to lead a team of practitioner editors to produce a 'Bench book' covering all aspects of court inquest work.

6.24 During the reporting year the final stages of this work were undertaken and, after all the hard work of those involved, a guide for coroners on the Bench was published in January 2025.[8]

6.25 This Bench guidance provides a resource for coroners and the public to help them locate key principles, practical information and precedents when dealing with inquests.

6.26 To help strengthen support and regional cooperation across England and Wales I am also re-appointing regional leadership coroners.

8 Courts and Tribunals Judiciary, 'Chief Coroner's Guidance for Coroners on the Bench', available at: https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-for-coroners-on-the-bench/

6.27 A small number of senior coroners was previously appointed to help provide welfare support (as outlined in the combined annual reports for 2021 and 2022 of HHJ Thomas Teague KC, who was then the Chief Coroner).[9]

6.28 I am reconstituting the geography and purpose of these appointments to ensure better consistency and parity with the wider judiciary. The regional leadership coroners will support me, and each other, with not only general welfare matters, but also those topics that arise regarding ways of working with the aim to increase better regional cooperation, a matter raised by the Justice Committee in its findings letter on the follow-up inquiry into the Coroner's Service for England and Wales.

6.29 Following an open and fair recruitment process I am pleased to be able to confirm I have appointed the following coroners who took up post on 1 January 2025:

- regional lead for the North East: Lorraine Harris, Area Coroner for East Riding of Yorkshire and Kingston Upon Hull
- regional lead for the North West: Kate Bisset, Area Coroner for Lancashire and Blackburn with Darwen
- regional lead for London: Graeme Irvine, Senior Coroner for London East
- regional lead for the Midlands: Louise Hunt, Senior Coroner for Birmingham and Solihull
- regional lead for the South East: Heidi Connor, Senior Coroner for Berkshire
- regional lead for the South West: Andrew Cox, Senior Coroner for Cornwall and the Isles of Scilly
- regional lead for Wales: John Gittins, Senior Coroner for North Wales (East and Central)

6.30 I have already tasked my Private Office with starting work to rejuvenate a number of Chief Coroner cadres, including the Service Death and Mass Incidents cadre (formerly named Disaster Victim Identification). This process will include the appointment of cadre members through a fair and open recruitment process, and establishing updated guidance working with relevant departments and organisations to ensure a level of national service is provided.

9 GOV.UK, 'Chief Coroner's combined annual reports 2021 to 2022', available at: https://www.gov.uk/government/publications/chief-coroners-combined-annual-reports-2021-to-2022

6.31 During my tenure as Chief Coroner, I hope to review and increase consistency as to engagement across coroner areas with the support and engagement of senior coroners and local authorities. This includes standardised portal referrals for those areas where police forces and NHS professionals cover a number of coroner areas.

6.32 It has always been the position of the Chief Coroner that a coroner area should provide an out-of-hours service, including weekends and bank holidays. The nature of the provision is a matter for detailed discussion and agreement between senior coroners and the relevant local authority. I hope to support the creation of a rota system in all coroner areas. I also want to increase awareness of what an out-of-hours service should provide, and to try to improve a consistent approach nationally. It is widely understood that a local coroner will be available for emergencies such as homicide cases, mass fatalities and decisions on organ and tissue donation. In some areas, an out-of-hours service may be required to do more, particularly in order to assist families who seek early burial for their loved ones or 'Out of England and Wales' orders (to move a body out of England and Wales, you need to notify the coroner and obtain an 'Out of England and Wales' certificate).

6.33 I have also been able to ensure that coroners have access to a small number of basic administrative functions currently afforded to the wider judiciary. These include an electronic library and use of the HR database to properly record details, including diversity data.

6.34 As well as advocating for national standards across coroner areas, I am also hoping to support the increased awareness of and support to coroners as part of the wider judiciary.

6.35 I have created two new roles, lead coroner for wellbeing and lead coroner for diversity and inclusion. I am pleased to appoint Nicholas Walker, Area Coroner for Hampshire, Portsmouth and Southampton, as wellbeing lead from 1 January 2025 and Nadia Persaud, Area Coroner for East London, as diversity and inclusion lead from 19 February 2025. Both appointments have been made for a three-year term.

6.36 With gratitude to the Lady Chief Justice and Senior President of Tribunals, 2024 saw coroners included in the fifth Judicial Attitude Survey. This was the first time coroners have been included in the survey that covers all salaried and fee-paid judge and non-legal members in England and Wales. The results were published in February 2025 and the responses of all judicial office holders showed that coroners reported feeling the highest stress levels of any area of judicial office. I will be working with others to consider the results, especially concerns regarding resources, stress and workloads.

Security

6.37 Judicial security concerns are at an all-time high, with several incidents having taken place, including at coroners' courts. This subject has seen a lot of press coverage. I am committed to working with coroners to engage appropriately with their relevant local authority as to how they are exercising their responsibility to provide adequate and safe accommodation. I will continue to advocate that this provision includes ensuring necessary safeguards for coroners as well as those who are attending coroner's courts.

Appointments

6.38 Schedule 3 to the 2009 Act provides the statutory basis for the Chief Coroner and Lord Chancellor to consent to the appointment of a person as a senior, area or assistant coroner. Having been responsible for supporting the Chief Coroner with this process during my time as Deputy Chief Coroner, I wanted to improve the consistency of recruitment and aim to professionalise the appointments process for assistant coroners.

6.39 I announced that from 2025 a yearly recruitment process will take effect to ensure that there are transparent timeframes for advertising and to ensure appropriate attendance at the Coroner Induction Course provided by the Judicial College.

6.40 This new process aligns how fee-paid coroners are recruited with the wider courts and tribunals judiciary.

Mergers: reduction in the number of coroner areas

6.41 Paragraph 2 of Schedule 2 to the 2009 Act allows the Lord Chancellor, by order, to alter coroner areas (including by combining two or more areas).

6.42 In 2024 the following mergers took place on 1 April bringing the total coroner areas to 77:[10]

- North Lincolnshire and Grimsby, merged with Lincolnshire (to be known as Greater Lincolnshire)

10 https://statics.teams.cdn.office.net/evergreen-assets/safelinks/1/atp-safelinks.html

- Exeter and Greater Devon, merged with Plymouth, Torbay and South Devon (to be known as County of Devon, Plymouth and Torbay)
- North Northumberland, merged with South Northumberland (to be known as Northumberland)

6.43 When a senior coroner retires, the relevant authorities consider whether a merger with a neighbouring area presents the opportunity to deliver a more consistent and standardised service for bereaved families. Merging areas can result in more coroner areas being of the same size and population.

6.44 The long-term aim of the Ministry of Justice has been to reduce the number of coroner areas to a total of 75. This was achieved on 1 July 2025 when the merger to create Kent and Medway took the number of coroner areas to 74. This provides an opportunity to reflect and review the overarching objective, to ensure that, moving forward, coroner areas are delivering an effective service for the bereaved.

Training

6.45 The judicial training year covers an April to March period.

6.46 In April 2024 the Judicial College appointed a new cadre of course directors, and in October a new cadre of syndicate tutors. I look forward to working with the new training team over the next few years and remain grateful to all those who previously supported this work.

6.47 Coroners' continuation training in 2024 to 2025 incorporated a session on inclusion. This focused on understanding, identifying and responding to exclusionary behaviour and promoting a positive, respectful and inclusive culture. This has also been provided to the wider judiciary.

6.48 I am working closely with course directors to ensure that the training delivered to coroners is representative of the work that they are undertaking in court, and for the 2025 to 2026 training year the continuation training will be focusing on the scope of an inquest.

6.49 As already outlined as part of my approach to professionalise the jurisdiction there will now be one annual training event for new assistant coroners.

6.50 In March 2024 the Chief Coroner's senior and area conference was held, the last conference organised by my predecessor.

Judge-led inquests

6.51 The Chief Coroner has a power under Schedule 10 to the 2009 Act to request the Lady Chief Justice to nominate a judge to conduct an investigation into a person's death. The Schedule 10 process will be suitable for cases in which national security sensitive material is in scope and the coroner has not been able to discharge their statutory functions because statute prevents disclosure of some security sensitive material to the coroner themself. The Lady Chief Justice must consult the Lord Chancellor before making a nomination.

6.52 During the calendar year 2024 one such request was made by HHJ Thomas Teague KC relating to the inquest into the death of Sean Fitzgerald where Sir John Saunders was nominated to conduct the investigation.

6.53 It continues to be a concern as to how judge-led inquests are funded. The scale involved means cases can often take years to investigate and conclude. The government has no formal policy in relation to providing centralised funding for such inquests. Due to the funding burden of responsibility falling on the local authority that has jurisdiction, it can have a detrimental effect on their ability to fund the routine work of the area.

Treasure

6.54 As well as conducting death investigations, coroners are responsible for conducting inquests into treasure finds. The purpose of a treasure inquest is to establish whether a find constitutes 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. In 2024 there was a 12% increase in finds reported to a coroner and there remain geographical and historical variations across England and Wales.[11]

6.55 Working with the Department for Culture, Media and Sport, the British Museum and the Coroners' Society of England and Wales, and with support from senior coroners, I will be reviewing the practical guide for coroners as currently published. It provides advice and also a set of standard letters and forms for use in treasure cases in England and Wales.

11 GOV.UK, 'Coroners statistics 2024: England and Wales', available at: https://www.gov.uk/government/statistics/coroners-statistics-2024/coroners-statistics-2024-england-and-wales#deaths-reported-to-coroners

6.56 I want to ensure that we will reflect any known impacts following the implementation of the Treasure (Designation) (Amendment) Order 2023. To my knowledge there was one case during the reporting year where a find fell within the new class of treasure, but we will need to ensure that the guide reflects working processes.

External engagement

6.57 Since taking up appointment I have continued to hold meetings with as many key representatives across the coronial jurisdiction as possible to develop relationships and maintain those already developed by my predecessors. I continue to have a close collaborative relationship with the Coroners' Society of England and Wales.

6.58 I have met with the Lady Chief Justice and other senior judges, and the Justice Minister responsible for coroner and wider death management policy. I also participate in the Ministerial Board on Deaths in Custody and have met with the Independent Advisory Panel on Deaths in Custody.

6.59 I have maintained the important engagement with the Chief Rabbi of the United Hebrew Congregations of the Commonwealth, representatives from the Muslim National Burial Council, the National Medical Examiner and the President of the Royal College of Pathologists. I have also met the Chief Inspector of Prisons and the co-chairs of the government's rapid review which is considering the threshold for determining short-form findings of unlawful killing in inquests.

6.60 I have also had the opportunity to meet with a number of groups including INQUEST and representatives of families affected by the use of infected blood and infected blood products following the Infected Blood Inquiry's report.

7. Conclusion

7.1 As I look ahead to 2025 and my wider tenure as Chief Coroner, two areas will be central to my role.

7.2 Firstly, I remain committed to scrutinising the number of cases that take over 12 months to conclude. While many of these delays are due to external investigations beyond a coroner's control, I will work closely with jurisdictions to better understand and anticipate where delays are likely and to understand where support can be provided. By asking each area to estimate the number of cases they anticipate being categorised as long-duration cases, I aim to ensure that our engagement is both proactive and tailored to local challenges.

7.3 Secondly, I am deeply mindful of the findings from the Judicial Attitude Survey, which revealed that coroners report the highest levels of stress across the judiciary. This is a serious concern. In response, I will continue to prioritise wellbeing and professional support for coroners. The appointment of a wellbeing lead and a diversity and inclusion lead marks the beginning of a broader effort to ensure that coroners feel supported, valued and equipped to carry out their vital work.

7.4 I remain grateful for the dedication of coroners and coroner services across England and Wales, and I look forward to working collaboratively to ensure that the service continues to evolve, improve and meet the needs of the public with compassion, fairness and integrity.

Her Honour Judge Alexia Durran
Chief Coroner

Annex

Cases over 12 months 2024, reporting period 1 January 2024 to 31 December 2024[12]

Coroner area	Number of cases over 12 months
Avon	72
Bedfordshire and Luton	24
Berkshire	58
Birmingham and Solihull	59
Black Country	56
Blackpool and Fylde	32
Buckinghamshire	37
Cambridgeshire and Peterborough	258
Carmarthenshire and Pembrokeshire	54
Central and South East Kent	18
Ceredigion	31
Cheshire	29
City of London	10
Cornwall and Isles of Scilly	37
Coventry	9
Cumbria	37
Derby and Derbyshire	43
Devon, Plymouth and Torbay	555
Dorset	38
Durham and Darlington	28
East London	69
East Riding and Hull	56

12 These figures are collected by the Chief Coroner's Office directly from each coroner area, via a report produced by Civica or WPC. Section 16 (3) of the Coroners and Justice Act 2009 provides that the Chief Coroner must keep a register of all cases over 12 months.

Coroner area	Number of cases over 12 months
Essex and Thurrock	161
Gateshead and South Tyneside	26
Gloucestershire	50
Greater Lincolnshire	39
Grimsby	283
Gwent	32
Hampshire, Portsmouth and Southampton	318
Herefordshire	10
Hertfordshire	87
Inner North London	31
Inner South London	264
Inner West London	41
Isle of Wight	422
Lancashire with Blackburn and Darwen	54
Leicester and South Leicestershire	51
Liverpool and Wirral	42
Manchester City	46
Manchester North	54
Manchester South	20
Manchester West	65
Mid Kent and Medway	26
Milton Keynes	11
Newcastle and North Tyneside	30
Norfolk	63
North East Kent	20
North London	82
North Wales (East and Central)	43
North West Wales	12
North Yorkshire and York (C)	112
Northamptonshire	98
Northumberland	24
Nottinghamshire and Nottingham	38
Oxfordshire	28
Rutland and North Leicestershire	20

Coroner area	Number of cases over 12 months
Sefton Knowsley and St Helens	31
Shropshire Telford and Wrekin	16
Somerset	38
South London	188
South Wales Central	219
South Yorkshire (East)	31
South Yorkshire (West)	36
Staffordshire	122
Suffolk	53
Sunderland	15
Surrey	98
Swansea	78
Teesside and Hartlepool	117
Warwickshire	30
West London	84
West Sussex, Brighton and Hove	66
West Yorkshire (Eastern)	60
West Yorkshire (Western)	136
Wiltshire and Swindon	93
Worcestershire	12

E03437144

978-1-5286-5965-9