



CHIEF CORONER

# Report of the Chief Coroner to the Lord Chancellor

First Annual Report:  
2013-2014



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## Introduction

1. This is the Chief Coroner's first annual report to the Lord Chancellor. Section 36 of the Coroners and Justice Act 2009 (the 2009 Act) provides that the Chief Coroner must give the Lord Chancellor a report for each calendar year. Section 36 came into force on 25 July 2013. This is therefore the first such report.
2. Section 36(5) requires the report to be given to the Lord Chancellor by 1 July. This report will therefore cover a period slightly less than 12 months, from 25 July 2013 to 30 June 2014. For the future, from 2015, the period covered will be precisely 12 months.
3. Section 36 contains a number of statutory requirements for the contents of the report. Each will be addressed below.

## Contents of report

4. As required by section 36(2)(a) of the 2009 Act the Chief Coroner wishes to bring a number of matters to the attention of the Lord Chancellor. These include the implementation of the statutory reforms which came into force in July 2013, the additional package of reforms which the Chief Coroner has devised and developed, and actions taken by the Chief Coroner under his powers and duties in the 2009 Act.

## Appointment of Chief Coroner

5. The post of Chief Coroner of England and Wales is a new post. It was created by section 35 and Schedule 8 to the 2009 Act which came into force on 1 February 2010.

6. The first post holder, HH Judge Peter Thornton QC, a senior circuit judge, was appointed by the Lord Chief Justice after consultation with the Lord Chancellor on 6 May 2010 but was asked by the new coalition Government not to take up his post at that time. He was however requested in May 2012 to take up his post with effect from September 2012 for a three year term.

7. The Chief Coroner's jurisdiction is England and Wales.

## The Chief Coroner's role

8. Judge Thornton was appointed as the first Chief Coroner in order to lead the coroner service of England and Wales, to set new national standards in the coroner system, to develop a national framework in which coroners will operate, and to implement and develop statutory and other coroner reforms. At the time of his appointment the then Lord Chancellor, Kenneth Clarke MP QC, 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.'*

9. The Chief Coroner has since his appointment been working to achieve those goals. As he said on his appointment:

*'I will aim to provide quality and uniformity in the coroner system, with a national consistency of approach and standards between coroner areas. Openness, inclusiveness, thoroughness and fairness must be at the heart of the process if it is to be effective and serve the needs of the public.'*

10. To achieve those aims the Chief Coroner has devised and developed a package of reforms (see below). They are designed to create across England and Wales a more modern, open, consistent and just coroner service. In all of these reforms, statutory and otherwise, the Chief Coroner maintains as central to his thinking the essential concept that bereaved families must at all times be at the heart of the coroner process.

## The coroner service

11. The coroner service of England and Wales remains essentially a local service. There have in the past been calls, as in the Luce Review, Death Certification and Investigation in England, Wales and Northern Ireland, The Report of a Fundamental Review 2003 (Cm 5831), for a national service, with coroners to be appointed and the service funded and run centrally, like other judicial services. But that has not happened. Coroners continue to be appointed locally, paid locally, the service is funded locally, and coroners' officers and support staff are employed locally.
12. Under the law coroners have two main functions. First, in relation to each death reported to them they explain the unexplained. If the death is not from natural causes, if it is unnatural, violent, in custody or of unknown cause, coroners will investigate so that answers are found, both for bereaved families in the first place and also for the wider public.
13. Some 220,000 deaths are reported to coroners each year. Just under half of those cases, some 95,000, will involve a post-mortem examination. The Chief Coroner believes that that figure is too high. He is encouraging coroners to use where appropriate less invasive post-mortem imaging (which is particularly welcome to faith groups) and to make sufficient well-focused early inquiries to see whether a finding that the death was from natural causes can be made without the need for any post-mortem examination.
14. Secondly, where appropriate, coroners report to prevent future deaths. This is an important part of their work and one which has been repeatedly emphasised by the Chief Coroner in training and discussion (see below).
15. It is important to say that there is much in the coroner service that is good. There are many coroners who investigate thoroughly, act with compassion and understanding, and at the same time provide a timely and efficient process. They are hard-working judicial office holders, proud of their independence, acting for the public good.
16. But the calls for reforms have stemmed from the less good practices of some coroners and the inconsistency in practice across England and Wales which a local system can sometimes produce as well as problems associated with insufficient funds in some areas.

## The statutory reforms

17. The relevant provisions of the 2009 Act came into force on 25 July 2013 along with the Coroners (Investigations) Regulations 2013 (the Investigations Regulations), the Coroners (Inquests) Rules 2013 (the Inquests Rules) and the Coroners Allowances, Fees and Expenses Regulations 2013. What follows in this section is not intended to be an exhaustive review of the statutory provisions, but a brief outline of some of the key points which the Chief Coroner believes are having particularly good effect.
18. The 2009 Act makes provision for the Lord Chancellor to combine coroner areas after consultation. There is also provision for the appointment of the Chief Coroner and the appointment of all coroners (senior, area and assistant coroners) by local authorities. The Chief Coroner also has certain statutory powers and duties (see below).
19. Under the previous statute, the Coroners Act 1988, emphasis was laid on the inquest, with inquests held in many cases. By contrast the 2009 Act provides for greater emphasis on the investigation, and even preliminary inquiries before an investigation, and less on the inquest. This requires coroners to focus on the earlier part of the process. If early investigation by the coroner, or even preliminary inquiries before that stage is reached, with or without a post-mortem examination, leads to the conclusion that the death was from natural causes the case can be recorded with a natural causes conclusion without the need for an inquest. This means that there will be fewer inquests with a natural causes outcome. Families will welcome that. Already there is an indication from the Ministry of Justice annual statistics that there may be fewer inquests across England and Wales. Ironically, this may increase the average time from death to inquest, because there are fewer short inquests. The Ministry of Justice statistics for 2013, however, cover only half a year since the statutory reforms commenced. Next year's statistics may provide a clearer picture.
20. The new provisions also provide for earlier release of the body, where appropriate, for burial or cremation. It is no longer necessary to open an inquest before the body may be released.
21. There is no longer a requirement for an inquest into a death in custody to be held with a jury where the death was from natural causes. This may reduce the number of inquests with juries, at present about 450, although the likely requirement to hold an inquest with a jury in cases where a person dies in local authority accommodation under deprivation of liberty safeguarding orders (under Schedule A1, Mental Capacity Act 2005) may in due course redress the balance.
22. The Chief Coroner worked on some of the detail of the 2013 Rules and Regulations with the Ministry of Justice. The Chief Coroner believes that they give the coroner service a more modern look. For example, there are more hearings in public now, all hearings are recorded, dates for inquests are set, most inquests will be held within six months, and if they are over 12 months they must be reported to the Chief Coroner. There is more disclosure to families and earlier disclosure, more involvement with families through notifications and explanation.

23. The Rules also provide for new possible verdicts, now known as conclusions. They include the new short-form conclusions of 'alcohol/drug related' and 'road traffic collision'. The outcome of the inquest, formerly known as the inquisition, is now known as the record of the inquest.

## The Chief Coroner's package of reforms

24. There are six main strands in the Chief Coroner's early package of reforms. Each is designed to provide a better, more effective and prompt process for bereaved families and to achieve greater consistency of standards in coroner areas across England and Wales.

### (1) The role of Chief Coroner

25. In the absence of a national coroner service the Chief Coroner remains the central national focus for reform. It is his role to establish national standards in what remains an essentially local service.

26. The Chief Coroner has a statutory duty to make an assessment in this report of the consistency of standards between coroner areas (section 36(3)). It is too early in the reform process to give a clear assessment, although the Chief Coroner believes that good progress is being made. He will return to this subject in next year's report.

27. The Chief Coroner is working towards greater consistency in a number of ways.

### Training

28. Training is an essential part of coroner reform. The Chief Coroner has devised, developed and implemented training for all coroners which for the first time is compulsory. Training is conducted by the Chief Coroner either under the auspices of the Judicial College (which trains all judicial office holders) or by the Chief Coroner and his office. The Chief Coroner is involved in all aspects of training and attends all courses.

29. There has been regional training for all coroners on the 2009 Act and the new Rules and Regulations, all of which came into force in July last year. And with the consent of the Judicial College others with an interest in the coroner service have been invited to share the training: local authority representatives, police, prosecutors, Police and Crime Commissioners, pathologists, the Independent Police Complaints Commission, the Health and Safety Executive and the Marine Accident Investigation Branch. To supplement the training the Chief Coroner with the Ministry of Justice produced The Chief Coroner's Guide to the Coroners and Justice Act 2009 (which is available on the judiciary website).

30. There is a new two-day residential continuation training course for all existing coroners. The course which will be held periodically from 2014 to 2015 focuses on judgecraft and aspects of good practice in court including decisions concerning Article 2 of the European Convention on Human Rights, reasoned rulings, structured summings up and avoiding the appearance of bias.

31. New coroners are particularly important. The Chief Coroner has written an information pack for lawyers (and judges) who would like to become coroners, How to Become a Coroner, and there is now a three-day induction training course for newly appointed coroners, a practical course which involves a mix of law, medicine and good

practice. This course will have been held twice by the end of 2014.

32. The Chief Coroner (with his office's resources) has also devised and delivered a number of separate courses, including a one-day course for all senior coroners (who have never been all together before) on Leadership, Management and Organisation, and special training for his newly created dedicated cadre of coroners who investigate deaths of service personnel. He also held a one-day event for bereaved organisations, which was very positive and constructive, listening to and discussing the concerns of those who have suffered bereavement. In December this year he will hold a one-day conference for local authorities, discussing their important role in the local coroner process.

33. Further courses are being planned. With the Judicial College and the course directors appointed with the Judicial College, the Chief Coroner is in the process of designing the next continuation course for 2015-2016. There is also a working group for training coroners' officers. This is a major new project. 400-500 coroners' officers will be trained in a number of regionally based two-day residential courses in 2015. The scope and content of the course will be informed by the College's training needs analysis for coroners' officers, the Chief Coroner's evaluation of the functions and duties of coroners' officers, advice from experienced coroners' officers and the feedback from the Chief Coroner's bereaved organisations conference.

34. In February 2015 senior coroners will meet again for a one-day course to discuss some important medical issues including the meaning of natural and unnatural death. The Chief Coroner will also hold a one-day conference in 2015 on deaths in custody. Further induction courses, continuation courses and specialist courses will also take place in 2015.

### **Advice and Guidance**

35. The Chief Coroner also works towards national consistency by providing written advice and guidance to coroners. Formal guidance is circulated to all coroners and published on the judiciary website for all to see. There are now 14 pieces of separate guidance. There is for example guidance on the following topics: mergers of coroner areas, coroner appointments, the cadre of coroners who investigate service personnel deaths, where to hold inquests, opening inquests, recording hearings, reports to prevent future deaths and the use of post-mortem imaging as an alternative to 'invasive' post-mortem examinations.

36. The Chief Coroner also gives guidance, when appropriate, in High Court cases when he sits on applications for judicial review and applications for orders for a fresh inquest (under section 13 of the Coroners Act 1988 (as amended), which remains in force). In the last year there have been about four of each.

37. The Chief Coroner has requested, and the Government has agreed in principle, that there needs to be a change in the law by way of amendment to section 13. At present the High Court may only quash an inquest and order a fresh inquest, as for example in the deaths at Hillsborough (the Chief Coroner sat on the Hillsborough cases with the then Lord Chief Justice and Mr Justice Burnett). But some section 13 cases require only a change to the record of the inquest, and do not need a fresh inquest, which may involve

extra time and expense, and above all extra distress for families. For example in the case of *Roberts v Coroner for North and West Cumbria* [2013] EWHC 925 (Admin), the outcome of the inquest recorded the deceased as a person unknown. Ten years later DNA testing identified the deceased. A simple alteration of the record by the High Court from person unknown to the named person would have been sufficient, but under the present law a fresh inquest had to be ordered.

38. Overall the Chief Coroner believes that it is his role to bring consistency, good practice and good justice to the coroner service. But there are also structural issues which need to be addressed so that good practice can flourish above a firm foundation.

## (2) Mergers

39. The second strand of reform is therefore a structural one. In England and Wales there are currently 99 coroner areas, with 90 senior coroners. It makes good sense to reduce those 99 coroner areas to about 75 in number, maybe fewer, so that each coroner area is an appropriate size in terms of numbers of deaths reported, geographically and in terms of special work involving prisons, major hospitals, mental health institutions and airports, all of which affect the workload of the local coroner service.

40. 60% of coroner areas have fewer than 2,000 reported deaths. That number of reported deaths is too low, and many areas have only a part-time coroner. Each coroner area should have approximately 3,000-5,000 reported deaths each year, with a full-time senior coroner in post. The Lord Chancellor has the power to combine, or merge, coroner areas after consultation (paragraph 2, Schedule 2 of the 2009 Act). Therefore, in order to create more efficient, more cost-effective working units, the Chief Coroner is making progress with the Ministry of Justice to merge smaller areas.

41. The Chief Coroner has given written guidance, Guidance No.14 Mergers of Coroner Areas, to help local authorities plan for the future, both in terms of coroner area size and succession of the senior coroner. The Chief Coroner is talking to a number of local authorities inviting them to consider merger. Several are interested.

42. 19 coroner areas were merged in July 2013 to create 9 new areas. Under current planning with the Ministry of Justice, the target of a reduction to about 80 coroner areas in total for England and Wales in the relatively short to medium term is realistic. 75 is the longer term objective.

## (3) Appointments

43. The third strand of reform is appointments. Coroners are now categorised by the 2009 Act in descending order of importance as senior coroners, area coroners (who are both salaried), and assistant coroners (who are fee paid).

44. Before the 2009 Act came into force on 25 July 2013, senior coroners (then known as coroners) were appointed by the local authority and all other coroners were appointed by the coroner. On occasions that caused difficulties.

45. Now under the 2009 Act all coroners are appointed by the local authority. Previously coroners were appointed with freehold tenure for life. Now newly appointed coroners must retire at the age of 70. The Chief Coroner has encouraged older coroners to consider retiring at about 75 and to give way to younger, and hopefully more diverse, post-holders. Some have answered the call.
46. But the main change in the statutory regime is that all appointments of all coroners require the consent of the Chief Coroner (as well as the Lord Chancellor). In order to fulfil this role effectively the Chief Coroner has produced Guidance No.6 The Appointment of Coroners. This guidance, which is designed to assist local authorities, sets out in detail the regime which local authorities are expected to follow in making appointments.
47. The Chief Coroner requires every appointment process to be open, transparent and fair. Each one is monitored by him. Posts must be advertised widely for an open competition. There is a full initial selection of candidates and an in-depth process of interview, with the Chief Coroner's office working with the local authority providing advice for example on technical questions as well as the process as a whole.
48. Where a senior coroner is to be selected the Chief Coroner (or a nominee) will be present at the final interviews, not voting but making sure the process is complete and fair and that he is fully informed for the exercise of his consent.
49. The local authority appointments process has worked well since the Chief Coroner became closely involved. There have been 10 new senior coroner appointments (the majority of them are women), 5 area coroner appointments and 32 assistant coroner appointments.
50. The Chief Coroner is encouraging a wide range of applicants for assistant coroner posts. In numerical terms there are more assistant coroners than any other. Some of them may also be the senior coroners of the future. Recent appointments have included a full time District Judge (Magistrates' Court) (with the agreement of the Chief Magistrate). The Chief Coroner has also had discussions with the Judge Advocate General whose cadre of judges are willing to be deployed to assist the coroner service as assistant coroners, subject of course to the normal appointments process. The Chief Coroner welcomes their expertise and experience from other judicial fields, as with part-time tribunal members who also work as assistant coroners. At the moment the coroner service, which is hard-pressed in terms of resources, has the benefit of some assistant coroners coming from other parts of public service at no extra cost. This includes full-time judges as well as CPS prosecutors and justices' clerks.
51. The Chief Coroner welcomes and encourages new assistant coroners. They have special induction training (as at paragraph 31 above), additional in-house training at the coroner's office and access to all the Chief Coroner's guidance and advice on the judicial intranet. Too often in the past there have been assistant coroners on the books who have played little or no part in the work of the local coroner service. At the same time some new assistant coroners have been appointed and trained but given no work. Some have been given work but no pay. Some have been given work which has been called training, also without pay. That is not good enough.
52. The Chief Coroner has therefore told senior coroners that he normally expects

assistant coroners to be given at least 15 days' work a year (as other part-time judges) and to be part of a local team of coroners, managed and supported by the local senior coroner in regular team meetings.

#### (4) Senior coroners

53. The post of senior coroner (formerly coroner) has changed. 50 years ago a coroner would have been male, part-time, probably from a local firm of solicitors, and assisted by a part-time secretary, perhaps one from his solicitors' office. The work of the coroner would have been to consider reports of deaths, investigate where appropriate and usually hold an inquest. The local authority would sign the cheque for coroner services, salaries and pathology bills at the end of the month.

54. All of that has changed. The Chief Coroner expects a senior coroner today to be more than just a coroner. He, or more likely she now (according to recent appointments), has a position at the head of the coroner service locally, has to lead on coroner work, to manage the caseload, organise and support the coroner team locally, work closely with the local authority and the police, manage the expectations of the public and bereaved people, provide an out of hours service and be ready for a mass fatality disaster.

55. That is quite a different job. And with training and guidance and discussion and support the Chief Coroner is helping senior coroners to cope with those additional functions of their role. He has held a one-day conference for all senior coroners on leadership, management and organisation. He has distributed the notes of the conference to senior coroners and he visits many coroner areas to discuss the new reforms, with coroners as well as coroners' officers, local authority representatives and the police.

56. The new breed of senior coroner has to manage the triangle of responsibility. At the apex of the triangle is the senior coroner, appointed but not employed by the local authority (or local authorities), who could be said to be line managed by either the Chief Coroner or the Lord Chief Justice (and only to be removed for incapacity or misbehaviour by the Lord Chief Justice and the Lord Chancellor, as with all other judges).

57. At another corner of the triangle are the coroners' officers, working for the coroner, but employed by the police (or in some cases the local authority), and line managed by the police. At the other corner of the triangle is the local authority (or local authorities), looking after the finances of the coroner service, appointing coroners, providing office and court accommodation, and employing support staff for the coroner who are line managed by the local authority.

58. That is not an easy triangle of responsibility. For example, if there is a disciplinary problem in the office the senior coroner may have no direct role in the process. That triangle can therefore only work well if the senior coroner leads the team, all the staff, and collaborates closely with the police and local authority, particularly the latter.

59. The role of the local authority in the coroner process today is fundamental. The Chief Coroner encourages local authorities to become closely involved in the process and work closely with the coroner. The Chief Coroner will hold a one-day conference with local authorities in December 2014 where all of this will be discussed. Local authorities need to

be hands-on. At present some are, some are not. After all this is public money being spent on a public service.

60. The Chief Coroner is also working with coroners and local authorities on a proposal for a new standardised scheme of salaries and fees for coroners. There is wide inconsistency in current rates of pay. The existing scheme, negotiated between the Coroners' Society of England and Wales and the Local Government Association and known as Coroners' Circular No.51, is out of date, includes anomalies such as so-called 'long inquest payments' and does not include assistant coroners. Greater consistency is required and there is, the Chief Coroner believes, momentum for change in this area.

### (5) Investigations and inquests

61. The fifth strand of reform is coroner investigations and inquests. In addition to the statutory changes (see paragraphs 17-23 above) the Chief Coroner has provided guidance and advice to all coroners in order to promote good practice.

62. The advice includes advice on the meaning of 'reason to suspect' in section 1 of the 2009 Act, on release of the body for burial or cremation, on what is required for notifying the Chief Coroner about a transfer, on the qualifications of pathologists commissioned by coroners, and on requests by lawyers to coroners to support their application for 'exceptional case funding' legal aid.

63. The Chief Coroner has also given advice to individual coroners on a wide range of topics. These include the release of confidential medical records, deprivation of liberty safeguarding orders, the use of the new power to discontinue an investigation, the new power under Schedule 5 to the 2009 Act to require by notice a person to make a statement, produce a document or attend court, the use of written evidence and admissions at inquests, handling the media and disclosing material to them, the use of section 39 of the Children and Young Persons Act 1933 to restrict the press from publishing the names of children, the circumstances in which the coroner is *functus officio* (i.e. having discharged his or her duty), and best practice in summoning jurors.

64. Whenever providing advice to coroners the Chief Coroner reminds coroners that any decision of a judicial nature is a matter for the exercise of their independent judicial judgment, and not a matter for the Chief Coroner. The Chief Coroner's advice is designed to do no more than give coroners the necessary tools for making their own decisions.

65. The Chief Coroner has also written to all coroners reminding them of the duty to set dates for inquests at the opening of an inquest. He has repeatedly stressed the need in training and discussions for setting dates and having timely hearings. Recent decisions, following complaints against coroners made to the Judicial Conduct Investigations Office, show that a delayed inquest may lead to formal disciplinary action. The Chief Coroner will be writing to all senior coroners shortly so that they can report to him all coroner investigations which are more than one year from the death, requiring coroners to explain why each such investigation has not been completed or discontinued.

66. The Chief Coroner is also working on reducing delays to inquests by inviting coroners to direct at the opening of an inquest that a medical report such as a

pathologist's report should be produced to the coroner within four to six weeks, the shorter the better. Ideally coroners should sit down with pathologists and hospital trusts to agree a standard timescale for producing reports, although the Chief Coroner is aware of concern amongst coroners about the shortage of pathologists in some parts of the country and this is an issue which will require attention in the coming year. Nevertheless long delays in the production of reports are not acceptable. In a recently upheld complaint to the Judicial Conduct Investigations Office the senior coroner was held responsible for not ensuring that a pathologist's report was produced promptly.

67. In addition the Chief Coroner has given formal guidance to coroners on the location of inquests (Guidance No.2), oaths and robes (Guidance No.3), the recording of hearings (Guidance No.4), opening inquests (Guidance No.9), warnings to juries (Guidance No.10), an inquest checklist (Guidance No.12), and using findings of fact from family court proceedings (Guidance No.13).

#### (6) Reports to prevent future deaths

68. Finally, it is an essential part of coroner work that they write reports with a view to preventing future deaths. This traditional role of the coroner now has added emphasis. The duty to report has been promoted from a Rule to the 2009 Act itself. It was previously a discretion; it is now a duty, not in all cases, but in cases where the investigation reveals to the coroner a concern that circumstances creating a risk of other deaths will occur (paragraph 7, Schedule 5 to the 2009 Act).

69. The Chief Coroner has designed a template to make it easier for coroners to write reports, and easier for individuals, organisations and government agencies to respond to them. All reports (and responses) must now be sent to the Chief Coroner and they are published on the judiciary website. Some reports are selected to pursue further. All of that is new. And the Chief Coroner encourages coroners to write reports.

## Promoting coroner reforms

70. For the promotion of these reforms, the spreading of good practice and the development of greater consistency across England and Wales, the Chief Coroner has given talks about his reforms to a wide range of stakeholders in the coroner service. He has spoken to senior coroners, the Coroners' Society of England and Wales (both national and regional societies), regional local authority coroner service managers, registrars, police, lawyers, bereaved organisations, the Victims' Services Alliance, the charity INQUEST, the Howard League for Penal Reform, the Ministry of Justice Burial and Cremation Advisory Group, funeral directors, the Patient Safety Section of the Royal Society of Medicine, Action against Medical Accidents, the Royal College of Nursing, the Ministerial Board on Deaths in Custody, the National Suicide Prevention Strategy Advisory Group and the Army Legal Services Annual Training Conference. He has also given the David Jenkins Annual Lecture to the Faculty of Forensic and Legal Medicine (he was appointed David Jenkins Professor by the Faculty) and The Minty Lecture to the Medico-Legal Society.
71. The Chief Coroner has discussed coroner work with ministers in the Ministry of Justice and Department of Health. In the House of Lords he has addressed the All Party Parliamentary Penal Affairs Group. He has spoken (along with the then Minister of Justice, Helen Grant MP) at the annual volunteers conference of the Coroners' Courts Support Service, whose work providing independent support and advice to bereaved families is welcomed and encouraged by the Chief Coroner.
72. He has also written about the reforms in the coroner service in *The Times* and given interviews on Radio 4's *Today* programme and *Law in Action* and to the *Solicitors Journal* as well as to a training programme for The University of Law. He has discussed coroner work with a number of media organisations.
73. He has opened new or newly refurbished coroners' courts in Gloucester, Essex, Stockport and Bolton, and the new digital scanning centre in Sheffield.
74. He has met and discussed coroner work with many individuals, organisations and government agencies. For example he has discussed the pilot scheme for medical examiners in Sheffield and a prototype local authority scheme for death certification in Essex. The Chief Coroner is grateful to all those who have expressed views and ideas.
75. The Chief Coroner also wishes to express a debt of gratitude for the work and support of his team in the Chief Coroner's office led by James Parker, for regular working cooperation from both the team in the Ministry of Justice coroners, burials, cremation and inquiries policy team led by Judith Bernstein and the team at the Judicial College led by Judith Lennard, the valued collaboration of the Coroners' Society of England and Wales, and for the many coroners who have been consulted or visited or who have assisted with training and many other aspects of the developing reforms. The Chief Coroner thanks them all.

## Statutory powers and duties

76. The following is a summary of the Chief Coroner's powers and duties under the 2009 Act and the 2013 Coroners Rules and Regulations and the action taken by the Chief Coroner during the last year.
77. Where a senior coroner exercises his discretion to report to the Chief Coroner under section 1(4) of the 2009 Act that he has reason to believe that a death has occurred in or near the coroner's area, that the circumstances of the death are such that there should be an investigation into it, and the duty to conduct an investigation does not arise because of the destruction, loss or absence of the body, the Chief Coroner may direct a senior coroner to conduct an investigation into the death (section 1(5)). Since July 2013 there have been 40 applications and the Chief Coroner has granted 33 of them.
78. The Chief Coroner must be given notice in writing of any request made by a senior coroner for an investigation to be carried out by another coroner including the outcome of the request (section 2(5)). The Chief Coroner has received 621 notifications.
79. The Chief Coroner also has a discretionary power to direct a coroner other than the coroner who apart from this direction would be under a duty to conduct it to investigate a person's death (section 3). By this power the Chief Coroner may direct transfers of investigations from one coroner area to another. The Chief Coroner has exercised this power twice, with transfers effected with the consent of the coroners concerned.
80. The Chief Coroner may notify the Lord Advocate that it may be appropriate for the circumstances of certain deaths of service personnel abroad to be investigated in Scotland under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (section 12 of the 2009 Act). A protocol facilitating the notification process has been agreed between the Chief Coroner, the Crown Office and Procurator Fiscal Service, the Scottish Government, the Ministry of Defence and the Ministry of Justice. The Chief Coroner has not yet made any notifications to the Lord Advocate.
81. The Chief Coroner also has a power in certain circumstances to direct a senior coroner to conduct an investigation into such a death despite the body being in Scotland (section 13). The Chief Coroner has also not yet used this power.
82. The Chief Coroner may designate suitable practitioners to make post-mortem examinations (section 14). The Chief Coroner has not exercised this power.
83. The Chief Coroner must keep a register of notifications by senior coroners of investigations lasting more than a year (section 16). That register will be opened on 25 July 2014, one year after the statutory provisions came into force. Coroners must notify the Chief Coroner of the reasons for not completing or discontinuing any investigation lasting more than a year (Regulation 26).
84. The Chief Coroner must monitor and train for investigations into deaths of service personnel (section 17). The Chief Coroner requires senior coroners to notify him of all such investigations and update him upon their progress and outcome. He has also created

a special cadre of coroners to conduct such investigations if and when necessary and he has held special training for them (see paragraph 32 above). The Chief Coroner has given guidance on the use and function of the cadre, Guidance No.7 A Cadre of Coroners for Service Deaths. The Chief Coroner has discussed the cadre and its operation with Ministers in the Cabinet Office and Ministry of Defence and consults regularly with the Royal British Legion to discuss such cases.

85. No appointment of a coroner may be made by a local authority without the consent of the Chief Coroner (and Lord Chancellor) (section 23, Schedule 3). The Chief Coroner has given his consent to the appointment of 10 senior coroners, five area coroners and 32 assistant coroners.
86. The Chief Coroner has responsibility to train coroners and coroners' officers (section 37): see paragraphs 28-34 above.
87. The Chief Coroner may carry out an investigation into a person's death (section 41, Schedule 10). He is at present conducting the investigation into the death of Dr Abbas Khan who died in custody in Syria in December 2013.
88. The Chief Coroner may also request the Lord Chief Justice to nominate a judge, former judge or former coroner to conduct an investigation (section 41, Schedule 10). He has not yet done so.
89. Senior coroners who report to prevent future deaths under paragraph 7 of Schedule 5 to the 2009 Act and Regulation 28 of the Investigations Regulations must send a copy of the report and any response to the Chief Coroner (Regulations 28(4) and 29(6)). The Chief Coroner may publish these documents (Regulations 28(5) and 29(7)). In practice they are published, with redactions where necessary, on the judiciary website.
90. Under regulation 19 of the Investigations Regulations the Chief Coroner has power to direct the receiving local authority to bear the costs of an investigation transferred by direction under section 3 of the 2009 Act. He has not exercised this power.
91. In addition under regulation 25 the Chief Coroner has power to require information in relation to a particular investigation or investigations. The Chief Coroner frequently requests details from coroners which are always complied with and as such has not needed to make a formal request under this section.
92. The Chief Coroner also has the power under regulation 27 to direct a coroner to retain documents for a period other than 15 years. He has not used this power.

## Conclusion

93. This is the first annual report to the Lord Chancellor and the first year of the statutory and other coroner reforms. Although these reforms need time to bed in, there are already considerable signs of positive change and the Chief Coroner is confident that coroners are embracing that change. The Chief Coroner believes that the reforms are therefore beginning to take effect.

94. The Chief Coroner will continue to develop and encourage reform, through training, guidance, advice, encouragement and support. He will monitor the reforms so that he can report to the Lord Chancellor about consistency of standards between coroner areas next year.

**HH Judge Peter Thornton QC**  
**Chief Coroner**  
**30 June 2014**

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