DEATH AND TAXES:

The past, present and future of the coronial service

1. In November 1875, an election took place for the office of county coroner for Suffolk. There were three candidates. One was a lawyer, one was a doctor, and the third was an auctioneer. You have probably already guessed who won. It was, of course, the auctioneer.

2. The editor of the *Spectator* was incandescent:

    > "We wish other counties would follow the example, and elect Coroners still more unfitted for the office by training and pursuits. There would then be a fair chance that this anomalous absurdity in our system, the election of a judge with serious powers and duties, by a mob, would be summarily abolished, and the Coroners chosen, like the County Court judges, on the responsibility of the Lord Chancellor. The only effect of the present system is to keep up a thoroughly bad precedent, and degrade an office which, if a few more duties were thrown on it, might be made extremely useful."

3. It took another 13 years for Parliament to abolish the system of choosing coroners by holding elections, but instead of entrusting the appointment process to the Lord Chancellor, as the *Spectator* had urged, the Local Government Act 1888 handed the task to the newly-created county and borough councils. The question what kind of professional qualification coroners should hold remained undecided. In 1879, a Parliamentary Select Committee had recommended that the office be confined to legal professionals assisted by medical assessors, but the prorogation of Parliament prevented that proposal from passing into law.

4. At the beginning of the nineteenth century, the coroner service was in a dire state. Yet it had its defenders. The radical journalist William Cobbett described it as “the institution for the protection of life and limb”. For the *Times* newspaper, the coroner was “eminently the magistrate of the poor”. In 1834, the physician Thomas Wakley, founder of the *Lancet* journal, wrote that the coroner’s office was “especially designed to protect the interests of the people, to shield the weak against the tyranny of the strong, to guard the peaceful citizen against the fury or unbridled rage of the cruel agent of power, to trace out the first steps of crime, and thus relieve the innocent from the curse of undeserved suspicion, and impose on the guilty the last and most weighty responsibilities of the law”.

5. There were many reasons for this early nineteenth-century perception of the coroner’s inquest as a popular tribunal through which abuse of power and disreputable conduct by the authorities could be exposed to the public gaze. Not only was it the people who elected the coroner, but the franchise was wider than for Parliamentary elections – all freeholders, including women, were entitled to vote. Jurors, too, were drawn from a larger pool than in criminal or civil proceedings. In cases involving deaths in custody (which Thomas Wakley and others argued should include workhouse deaths), prisoners would sit as members of the coroner’s jury. The inquisitorial nature of the process meant that jurors were used to asking their own questions and would even call witnesses whom the coroner regarded as unnecessary or irrelevant.

6. Above all, the system provided free and comparatively easy access to a public judicial investigation. Lawyers were rarely involved and it was the local magistrates, as the forerunners of modern local authorities, who had

to bear the cost. What's more, no minimum standard of proof or suspicion was required to justify the launching of an investigation. In 1728, the Dorset coroner conducted an inquest into the death of a youth whose body had been found on a riverbank on the strength of a reported sighting of the lad's ghost. Mind you, it's worth remembering that at that time, coroners were still entitled to claim a separate fee for each individual case that they investigated.

7. Not everyone held the inquest process in high esteem. For some, it was blighted by a lack of professionalism on the part of coroners. In 1824, Thomas Denman – afterwards Lord Chief Justice – observed that the coroner was "rarely a person of high legal attainments". Some years later, the physician Sir Dominic Corrigan described the coroner system as "a gross burlesque on jurisprudence" and "an absolute disgrace to the administration of justice". Even his colleague Thomas Wakley, who by this time had got himself elected as coroner for West Middlesex, castigated what he called the "imbecility and ignorance" of coroners.

8. It was even worse in Ireland, where coroners enjoyed – if that's the right word – a reputation for drunkenness and corruption. In 1818, the Reverend Peter Browne, Dean of Ferns, wrote to Prince Frederick, Duke of York and Albany, complaining that coroners in Ireland were, as he put it, "generally speaking the lowest and most contemptible characters".

9. Of course, matters were not helped by the circumstances in which inquests commonly took place. There were no coroners' courts in those days. The usual place of hearing for an inquest was the local public house. Wakley's Victorian biographer, Sir Samuel Squire Sprigge, did not approve,

deriding the typical inquest as “a dreary farce … where the majesty of death evaporated with the fumes from the gin of the jury”.

10. Charles Dickens witnessed inquests in his capacity as a journalist, and even served on a coroner’s jury. As it happens, the coroner on that occasion was none other than Thomas Wakley. In a trenchant article in *Household Words*, Dickens castigated the practice of hearing inquests in taverns, but he reserved his most pungent criticism to a scene in *Bleak House*, published a couple of years later in 1852:

    > “At the appointed hour arrives the coroner, for whom the jurymen are waiting and who is received with a salute of skittles from the good dry skittle-ground attached to the Sols Arms. The coroner frequents more public-houses than any man alive. The smell of sawdust, beer, tobacco-smoke, and spirits is inseparable in his vocation from death in its most awful shapes. He is conducted by the beadle and the landlord to the Harmonic Meeting Room, where he puts his hat on the piano and takes a Windsor-chair at the head of a long table formed of several short tables put together and ornamented with glutinous rings in endless involutions, made by pots and glasses. As many of the jury as can crowd together at the table sit there. The rest get among the spittoons and pipes or lean against the piano”.

11. Now, the public house was not, perhaps, quite as unseemly a venue as Victorian society came to think. There was a perfectly good reason to use such establishments – and no, it isn’t the reason some of you probably have in mind. The fact is that during the eighteenth and nineteenth centuries, there was a shortage of public buildings. In many towns, the local inn provided the only available space for a large gathering, whether

civic or otherwise. Nor were coroners the only people who used them for such purposes. Public houses also served as auction rooms, magistrates' courts and even, believe it or not, places of solemn worship. Until the Catholic Relief Acts lifted the last restrictions on building new Catholic churches, it was commonplace for itinerant priests to ride from town to town, celebrating Mass in local taverns.

12. All the same, we must admit – not, in my case, without a faint twinge of regret – that the practice of conducting inquests in taverns could not continue. Now, you will find it confidently asserted by various authorities that it was abolished by the Coroners Act of 1887. That is not so. The 1887 Act was completely silent about it. The earliest prohibition I have been able to find is contained in section 21 of the Licensing Act 1902, which forbade coroners to use public houses for inquests "where other suitable premises have been provided". Section 21 was repealed in 1910 and I cannot trace any successor to it, raising the tantalising possibility that there currently exists no legal prohibition – not even a qualified one – against holding inquests in pubs. If so, it occurs to me that I might, perhaps, consider issuing some measured guidance on the topic.

13. How did the custom of investigating death in a tavern ever come about in the first place? To answer that question, it's necessary to take a brief detour into the origin of the modern coroner.

14. It is usually said that the office of coroner dates back to the twelfth century, more specifically to the Articles of Eyre of 1194. That is certainly the earliest date that is properly documented, but it does not exclude the possibility of an even remoter genesis. On any view, the position of coroner is today the oldest surviving judicial office in England and Wales.

15. From early accounts of inquests, whether fictional or otherwise, we get little sense that the bereaved were at the heart of the process. That is a modern development about which I shall say more a little later. In the olden days, the person at the heart of the process was the King. That is because the original point of the coroner was to raise revenue on behalf of the Crown. His jurisdiction was not confined to death investigation but embraced many other responsibilities. His duty was to "keep the pleas of the Crown", that's to say that he had to enforce the monarch's financial prerogatives. He was, in effect, a tax collector. The reason he investigated unnatural deaths was not for the benefit of the bereaved, but because the instrument of such a death, known as a 'deodand', was forfeit to the Crown. It might be the horse that threw its rider and killed him or it might be the sword with which one man slew another. Whatever it was, it had to be assigned a monetary value, which is why indictments for murder used to specify the value of the weapon that was alleged to have been used to inflict the fatal wound. But the royal interest in revenue was not confined to cases of death. The coroner also claimed jurisdiction over shipwrecks and treasure trove, as well as other potential sources of royal revenue.

16. With the passage of the centuries, the coroner's tax-collecting responsibilities gradually disappeared or fell into disuse or were transferred to other officials. It was section 44 of the Coroners Act 1887 that purported to extinguish the last trace of the coroner's revenue-raising responsibilities:

> "A coroner shall not take pleas of the Crown nor hold inquests of royal fish nor of felonies except felonies on inquisitions of death; and he shall not inquire of the goods of such as by the inquest are

found guilty of murder or manslaughter, nor cause them to be valued and delivered to the township."

17. Yet the ancient revenue duties did not entirely dissipate. To this day a faint echo still reverberates in the coroner's residual jurisdiction over treasure. With that sole exception, nothing now survives of his ancient role of royal debt enforcement. On the contrary, the coroner is now primarily charged with the solemn duty of conducting public, judicial death investigations, at the heart of which lie the deceased and their bereaved families.

18. The slow rate at which the office of coroner evolved over many centuries has perhaps concealed the magnitude of the distance travelled. So gradual was the development from one extreme to its opposite that it went largely unnoticed. As with so many other social reforms, it was during the Victorian age that people woke up to the need for change. The inquest system was by then long overdue for modernisation, and at the forefront of that project lay the need to professionalise its judiciary.

19. But the case for modernisation demanded the resolution of two separate yet related questions. In the first place, it's all very well advocating professionalisation, but what are the limits and purpose of a modern inquest? Should it be confined to a medico-legal inquiry into the cause of death or should it extend to a wider forensic investigation embracing questions of culpability? Secondly, in order to professionalise the coronial process, it was first necessary to identify the profession to which it ought properly to be entrusted (presumably not auctioneers). But should inquests continue to be conducted by people with a legal background, or was there a place for the emerging medical profession?

20. These two issues – the definition of the scope of a coronial investigation and the professionalisation of the office, although strictly distinct, overlapped to some extent. Neither was finally resolved until recent times and even today some tensions still linger.

21. During the nineteenth century, the dominant question was: who should conduct inquests, lawyers or physicians? The proper scope of the inquest was not, at that time, as controversial as it later became. Everyone understood that some inquests would necessarily involve questions of blame. In cases of murder, for instance, the coroner's inquisition formed the basis of the indictment on which the person accused would later stand trial at the assizes. It was the Criminal Law Act 1977 that finally abolished that particular function of the inquest. It is said that the last person to be committed for trial by a coroner's court was Lord Lucan. Nowadays, of course, section 10(2) of the Coroners and Justice Act 2009 prohibits coroners from even appearing to determine any question of civil liability or any question of criminal liability on the part of a named person.

22. During the nineteenth century, however, coroners' juries were far less inhibited. Let me mention a particularly inflammatory example from Ireland during the terrible famine that followed the failure of the country's potato crop. Sir Robert Peel's administration had set up a Relief Commission for Ireland, headed by Sir Randolph Routh. Its principal purpose was to oversee the funding and distribution of relief to the Irish poor. In January 1847, an inquest took place at the Galway workhouse into the death from malnutrition of a woman called Mary Commons. By that date, Peel had left office and the new Prime Minister was Lord Russell. The coroner's jury sought to return a verdict in these terms:

> "We find that the deceased, Mary Commons, died from the effects of starvation and destitution, caused by a want of the common necessities of life; and as Lord John Russell, the head of her Majesty's government, has combined with Sir Randolph Routh, to starve the Irish people, by not, as was their duty, taking measures to prevent the present truly awful condition of the country, we find that the said Lord John Russell and the said Sir Randolph Routh, are guilty of the wilful murder of said Mary Commons".

The coroner refused to accept the verdict and compelled the jury to adopt a modified form of words which nevertheless preserved an element of condemnation of government policy. Even so, the case powerfully illustrates the strand of popular radicalism that characterised some Victorian inquests, traces of which still occasionally surface.

23. The common assumption that inquests would determine questions of culpability may help to explain why the Victorians regarded the definition of the proper scope and limits of an inquest as less urgent than the question who should conduct it. It was the emergence of the modern medical profession that sharpened that particular debate.

24. Although there was no formal requirement that coroners should be trained in either law or medicine, they tended in practice to have a legal background. Their knowledge of medicine was, at best, rudimentary.

25. It was, you may not be surprised to hear, Thomas Wakley who led the campaign for medically qualified coroners through the medium of his new journal, the *Lancet*. He did not spare the lawyers:

> "The training of the mind to act for the law, and to fulfil all its injunctions in the court of the Coroner, is not to be effected in the

red-and-black-ink shops of scribbling and miserable-minded attorneys, but in those high marts of natural law, the Temples of Medical Science.... Attorneys are elected coroners, and there they sit, untroubled, ungalled, unstimulated, unnoticed by the public, careless if unnoticed, insolent if reproached, afraid to be touched – in point of fact shrunk from, as holders of the very whip which should be administered on their own backs."

26. This debate was not confined to the pages of learned journals. That it became familiar to the educated public is shown by the inclusion of an extended reference in George Eliot's great novel, *Middlemarch*, which, although published in the early 1870s, was set 40 years earlier. Picture a dinner party at which the guests include two physicians, Dr Lydgate and Dr Sprague, as well as the local coroner, Mr Chicheley. Mr Chichely is a lawyer – a circumstance of which Dr Lydgate rather tactlessly loses sight:

"'Hang your reforms!' said Mr Chichely. 'There's no greater humbug in the world. You never hear of a reform but it means some trick to put in new men. I hope you are not one of the *Lancet*'s men, Mr Lydgate – wanting to take the coronership out of the hands of the legal profession: your words appear to point that way.'

'I disapprove of Wakley,' interposed Dr Sprague, 'no man more: he is an ill-intentioned fellow who would sacrifice the respectability of the profession, which everybody knows depends on the London Colleges, for the sake of getting some notoriety for himself. There are men who don't mind about being kicked blue if they can only get talked about. But Wakley is right sometimes,' the Doctor added, judicially. 'I could mention one or two points in which Wakley is in the right.'

> ‘Oh, well,’ said Mr Chichely, ‘I blame no man for standing up in favour of his own cloth; but, coming to argument, I should like to know how a coroner is to judge of evidence if he has not had a legal training?’
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> ‘In my opinion,’ said Lydgate, ‘legal training only makes a man more incompetent in questions that require knowledge of another kind. People talk about evidence as if it could really be weighed in scales by a blind Justice. No man can judge what is good evidence on any particular subject, unless he knows that subject well. A lawyer is no better than an old woman at a *post-mortem* examination. How is he to know the action of a poison? You might as well say that scanning verse will teach you to scan the potato crops.’
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> ‘You are aware, I suppose, that it is not the coroner’s business to conduct the *post-mortem*, but only to take the evidence of the medical witness?’ said Mr Chichely, with some scorn.”

27. I wish I had time to recite the whole of this exchange, which occupies two full pages, but I must confine myself to the author’s characteristically waspish comment:

> “This was one of the difficulties of moving in good Middlemarch society: it was dangerous to insist on knowledge as a qualification for any salaried office.”

28. The question which profession better equips a person to perform the duties of a coroner is one that has persisted into the present century. The third report of the Shipman Inquiry, published in 2003, declared that “the conduct of inquests apart, the job of coroner requires medical knowledge far more often than legal knowledge, and entails a medical judgement far

more often than a legal one.” In the same year, however, the Fundamental Review led by Tom Luce concluded that “a legal qualification and experience of practice as a barrister or solicitor should be required for coroners”. In the end, it was the Luce view that prevailed. The Coroners and Justice Act 2009 provides that all coroners must satisfy the normal judicial appointment criteria. Subsequent experience has, I think, vindicated Tom Luce, not to mention Mr Chichely.

29. We should not overlook the important part played by the Coroners' Society of England and Wales in professionalising the inquest system. Founded in 1846, the Society's original purpose was to foster co-operation between coroners, in the words of Serjeant William Payne, “ for the more effective discharge of the duties of their office”. The mutual support and collaboration that resulted undoubtedly served to raise professional standards and promote better practice in the decades that followed.

30. The cumulative result of the changes I have already described, coupled with the passage of the Coroners and Justice Act 2009, is that the landscape coroners today inhabit has been transformed. In August 2020, providing written evidence to the Commons Justice Committee, Tom Luce had this to say:

> “When in 2001–3 my Fundamental Review colleagues and I reviewed the service it was customary to refer to it as ‘quasi-judicial’; I am now confident that the ‘quasi-’ qualification should be dropped. It is developing into a properly judicial service and continues to deepen that essential characteristic of its work to an impressive extent worth public recognition”.

31. And so, while we should never be complacent about continuing professional development, I think we can now confidently say that coroners have earned the right to be regarded and treated as members of the wider judicial family on an equal footing with their colleagues from other jurisdictions. When it comes to the modernisation of the inquest process, too, considerable progress has been achieved, yet that task remains unfinished.

32. Now, the reason we are marking the tenth anniversary of the modern reforms this year is that although they were enacted in 2009, they were not implemented until 2013. Even then, some of the Act's provisions were either delayed – for example the introduction of the Medical Examiner System – or, like the provision for appeals from coroners' decisions to the Chief Coroner, abandoned altogether.

33. The 2009 Act changes introduced an element of central oversight of the coronial service through the new office of Chief Coroner, improved some aspects of its organisation and subjected coroners to the same professional standards as their judicial colleagues in other jurisdictions.

34. The policy of all three Chief Coroners who have held the position since 2013 has been to use this reformed structure to create a more modern, consistent, open and just service, with the object of reducing unnecessary delays and putting bereaved families at the very heart of the process. Over the past 10 years, despite the unprecedented difficulties caused by the Covid-19 pandemic, there have been many positive steps towards achieving these objectives. Before turning to the challenges we still face, let me pay tribute to those who brought about those improvements.

35. The first Chief Coroner was His Honour Judge (now Sir) Peter Thornton KC. He almost found his office abolished before he could take it up, but fortunately the Government of the day relented. It is to Sir Peter's pioneering work that the service owes the present system by which the Chief Coroner's office operates. He issued the first law sheets and guidance notes, and his successors have adopted the template he established. It was Sir Peter who oversaw the drafting and publication of the first-ever bench book for coroners. He also set up the training system, assisted by the Judicial College. He had to forge a constructive working relationship with the Coroners Society of England and Wales, overcoming understandable early reservations from some coroners along the way.

36. Sir Peter Thornton was succeeded by His Honour Judge Mark Lucraft KC, now the Recorder of London, who continued and consolidated the practices introduced by his predecessor and began work on the new and expanded edition of the bench book (due to be published shortly), a project that one of the deputy Chief Coroners, Her Honour Judge Alexia Durran, has overseen. However, the outstanding event of Judge Lucraft's tenure of office was, of course, the Covid-19 pandemic. Not only did he have to steer the service through the extraordinary challenges caused by the rise in deaths, he also had to handle the serious welfare implications for coroners and their officers and staff, who faced even greater difficulties than those in other occupations apart from healthcare. One of his initiatives was the decision to set up an informal group of senior coroners to provide mutual support and disseminate good practice throughout the lockdowns that followed. That group led directly to the creation in 2021 of the more formal system of regional leadership coroners that we now have.

37. It was Judge Lucraft who appointed the first two Deputy Chief Coroners, Her Honour Judge Alexia Durran and Derek Winter, Senior Coroner for Sunderland. They have provided a welcome degree of stability and continuity to the work of the Chief Coroner's office and they continue to undertake a generous proportion of the Chief Coroner's day-to-day responsibilities – so much so that in certain aspects of my role it would be truer to say that I deputise for them than that they deputise for me.

38. I became the third Chief Coroner on 24 December 2020. I have enjoyed the advantage of being able to reap where my predecessors have sown. If there is one single event that might be said to have defined my own term of office, I suppose it is the national tour that I carried out between January 2022 and March 2023. That tour, the first of its kind ever undertaken by a Chief Coroner, has enabled me to make an informed and up-to-date assessment of the current state of the coroner service and its likely future trajectory.

39. In 2004 there were 127 coroner jurisdictions in England and Wales. The average caseload per jurisdiction was then just over 1,500 reported deaths. Many of the old coroner 'districts' have been merged since then, so there are now 80 coroner areas, with some future mergers anticipated. Larger areas support a greater number of coroners, allowing a more collegiate approach, improving 'out of hours' cover, and introducing economies of scale for local authorities.

40. Chief Coroner guidance has been issued on a wide variety of topics and successive Chief Coroners have provided direction through regular communications and training events, all of which have led to greater

consistency between coroner areas. The move towards a smaller number of coroner areas has also helped to increase consistency of practice.

41. As technology has developed, we have seen significant modernisation of the coroner service, including the ability to undertake remote hearings, the increased use of scanning in appropriate cases rather than fully-invasive autopsy, and the digitisation of coroners' workflows and processes. Access to and use of technology vary between coroner areas, but in general IT advances have significantly improved the way the service is managed and delivered.

42. During the past two decades, the way in which coroners and others involved in disaster victim identification and the management of cases resulting in mass fatalities has changed radically for the better.

43. The provision of national leadership has meant that in addition to the excellent support that has for many years been provided by the Coroners Society for England and Wales, coroners have had new opportunities to share best practice through regular training events, conferences and communications. The appointment of regional leadership coroners has improved collaboration and is, I hope, helping to provide better welfare support.

44. What about the other side of the balance sheet? I am afraid I have to say that in spite of all the considerable improvements that have taken place since 2013, Tom Luce's description of the coroner system as a largely "forgotten service" remains recognisable.

45. In all but a handful of areas, teams of coroners' officers are understaffed and overworked, resulting in avoidable delays to cases, lack of resilience, and damage to the officers' welfare. 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 it is recognised that more officers or administrative staff are needed, it can take an excessive length of time to fill vacancies.

46. Another source of concern is the unsatisfactory nature of the premises some coroners and staff are obliged to put up with. Too many buildings are dilapidated and there are still some coroner areas that have no dedicated courtrooms at all. In some areas, the irreducible minimum requirements of a coroner area of any sort are just not being met. During my tour, I challenged many local authority representatives about the inadequate accommodation they provide. We have achieved some notable successes, but I'm afraid the process of change is painfully slow.

47. I believe there is scope, in some areas, for partial relief of resourcing pressures through the adoption of more efficient working practices. I therefore encourage coroners to exchange ideas for improving practice through training events and by means of items published in the Chief Coroner's newsletter.

48. In many areas there are not enough coroners, particularly salaried area coroners. This places senior coroners under excessive pressure, jeopardising their welfare and undermining performance. We have already managed to achieve some rebalancing of the ratio of fee-paid to salaried coroners, but there is still work to be done in improving the

composition of the service. Too many areas still rely exclusively on fee-paid assistant coroners to support the senior coroner, even though most assistant coroners have competing professional commitments which prevent them from offering the flexible support that is really needed.

49. Many of the problems I have identified can be traced to the unique system of governance that still prevails in a majority of coroner areas. The involvement of police forces and local authorities in resourcing most coroner areas creates a 'triangle of responsibility', with the senior coroner, relevant local authority and policing body having to agree many aspects of how the service will function. These complicated arrangements can delay or even paralyse decision-making and are liable to generate disagreement to the detriment of performance.

50. Although coroners' officers and other staff work to the direction of the coroner, they are formally employed and line-managed by either the local authority or police force. This can generate conflict and confusion. There are frequent misunderstandings about the boundary between independent direction by the coroner and legitimate line-management by the employer.

51. 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 own financial situation happens to be precarious.

52. With a view to moving away from the 'triangle of responsibility', I have encouraged 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.

53. Court security arrangements vary considerably and are rarely adequate. The local organisation of the coroner service means there is no central organisation comparable with 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 little or no wider experience of judicial security requirements.

54. We must frankly acknowledge that the additional pressure the coroner service has experienced since 2020 is not a purely temporary consequence of the pandemic. Anecdotal evidence from my tour – corroborated to some extent by statistics published by the Ministry of Justice – suggests, first, that the numbers of reported deaths are rising and will continue to do so and, second, that the complexity of coronial investigations is on the increase.

55. I think the main reason for the higher numbers of reported deaths is that recent changes in medical practice have meant that more people are dying from natural causes without having been seen recently by a medical practitioner, with the result that there is no-one who can sign a medical certificate of cause of death. When such a certificate cannot be issued, the patient's death must be reported to the coroner, so the number of coroner referrals has gone up as a result.

56. I have liaised with the Government about the increase in the number of natural deaths reported to coroners resulting from recent changes in medical practice, and I hope we will soon see a principled solution to the problem.

57. This increase in work has been compounded by a corresponding increase in case complexity, which appears to result from a combination of factors. The increased professionalism of the coroner service has imposed more stringent processes and demands. The introduction of the medical examiner system means that complex cases in which reportable factors might previously have been missed are now rightly being identified. Coroners also face increased demand 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 European Convention on Human Rights has fuelled persistent demands for coroners to decide that Article 2 is engaged, a state of affairs about which the Court of Appeal has recently expressed concern.

58. One of the key purposes of the 2009 Act reforms was to accelerate the inquest process. Unfortunately, delay remains a significant challenge for the service. It is true that the average time taken to process a coronial investigation has reduced slightly since last year, but inquests are still taking too long to complete.

59. Although long-delayed cases represent only a small proportion of the total number of reported deaths the coronial system handles each year, it is important to recognise their disproportionate 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 timeframe is

one of the essential elements of achieving a just outcome. Delays to death investigations force grieving families to wait for answers and corrode public confidence in the system. As my predecessors and I have said on many occasions, it is essential that we keep the bereaved at the heart of the inquest process. Providing an efficient system that avoids unnecessary delay is, in my view, the single most important element of achieving that objective.

60. Delays can also impact on public learning, which in the worst circumstances could result in a risk of future deaths not being identified in time to prevent further fatalities. In the eyes of many, that danger is compounded by the absence of any effective system of monitoring the outcome of reports for the prevention of future deaths that coroners issue. Coroners themselves have no power to monitor responses to such reports. That is as it should be, for they are judges, not regulators.

61. Against a backdrop of continuing backlogs, the increasing volume and complexity of cases, and given also the understaffing and lack of resources that I have described, it is scarcely surprising that avoidable delay persists.

62. A common cause 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, and it is something that coroners and their officers repeatedly raised with me during my tour. In some areas, specialist pathologists, and even forensic pathologists, are so scarce that obtaining a report can take more than 12 months.

63. There is an urgent need for action to tackle the shortage of pathologists. It is a problem that is not confined to the coroner service, but causes serious delay in other proceedings where *post-mortem* evidence is required. I'm glad to say that the Government, led by Ministers at the Ministry of Justice, is now taking this situation seriously with a view to resolving it.

64. Unlike other judicial appointments, which are handled by the Judicial Appointments Commission, the selection of coroners remains in the hands of local authorities. The 2009 Act introduced a requirement for the Chief Coroner and Lord Chancellor to consent to each appointment. My predecessors and I have taken an active interest in coroner recruitment in order to ensure that local authorities apply and follow a fair process and also to satisfy ourselves that successful candidates are of good character. However, the Chief Coroner has no role in interviewing candidates or making appointment decisions. When the Chief Coroner, or the Chief Coroner's nominee, attends an interview, he or she is there simply to observe. As one of my predecessors succinctly put it, the Chief Coroner has a veto, but no vote.

65. During my time in office, I have overseen more than a hundred coroner appointment competitions, of which no fewer than a dozen have been for senior posts. In most of those senior coroner competitions, I have personally attended the interviews. I recognise, of course, that the task of appointing a judge is a weighty one requiring specialist expertise that local authorities cannot always be expected to possess. While we have been fortunate in the successful candidates, I do have reservations about the robustness of the process that is used to select senior coroners. There is no judge on the interview panel and usually no one with a detailed

knowledge of coronial law. Although the Deputy Chief Coroners do an excellent job of providing suitable questions for the panel to use, this does not guarantee that interviews are always properly conducted.

66. The role of senior coroner is an important leadership position. He or she is responsible for the management and effective operation of the area and for working with the local authority and police to ensure that the area receives the resourcing it needs. Above all, however, it is a judicial position; the senior coroner must have the legal knowledge, judgement and skills necessary to be effective as a judge. I am not convinced that the current recruitment process enables those requirements to be properly tested.

67. One way to address the weaknesses I have identified in the selection of senior coroners might be to include judicial members in recruitment panels.

68. Coroners do not receive the same press support, or Human Resources support as their colleagues in other jurisdictions, nor are they included in many of the national policies that apply to other judges. Their unique position as judges appointed, but not employed, by local authorities also means that local authority policies often do not apply to them. Indeed, it would not usually be appropriate for such policies to apply to members of the judiciary.

69. The past decade has seen significant progress in modernising the coroner service through a combination of area mergers and national guidance, training and oversight provided by successive Chief Coroners. That progress will continue. However, the structure of many coroner areas has

not yet been updated to accord with the deeper implications of those national reforms. My tour has exposed the need for structural reform to simplify and streamline the governance and management of individual coroner areas.

70. It is vital that the coroner service completes and consolidates the process of professionalisation that I have described by doing what it can to replicate the best working practices of other jurisdictions. There are measures that local authorities can take to streamline and modernise the service they provide, for example through the recruitment of more salaried coroners to reduce the excessive reliance on fee-paid assistants, improving recruitment practices, and by moving away from the 'triangle of responsibility' to adopt a simpler system.

71. Coroners provide a vital service to the community, but they do so with inadequate resources. They will continue to face significant challenges for the foreseeable future, and there is a limit to what can be achieved within the framework of the 2009 Act reforms. Of course, as a judge, I do not intervene on matters of policy. The structure of the coronial service and its funding model are matters for the Government and Parliament to consider.

72. Yet, despite the concerns I have expressed, 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 in the difficult circumstances that prevail, and I am confident that they will show the same dedication in the years that lie ahead.

73. I have already referred to the immense burden of work undertaken by the Deputy Chief Coroners. I cannot close without also mentioning the contribution of the Chief Coroner's private office. Its tiny but exceptionally able team, comprising just six civil servants, has been led throughout the past decade by the brilliant and indefatigable James Parker. His presence since the office of Chief Coroner was first set up makes him the embodiment of the institution's collective memory. My predecessors and I are deeply grateful to him, to the Deputy Chief Coroners and to all members, past and present, of the Chief Coroner's private office. I thank them all.

74. As I have tried to show, the focus and indeed the very purpose of the coronial death investigation process has evolved over the centuries. I do not think I can improve on the description of its modern purpose which the Commons Select Committee on Constitutional Affairs offered in 2006:

> "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."

75. That summary makes explicit the close connection between the inquest process and death certification. More importantly, it underlines a profound truth about the focus of death investigation, a truth that is

sometimes in danger of being overlooked. My predecessors and I have often spoken of putting the bereaved at the heart of the process. The Government of the day used a similar expression in the position paper it issued in advance of the 2009 Act. But a duty to put the bereaved at the heart of the process cannot exist in a vacuum. It presupposes the existence of a prior duty to the deceased. Surely, the ultimate reason for the centrality of bereaved families is that the coroner's inquest exists to discharge a posthumous duty to the dead whom they represent? That is why I like to say that it is the deceased, and by extension the bereaved, who should be at the heart of the process.

76. Hardly anyone denies the continuing power and influence of those who have gone before us. What is tradition if not, in G. K. Chesterton's words, "the democracy of the dead"? Our law upholds and enforces dispositions of property contained in validly executed wills. The common law itself may be said to rest, at least in part, upon the authority of the dead. That, perhaps, is what lies behind the legal convention that used to prevent judges and counsel from citing living authors. Even the desire of some to erase the past testifies to its continuing sway.

77. There may be cases where the interests of the deceased and the bereaved do not perfectly align. In those rare situations, the inquisitorial nature of an inquest guarantees that the court's duty to the deceased will prevail. Recognising the ultimate priority of the deceased also serves to remind us that the coroner's inquest touches not a corpse, but the death of a person. That is why, to take one example, recent guidance encourages coroners to admit pen portrait material at inquests. In the end, it is only by upholding and defending the centrality of the deceased that we can protect their families against the risk of being marginalised.

78. It is time for me to finish. To me, history is not a dustbin. It is more like a long-neglected attic, full of once-treasured relics, waiting to be explored. I hope you have enjoyed shining a torch into some of its dark and dusty corners as much as I have. I conclude with some words taken, as it happens, from a judgment of the late Lord Denning concerning treasure trove. Let us now "leave the old authors and let them rest in their graves".

79. Thank you.