Courts and Tribunals Judiciary

Extraordinary Report of the Chief Coroner

The coroner service 10 years post-reform

11 January 2024

Contents

Introduction

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

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

The purpose of the coroner service

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

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

A coronial death investigation is a form of summary justice, providing answers to four statutory questions, namely who the deceased was and when, where and how (usually confined to meaning 'by what means') the deceased came by his or her death. Where the enhanced duty of investigation arises under Article 2 of the ECHR, the coroner or jury must examine the wider circumstances in which the death occurred, but still cannot express an opinion on any topic other than the four

statutory matters to be ascertained. The attribution of blame forms no part of the coroner's role. The 2009 Act expressly prevents inquest determinations from being framed in such a way as to appear to determine any question of civil liability or any question of criminal liability on the part of a named person.

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

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

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

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

2 Sophocles, Antigone, lines 450-459.

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

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

The local funding model

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

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

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

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

4 Coroners and Justice Act 2009, section 24.

The 2009 Act reforms

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

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

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

Other notable changes made by the 2009 Act included:

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

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

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

The positive impacts of reform

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

The professional standing of coroners

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

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

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

The distribution of coronial work

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

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

Consistency

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

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

Use of technology

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

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

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

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

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

Collaboration

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

The current state of the coroner service

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

Tour findings

The overarching findings from my tour were as follows:

The service has insufficient personnel

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

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

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

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

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

The primary concerns I have identified are as follows:

1. Dilapidated buildings

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

2. Insensitively sited accommodation

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

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

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

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

3. A lack of dedicated courtrooms

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

There remains a general need for more salaried Area Coroners

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

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

The benefits of appointing an Area Coroner include:

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

The 'triangle of responsibility' creates operational difficulties

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

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

Judicial independence is impacted by the current resourcing structure

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

Problems I have recently encountered include:

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

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

2. Inappropriate action in relation to capability concerns

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

3. Disagreement over staff direction

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

4. Inability to provide appropriate funding

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

Court security arrangements vary considerably and are rarely adequate

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

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

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

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

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

Recent work increases are likely to be permanent

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

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

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

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

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

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

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

Delay

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

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

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

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

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

Judge-led inquests

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

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

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

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

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

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

The appointment of coroners

Local authorities are responsible for appointing coroners.

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

10 https://coronerspatersoninvestigation.org/

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

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

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

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

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

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

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

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

Coroner support

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

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

The future of the service

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

Current and prospective action

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

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

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

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

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

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

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

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

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

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

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

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

Defining the coroner's role in the administration of justice

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

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

Conclusion

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

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

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

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

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

HHJ Thomas Teague KC
Chief Coroner