Written evidence from the Chief Coroner of England and Wales (COR0081)

Contents

Executive summary

1. The Chief Coroner's submission to the Justice Committee's inquiry in to the coroner service covers a number of areas. It aims to encompass the seven topics identified by the Committee in its call for evidence.

2. Section 1 sets out the functions and role of the Chief Coroner. Sections 2 – 5 aim to give a comprehensive description of the judicial role and function of the coroner and of the coroner jurisdiction, including an account of the current statistical picture. Sections 6 and 7 cover the coroner service i.e. the infrastructure that delivers coroner investigations and inquests, including a comprehensive account of how coroners and

local authorities should interact. Related issues, including the type of service offered to the bereaved, consistency and fairness (including issues around legal aid) are also discussed.

3. Section 8 covers mass fatalities and related issues, including an account of how the coroner service has responded to the major terrorist events in recent years.

4. Section 9 deals with Prevention of Future Death reports, whilst section 10 gives an account of the significant work undertaken by coroners and the wider service in responding to the challenge of COVID-19.

5. Finally, section 11 gives a comprehensive and up-to-date account of coroner training.

6. As he approaches the end of his term in office. the Chief Coroner would like to take the opportunity to thank all coroners, coroners' officers and other staff, and those in local authorities and the police supporting the coroner service for their dedication, particularly in this most difficult of years. Their hard work, providing answers for the bereaved and for the wider public forms a significant contribution to the public service.

The function and role of the Chief Coroner

7. The Chief Coroner of England and Wales is His Honour Judge Mark Lucraft QC the second holder of that office. He was appointed to the role in October 2016 by the Lord Chief Justice. He is also the Recorder of London, the most senior circuit judge in England and Wales and the most senior judge at the Central Criminal Court (Old Bailey), a post to which he has recently been appointed. Exceptionally, because of the need to provide continuity of leadership and support for the coroner service in this unprecedented period of pandemic emergency, at the invitation of the Lord Chief Justice he is combining those jobs in the short-term, although ordinarily the role of Chief Coroner and Recorder of London are not judicial roles which can (or should) be combined.

8. HHJ Lucraft QC will finish his term as Chief Coroner in the Autumn of 2020 and a new judge will occupy that role after an appointment process.

9. The office of Chief Coroner was created by the Coroners and Justice Act 2009 as part of the widespread statutory reforms which were made at that time to the coronial system. The Chief Coroner must be a High Court or Circuit Judge under the age of 70, and the appointment is made by the Lord Chief Justice in consultation with the Lord Chancellor.

10. The extent of the Chief Coroner's jurisdiction is England and Wales.

11. The office has a range of formal powers and duties, including (but not limited to):

    (a) approving ("consenting" in the language of the Act) to the appointments of all coroners;

    (b) directing an inquest to be held in the absence of a body;

(c) global case management powers (including directing transfers of inquests between coroner areas in certain circumstances, and requesting the Lord Chief Justice and Lord Chancellor to appoint judges in certain high-profile or complex inquests);

(d) publishing Prevention of Future Death Reports;

(e) receiving notifications of investigations taking longer than a year and keeping a register;

(f) keeping a register of service personnel death investigations;

(g) reporting annually to the Lord Chancellor and parliament.

12. The Chief Coroner may conduct inquests at first instance by virtue of the office or as a nominated judge. For example, the Chief Coroner conducted the inquests in to the Westminster Bridge attack and the London Bridge and Borough Market attacks in 2017. These inquests were complex, lengthy and of international and press interest given the awful profile of the events in the heart of London and the impact on families from across the world. The Westminster Bridge inquests spanned six weeks of hearings. The London Bridge and Borough Market inquests spanned some eight weeks. At each of these inquests there were a number of interested persons. These included not only the families of the victims and perpetrators but also the Metropolitan Police, the City of London Police, Transport for London, the London Ambulance Service and the Security Services. The Inquest hearings provided an opportunity for a detailed analysis of the events, the investigations into the perpetrators after the event, what was known about them before the events, and also the response of the emergency services following the attacks. Some significant matters of concern were raised in the prevention of future death reports at the conclusion of the inquests.

13. By convention, the Chief Coroner also sits in the Divisional Court hearing some of the most important judicial and statutory review cases concerning coroners.

14. Those formal functions only provide a partial view of the role of the Chief Coroner: they are the 'tip of the iceberg'. Much of the Chief Coroner's role involves non-statutory leadership to coroners. The Chief Coroner promotes consistency and good practice in coroners' courts, including organising training for coroners and coroners' officers (which is provided through the Judicial College), encouraging good and collaborative working between coroners and their relevant local authorities, encouraging (through close working with local authorities) coroner area mergers, issuing Guidance on law and practice and providing judicial leadership including pastoral supervision and welfare. The Chief Coroner also produces Memoranda of Understanding with a number of organisations to encourage good working practices between coroners and third parties such as the Health and Safety Executive and the Care Quality Commission. Unsurprisingly, because of the decentralised, local nature of the coroner service, much of the work of the Chief Coroner takes place in the interstices between the statutory provisions and day-to-day operational practice and requires diplomacy, patience and communication.

15. The Chief Coroner has a key co-ordinating role should there be a mass fatality, terrorism or other event with Disaster Victim Identification (DVI) aspects that occurs in England & Wales or a similar event overseas involving UK nationals.

16. The Chief Coroner also has a significant role in representing the views and interests of coroners and the coroner service to central government. In addition to the annual report submitted to the Lord Chancellor, he meets with the Minister with coroner responsibility at the MOJ from time to time, as well as the Lord Chancellor. His office engages with the Ministry of Justice and with wider government on his behalf (and on behalf of coroners) on myriad issues including new legislation, government consultations and initiatives and operational matters. Officials from his office participate in committees and working groups where a perspective on the coroner system is needed.

17. The Chief Coroner has also, exceptionally, intervened (meaning, took 'interested party' status or equivalent) in court proceedings which involve very high profile or complex cases. He is always a non-partisan interested party or intervener and his position is merely to set out the current case law on an issue and to ensure that legal certainty for coroners and all other interested persons prevails and legal disputes are minimised. Examples of his intervention include cases in the Supreme Court regarding the standard of proof in deaths by suicide and in the Divisional Court regarding expedited decision making by coroners.

18. In February 2019 two Deputy Chief Coroners were appointed, HHJ Alexia Durran and the Senior Coroner for Sunderland, Derek Winter DL. This is an acknowledgment of the breadth of the work undertaken. The Chief Coroner is supported by a private office comprised of civil servants and lawyers who sit within the Judicial Office which supports the Lord Chief Justice and the senior judiciary in upholding the rule of law and in delivering justice impartially, speedily and efficiently.

19. The first holder of the office (HH Sir Peter Thornton QC) introduced the practice of producing Guidance notes and law sheets for coroners. This is now a significant component of the Chief Coroner's role. In the interest of openness and to assist users of the coroner service, these are routinely published on the Chief Coroner's section of the Courts and Tribunals Judiciary website: https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/. They cover a wide range of topics, including for example coroner appointments, conclusions, merger of coroner areas and post-mortem examinations. Each is intended to summarise the relevant law and give advice. The present Chief Coroner has continued producing such documents. Guidance documents are reviewed and revised from time to time. These Guidance documents are not issued under any statutory power and are not practice directions (or even akin to practice directions). They are advisory only and have no binding effect on coroners. Indeed, the Chief Coroner himself has made clear that, when sitting as a judge in the Divisional Court, he is not in any way bound by the contents of such Guidance notes. However, they aim to standardise approach and practice, clarify the law and assist coroners, bereaved families and practitioners alike. There are now some forty Guidance notes. Most of the recent notes have addressed various aspects of the impact of coronavirus on the work of the coroner.

The role of the coroner

20. The principal statute governing coroners and inquests today is the Coroners and Justice Act 2009 ("CJA"). It was enacted following a lengthy law reform process which began with the Fundamental Review of Death Certification and Investigation of 2003. It was substantially brought into force in 2013, accompanied by the Coroners (Investigations) Regulations 2013 ("the Regulations") and the Coroners (Inquests) Rules 2013 ("the Rules").

21. The 2009 Act presented an integrated system of death investigation, with a Medical Examiner acting as the 'first port of call' for all deaths in England and Wales, and as now, only certain cases going on to be investigated by the coroner. As the Committee will know, the statutory provisions relating to Medical Examiners have not been commenced in their totality but the Chief Coroner is pleased that there is now a non-statutory, partial medical examiner scheme in place, led by the National Medical Examiner, Dr Alan Fletcher, with whom the Chief Coroner works closely. The Chief Coroner looks forward to the extension of the scheme from hospitals to also cover community deaths, and it being put on a statutory basis in due course.

22. Each coroner is an independent judicial officer with responsibility for investigations and inquests in his/her area. It is the individual coroner who makes decisions about such matters as the scope of inquiry and evidence to be gathered for and adduced in an inquest. The Chief Coroner has no general power to direct coroners in their work and does not have disciplinary powers over coroners (who are subject, like all judges, to the Judicial Conduct Investigations Office in that regard).

23. In England and Wales is the legal requirement that for each death there must be a record (registration) of that death (to the Registrar of Births and Deaths) with a medical explanation of the cause of death. This is the underpinning principle for all aspects of death certification and investigation.

24. In the simplest terms, for those deaths which cannot be registered directly via a Medical Certificate of Cause of Death completed by a medical practitioner, the role of the coroner (but not the only role) is to provide the Registrar of Births and Deaths with the information they need in order to properly and legally register a death and to contribute to accurate mortality statistics.

25. In practice this means that where the cause of death is unknown (and so cannot be reported to the Registrar with a medical explanation of the cause), the death is reported to the coroner. If the coroner subsequently establishes the death is of natural cause, it can be dealt with via the Medical Certificate route as above and the coroner needs no more involvement.

26. Where the death is 'unnatural', remains unknown or in other specific circumstances, having had the death reported to them, the coroner will usually proceed to a formal investigation (within the meaning of that term in the 2009 Act) which in many cases leads to a formal court proceeding called an inquest. The coroner's investigation here is a legal one into the circumstances in which the deceased came to his or her death: they explain for the benefit of the bereaved family and society who died, when and where they died and 'how' the death occurred (that 'how' explanation taking place within certain well-established legal parameters). As above, the inquest process also

provides the necessary information to register the death, including providing the medical cause of death.

27. The management of death by society, the investigation of and explanation of the circumstances of death and the certification of death has a complicated structure. There are many intertwining roles and responsibilities across different organisations and across the public and private sector (by way of example, many practical aspects of burial and cremation - which is a critical part of the national infrastructure for death management - are nearly wholly provided by the private sector i.e. funeral directors). In a death which is not a naturally occurring one, the coroner sits at the centre of the framework. Coroners have many responsibilities both before, during and after an inquest. The Chief Coroner has consequent obligations to coroners and to the coroners' service at all stages of the death investigation process. A coroner's workload consists of a wide range of tasks. These include receiving reports of deaths, making initial enquiries (including sometimes arranging post-mortem examinations) and releasing bodies for burial and cremation. They also include pursuing more extensive coronial investigation, case-managing inquests and holding inquest hearings. Further details on these statutory functions are set out below. In multiple deaths in a public disaster or terrorist incident, the coroner is also on the 'front-line' of the response.

Statistics

28. The Ministry of Justice collects and publishes annual coroner statistics. In 2019 the number of registered deaths in England and Wales rose by 2% on the 2018 figures to 530,857. Just over half of all deaths recorded are from natural causes certified as such by a general practitioner or a hospital doctor and therefore do not require a report to the coroner. Where it is not clear that a death is from natural causes it must be reported to the coroner. There were 210,900 deaths reported to the coroner in 2019, which accounts for 40% of all deaths in England and Wales. This is a decrease of 4% on the number of deaths reported in 2018 and can mainly be attributed to the removal of the requirement to report Deprivation of Liberty Safeguard (DoLS) deaths to the coroner. The statistics for 2020 will be published in May 2021.

29. Many cases reported to the coroner are signed off by the coroner after preliminary enquiries (either with or without a post-mortem examination), as being deaths from natural causes. In these cases, a formal investigation under the 2009 Act is not required and therefore there is no inquest. In 2019 there were 82,100 post-mortem examinations ordered by coroners, a reduction of 4% on the previous year. Overall, the figure of deaths reported to the coroner but where a formal investigation is not required, equates to 39% of the deaths reported to the coroner.

30. Where it is clear that a death was not from a natural cause or where the post-mortem examination does not provide the cause, the death investigation proceeds to inquest. 30,000 inquests were opened in 2019 (an increase of 3% on the previous year). This represents 14% of all the deaths which have been reported to the coroner. Deaths in which an inquest is necessary are therefore a significant minority of the 210,900 deaths reported to coroners each year.

31. Deaths occurring in state detention (excluding DoLS) fell from 514 in 2018 to 478 in 2019, a reduction of 7%. The decline is driven by a 16% and 5% fall in reported deaths of individuals detained under the Mental Health Act 1983 and in prison respectively. In 2019 there were 527 inquests held with juries. This is up from 423 jury inquests held in 2018 but still only equates to 1%-2% of all inquests. Jury inquests are only held in certain limited circumstances, usually because the unnatural death was in state detention, a death as a result of police deployment of firearms, where significant Article 2 issues are at stake, or where the coroner has exercised their discretion to conduct the inquest with a jury. Deaths in state detention remain of particular concern to coroners and many generate prevention of future death reports where a coroner has a duty to make reports to a person, agency, government department or local authority where they believe action should be taken to prevent future deaths.

32. These figures reveal much about how the coroner system works and about the role of the coroner. Most people who have only a cursory knowledge of the system equate the coroner with the inquest; that is, the formal court proceeding which is the culmination of the investigation into the circumstances of a death. Each inquest is of significant importance to the bereaved family and others. However, only around 14% of cases reported to coroners reach the inquest stage. As set out above, many of those 210,900 reported deaths annually are assessed by a coroner and appropriately diverted to be registered without the need for a coroner investigation or inquest. This sort of preliminary or investigation work, which typically takes place on paper, in the office, forms a very large part of a coroner's day-to-day role.

33. It is also important to understand what kind of cases make up those 30,000 that proceed to inquests annually. The majority are relatively straightforward in terms of the facts and the legal issues in play. This is not to underplay the significance, emotional difficulty and importance of each inquest for the bereaved family. However, the majority of inquests are not like the complex, high profile inquests which can often feature in the news, which may have an adversarial subtext. It would be inaccurate to assume that all inquests were like those.

34. In many inquests the only people present at the hearing are the bereaved family, the coroner and perhaps, but not always, an usher, coroner's officer or other member of staff. The family will be unrepresented (and there will be no need for them to have lawyers). In a significant minority of inquests, there is no one at all at the inquest apart from the coroner. In these cases, the bereaved family will have been contacted, but they have chosen not to attend. Evidence is taken in a 'documentary' form (i.e. written, without oral evidence).

35. The complexity of a case will always depend on the issues at hand and complexity within coroner cases exists on a spectrum. Some – many – are relatively modest. Some – a minority – are very complex. But it is the view of the Chief Coroner that parliamentarians and policy makers should have a clear view of the very broad spectrum of cases coroners deal with.

The purpose of the death investigation and inquest

36. An inquest is an inquiry into a particular death, with the individual deceased person as the focus of that inquiry. As such, the investigation and evidence will concentrate on the circumstances and causes of the particular death.

37. The primary purpose of any coronial investigation (including any inquest) is to provide answers to four factual questions: who the deceased person was; and how, when and where he/she came by his/her death. Those questions have been prescribed in the legislation going back to the Coroners Act 1887. Section 5(1) of the CJA provides that the purpose of a coroner's investigation is to answer those questions and to provide certain formal particulars required for registration of a death (e.g. date and place of birth). Section 5(3) states that the coroner or jury should not express an opinion on any other matter concerning the death, subject to the coroner's power to issue a Prevention of Future Death (PFD) report.

38. An inquest is a fact-finding process, with the coroner deciding what evidence to gather and what witnesses to call at the inquest hearing. The scope of inquiry must be sufficient to establish the answers to the four statutory questions, notably how the deceased person came to die. However, the inquiry will very often be wider in scope than strictly necessary to answer those questions. It is a matter of judgment for the coroner to determine the parameters of the inquiry and how far he/she will trace the causal chain leading to the death. The scope of that inquiry may be widened as new topics emerge or narrowed as issues fall away. Coroners have powers to require the provision of evidence and to summons witnesses to attend inquests. In practice, they can also draw on material produced by other investigations into the death (e.g. by the police).

39. In preparation for an inquest, the coroner will gather evidence and will disclose relevant documents to those designated as "interested persons" (which include members of the bereaved family and other people and organisations with a proper interest in the inquest). Coroner Rules now provide for interested persons to have a general right to disclosure of relevant evidence. In more complex matters the coroner will usually hold one or more pre-inquest hearings, at which interested persons can address issues such as scope of inquiry, evidence being gathered, disclosure and witnesses to be called.

40. An inquest may be heard either by a coroner alone or a coroner sitting with a jury (7-11 jurors). Section 7 of the CJA lays down certain classes of case where the inquest must be held with a jury. Section 7(3) also gives the coroner a residual discretion to have a jury in cases where it would not be mandatory.

41. At the inquest hearing, the coroner will call all witnesses and the coroner him/herself will examine each witness first. All interested persons are entitled to examine witnesses themselves or through a lawyer about relevant matters within scope. At the end of the evidence, interested persons may make submissions to the coroner on questions of law, including the available conclusions. Although interested persons are not permitted to make an address on the facts to the coroner or jury, submissions on the available conclusions may be made to the coroner with appropriate reference to the facts and evidence.

42. At the end of an inquest, the coroner or the jury (if there is one) must return a determination answering the four statutory questions: who the deceased person was; and when, where and how he/she came by his/her death. Except for conclusions of unlawful killing, under the law at present coroners apply the civil standard of proof for inquest conclusions (known before the 2009 Act as 'verdicts'). In particular the civil standard now applies to conclusions of suicide (although the case of *Maughan,* through which the Court of Appeal provided clarity on the question of standard of proof for a conclusion of suicide, has found its way to the Supreme Court and judgment is awaited). The Rules require that the determination be recorded in a Record of Inquest form which appears in a Schedule. Section 10(2) prohibits any determination from being framed in such a way as to appear to determine any question of criminal liability of a named person or any question of civil liability at all.

43. The question of "how" the deceased person came by his or her death is usually the most significant in an inquest. In most inquests, it is taken as meaning "by what means" the deceased person came to die, a question directed to the immediate means of death. It is often answered by the coroner or jury giving a brief account of the death in section 3 of the Record of Inquest and recording in section 4 one of several well-known short-form inquest conclusions (e.g. accidental death, suicide, etc.). However, it has always been legitimate to replace the short-form conclusion with a brief narrative (ensuring that they are non-judgmental) of the means of death.

44. Article 2 of the ECHR (the right to life) has been found by the Strasbourg Courts to entail procedural obligations on member states. These include a general obligation on states to have adequate systems for death investigation and law enforcement. They also include in certain circumstances a duty on the state to establish independent investigations into deaths which satisfy standards laid down in Convention case law. In *R (Middleton) v West Somerset Coroner* [2004] 1 AC 182, the House of Lords considered whether inquests in England and Wales satisfy the Convention standard of an effective means of investigation. It decided that, where the Article 2 obligation to establish an independent investigation is engaged in relation to a death and it has not been discharged by some process other than the inquest (e.g. a contested criminal trial or other inquiries / investigations), the ordinary approach to inquest conclusions must be modified in one respect to satisfy the Convention standard of effectiveness. The words "how the deceased came by his or her death" in the statutory provisions should in such cases be read as meaning "by what means and in what circumstances the deceased came by his or her death". In practical terms, this may require the coroner to return, or elicit from the jury, a narrative conclusion in a somewhat longer form and in more judgmental terms. This broader form of conclusion may address underlying and contributory causes of death. It may address circumstances surrounding the death which may have been causative of death but cannot be proved probably to have been causative.

45. The broader approach to the "how" question established in *Middleton* has been given statutory force by sections 5(2) and 10(1) of the CJA. It only applies in those cases where the obligation of the state to carry out an independent investigation is engaged and where that obligation has not been discharged by other means. Such inquests are known as "*Middleton*" inquests.

46. The Article 2 procedural obligation of the state to carry out an independent investigation into a death has been held to be automatically engaged in certain classes of case, including deliberate killings by state agents and violent deaths in state custody (including suicide). It is also engaged where on the evidence there is an arguable case that the state or its agents committed a breach of a substantive Article 2 duty in relation to the death. The threshold test of "arguable breach" is a low test of evidential sufficiency, but it still requires a basis in the evidence which is more than speculative or remote.

47. The principal effect on an inquest of a decision that the Article 2 procedural obligation is engaged will be upon the available inquest conclusions. A decision that the Article 2 procedural obligation is engaged and that the inquest will adopt the approach set out in *Middleton* may have the result that a somewhat expanded form of narrative conclusion is returned. However, the conclusion must still comply with the statutory requirements, including the prohibition on findings appearing to determine civil or criminal liability and the requirement that inquest conclusions should not extend beyond answering the statutory questions and providing particulars for registration of the death.

48. Engagement of Article 2 in an inquest should usually have little or no effect upon the scope of inquiry and the conduct of the inquest. A properly conducted inquest should usually involve a sufficient inquiry to answer the broader question "in what circumstances" the person came by his/her death.

49. In an inquest, the coroner will decide whether or not the Article 2 procedural obligation is engaged such that the approach laid down in the *Middleton* case should apply. The answer to the question may be obvious or it may be difficult to decide. In making the decision, the coroner will decide on the available material whether the obligation is automatically engaged and, if not, whether it is arguable that the state or its agents breached one of the substantive Article 2 duties in relation to the death. This decision may be made in a pre-inquest hearing, but it will sometimes be made at the inquest itself (especially if there is insufficient material to answer the question properly before the inquest).

50. It is important, for the purposes of a proper understanding of the type and scale of coroner work (and relevant to discussions around legal aid, support for families and so on) to grasp that in the vast majority of the 30,000 inquests annually the Article 2 procedural obligation is not engaged.

Recent case law decisions in coronial law

51. As has been discussed above, the vast majority of inquests are straightforward in terms of the legal and factual issues which fall to be decided by the coroner. However, there are some inquests which raise novel or complex questions of law and which are eventually heard in the Divisional Court, Court of Appeal or Supreme Court. Although these cases are relatively rare, it is a measure of the difficult legal issues that coroners must sometimes grapple with amongst their everyday work.

Article 2

52. As set out above in detail, the procedural obligation under Article 2 is ordinarily discharged by an inquest and so the vast majority of cases do not engage Article 2 obligations. What the Lord Chief Justice has called an "intense, indeed hard-fought debate"[1] precedes many inquests about whether the coroner's investigation is one governed by Article 2 even although in most cases the scope of the investigation and inquest is unlikely to be affected by the question of whether the Article 2 procedural obligation applies. There are two recent cases in which Article 2 has been considered in detail in the higher courts including analysis of the Strasbourg litigation.

53. In *R (Parkinson) v HM Senior Coroner for Kent [2018] EWHC 1501 (Admin)* the Divisional Court considered the applicability of Article 2 in medical cases. The court held that an enhanced duty of investigation exists where there has been a breach of the state's substantive obligations under Article 2 of the kind which is a systemic failure rather than simply medical negligence. If there is no systemic issue which arose in the care of a patient there is no enhanced duty of investigation under Article 2.

54. In a subsequent medical care case the Divisional Court held that in the absence of either systemic dysfunction arising from a regulatory failure or a relevant assumption of responsibility in a particular case, the state will not be held accountable under Article 2. That case was appealed to the Court of Appeal in which the Lord Chief Justice gave the leading judgment *(R (Maguire) v HM Senior Coroner for Blackpool & Fylde & Ors [2020] EWCA Civ 738)* the Court made it clear that in a medical care case the question is whether there is a positive obligation owed under Article 2 for the state to protect life and this is dependent on the circumstances. In that particular case there was no basis for believing that the deceased's death was the result of a breach of the operational duty of the state to protect life under Article 2 and it followed that the procedural obligations on the state did not arise.

Standard of Proof

55. For some bereaved families one of the most distressing conclusions can be when a coroner returns a conclusion of 'suicide' (although there is a well-developed debate within academic and third-sector circles about the issue of clarity and plain speaking when suicide occurs and different participants in those debates, including bereaved people, take different views). Coroners, as judges, apply the law faithfully and the Chief Coroner has provided Guidance on the appropriate language to be used when finding a conclusion of suicide[2].

56. The recent case *of R (Maughan) v Senior Coroner for Oxfordshire [2019] EWCA Civ 809*, heard in the Court of Appeal in which the Chief Coroner appeared as an Interested Party endorsed the Divisional Court's view, that the standard of proof required for a jury to return a conclusion of suicide is the civil standard, i.e. the balance of probabilities. This applies whether it is a short form or narrative conclusion. This overturned 35 years of settled law. The Court considered that the standard of proof for a jury to return a conclusion of 'unlawful killing' remains the criminal standard, pending any legislative change. This case was appealed to the Supreme Court and judgment is due to be handed down imminently.

[1] R (on the application of) Maguire v HM Senior Coroner for Blackpool & Fylde & Ors [2020] EWCA Civ 738, paragraph 77.

[2] Guidance No.17 Conclusions: Short-form and narrative, paragraphs 60 – 63

Prioritisation of investigation in to death

57. Following the judgment of the Administrative Court in *R (Adath Yisroel Burial Society) v Senior Coroner for Inner North London [2018] EWHC 969 (Admin)* in which he was an Interested Party, the Chief Coroner issued Guidance No. 28 in 2018. This case was brought against a coroner's policy of following a 'cab rank' rule in dealing with reports of deaths into her jurisdiction. The judgment reflected two important legal considerations, that a coroner should be open to representations that a particular case should be treated as a matter of urgency (whether for religious or other reasons) and that proper respect should be given to representations based on religious belief.

The coroner service, infrastructure, and the delivery of a service for the bereaved

58. The coroner service of England and Wales remains essentially a local service. There is no national structure. Coroners are appointed and paid locally, the service is funded locally including the provision of courts and other accommodation and IT systems and coroners' officers and support staff are employed locally by police and or local authorities.

59. Each coroner area has a senior coroner supported by assistant coroners (who are fee paid part-time coroners). In many areas there will also be an area coroner, which is a salaried position and acts in effect as a deputy to the senior coroner. The area coroner provides a layer of permanence and continuity in addition to that provided by the senior coroner and this can be very important, particularly in a busy coroner area. Even without an area coroner the senior coroner should nominate an assistant to be the deputy in the event of a prolonged absence. The appointment of an area coroner provides considerable additional resilience to an area. Over the last five years far more coroner areas have appointed a full-time or part-time area coroner. There are now 32 area coroners. This is a development the Chief Coroner has encouraged and supported.

60. The role of the senior coroner, a post which came into force for the first time with the implementation in 2013 of the Coroners and Justice Act 2009, provides both judicial leadership on reports of death and investigations and inquests (typically dealing with the most complex inquests as well as dealing with the full range of judicial work in the area) as well as significant judicial-administrative responsibilities, including listing and deployment as well as involvement with myriad administrative and leadership matters, working with the relevant local authority in a constructive way.

61. The role embraces the following. The senior coroner:

- stands at the head of the local coroner service;
- provides collaborative leadership;
- leads on coroner work and manages the caseload and directs listing;
- organises and supports their coroner's office and team including coroner's officers, staff and assistant coroners.
- works closely with the local authority and the police;
- is on call all the time as required in statute (or on a rota basis with an

area/assistant coroner);

- is prepared for a mass fatality disaster including with a disaster victim identification (DVI) component, as well as other events such as a terrorist related incident or pandemic scenarios. This function includes senior participation in the Local Resilience Forum (LRF) on DVI and terror incidents, mass fatalities and excess deaths.

62. A well-functioning coroner area requires a constructive relationship based on mutual understanding, confidence and respect between the senior coroner and the relevant authority.

63. It is the statutory responsibility of the relevant local authority to provide "staff and accommodation" as set out under section 24 of the Coroners and Justice Act 2009. In practice the role of the local authority extends beyond that of the simply providing some staff and buildings; the infrastructure required to run the service (implicit in the term 'accommodation') includes, amongst other things, security, administrative and IT provision, a public facing website, adequate office and courtroom accommodation, access to case law resources including text books, legal and HR support where necessary and so on.

64. The senior coroner has judicial functions, including judicial-administrative responsibilities, as set out above. Coroners have, in law, a wide judicial discretion to conduct investigations into a death and they may make whatever enquiries seem necessary. They have wide powers to investigate at pre-investigation, investigation and inquest stages.

65. For the relationship to be effective, it is important that the relevant authority appreciates that coroners are independent judicial office holders, and not employees or a department of the local authority and as such the local authority may not interfere in matters within the exclusive jurisdiction of the coroner.

66. This does not, however, mean that coroners have exclusive rights over all things coronial. Much needs to be the subject of sensible discussion and agreement. The relevant authority has a proper duty to manage public finances and a legitimate interest (including a reputational interest) in maintaining public confidence in the effective administration of the local justice it is required to help deliver.

67. It is very important that all parties understand the nature of the respective roles and of their relationships and that they calibrate the nature of their engagement carefully and with respect. As part of that process of calibration, the relevant authority should respect the seniority and status of the coroner as a judge (and the leader of the coroner service locally) and the relevant authority will inevitably be required to accept they do not have the same level of direct control over the work of the local coroner service as they would over another local authority department. This is axiomatic.

68. However, in the same spirit, the senior coroner should not harbour a fixed idea of his or her role and domain. The role of the senior coroner, particularly when they are working to administer and lead the local jurisdiction, rather than conducting an individual inquest into a death, requires that the senior coroner also respect the

proper interest of the relevant authority in their shared task of delivering justice locally for the bereaved. Any differences of view about arrangements for the running of the service should be aired constructively and resolved quickly; a good relationship will make this possible.

69. The relevant (local) authority should (and is required by law) to provide suitable accommodation for all coroners, coroners' officers and administrative support staff. Whilst 'suitable' is not defined in statute, in the opinion of the Chief Coroner, and in an ideal world, 'suitable' should mean, amongst other things, that it should be appropriate in terms of the dignity of the deceased and their families and should be of a good and safe standard physically. It would include (for example) adequate private rooms for the bereaved family to use during the course of an inquest. Security arrangements for staff, judiciary and the public is an important factor. In terms of an efficient coroner's office, ideally, all personnel should be close together in one building. The coroner's court should be in the same premises where possible. Where the local court is not large enough for jury inquests, courts should be made available to the coroner for jury inquests on a regular basis. Coroner areas should actively work towards these arrangements.

70. Coroners' officers and other staff are typically employed either by the police authority or local authority, but work at the direction of the coroner. Other staff are usually employed by the local authority (although there are no fixed rules on this matter). Coroners' officers and other staff are not employed by the senior coroner. The senior coroner is not the line manager of those members of staff in the sense that that term is normally used. However, the senior coroner (and the coroners in the area more widely) are entitled to direct the work of the coroners' officers and other staff because the role of those members of staff is, amongst other things, to carry out tasks in pursuit of the coroner's judicial function. The service could not work unless this was so.

71. In order that coroners can carry out their functions, it is the Chief Coroner's view that there should be appropriate staffing levels. In complex jurisdictions, more should be provided. Where the police employ coroners' officers, they should not work in different buildings elsewhere in the coroner area or in police stations, but working together in one place with the coroner and other staff. This produces greater resilience, efficiency and effectiveness of working. It serves the public better. The coroner's premises should, where possible, be close to the registration services and other relevant local authority staff (and Medical Examiner service when implemented).

72. The Chief Coroner works with senior coroners, local authorities and others in order to promote these ideas, including via national annual conference with local authorities and the document 'A Model Coroner Area', which is published annually alongside the Chief Coroner's Annual Report (and a new version of this document will be published alongside the next Annual Report).

The case for a National Coroners Service and the extent of unevenness of coroners' services including the experience of the bereaved

73. The question of a national coroner service has been the subject of debate for a number of years.

74. As set out above, the coroner service is a local service. Where the relevant local authority understands the importance of the service and funds it properly and where the senior coroner is working effectively together with the relevant authority (and there is effective leadership across the board), it is much more likely that high quality outcomes for bereaved people (and justice for the wider public) will be achieved. There are many examples of excellent local delivery. For example, in the South Wales Central coroner area, an old school building has been converted in to a new and dedicated coroners court and offices, bringing all the staff together in to one place and providing first-class accommodation for court users and the bereaved. Other examples include Milton Keynes, where there has been really excellent strategic and close working between the senior coroner and the local authority and other local agencies, and Manchester City, where the local authority have invested in court accommodation which is arguably more modern and better equipped than the most up-to-date parts of the HMCTS estate.

75. Coroner areas which seem less well able to cater for the needs of the bereaved and other participants often suffer from a lack of investment. Clearly some local authorities suffer from significant budgetary pressures. Sometimes there is a lack of understanding or interest about the service, and sometimes a lack of vision from the local authority about what kind of coroner service they want to provide for their citizens and voters. There may be a number of reasons for that. This can sometimes be mirrored by a senior coroner who, for whatever reason, finds it difficult to make the relationship with the local authority work.

76. When thinking about a national service, the word ’consistency is often used. But it is important to reflect on what ‘consistency’ actually means and what problems improvements in consistency would address. Consistency in the coroner service should mean consistency of the service offered and the consistency of experience when interacting with the service. Achieving consistency would mean reducing unevenness in funding, staffing levels, capability and infrastructure between coroner areas. A properly funded national service may lead to greater consistency – but (as the saying goes) the devil would be in the detail. An underfunded national service may find it hard to make significant improvements.

77. Whilst there should also be broad consistency around the range of approaches to judicial decisions (and in part this is what Chief Coroner Guidance and training is designed to encourage) it is important to emphasise that every case is different and the nature of the ‘inquisitorial’ jurisdiction means that each coroner makes independent fact-finding judicial decisions in the context of each case. The coroner has, in law, wide discretion when pursuing their investigation in to a death. This means that even if a national service was introduced, this wide discretion when investigating an individual case would still exist. As independent judicial office holders, coroners remain responsible for their own judicial decisions and the Chief Coroner cannot direct them to make a particular kind of decision in an individual case or a group of cases, neither can he intervene in any other way in individual cases.

78. The Chief Coroner has set out publicly many times that the focus of the inquest should be on the bereaved next of kin and all parts of the investigation process should have the family at the centre of it and ensure that full dignity is afforded to the deceased and the family. In recent years he has ordered and delivered training for all coroners to ensure that the inquest process is accessible and helpful for families. He and his office have worked with government on several occasions in this space, including in developing changes to address issues raised by Bishop James Jones and Dame Elish Angiolini in their respective, recent reports. At all times coroners and their officers should treat the bereaved carefully and with sensitivity. This is particularly so with regards to the more distressing aspects of the investigations process for example post-mortem examinations.

79. The Chief Coroner is aware that the first and only time that many people interact with a court or judge is if they attend an inquest in whatever capacity. As set out above, the vast majority of inquests which are attended by families are straightforward and legally uncontentious (although as already stated this is in no way to underplay the emotional stress of the experience for the family). The coroner is different from a judge in a civil or criminal matter in that the coroner is actively encouraged to ask questions on behalf of the family and participate in the process themselves in order to establish the facts of the death. The process at its heart is inquisitorial not adversarial (in the technical, legal meaning of these terms), although the fact that an inquest is not adversarial does not mean that searching, probing questions should not or will not be asked, or that those giving evidence will always find it an easy experience (because of the nature of the issues). The role of the coroner is (in part) to make sure the process is conducted fairly and that interested persons are able to have relevant questions posed. Coroners (and sometimes lawyers) are able to assist unrepresented interested persons in establishing the circumstances of the death.

80. There are occasionally inquests in which all interested persons are represented by lawyers, particularly where there is a jury. As set out above, jury inquests only account for 1-2% of all inquests but inevitably some of these are high-profile and/or contentious. It is perhaps inevitable in this kind of inquest that the families' experience will be rather different to those of the families involved in the remaining 98-99% of inquests. The Chief Coroner's view is that the vast majority of families are well supported during the inquest proceedings not least because the coroner guides them, as an interested person, through that process, and the inquest can provide resolution for the family.

81. As part of wider work to make the system serve the bereaved better, and emanating from the work undertaken by MOJ following the respective reports of Bishop James Jones and Dame Elish Angiolini, a toolkit for inquest lawyers is under construction with MOJ, the Solicitors Regulation Authority and the Bar Standards Board and there is also a protocol for Government lawyers in the new version of the MOJ Guide to Coroner services. It is hoped that both these documents will improve the quality of advocacy from all lawyers at inquest.

82. The Chief Coroner has introduced an appraisal system for coroners. In April 2019 senior coroners were tasked with appraising the assistant coroners in their area. The appraisals were to be concluded by the end of March 2020. The aim of the appraisal system is to identify training needs. As a feature of the process it will involve the

senior coroner observing the court and office work and skills of assistant coroners. It is hoped that this may also identify inconsistencies of approaches to cases across a coroner area. The aim is to review the appraisal system now that it has been in place for a 12-month period and to roll-out appraisals for salaried as well as fee-paid coroners.

Pathology services

83. In successive Annual Reports, the Chief Coroner has raised the issue of the state of pathology services for coroners.

84. The Chief Coroner remains very concerned about the pathology service to coroners. There are a dwindling number of pathologists prepared to carry out post mortem (PM) examinations requested by a coroner and the service is severely under-funded.

85. A PM examination is not a requirement of death investigation by the coroner although the accurate determination of the cause of death can sometimes only be identified by a PM examination. The general trend over the last twenty years has been a decrease in first PM examinations requested by coroners, from 59% in 1997 to 39% in 2018 of all deaths reported to coroners.

86. PM examinations are carried out, for the most part, by consultant histopathologists or, in some special cases, consultant Home Office registered forensic pathologists.

87. Local pathology services are seriously stretched with the result that coroners are sometimes forced to wait for a PM examination to be performed. This in turn delays the release of the body to family for burial or cremation as well as having an adverse impact on mortuary capacity. There is a lack of control and oversight of the pathology provision partly as no government department, or the NHS, considers it has responsibility for this vital service. The proper recording of the cause of death leads to better mortality statistics and the lessons to be learned from all deaths.

88. Professor Peter Hutton, in his March 2015 Report, described the immediate future of both forensic and non-forensic pathology services as ‘fragile, and corrective action needs to be taken now’. The Chief Coroner repeats his belief that action is required in both the short term and the longer term. For the longer term he repeats the proposal that pathology services for coroners are organised regionally. Some 12 to 15 regional centres of excellence should be created, providing mortuary, PM examination and post-mortem imaging (CT scanning) facilities.

89. Short-term solutions are much more difficult. In the absence of any Government action the Chief Coroner continues to encourage coroners and their local authorities to nurture and support existing arrangements as best they can. That is unlikely to be enough. In the short to medium-term at least, imaging facilities are likely to develop through the private sector, and, as is current practice, although not desirable, at a cost to the families (within the range of £400 to £1,000 per scan). In due course the Chief Coroner would like the government, via the NHS, to provide PM imaging for all cases. In many cases imaging will be able to replace more invasive PMs. Death and life are part of one continuum and we should all aim for the quality of care in death as we would in life.

90. In the short-term NHS Trusts could make autopsy work by their employed pathologists part of the working contract, for separate fees. Learning lessons from death should once more become an integral part of learning about life.

91. As a result of the shortage of coroner's pathologists many coroners are facing delays in releasing bodies and taking cases to inquests. Although pathologists' reports should be provided to the coroner within three to four weeks, the dwindling numbers willing to do the work prevents this from happening. This needs to change.

92. The Chief Coroner continues to work with the Royal College of Pathologists and others on these issues.

Access to legal aid

93. The provision of legal aid (or related funding) for coroner investigations and inquests is a matter for government, and parliament rather than the judiciary.

94. The Chief Coroner would like to make some general observations on the situation in inquests which he hopes will allow the Committee to consider the issues in the round.

95. First, the Chief Coroner believes it is an uncontroversial statement to say that not all interested persons at an inquest (including bereaved people) need to be represented by lawyers in order to enjoy proper participation. There are around 30,000 inquests annually, and as stated above, the majority are relatively straightforward in terms of the facts and the legal issues in play. This is not to underplay the significance, emotional difficulty and importance of each inquest for the bereaved family or other participants and witnesses. However, the numerical majority of inquests are not like the complex, high profile inquests which can often feature in the news, which may have an adversarial subtext.

96. Second, it is important to understand that the coroner investigation is a relatively narrow form of inquiry. Parliament confirmed this in the 2009 Act. In most cases the inquest has a relatively modest and pragmatic objective, which is to provide a limited account or explanation of the 'proximate' circumstances of a death. The purpose of the inquest, even when the Article 2 procedural duty is engaged, is not to provide an answer to any sort of 'why' question, in the sense of any deeper societal explanation for a death. Nor can the inquest attribute personal blame in the sense the criminal courts do. In some situations, this means there may be a dissonance between what a participant might want an inquest to deliver, and what is legally possible. It is natural that some participants or advocacy organisations might want to see inquests having a generally wider or deeper scope, or that lawyers on all sides should be a more common feature. Ultimately, the purpose and parameters of death investigation are a matter for policy makers in government and for parliament.

97. Thirdly, there is much to be said for a form of justice, for the deceased person and their family, and wider society, which is delivered locally, usually close to the community where the deceased person lived and died, in a format (because it is focused on fact-finding) that ought not to need lawyers, at least in many legally straightforward cases. There is much to be said for such a local approach to justice

which can be delivered in a timely way, rather than a form of death investigation which may be routinely long and complex. There are also arguments which could be advanced that simply adding more lawyers in to the system would not necessarily, uniformly help bereaved families in all cases.

98. It is true that there are some cases (whether with a jury or without) which are complex, lengthy and raise issues of wide importance or interest. They may involve significant disclosure of documents and hear evidence from many people. This means that there may well be cases where effective participation requires some form of state-funded representation and there are important arguments advanced about the perception (as well as the actuality) of equality of arms. Clearly the task for any government is therefore to work out what general form any scheme should take, including the overall cost, and to decide how to make an assessment of need in each individual qualifying case – but that is ultimately a task for policy makers and then parliament in terms of balancing different public policy interests.

99. The Chief Coroner believes coroners cannot be complacent about the experience of families in inquest proceedings – for example a key focus of his work has been on improving training to ensure as far as possible that families get a consistent and high-quality experience. However, it is also fair to say that in some inquests, particularly those where the state is said to have some involvement in the death, it may be difficult to avoid a situation where some participants come away with a measure dissatisfaction and sometimes this may simply be due to some of the underlying issues with the particular death rather than the inquest process itself. The aim of the coroner process is to provide is a forum in which - within the relatively limited parameters of the investigation and inquest - the process gets to the facts in a fair way.

Mass fatalities and Disaster Victim Identification

100. The coroner service in England and Wales has a significant amount of expertise and (sadly) recent experience in dealing with multiple deaths following a mass disaster, and with deaths following other incidents where there may be a Disaster Victim Identification ('DVI') and/or terrorism component. The recommendations of Lord Justice Clarke in the *Marchioness* report (which was a public inquiry into the way in which coroners and police dealt with the sinking of the Marchioness pleasure boat on the River Thames with the loss of 51 lives in 1989) are the fundamental basis upon which coroners and others (including, in particular, the police) approach these sorts of cases. The guiding principles are the provision of honest and, as far as possible, accurate information at all times and at every stage, respect for the deceased and the bereaved, a sympathetic and caring approach throughout and the avoidance of mistaken identification.

101. The Chief Coroner continues to have oversight of the arrangements for major cases involving mass fatalities, terrorist incidents with loss of life in England and Wales and other deaths of nationals from England and Wales overseas. Following major incidents, the Chief Coroner liaises with coroners, the Foreign and Commonwealth Office, the Home Office, the Ministry of Justice, the Cabinet Office, the police, other Agencies and local authorities in order to ensure that the arrangements for repatriation of bodies to England and Wales and subsequent

investigations are sound.

102. In 2017 the Chief Coroner reformed the cadre of specialist coroners in this area of work and a generic set of DVI documents has been developed. The cadre now has two senior coroner co-chairs. Professor Dr Fiona Wilcox and Professor Cathie Mason have fulfilled this role since the autumn of 2017 and will hand on the responsibility to senior coroners Joanne Kearsley and Darren Salter in October 2020. The cadre receive specialist training and there is a rota in place to ensure that for any event in England and Wales or overseas, a coroner is on call to respond. The training is run by the Chief Coroner in conjunction with the UK Disaster Victim Identification Unit (UKDVI). The Chief Coroner wishes to express his sincere thanks to Detective Superintendent Alan Crawford (now retired), to Detective Chief inspector Peter Sparks and to Detective Inspector Howard Way OBE for all of their help and ongoing assistance. UKDVI has played an extensive role in the training of all coroners and coroners' officers as well as spearheading the response to incidents in the UK and throughout the world. The DVI expertise developed by coroners have played a key role in enabling coroners to plan and advise on excess death planning as part of the COVID-19 pandemic, with Local Resilience Forums and other partners.

103. Within England and Wales, in the period between 22 March 2017 and 14 June 2017 there were three terror incidents that resulted in mass fatalities. Westminster Bridge, the Manchester Arena, London Bridge and Borough Market were the subject of terrorist activity with the loss of many lives and numerous serious injuries. Regrettably, other mass fatality incidents have occurred in recent years. On 14 June 2017 fire broke out at Grenfell Tower. The fire developed and engulfed the tower. 71 people died as a result of the fire. In February 2018 an explosion in Leicester resulted in five deaths and in October 2018 a helicopter crash killed the five people on board including the pilot and four passengers including the owner of Leicester City football club Vichai Srivaddhanaprabha. In October 2019 the bodies of 39 Vietnamese nationals were found in the trailer of an articulated refrigerator lorry in Grays, Essex. In November 2019 there was the terror attack at Fishmongers' Hall and in February 2020 a terror-related knife attack occurred in Streatham Hill. Each of these horrific incidents led to the extensive involvement of the coroner service and of the local senior coroner. In each case the Chief Coroner played an important role in helping marshal the response of the service to events of national significance and interest as well as liaising between the relevant senior coroner and local authority, and central government and other Agencies.

104. When a mass fatality (or incident with a terrorism or DVI component) incident occurs, depending on where and how it takes place, the senior coroner with responsibility for the area will be notified by the police of the deaths and will be involved in the process of the identification of the victims. The coroner will be part of the initial response along with the emergency services. The identification of those killed (and those injured) in any incident – whether it be a terrorist incident, a suspected terrorist incident, or a fire – can be a lengthy process. The site where the incident takes place may not be safe and where terrorist activity is the cause, there may be a live police investigation to ensure there are no other devices or attackers. In other incidents the scene may well be a crime scene and the police will need to have an eye on securing evidence for any prosecution that may ensue. If the incident is an explosion or a fire it may have caused substantial damage to the fabric of the building

where it has taken place as well as causing substantial disruption to the bodies of those killed.

105. The coroner and all others involved in the safe removal of bodies from a scene work to internationally agreed standards of identification.

106. Events worldwide (such as the bombings in Sri Lanka in April 2019) have continued to show that it is important to deal with the process of identification in a clear and methodical way to make sure that the correct identifications are made. Where a plane crashes onto open land the plane manifest will provide an accurate list of those on the plane and will be a key feature of the identification of those involved. However, a bomb explosion in a public space or a fire in a tower block poses many questions. There is unlikely to be any fully comprehensive manifest or list of those present. These are therefore considered 'open' incidents in the context of identification. The formal identification process seeks to reconcile ante-mortem and post-mortem elements to ensure accurate identification and to arrive at an accurate number of those who have died. Where fingerprint, dental, DNA and other similar records are available, they are compared to the body that has been found. The coroner and others engaged in the aftermath of events work as quickly as the conditions allow to formally identify those involved. The importance of accurate identification, for families and for the process of justice cannot be overemphasised. Once identification of a body is confirmed to the satisfaction of the coroner through trained police family liaison officers there will be discussions with families as to the next stages.

107. It is interesting to consider that in these sorts of 'open' incidents, the statutory question which is normally the most easily answered in the majority of 'normal' coroner cases (i.e. answering the question 'who' died) can become the most complex aspect of the investigation. Answering that question can require significant specialist forms of investigation (such as forensic anthropology or odontology) because of the nature of the human remains. This is just one illustration of the breadth of work coroners, as judicial decision-makers, are required to do.

108. The Chief Coroner has continued to work closely with each of the senior coroners in the coroner areas where these incidents have taken place.

Reports to Prevent Future Deaths

109. Coroners are required in law to submit to the Chief Coroner reports to prevent future deaths (PFD reports). Each report is an important statement by a coroner raising a matter of concern arising out of an investigation or inquest on action that should be taken to prevent future deaths.

110. Between July 2018 and June 2019 there were 505 PFD reports issued by coroners. Between July 2019 and June 2020, the number is 386. This reduction is likely to be accounted for by the three-month period of lockdown from late March to late June, which significantly reduced the number of inquests being held (the inquest itself is the process via which most PFD reports are produced). Reports, and responses to them, are routinely published by the Chief Coroner on the judiciary website (sometimes with redaction for data protection purposes). Through this route the

reports are made public and accessible to all who may have an interest in them. Email alerts are available.

111. The Chief Coroner encourages all coroners write and submit PFD reports where appropriate and as mentioned above. Guidance on PFD Reports will be refreshed and re-published in 2020. In addition, the Chief Coroner is exploring ways in which publication of the reports may be enhanced and made easier to research and digest.

112. The Chief Coroner is engaged in improvement work on PFD reports in three respects. First, he intends to issue new Guidance in the Autumn of 2020 to help coroners approach the writing of PFD reports, in an aid to encourage, amongst other things, consistency of use. Second, Judicial College coroner training in 2020/21 will cover PFDs. Third, he is pursuing a longer-term project to put the published PFDs on a more accessible platform on the web, with better search functionality and metadata on each report available.

COVID-19

113. At the outset, the Chief Coroner would like to stress that he and those working in the coroner service are acutely conscious both of the lethal effects of the COVID-19 pandemic and (in particular) of the selfless commitment of health and social care staff to their life-saving work. He is eager to ensure that coroners perform their proper role, undertaking rigorous investigations into relevant deaths within their jurisdiction.

114. Coroners and their staff have made a significant public service contribution to managing the effects of the pandemic to plan, act and adapt to ensure death management, certification and investigation was (and is) in a position to deal with the excess deaths brought about by the pandemic. Obviously non-COVID deaths have also had to be processed during the pandemic too as normal. Coroners have achieved this in very difficult circumstances and the Chief Coroner thanks them all for their effort and dedication. The additional, demanding and stressful work everyone has had to do including the Chief Coroner and his office to assist the bereaved in these unprecedented times has been a very significant challenge.

115. On 5 March 2020 the first death in England reported to be from COVID-19 was recorded. Through March, April, May and June the figure rose in England and Wales. At the time of writing, the numbers of deaths from COVID seem to be diminishing.

116. In simple terms and in most instances a death due to COVID-19 is a natural cause death (i.e. a naturally occurring disease process running its natural course, where nothing else is implicated) and therefore, in law, does not fall to be reported to a coroner. The vast majority of COVID-19 deaths, being of natural cause, from a natural illness, should not be (and are not being) reported to a coroner at all. Instead the death registration (with the medical cause of death) should be provided through the Medical Certificate of Cause of Death (MCCD), completed by a medical practitioner.

117. The simplicity of this statement belies a very significant complexity in terms of death certification during the pandemic and the coronial involvement in the death management process throughout the pandemic.

118. Planning for significant numbers of excess deaths falls to Local Resilience Fora (LRF) which brings together all the relevant local organisations and statutory bodies including the police, ambulance service, GPs, hospitals, local authorities and so on. These organisations already had plans in place in case of excess death scenarios (for example in relation to 'pan flu' type epidemics). The coroner is a central participant in and component of the LRF. Recent experience with mass fatality and terrorism, and the training for coroners on those issues, has been invaluable in exposing coroners to the LRF structure and their role in it. This is because the LRF is also the organisation which responds locally to the death management aspects of those sorts of emergency events. This meant that when the pandemic emerged and the scale of the emergency became obvious, coroners were able to respond as part of the LRF structure effectively.

119. The COVID pandemic threw up many unprecedented issues. Before, and during the early stages of the pandemic, there was great uncertainty amongst planners as to how many excess deaths would occur and concerns existed nationally that the system could be overwhelmed by numbers of excess deaths, with the result that there would be intolerable pressure on the death management system including insufficient capacity within the health service to diagnose COVID as an illness in life, body storage capacity, post-mortem examination capacity, the ability to manage funerals, the ability to process and register deaths and other resilience factors.

120. For perhaps obvious and entirely understandable reasons, government departments and other national agencies tasked with responding to the pandemic were not always familiar with the intricacies of death investigation and certification. The Chief Coroner played an absolutely key role in the national response to the challenge of the pandemic. This included very close liaison with the Ministry of Justice, Public Health England, the Health and Safety Executive, NHS England and DHSC, the General Register Office, the Cabinet Office and many other national and local organisations such as the National Association of Funeral Directors, British Medical Association, the Royal College of Pathologists. He gave, via his officials, expert advice to HMG on the wider legal and practical ways in which the death management system functions. This included a critical role in working out the consequences of changes in the law and in working practice, for example with regard to the relaxation on requirements for doctors to sign the Medical Certificate of Cause of Death, deaths in the community as opposed to in hospital, deaths in prisons, workplace deaths.

121. Perhaps the most obvious example of this is the centrality of the work done by the Chief Coroner on the relevant provisions of the Coronavirus Act 2020 which gained Royal Assent on 25th March 2020 and remains the law. This made substantial and significant changes to the way in which deaths were certified and the consequent significant adjustments in working practices during the pandemic. It was critical that there was a multi-agency, joined-up response by organisations and so liaison was crucial. Many organisations issued Guidance to explain the new system to their members and the Chief Coroner was involved in discussions behind the scenes in almost all cases.

122. Specifically, in terms of coroners, the report of death to them of a deceased person with suspected COVID required an even greater coordination with a variety of agencies than perhaps the coroner was used to. Coroners are used to dialogue with medical practitioners who may have reported a death or been involved in a last illness and this role greatly increased. Some deaths due to COVID-19 may also be in such a category to require more detailed explanation (such as a death in prison where an inquest in mandatory in both natural and unnatural deaths). The Chief Coroner's approach was that coroners remain at the backstop of death investigation and perform a safeguarding function and oversight for each individual death.

123. The Chief Coroner produced a number of Guidance documents during the pandemic as follows. Links are included:

- Guidance No. 34: Chief Coroner's Guidance for coroners on COVID-19 (26th March 2020) https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/chief-coroner-guidance-no-34-covid-19_26_march_2020-2/

- Guidance No. 35: Hearings during the pandemic (27th March 2020) https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/chief-coroner-guidance-no-35-hearings-during-the-pandemic-2/

- Guidance No. 36: Summary of the Coronavirus Act 2020, provisions relevant to coroners (30th March 2020) https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/chief-coroners-office-summary-of-the-coronavirus-act-2020-30-03-20-2/

- Guidance No. 37: COVID-19 deaths and possible exposure in the workplace (20th April 2020, amended 1st July 2020) https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/chief-coroners-guidance-no-37-amended-01-07-20-2/

- Guidance No. 38: Remote participation (11th June 2020) https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/chief-coroners-guidance-no-38-remote-participation-11-06-20-2/

- Guidance No. 39: Recovery from the COVID-19 pandemic (29th June 2020) https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/guidance-no-39-recovery-from-the-covid-19-pandemic_-2/

124. The period from 23 March 2020 when the Prime Minister announced measures described as a 'lockdown' had a significant impact on the running of coroners' offices and courts. The Chief Coroner set up regular meetings of a group of coroners representing all regions of England and Wales to monitor the coroner response to death reports and the on-going work on inquest hearings. This group met

initially twice weekly, then weekly before moving to fortnightly intervals and has been an invaluable source of information to the Chief Coroner and has fed into the issuing of Guidance to coroners on topics connected with the pandemic. The meetings continue and will do so for the foreseeable future.

125. The period of lockdown has meant that many inquests have had to be adjourned or postponed. For as long as it remains a requirement, social distancing will require the coroner service to adapt its practices. Some courtrooms will not be suitable for holding anything but the most straightforward of inquest hearings. The Chief Coroner has issued Guidance to assist with the holding of remote hearings, but there will be some significant inquests that can only be held with all participants present. Unlike in other jurisdictions, the current law means that coroners themselves must be present in the courtroom for all hearings. Jury inquests are a vital part of the armoury of the coroner and public involvement in the examination of the circumstances surrounding some deaths. Sufficient resource will need to be provided by local authorities to coroners to enable them to carry out this part of their statutory functions and coroners will have ensured their local authority is aware of these impacts of COVID-19 (and local authorities are likely to have added them to their risk register). The Chief Coroner has issued Guidance to assist coroners in planning for the recovery from the pandemic. There is a backlog of inquests to be heard. The size of the backlog will vary from coroner area to coroner area. Many areas are holding a significant number of partially remote inquest hearings using facilities such as Microsoft Teams or the Cloud Video Platform (CVP). Some areas have a number of jury inquests waiting to be heard. The Chief Coroner is keen for coroners to work with the relevant local authority to identify rooms or halls within the local authority estate or beyond that may make suitable venues for these inquests to be heard. Much work is being done on progressing this across the areas. Until the inquest is concluded families cannot have the death certificate (although the coroner provides a certificate of the fact of death, also known as an interim death certificate).

126. Analysis of the annual death registrations shows that, on average, there are some 10,000 or so deaths each week of the year. There are seasonal variations and with a harsh winter, or a flu epidemic, a rise in the number of deaths that occur. When this occurs, there is a related increase in the number of deaths reported to coroners and these additional death referrals add to the pressures on the coroner service. Clearly, in this exceptional year excess death from COVID-19 is likely to have led to an increase in deaths reported to coroners, although the full picture will not be known for some time, until official ONS data on coroner cases becomes available in 2021.

127. In any case, coroners will also be at the forefront of the response to any 'second wave' or spike in cases over the coming winter months.

128. Finally, the Chief Coroner proposes two targeted law changes which government and parliament may wish to consider, specially related to COVID-19 (his annual report contains a wider list of suggested law changes). These are:

i. Inquests without a hearing in non-contentious cases. This is a longstanding policy suggestion and proposals have been put forward in successive Chief Coroner annual reports since 2014. It would address some significant issues in the system which will occur as a result of COVID-19.

ii. Enabling provisions to allow virtual hearings in the coroners courts (i.e. pre-inquest reviews and inquests to take place where all participants participate remotely, including the coroner, and allowing public access, meeting the existing requirement in the Coroners and Justice Act 2009 that inquests must be take place in public).

129. (i) would involve inserting new clause 6A in to the Coroners and Justice Act 2009 (the policy rationale, and this draft clause, are set out in previous Chief Coroner Annual Reports – the clause is reproduced below). There are 30,000 inquests in England and Wales. These include many cases in which those most likely to attend (the bereaved family) are contacted and indicate they are content not to attend. In practice many hearings take place in a completely empty court room, with the coroner conducting the hearing to no-one (other than a recording device). Under this arrangement, coroners would issue a written ruling (like a judgment). The particular issues this would address in relation to the COVID-19 pandemic are:

(a) reduce the need to hold hearings in court in which there is no practical need or public interest in doing so, which contributes to the effort to stop the spread of the virus.

(b) provide a parallel 'stream' for inquests, freeing up physical space for those inquests which need it and thereby helping to reduce the backlog quicker.

(d) There are existing Rules (see Guidance - https://www.judiciary.uk/wp-content/uploads/2018/11/Guidance-No.-29-Documentary-inquests.pdf) which provide for 'documentary' or 'Rule 23' inquests which come very close to being entirely on paper, but where a limited public hearing must still take place. This proposal would therefore just be a natural extension of that existing arrangement.

(e) The Chief Coroner would provide extensive Guidance to coroners accompanying any law change, ensuring that a 'paper' inquest process is conducted fairly and that cases which do genuinely need a full public hearing would continue to have one. For example, any cases which required a jury would obviously still continue to be heard in public, as well las any cases where there are contentious issues, such as failures in care in hospital and so on.

6A Inquest without a hearing
(1) An inquest into a death must be conducted with a hearing, unless subsection (2) applies.

(2) An inquest into a death shall be held without a hearing, if the senior coroner is of the opinion that –

(a) the details required for the Record of Inquest are complete and not disputed,
(b) no interested person reasonably requires a hearing, and
(c) there is no public interest which requires a hearing.

130. (ii) an enabling power would create parity with the criminal courts. Although partially virtual hearings are possible and indeed taking place in the coroner's courts, and accepting that some cases are not amenable to virtual hearing, the ability to hold wholly virtual hearings would avoid coroner courts being left as outliers.

Coroner Training

131. The Chief Coroner trains approximately 1,000 people in coronial work each year: 380 coroners and approximately 600 coroners' officers. This training, under the auspices of the Judicial College (which trains all judges and tribunal members), has been highly successful. Training is delivered through a combination of two-day residential courses, which are all compulsory. These include an induction course for newly appointed assistant coroners, continuation courses for all coroners and continuation courses for all coroners' officers as well as one-day events. These training programmes promote consistency and are designed to tackle criticisms of the service.

132. The 2019-2020 continuation course for coroners focused on the inquest. Scenes from a fictionalised inquest were filmed and formed the basis for work in syndicates with the action being stopped at various stages and group discussion along the lines, this has taken place, what would you do? This was complemented by a series of talks on how you should best prioritise death referrals, dealing with the vulnerable in coroner's courts, transgender issues. For 2020/2021 the plan is that the courses will look at conclusions to inquests, prevention of future death reports, as well as a refresher on issues around DVI (disaster victim identification). Professor Peter Brennan has agreed to speak on human factors. He spoke to all senior and area coroners in February 2019 and the Chief Coroner decided that all coroners would benefit from his talk.

133. As a consequence of the COVID-19 pandemic the Chief Coroner and the coroner course directors have been adapting training for delivery on-line. As the shape of in person training remains uncertain, it is very likely that continuation training will be delivered on-line.

134. In 2018-2019 coroners' officers' training covered preparedness for a mass fatality event. This complemented the training of all coroners on mass fatalities the year before, in 2016-17. In 2019-20 coroners' officers received training about deaths in police custody and in residential care home settings for the older population. The theme of the 2020/21 cycle of training for Coroner's Officers will be the quality of explanations provided to bereaved families about a range of issues including pathology, medical complications arising in a hospital setting, toxicology and medical terminology so as to ensure families have a clear understanding of the coronial investigation. As set out above with coroner training the course director with primary responsibility for leading officer training (Alan Wilson, a senior coroner and course director) is adapting the materials for on-line delivery.

135. Underpinning all of the training is the careful use of language and equal treatment with particular reference to the Equal Treatment Bench Book and dealing with the vulnerable.

136. The feedback from all the courses is positive and shows that the training has been well received, with high levels of achievement in learning outcomes, aims and usefulness. Great emphasis is placed on work in syndicates. Through discussion participants learn how best to tackle practical problems.

137. The training is devised by the Chief Coroner's training committee, which is comprised of the Chief Coroner, those coroners who are Course Directors, representatives of the Judicial College, and officials from the Chief Coroner's office. They are all supported by two experienced coroners' officers.

138. The Chief Coroner supports the use of technology for the promotion and delivery of training. For example, in 2019 the Chief Coroner made a short promotional video about the coroner and coroners' officer training for 2019-20 which was sent out by the Judicial College to encourage early bookings. In addition, the Course Directors have introduced the use of other teaching apps to encourage participation especially in plenary or larger group sessions.

139. The Chief Coroner has been extremely impressed with the quality of the work and the commitment of the Course Directors. All Course Directors are appointed following an open selection process at the Judicial College. There are currently nine Course Directors. Expressions of interest for the appointment of additional Course Directors drew significant interest, and six new Course Directors have now been appointed and tasked to specific areas of training.

140. In addition to the annual residential courses, there have been a number of one-day training events in the course of the year. They include the Chief Coroner's annual conference for senior and area coroners and a course on medical issues. In 2019 the Chief Coroner's one-day conference was held at Westminster Central Hall led by the Chief Coroner. His Honour Peter Rook QC, Bridget Dolan QC, Lord Justice Singh, Professor Peter Brennan and Charles DeLacey all gave excellent presentations on topics of great interest to coroners. Due to the COVID-19 pandemic the event planned for March 2020 had to be cancelled.

141. In addition, all coroners and coroners' officers will see at their training or view on the Judicial College Learning Management System (LMS) an interview by Deputy Chief Coroner Derek Winter with Dame Elish Angiolini who conducted an independent review of deaths and serious incidents in police custody.

142. The first in a series of one-day courses on medical Issues took place in 2015-2016. The subject matter was the head and the brain. In 2016-2017 the course focused on the heart, and then in 2018 – the bowel. In 2019 the one-day training dealt with the care of the older population. These medical training days have taken place at the Queen's Medical Centre in Birmingham. The Chief Coroner is extremely grateful to Louise Hunt, a senior coroner and course director for putting the courses together, and to the medical experts who have made their time available to address coroners. The courses have been of the highest quality and in common with all the coroner and coroners' officer training the speakers are filmed and those films are catalogued onto Learning Management System for further viewing by way of Induction or refresher.

143. There was to be a one-day training event for local authorities in February 2020, but this had to be cancelled due to the issues around the then emerging COVID-19 pandemic. The Chief Coroner has held workshops on appointments: one for those assistant and area coroners seeking appointment as an area or a senior coroner, and another for those seeking the first appointment as an assistant coroner. Demand has been particularly strong for those seeking a first appointment and it is likely the workshops will be repeated. The Chief Coroner has now developed this course for delivery on-line. The latest workshops are taking place in August and September online via Microsoft teams, with a plenary Q&A session following the participants viewing the presentations online in advance. There are currently over 130 participants signed up for the two sessions.

144. The Chief Coroner is aware of training initiatives by local Coroners' Societies and the commitment of many coroners to training with their local NHS Health Trusts, GPs and other stakeholders

145. In April 2019 the non-statutory Medical Examiner scheme was introduced within NHS Hospital Trusts in England. The Chief Coroner has a regular dialogue with the National Medical Examiner Dr Alan Fletcher. Plans were put in place for the Chief Coroner with the assistance of the Royal College of Pathologists and the National Medical Examiner to run eight regional training days for coroners and medical examiners. Due to the COVID-19 pandemic these plans had to be put on hold. This issue will be addressed when circumstances allow.

146. The Chief Coroner has also given a presentation for around 80 CiLex fellows on coronial appointments.

2 September 2020