



Ministry  
of Justice



# **Coroners Statistics Annual 2015 England and Wales**

Ministry of Justice  
Statistics bulletin

Published 12 May 2016

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## Introduction

This annual bulletin presents statistics of deaths reported to coroners in England and Wales in 2015. Information is provided on the number of deaths reported to coroners, post-mortem examinations and inquests held, and conclusions recorded at inquests. The data are collected via statistical returns completed by coroners. For previous editions of this report, please see:

[www.gov.uk/government/collections/coroners-and-burials-statistics](http://www.gov.uk/government/collections/coroners-and-burials-statistics)

This publication should be read alongside the statistical tables which accompany it, also found via the link above. There is also a supporting comma-separated values (CSV) file to allow users to carry out their own analysis.

In addition to the bulletin and tables, we have published a coroners' statistical tool (also available at the link above). The tool provides easier access to local level data and allows the user to compare up to four areas of interest, for example, it is possible to compare a coroner area with a geographical region, England or Wales.

The Explanatory Notes section at the end of this bulletin provides information about statistical revisions, and the symbols and conventions used.

If you have any feedback, questions or requests for further information about the bulletin, please direct them to the appropriate contact given at the end of this report.

### **The legislation**

Coroner services in England and Wales are governed by Part 1 of the Coroners and Justice Act 2009 (the 2009 Act), as well as the rules and regulations made under it. The 2009 Act came into force in July 2013, largely replacing the Coroners Act 1988<sup>1</sup> (the 1988 Act).

The 2009 Act and its rules and regulations can be accessed via the links below:

[www.legislation.gov.uk/ukpga/2009/25/contents](http://www.legislation.gov.uk/ukpga/2009/25/contents)

[www.legislation.gov.uk/2013?title=coroners](http://www.legislation.gov.uk/2013?title=coroners)

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<sup>1</sup> The Coroners Act 1988 was repealed in July 2013 with the exceptions of section 13 (application for a fresh coroner investigation or inquest) and 4A(8) (a coroner in Wales being regarded as a coroner for the whole of Wales).

## Chief Coroner

The 2009 Act created the post of Chief Coroner to provide judicial oversight of the coroner system and leadership, guidance and support to coroners. The Chief Coroner's main statutory responsibilities are to:

- approve all coroner appointments made by local authorities (along with the Lord Chancellor);
- keep a register of coroner investigations lasting more than 12 months;
- collate, monitor and publish coroners' reports to authorities to prevent future deaths; and
- give the Lord Chancellor an annual report, which is published and laid before Parliament (see 'Chief Coroner's annual report' section below).

On 8 April 2015, it was announced that the Lord Chief Justice, after consultation with the Lord Chancellor, had extended the term of office of His Honour Judge Peter Thornton QC as Chief Coroner of England and Wales to 1 October 2016.

Further information on the Chief Coroner is available at:

[www.judiciary.gov.uk/about-the-judiciary/office-chief-coroner](http://www.judiciary.gov.uk/about-the-judiciary/office-chief-coroner)

## Coroner areas and structure

Under the 2009 Act, each coroner area has one senior coroner, and one or more assistant coroners. A coroner area may also have an area coroner (who may function as a deputy to the senior coroner).

For information on changes to coroner areas, please see Annex A.

## Investigations

Under the 2009 Act, a coroner conducts an 'investigation' into a death (which may or may not include an inquest). Much of the coroner's investigation takes place before any formal inquest hearing, and includes the coroner considering whether the duty to hold an inquest applies to an individual case.

A coroner has a duty to investigate a death if:

- 1) the coroner is made aware that the body is within that coroner's area, and
- 2) the coroner has reason to suspect that:
  - a) the deceased died a violent or unnatural death;
  - b) the cause of the death is unknown; or
  - c) the deceased died while in custody or state detention<sup>2</sup>.

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<sup>2</sup> Includes deaths that occurred while the individual was subject to a Deprivation of Liberty Safeguard (DoLS) authorisation. See section on 'changes in reporting' for more information

The coroner must then establish who has died and how, when, and where they died.

A coroner's inquest is held for all deaths in custody or state detention. An inquest with a jury is held where the deceased died while in custody or state detention and the death was violent or unnatural, or of unknown cause; where the death resulted from an act or omission of a police officer or member of a service police force in the purported execution of their duties; or where the death was caused by an accident, poisoning or disease which must be reported to a government department or inspector. Jury inquests are not required where the deceased died in custody but from natural causes.

Once the post-mortem examination (including any histology or toxicology) has concluded, the coroner must decide how to proceed. There are three main options:

- The post-mortem examination reveals that the deceased died of natural causes and the coroner considers that it is not necessary to (investigate or) continue the investigation. There will be no inquest.
- The post-mortem examination reveals that the deceased died of natural causes but the coroner considers that it is necessary to (investigate or) continue the investigation. The coroner must then hold an inquest.
- After the post-mortem examination, the coroner (still) has reason to suspect that the deceased died a violent or unnatural death, or the cause of death is unknown, or the deceased died while in custody/state detention. The coroner must then hold an inquest.

### **Inquest conclusions**

At the end of an inquest, the coroner (or jury if applicable) completes a form entitled 'Record of an inquest'. This form documents the 'conclusion' of the coroner or jury as to who died and how, when, and where they died.<sup>3</sup>

A conclusion consists of the legal 'determination', which states who died, and where, when and how they died; and 'findings' which allow the cause of death to be registered. The coroner or jury may use one of the following short form conclusions<sup>4</sup>:

- accident or misadventure
- alcohol/drug related

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<sup>3</sup> The 1988 Act term 'verdict' was replaced by the 2009 Act term 'conclusion'.

<sup>4</sup> 'Alcohol/drug related' and 'road traffic collision' are new short form inquest conclusions under the 2009 Act, which came into effect from July 2013.

- industrial disease
- lawful killing
- unlawful killing
- natural causes
- open
- road traffic collision
- stillbirth
- suicide

### **Suspension of investigation / adjournment of inquest**

Under Schedule 1 to the 2009 Act a coroner must suspend an investigation (and if an inquest has been opened, adjourn that inquest) in the following circumstances:

- If asked to do so by a prosecuting authority because someone may be charged with a homicide or related offence involving the death of the deceased (paragraph 1 of Schedule 1);
- When criminal proceedings have been brought in connection with the death (paragraph 2 of Schedule 1) ;
- Where there is an inquiry under the Inquiries Act 2005 (paragraph 3 of Schedule 1);
- If it appears to the coroner that it would be appropriate to suspend an investigation or adjourn an inquest (paragraph 5 of Schedule 1).

### **Chief Coroner's annual report**

The Chief Coroner's annual report to the Lord Chancellor is a statement on the coroner system for the previous calendar year. It must contain an assessment of consistency of standards between coroner areas; information about investigations that have taken over 12 months to complete; and a summary of reports to prevent future deaths and the responses to these. The annual report is published on the Chief Coroner's section of the judiciary website<sup>5</sup>.

Coroners are therefore now required to notify the Chief Coroner of any investigation that lasts more than a year and to notify the Chief Coroner of the date on which any such investigation was subsequently concluded.

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<sup>5</sup> [www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/chief-coroners-annual-report-2014-15/](http://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/chief-coroners-annual-report-2014-15/)

## Further information

For further background information on coroners and a flow-chart detailing the possible outcomes involved when a death is reported to a coroner, please refer to 'A Guide to Civil and Administrative Justice Statistics', which is available at:

[www.gov.uk/government/statistics/guide-to-civil-and-administrative-justice-statistics](http://www.gov.uk/government/statistics/guide-to-civil-and-administrative-justice-statistics)

A Glossary providing brief definitions for some of the terms used in this bulletin can also be found at the link above.

## Related statistics

All deaths in England and Wales must be registered with the Registrar of Births and Deaths. For those deaths where a coroner conducts an inquest, the death will be registered at the conclusion of the inquest, and the cause of death classified according to the conclusion recorded by the coroner. Statistics on registered deaths in England and Wales are published by the Office for National Statistics (ONS) in their series on mortality statistics. These can be accessed from the ONS website at:

[www.ons.gov.uk/ons/taxonomy/index.html?nscl=Mortality+Rates](http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Mortality+Rates)

The Ministry of Justice's coroner statistics differ from ONS figures because they count two different, albeit related, events. The Ministry of Justice's coroner statistics provide the number of deaths which are reported to coroners in England and Wales. These include deaths reported to coroners which occurred outside England and Wales. The ONS mortality statistics, based on death registrations, report the number of deaths registered (irrespective of whether a coroner has investigated) in England and Wales in a particular year, and therefore do not include deaths that occurred outside England and Wales.

The proportion of deaths which are reported to coroners has been estimated<sup>6</sup> using death registration figures published by ONS. Estimates for 2015 have been calculated using ONS' monthly provisional figures on death registrations, while percentages for 2014 and earlier years have been calculated using final annual death registration figures for the relevant year.

This publication includes figures for deaths which occurred in state custody. Statistics on deaths in prison custody are also published by the National Offender Management Service (NOMS), accessible via the following link:

[www.gov.uk/government/collections/safety-in-custody-statistics](http://www.gov.uk/government/collections/safety-in-custody-statistics)

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<sup>6</sup> Statistics on the number of registered deaths in England and Wales are published by the Office for National Statistics. A final figure for the total number of registered deaths in 2015 has not yet been published, so a provisional figure from ONS, derived from the monthly figures for death registrations in England and Wales, has been used.

The figures for deaths in custody in this publication relate only to those deaths which have been reported to a coroner and then reported to MoJ, whereas the NOMS publication includes all deaths which have occurred in prison custody and those which occurred whilst the offender was released on temporary licence for medical reasons.

### **Changes in reporting**

This publication introduces for the first time figures on deaths that occurred while an individual was subject to a Deprivation of Liberty Safeguard (DoLS). DoLS authorisations occur when 'the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements'<sup>7</sup>. Such arrangements constitute a form of state detention. The coroner data return for 2015 was modified to collect data on the number of deaths that occurred while the deceased was subject to a DoLS, as a category within the state detention section of the data return.

Prior to 2015, data related to deaths of individuals subject to DoLS authorisations, e.g. deaths reported, post-mortem examinations and inquests held as well as conclusions record at inquests should have been included within the coroners' returns. New information collected for the first time this year records the specific number of deaths of individuals subject to DoLS authorisations within the state detention section of the data return.

Collection of this information has coincided with a substantial increase in the overall number of DoLS authorisations issued in England and Wales following the Supreme Court judgment in the Cheshire West case<sup>8</sup> and has had a significant impact on a number of key statistics reported within this publication. The Health & Social Care Information Centre (HSCIC) 2014-15 Annual report records that on 31 March 2015, there were 36,215 active DoLS authorisations in place in England compared to 2,300 on 31 March 2014<sup>9</sup>.

In 2015, there were 7,183 deaths of individuals subject to DoLS authorisations reported to coroners. Equivalent data on the specific number of this type of death was not collected in 2014, although they should still be included within all other figures, e.g. deaths reported to the coroner, inquests held etc.

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<sup>7</sup> The safeguards do not apply when someone is detained ('sectioned') under the Mental Health Act 1983

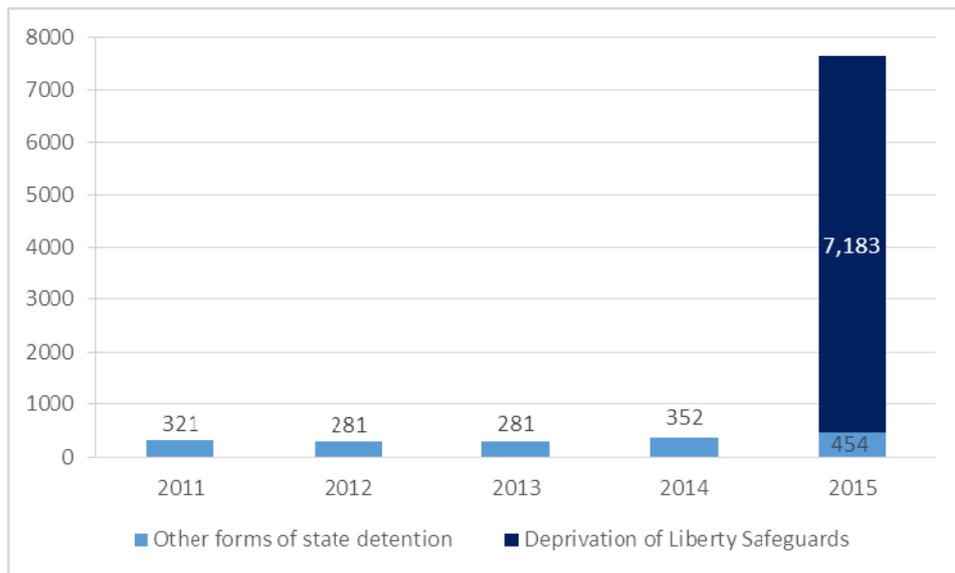
<sup>8</sup> The Supreme Court's 2014 judgment in the cases of P v Cheshire West and Chester Council and P&O v Surrey County Council (Cheshire West) clarified the circumstances in which a DoLS is likely to be required and made it clear that many more circumstances amounted to a deprivation of liberty by the state. The Supreme Court decided that deprivation of liberty arose when the person concerned 'was under continuous supervision control and was not free to leave' and that the deprivation was the responsibility of the state. It did not matter that the patient in hospital or the resident of a care home was content or compliant or voiced no objection if in fact they did not have capacity to consent to the arrangements.

<sup>9</sup> [www.hscic.gov.uk/catalogue/PUB18577/dols-eng-1415-rep.pdf](http://www.hscic.gov.uk/catalogue/PUB18577/dols-eng-1415-rep.pdf) Figure 3.2, page 25

However, as the number of DoLS authorisations as of 30 March 2014 was only 2,300, the number of deaths of individuals subject to a DoLS authorisation in 2014 would have been minimal.

Figure A below shows that the inclusion of deaths of individuals subject to DoLS authorisations within the number of deaths in state detention, has distorted the long-term trend. However, the trend in deaths in state detention excluding DoLS is in line with that seen previously and within the Safety in Custody statistics quarterly bulletin (see 'Related statistics' section above).

**Figure A: Number of deaths in state detention, by type of detention, 2011-2015**



The large increase in DoLS authorisations and the corollary increase in deaths of individuals whilst subject to DoLS has had an impact on a number of key statistics reported within this publication:

- There were 6,968 more inquests opened in 2015, up 27% on the previous year, reversing the downward trend seen in the previous three years, driven by the increase in the number of deaths of individuals subject to DoLS authorisations reported, all of which require an inquest.
- Of all inquests that concluded in 2015, the death by natural causes conclusion saw the largest increase, up 6,170 to 11,043 (+127%). This increase can be attributed to the fact that almost all (94%) of DoLS inquests record a conclusion of death by natural causes.

**Table A: Number of deaths under Deprivation of Liberty Safeguard (DoLS), reported to coroners, by gender and inquest conclusion group, 2015**

	Male	Female	Total
<b>Natural causes</b>	2,497	4,263	6,760
<b>Other causes</b>	194	229	423
<b>Total</b>	2,691	4,492	<b>7,183</b>

- As a result of the majority of DoLS inquests recording a conclusion of natural causes, the proportion of post-mortems being carried out in inquests has reduced (down 20 percentage points to 56% in 2015) – post-mortems are not required in deaths recorded at inquest as being due to natural causes.
- Reporting on an increased number of deaths of individuals subject to DoLS authorisations has also impacted on the average time taken for a case to be concluded, down 8 weeks (from 28 weeks in 2014 to 20 weeks in 2015). In uncontroversial cases, an inquest may be carried out as a 'paper' inquest i.e. decided in open court but on the papers, without witnesses having to attend, and with the relevant medical data being analysed without a post-mortem.

### **Users of the statistics**

The main users of these statistics are coroners and Ministers and officials in central government to assist in developing coroners' policy and its subsequent monitoring. Other users include the Chief Coroner, local authorities (who are responsible for appointing and paying coroners as well as funding their services), other central government departments, and those non-governmental bodies, including various voluntary organisations, with an interest in coroners and inquests. The statistics are used to monitor the volume and types of cases dealt with by coroners in England and Wales each year.

### **Date of next publication**

The next edition of Coroners Statistics Annual 2016 is scheduled to be published in May 2017, covering statistics for calendar year 2016.

## Key Findings

- 236,406 deaths were reported to coroners in 2015, an increase of 12,565 (6%) from 2014, reflecting the rise in the number of registered deaths<sup>10</sup> from 2014 to 2015 (up 6%) and the increase in the number of deaths under Deprivation of Liberty Safeguard (DoLS) authorisations reported to coroners.
- Just under half (45%) of all registered deaths<sup>6</sup> were reported to coroners in 2015, the same level seen in 2014 and 2013. Over the last ten years, this proportion has been generally consistent, within the range of 45% to 47%.
- In 2015, newly collected figures on deaths of individuals subject to DoLS authorisations show that there were 7,183 such deaths.
- The number of inquests opened in 2015 increased by 6,968 (up 27%) to 32,857, driven by the increase in DoLS authorisations and the corollary increase in deaths while subject to DoLS. All such cases require an inquest.
- There were 89,206 post-mortem examinations ordered by coroners in 2015, 38% of all cases reported to them. This is down two percentage points since 2014, consistent with the long-term downward trend.
- For those inquests concluded in 2015, there were 35,473 total inquest conclusions recorded, up 22% on 2014, reflecting in part the rise in the number of inquests opened. Inquest conclusions of natural causes were up 127% on 2014 to 11,043, driven by the majority (94%) of DoLS cases having an inquest conclusion of natural causes. The number of inquests resulting in a conclusion of natural causes, excluding those for 6,760 deaths of individuals subject to DoLS authorisations, was stable with the previous year.
- In 2015, post-mortem examinations were conducted in 56% of inquest cases, down 20 percentage points on 2014, driven by the increase in deaths of individuals subject to DoLS authorisation – all such cases require an inquest, with the majority recording an inquest conclusion of natural causes; a post-mortem examination is therefore unlikely to be required to determine the cause of death and the inquest may well be a ‘paper’ inquest.
- Just three of the ten possible inquest short form conclusions account for almost 67% of all conclusions recorded. These are natural causes (31%) accident and misadventure (22%) and unclassified inquest conclusions (14%).
- The estimated average time taken to process an inquest in 2015 was 20 weeks, with a minimum of 5 weeks and a maximum of 61 weeks across

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<sup>10</sup> A provisional figure for the number of registered deaths in 2015 in England and Wales has been used, derived from monthly figures produced by the Office for National Statistics.

coroner areas. This is an improvement of 8 weeks, when compared to 2014. This can largely be attributed to DoLS where, in accordance with the Chief Coroner's guidance,<sup>11</sup> in uncontroversial cases the inquest can be a 'paper inquest' i.e. decided in open court but on papers without the need for witnesses or a post mortem.

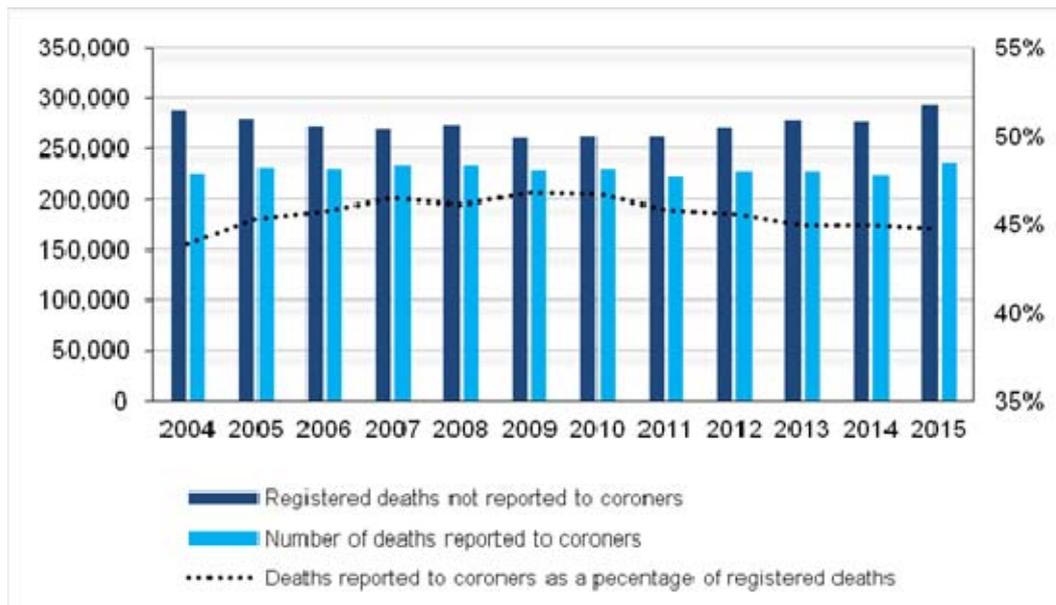
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<sup>11</sup> [www.rcgp.org.uk/~media/Files/RCGP-Faculties-and-Devolved-Nations/SW-England-Wales/Tamar/Chief%20Coroner%20Guidance%20on%20DOLS.ashx](http://www.rcgp.org.uk/~media/Files/RCGP-Faculties-and-Devolved-Nations/SW-England-Wales/Tamar/Chief%20Coroner%20Guidance%20on%20DOLS.ashx)

# 1: Deaths reported

The number of deaths reported to coroners in 2015 rose by 12,565 (6%) from the previous year - from 223,841 in 2014 to 236,406 in 2015 which reflects the increase in the number of deaths registered in England and Wales (up 6%). The proportion of registered deaths in 2015 that were reported to coroners was 45%, no change from 2013 and 2014.

**Figure 1: Registered deaths and deaths reported to coroners, England and Wales, 2004-2015**



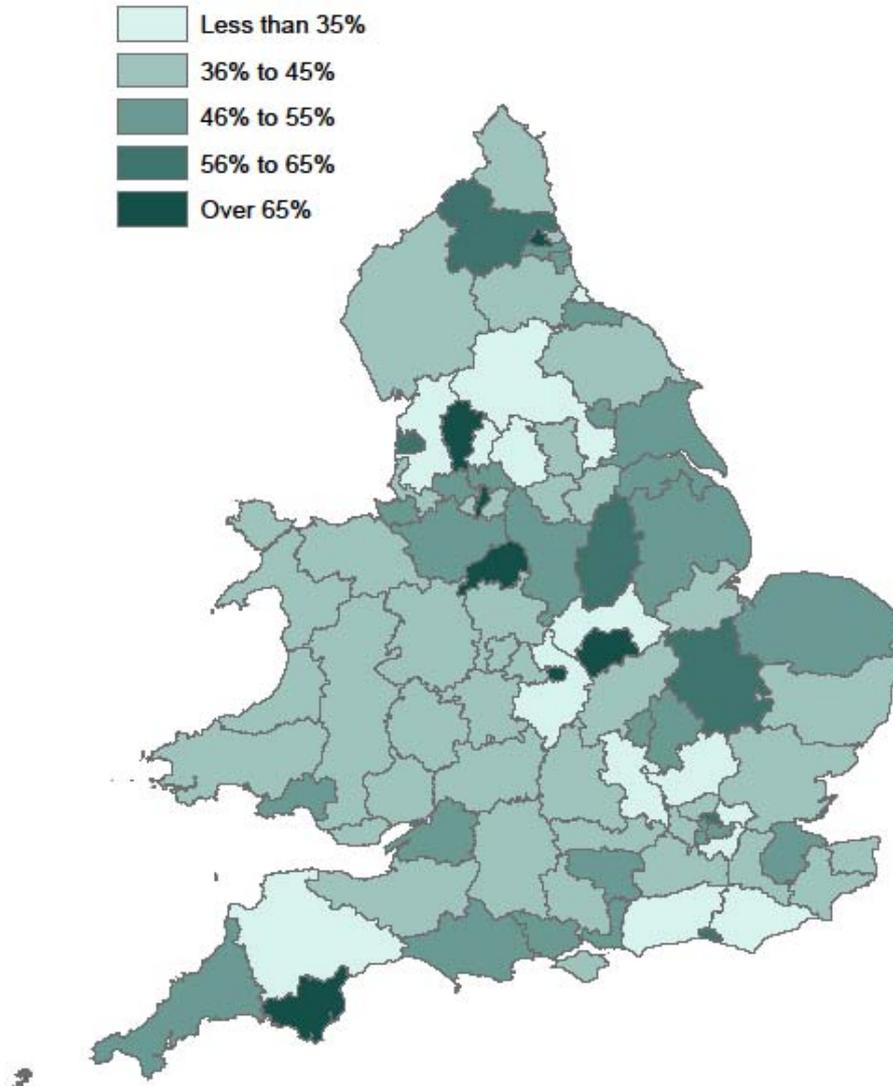
Over the last decade, the number of registered deaths in England and Wales has decreased from 512,993 in 2005 to 501,424 in 2014 rising to 529,613<sup>12</sup> in 2015. The number of deaths reported to coroners has also fluctuated over the last ten years with 232,401 deaths reported in 2005, rising to a high of 234,784 in 2008. The number of deaths reported to coroners fell to its lowest since 2001 to 223,841 in 2014, rising by 12,565 deaths in 2015.

Map 1 below shows deaths reported in each coroner area in 2015 as a percentage of the total deaths in each area <sup>13</sup>.

<sup>12</sup> Provisional figure based on ONS monthly death registration figures for 2015

<sup>13</sup> The reported deaths figure for 2015 is provisional, based on ONS monthly death registration figures

**Map 1: Deaths reported to coroners as a percentage of total registered deaths in each area<sup>14</sup>, England and Wales, 2015**



The proportion of deaths reported to the coroner varies from 26% in Rutland and North Leicestershire to 92% in Stoke-on-Trent and North Staffordshire.

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<sup>14</sup> The ONS death registration figures are based on area of usual residence whereas the coroners' figures are based on the area where a person died. Therefore the coroner office for the City of London shows a distorted figure of 476% due to the low levels of residence and high level of commuters.

## 2: Post-mortem examinations held and inquests opened

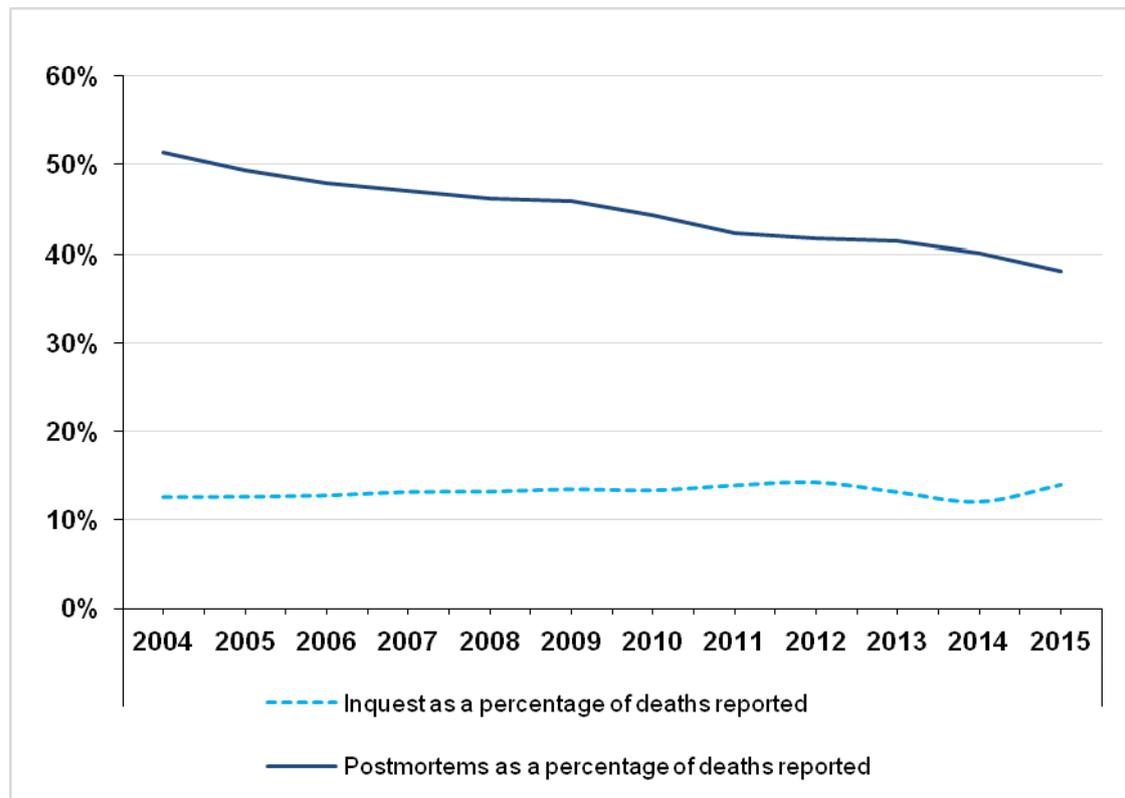
Post-mortem examinations were held for 89,206 deaths reported to coroners in 2015, down 669 (1%) from 2014.

Post-mortem examinations were ordered by coroners in 38% of all deaths reported to them in 2015, down by two percentage points on 2014, and consistent with the existing long-term downward trend. Since 1995, the proportion of post-mortem examinations ordered has decreased by 23 percentage points, from 61% to 38% (see Table 3).

There were 32,857 inquests opened in 2015, an increase of 27% on 2014, driven by the increase in deaths of individuals subject to DoLS authorisations, as all such cases require an inquest<sup>15</sup>.

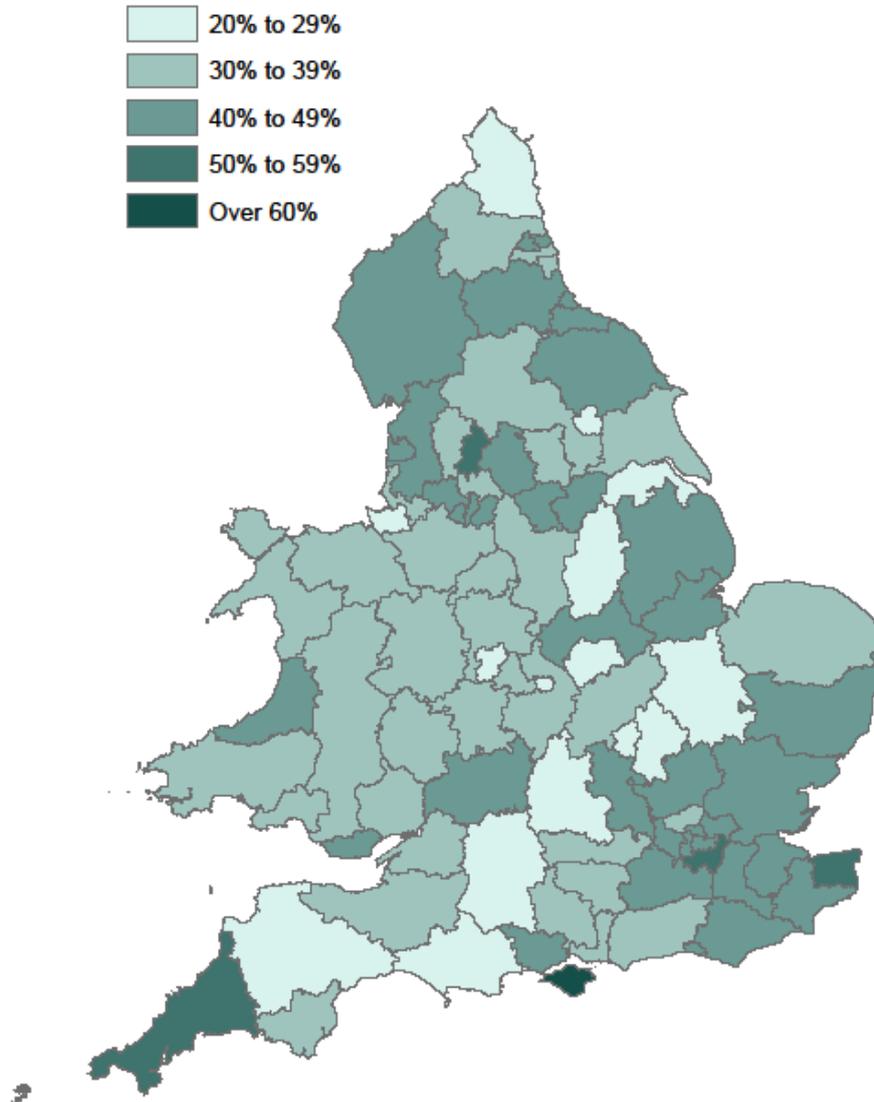
Inquest cases represented 14% of all the deaths reported to coroners in 2015, an increase of two percentage points on 2014.

**Figure 2: Post-mortems and inquests as a percentage of deaths reported to coroners, England and Wales, 2004-2015**



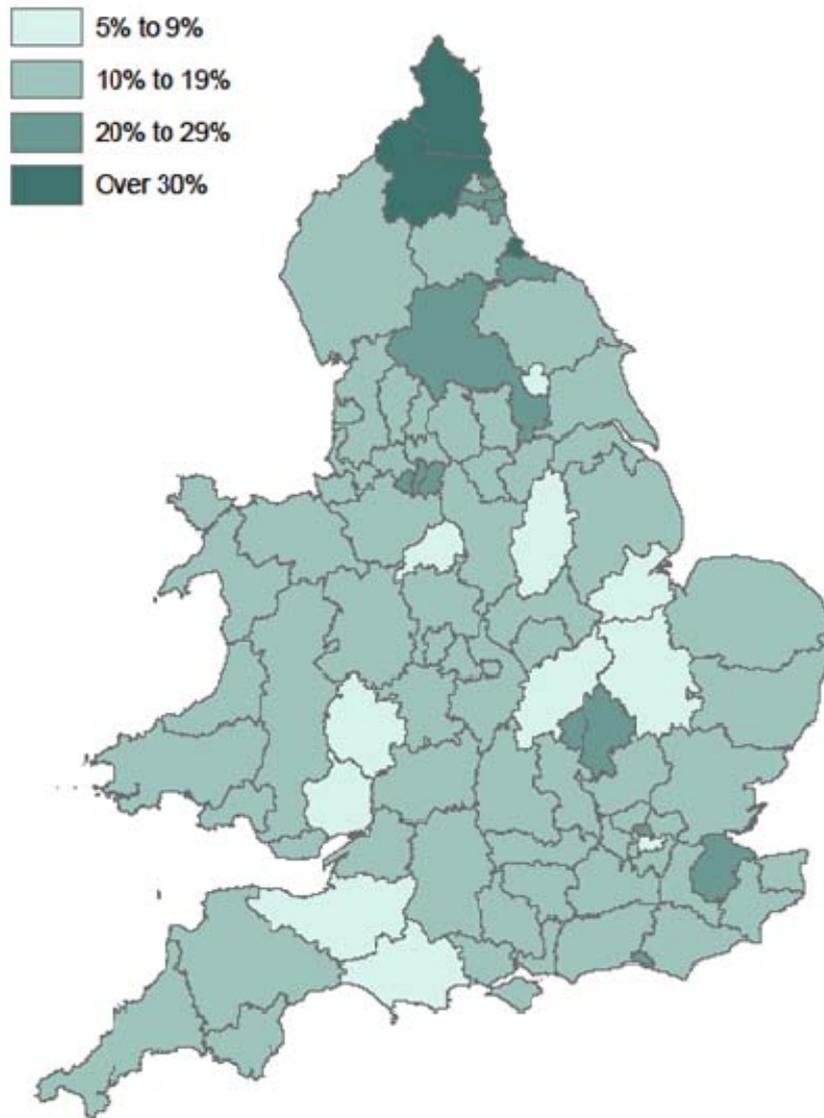
<sup>15</sup> More information on DoLS can be found in the [changes to reporting section](#) of the Introduction to the publication

**Map 2: Post-mortems held as a proportion of deaths reported to coroners, England and Wales, 2015**



The proportion of post-mortems carried out varies from 20% in the City of London to 62% in Isle of Wight.

**Map 3: Inquests opened as a proportion of deaths reported to coroners, England and Wales, 2015**



The proportion of inquests carried out varies from 5% in Gwent to 36% in Hartlepool (when excluding Isles of Scilly, due to small numbers).

### **Post-mortem examinations in inquest cases**

When an inquest is opened, a post-mortem examination will usually be conducted. In 2015, over a half (56%) of inquest cases involved a post-mortem, down 20 percentage points on 2014 continuing the declining trend seen over the past decade (from 93% in 2006). Historically, it was quite rare for an inquest to be opened without a post-mortem; however, since 1997 this proportion had been gradually increasing, with sharp increases seen in the last two years. In 2015, 44% of all inquests had no post-mortem, compared with 24% in 2014 and 16% in 2013. This may be attributed to the provisions in

the Coroners Act 2009 which came into effect in July 2013, allowing a coroner to conduct a brief investigation prior to making a decision on whether to hold a formal inquest. These are captured in the potential inquest cases below.

### **Post-mortems in non-inquest cases**

In the majority (84%) of cases referred to coroners, there is no inquest. In 2015, there were 66,549 non-inquest cases where a post-mortem was held. The percentage of non-inquest cases that required a post-mortem has remained at 34% for the past four years although this proportion had fallen steadily prior to this; at the beginning of the time series, in 1995, it was 56%.

### **Post-mortems in potential inquest cases**

Prior to July 2013, cases were either categorised as 'inquest' or 'non-inquest' cases. Changes in the way coroners are able to conduct an investigation mean that there is now a third category of 'potential inquest' cases. This means that the coroner is investigating the death, but has not yet decided whether it is necessary to hold an inquest. Depending on whether or not the coroner deems it necessary to hold an inquest, these cases will all eventually end up in either the 'inquest' or 'non-inquest' category.

In 2015, there were 4,971 potential inquest cases being dealt with by coroners in England and Wales, with almost all (87%) requiring a post-mortem.

### **Cases requiring neither an inquest nor a post-mortem**

There were 132,029 cases reported to coroners where there was neither an inquest nor a post-mortem. This type of case has generally been increasing in number in recent years (in 2005 there were 116,047 such cases), with this year increasing by 4,383 cases (3%). The proportion of cases where there was neither an inquest nor a post-mortem examination has remained stable over the last four years, at 66%. Prior to this time the proportion had been increasing, since the time series began in 1995, when it stood at 44%.

### **Post-mortem rates, histology<sup>16</sup> and toxicology<sup>17</sup>**

Post-mortem examinations can be classed as either standard or non-standard, depending on the cost of the examination. A non-standard post-mortem is charged at a higher rate than a standard post-mortem and is defined as a post-mortem which requires special skills. A non-standard post-mortem could, for example, require a paediatric or specialist pathologist. In 2015, almost all (95%) of post-mortems were ordered at a standard rate - this has remained at the same level since 2011.

In 2015, 18,659 post-mortems included histology; and despite an increase in the overall number by 226 from last year, the proportion of post-mortems which included histology which has remained at 21% of all post mortems. In

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<sup>16</sup> Histology in the context of post-mortems is the examination of tissues under a microscope.

<sup>17</sup> Toxicology in the context of post-mortems is the study of body fluids and tissues for the detection of drugs.

2015, 14,732 post-mortems held included toxicology (17% of post-mortems held), which was 1,028 more than in 2014, an increase of 8%. This follows the steady rising trend seen since 2011.

### **Out of England and Wales Orders**

To remove a body of a deceased person out of England and Wales, notice must be given to the coroner within whose area the body is lying. When the coroner gives permission for the removal of a body, an Out of England and Wales order is issued.

Coroners issued 5,339 Out of England and Wales orders in 2015, compared with 5,232 issued in 2014. In both years, the number of orders issued represented 2% of the total number of deaths reported to coroners – this proportion has been stable at this level since 2011 (see Table 5).

### **Deaths abroad**

Of the 236,406 deaths reported to coroners in 2015, around 1% (1,874) were reports of deaths that had occurred outside England and Wales. This has remained at the same level since 2011.

### **Deaths in State Detention**

In 2015, a total of 7,667 deaths which occurred in state detention were reported to coroners<sup>18</sup>, an increase of 7,315 deaths on the previous year and representing 3% of all deaths reported to coroners.

Prior to 2015, deaths of individuals subject to Deprivation of Liberty Safeguard (DoLS) authorisations were not collected separately within the 'Deaths in state detention' section of the coroners' return although all such deaths would have been reported to coroners and included in published statistics although the number would have been minimal.

In 2015, newly collected figures show that there were 7,183 deaths of individuals subject to DoLS<sup>19</sup> authorisations – the large increase since 2014 is in line with that seen in the number of active DoLS authorisations; as of 31 March 2015, there were over 36,000 compared with 2,300 as of March 2014. Deaths of individuals subject to DoLS authorisations accounted for 94% of all deaths in state in detention in 2015.

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<sup>18</sup> This data only represents deaths in custody which were referred to a coroner and subsequently reported to MoJ in the coroner's annual return.

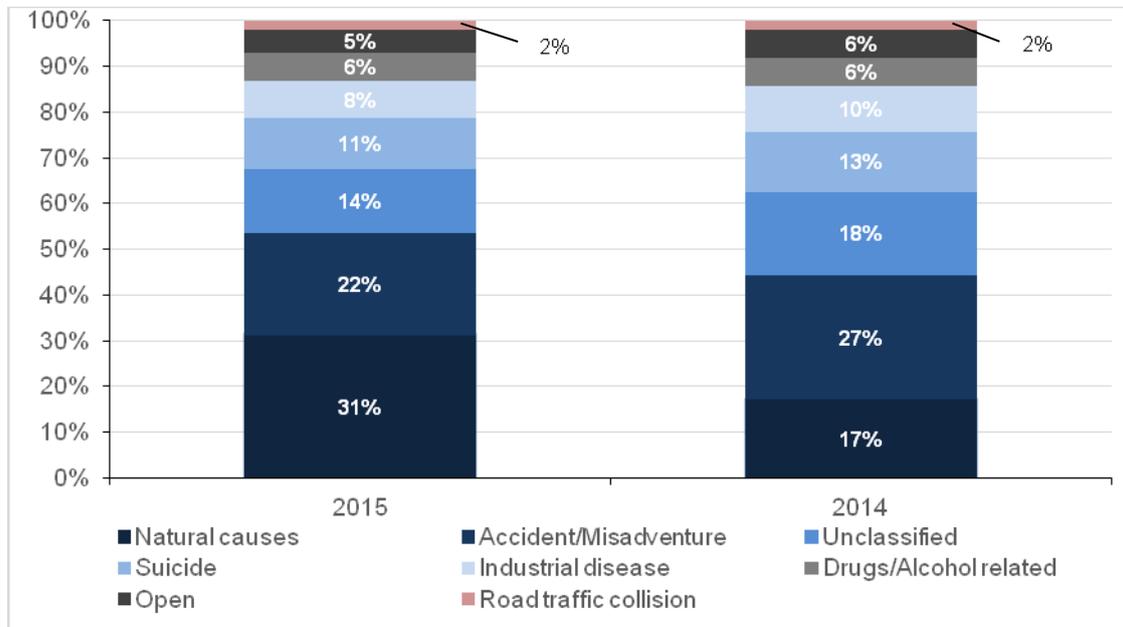
<sup>19</sup> See introduction, section changes to reporting for more information on DoLS.

### 3: Inquests Completed

There were 35,473 inquest conclusions recorded in 2015, up by 6,320 (22%) from 2014, in part reflecting the increase in the number of inquests opened. This is the highest number of inquest conclusions recorded since the series began in 1995.

Historically, the most common inquest conclusions (in order of frequency observed) were death from natural causes, death by accident or misadventure and unclassified conclusions. In 2015 the most common conclusions (by order of frequency) continue to be death from natural causes (11,043 or 31%), death by accident and misadventure (7,977 or 22%), and unclassified (4,870 or 14%).

**Figure 3: Conclusions recorded at inquest, by category and as a proportion of all conclusions, England and Wales, 2014 and 2015<sup>20 21</sup>**



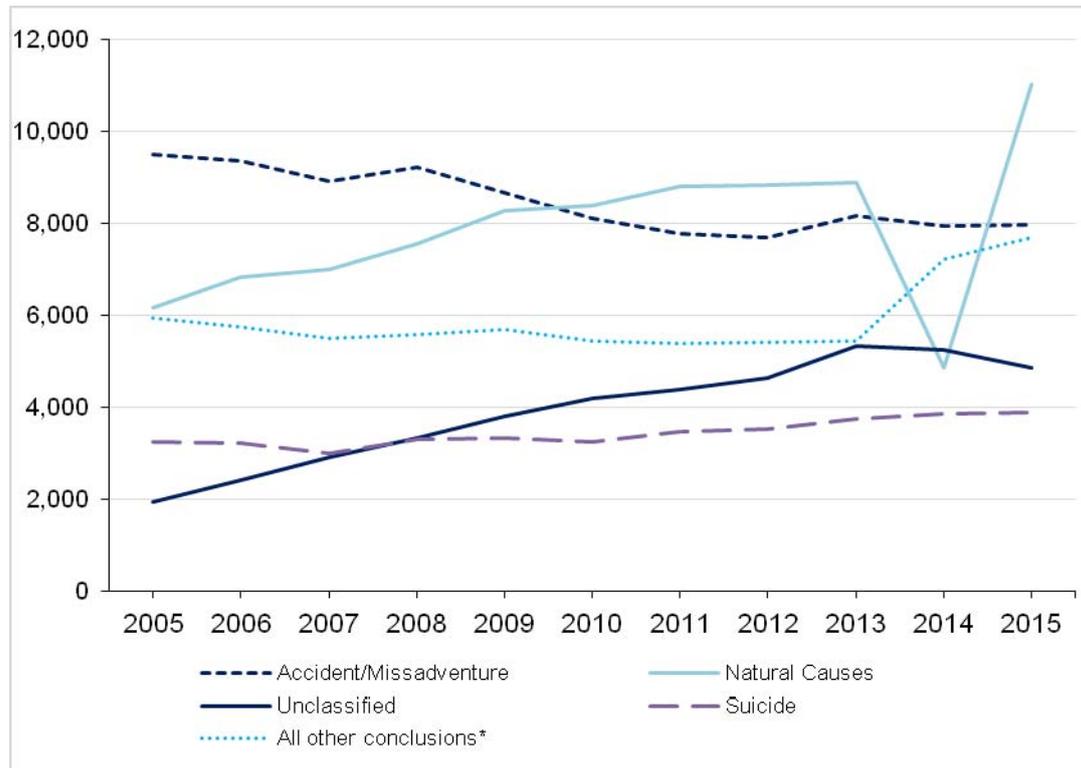
The conclusion category driving the increase seen when compared to 2014 is death by natural causes, which increased by 127% (6,170 more conclusions), driven by the majority (94%) of deaths of individuals subject to DoLS authorisations having an inquest conclusion of natural causes. Historically, natural cause conclusions had been steadily increasing, until last year (2014),

<sup>20</sup> Figures may not equal 100% due to rounding.

<sup>21</sup> All other conclusions (including Killed unlawfully, Killed lawfully, Attempted or self-induced abortion, Cause of death aggravated by lack of care, or self-neglect, Want of attention at birth, Stillborn, Disasters) were not included in the chart as they represented less than 0.5% of the short-form conclusions

where they fell by 4,008 or 45% compared to 2013. This was explained to be in part due to the Coroners Act 2009 coming into effect in July 2013, which meant coroners could issue a death certificate without holding an inquest when it is known that a death has occurred naturally. In 2015, the number of inquests recording a natural causes conclusion, excluding DoLS, was stable compared with the previous year.

**Figure 4: Number of conclusions recorded at inquests, England and Wales, 2004-2015**



\*Killed unlawfully, Killed lawfully, Attempted or self-induced abortion, Cause of death aggravated by lack of care, or self-neglect, Want of attention at birth, Stillborn, Disasters, Open, Industrial Diseases, Drugs/Alcohol Related<sup>22</sup>, Road traffic collision

For the remaining conclusion types, drugs and alcohol related cases increased by 622 cases (up 38%) to 2,267 and road traffic collisions by 177 cases (up 27%) to 779. These two categories were added as short form conclusions in 2014, resulting in the large increase seen in figure 4, for the ‘all other conclusion’ group. The remaining conclusions either saw a slight decrease or remained stable when compared to 2014.

Although overall accident and misadventure inquest conclusions remained stable when compared to 2014, with 7,977 conclusions, the trend differed by gender – females up 5% (172 cases) and males down 3% (136 cases).

<sup>22</sup> For years 2004-2013, this includes the previously used conclusions “Dependence on Drugs” and “Non-dependence on Drugs”

In 2015, the number of unclassified conclusions decreased by 391 cases (down 7%) to 4,870, continuing the trend change seen in 2014, where unclassified cases decreased for the first time. Prior to 2014, unclassified cases had been increasing year on year since records began in 1995. The proportion of conclusions that were unclassified had also been increasing year on year, from 1% in 1995 to 18% in 2014, until 2015, where it dropped by 4 percentage points to 14%. This decrease in unclassified conclusions is likely due to the large increase seen in natural causes conclusion category.

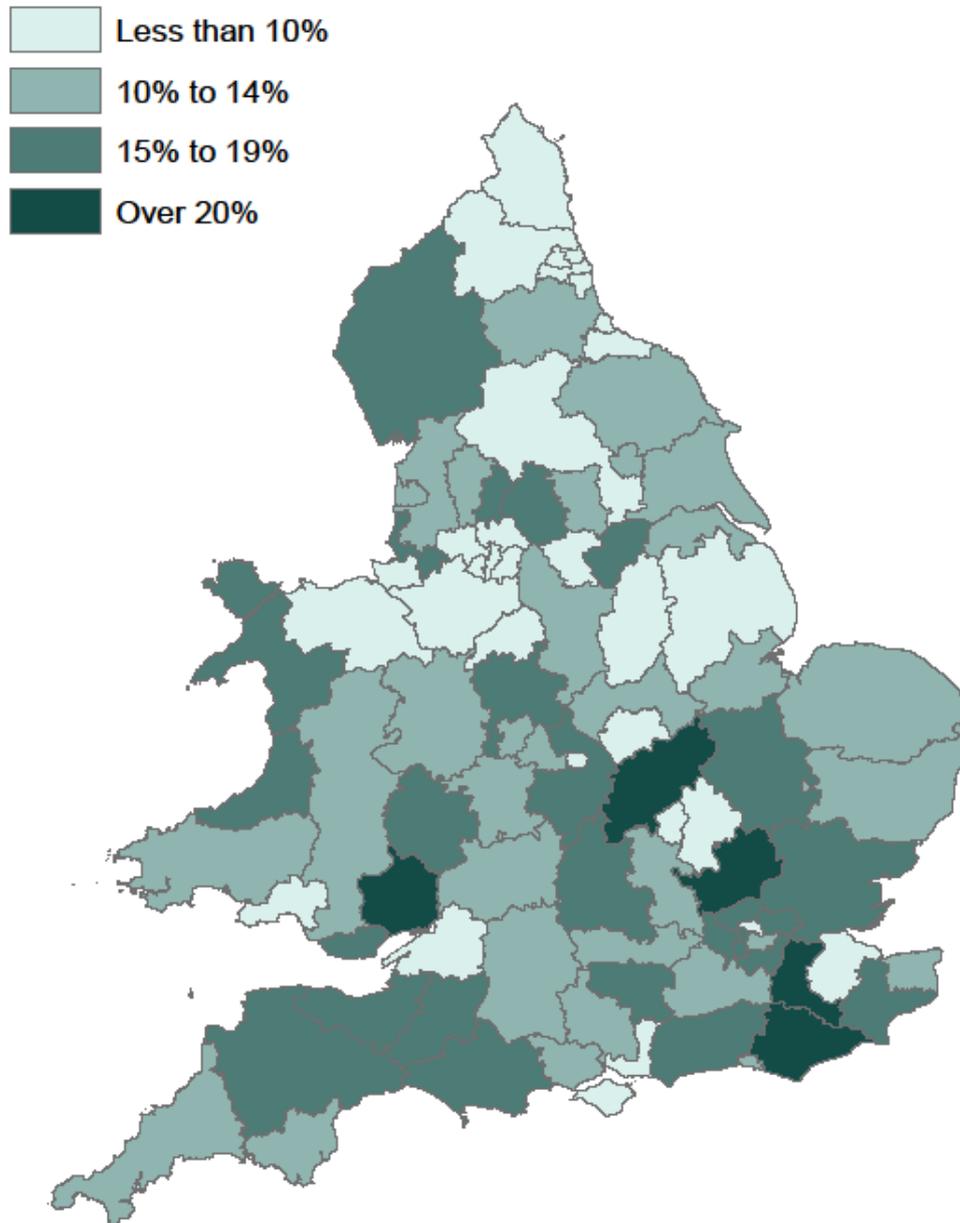
The rise in proportion of unclassified conclusions seen until 2014 is partly due to the increasing use of what are known as 'narrative conclusions' by some coroners. In these cases, the conclusion is recorded as unclassified. As well as narrative conclusions, this category includes short non-standard conclusions which a coroner or jury might return when the circumstances do not easily fit any of the standard conclusions<sup>23</sup>.

As a proportion of all conclusions, death by accident or misadventure has been declining steadily, from 35% of conclusions in 2005 to 22% in 2015, with an increase to 27% in 2014. Open conclusions have been decreasing over the same period, particularly over the last few years - they accounted for 5% in 2015 compared with 9% in 2005. The proportion of inquest conclusions recorded as suicide has decreased to 11% in 2015 since peaking in 1995 at 18%.

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<sup>23</sup> An analysis on unclassified conclusions can be found in the Coroners Statistics 2012 publication (Annex A), available at: [www.gov.uk/government/publications/coroners-statistics](http://www.gov.uk/government/publications/coroners-statistics)

**Map 4: Suicide conclusions as a proportion of all inquest conclusions, England and Wales, 2015**



The proportion of conclusions recorded as suicide varies from 0% in Gateshead and South Tyneside, to 27% in Gwent (when excluding City of London and Isle of Scilly, due to small numbers). A majority of the coroner offices (56) recorded suicide conclusions in 10% to 19% of inquests.

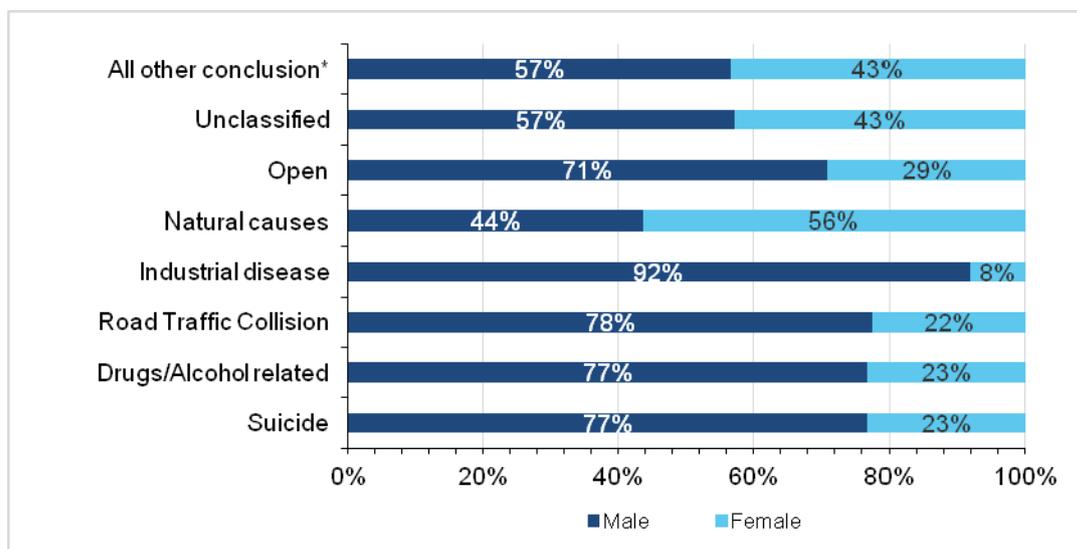
#### **Differences in conclusions recorded by gender**

The pattern of conclusions recorded differs between males and females. Male deaths accounted for 60% of all conclusions recorded in 2015, however they accounted for just over half (54%) of deaths reported; this suggests that males

are more likely to die in circumstances that lead to an inquest. Female deaths accounted for about 40% of all conclusions recorded in 2015 (and 46% of deaths reported).

- Of the 3,899 conclusions of suicide, 77% were for males and 23% for females.
- Of the 1,736 open conclusions, 71% were for males and 29% for females.
- 56% of the 11,043 conclusions of death from natural causes were for females, the remaining 44% were for males.

**Figure 5: Conclusions recorded at inquests by sex, England and Wales, 2015**



\*Killed unlawfully, Killed lawfully, Attempted or self-induced abortion, Cause of death aggravated by lack of care, or self-neglect, Want of attention at birth, Stillborn, Disasters, Accident and misadventure

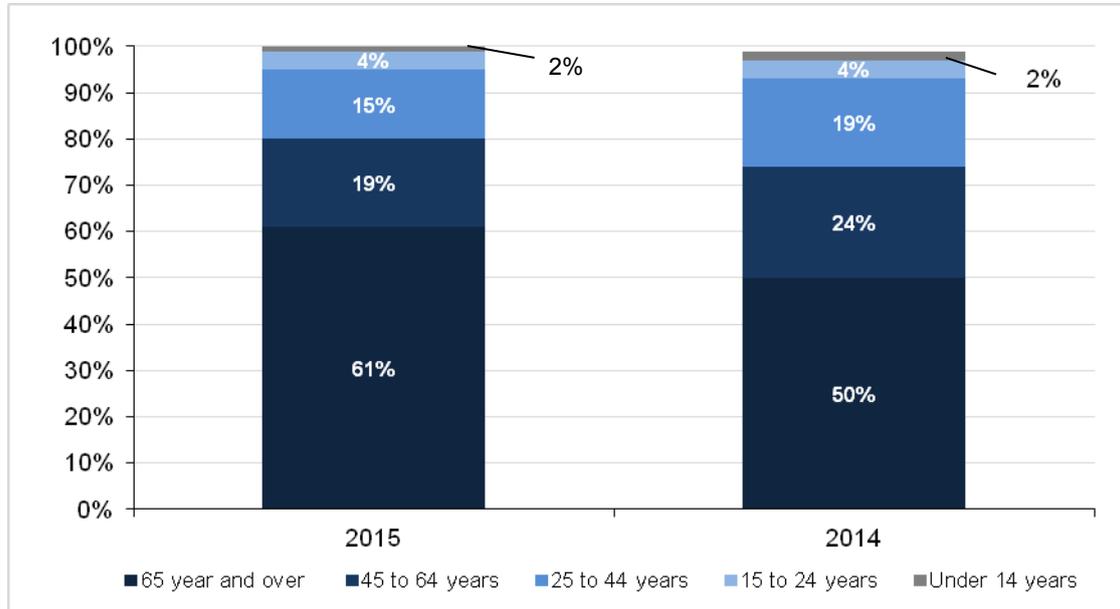
**Age of deceased in inquests where a conclusion was recorded**

Since 2008, coroners have been asked to provide information (in summary form) on the ages of persons in inquest cases where a conclusion was recorded. Of the inquests completed in 2015, three-fifths related to persons who were aged 65 years or over at time of death compared with 5% which related to persons under 25 year of age (see Table 8). Although an age breakdown of registered deaths in England and Wales in 2015 is not yet available, ONS figures for 2014 show that 84% of registered deaths in England and Wales were persons aged 65 or over, with only 1% aged under 25 years old.

The profile of the age of deceased in inquests has changed compared to 2014, i.e. half of inquests completed in 2014 related to persons aged 65 or over compared with 61% in 2015. This may be due to the increase in the

number of deaths of individuals subject to DoLS authorisations, all of which require an inquest and may predominantly relate to the older population.

**Figure 6: Age of deceased in inquests where a conclusion was recorded, England and Wales, 2015<sup>24</sup>**



### Inquests with juries and adjourned inquests

The number of inquests held with juries in 2015 was 457 (representing 1% of all inquests), an increase of 60 compared to 2014.

Both the number and proportion of inquests held with juries showed a downward trend until recent years but the trend appears now to have stabilised, with the proportion remaining between 1% and 2% for the last eleven years (see Table 9).

In 2015, 728 inquests were adjourned (and not resumed) by the coroner under Schedule 1<sup>25</sup> of the Coroners and Justice Act 2009 because criminal proceedings took place. This represents 2% of all inquests concluded, the same proportion as 2014 and 2013, and slightly less than in earlier years - around 3% since 2006.

<sup>24</sup> The 'age not known' category has been excluded from the chart due to small numbers (less than 0.5%). Totals may not add up to 100% due to rounding.

<sup>25</sup> Schedule 1 of the Coroners and Justice Act 2009 states that the coroner should adjourn an inquest in the event that criminal proceedings may or will take place.

### **Time taken to process an inquest**

The estimated<sup>26</sup> average time taken to process an inquest in 2015 (defined as being from the date the death was reported until the conclusion of the inquest) was 20 weeks (see Table 13)<sup>27</sup>, a reduction of 8 weeks compared to 2014. This can largely be attributed to DoLS where, in accordance with the Chief Coroner's guidance, in uncontroversial cases, an inquest can be a 'paper inquest', i.e. decided in open court but on papers without the needs for witnesses or a post-mortem.

The maximum average time taken to process an inquest in 2015 was 61 weeks, and the minimum average time was 6 weeks. The large range of average time (55 weeks – based on 6 and 61 weeks) could be due to the fact that coroners' caseloads can vary greatly and a direct comparison between coroner areas is therefore not advised.

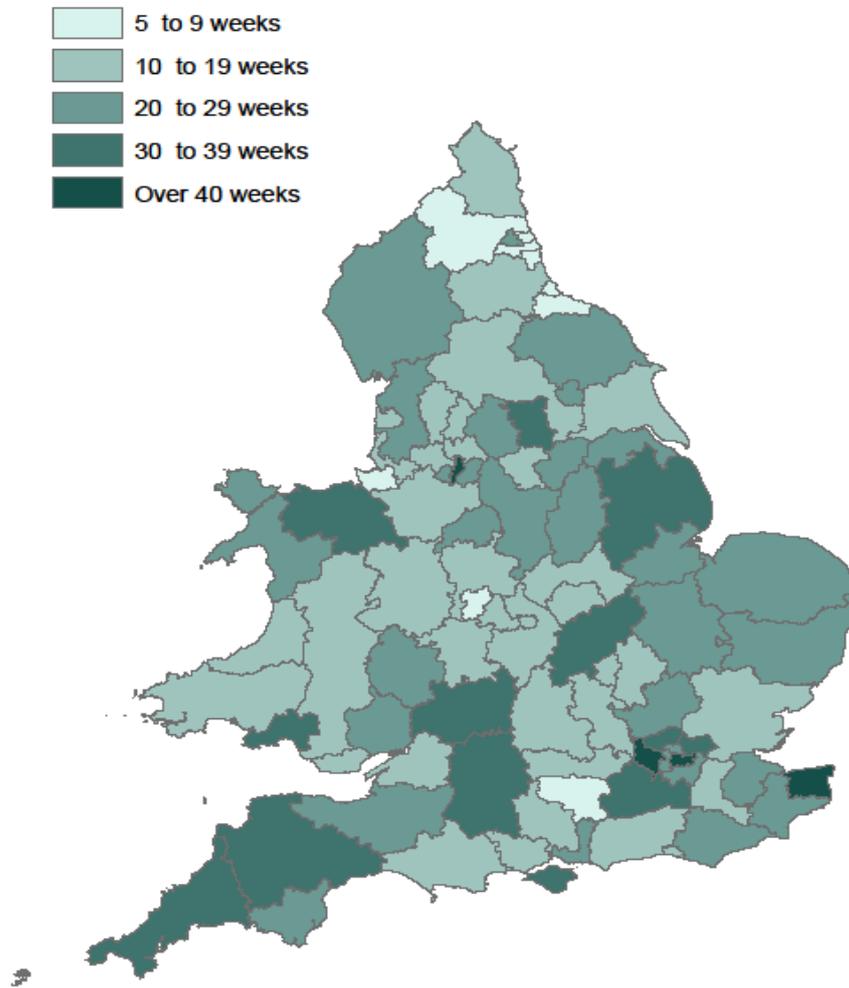
More information about how the average time taken has been estimated can be found in the [explanatory notes](#) section of this report.

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<sup>26</sup> A direct average of the time taken to process an inquest cannot be calculated from the summary data collected; an estimate has been made instead. Please see the [explanatory notes section](#) of this report for more information.

<sup>27</sup> Only deaths occurring within England and Wales are included in this estimation.

**Map 5: Average time taken to process inquests, England and Wales, 2015**



The average time taken to process an inquest varies from 6 weeks in Hartlepool to 61 weeks in West London.

## 4: Treasure and Treasure Trove

On 24 September 1997, the Treasure Act 1996 came into force and replaced the common law of Treasure Trove in England and Wales. The 1996 Act introduced new requirements for reporting and dealing with finds. Not all finds need be the subject of an inquest. For more information please see:

[www.legislation.gov.uk/ukpga/1996/24/contents](http://www.legislation.gov.uk/ukpga/1996/24/contents)

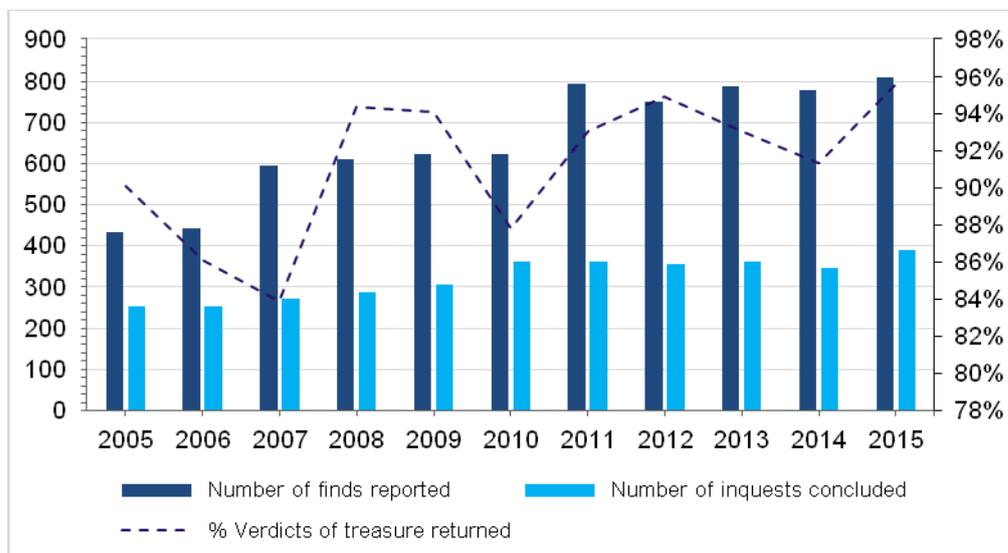
In 2015, 810 finds were reported and 390 inquests were concluded. In addition, there were seven inquests held into Treasure Trove in 2015 (relating to finds made before the current Act came into force), and it is likely that a few such inquests will continue to be held from time to time.

The number of finds reported has been steadily increasing over the last ten years; in 2015 there was an increase of 4% compared to 2014. Of those 390 inquests concluded in 2015, 96% (373) returned a verdict of treasure, a rise from 91% (317) in 2014.

An annual report on the operation of the Treasure Act 1996 is published by the Department for Culture, Media and Sport. For more information please see:

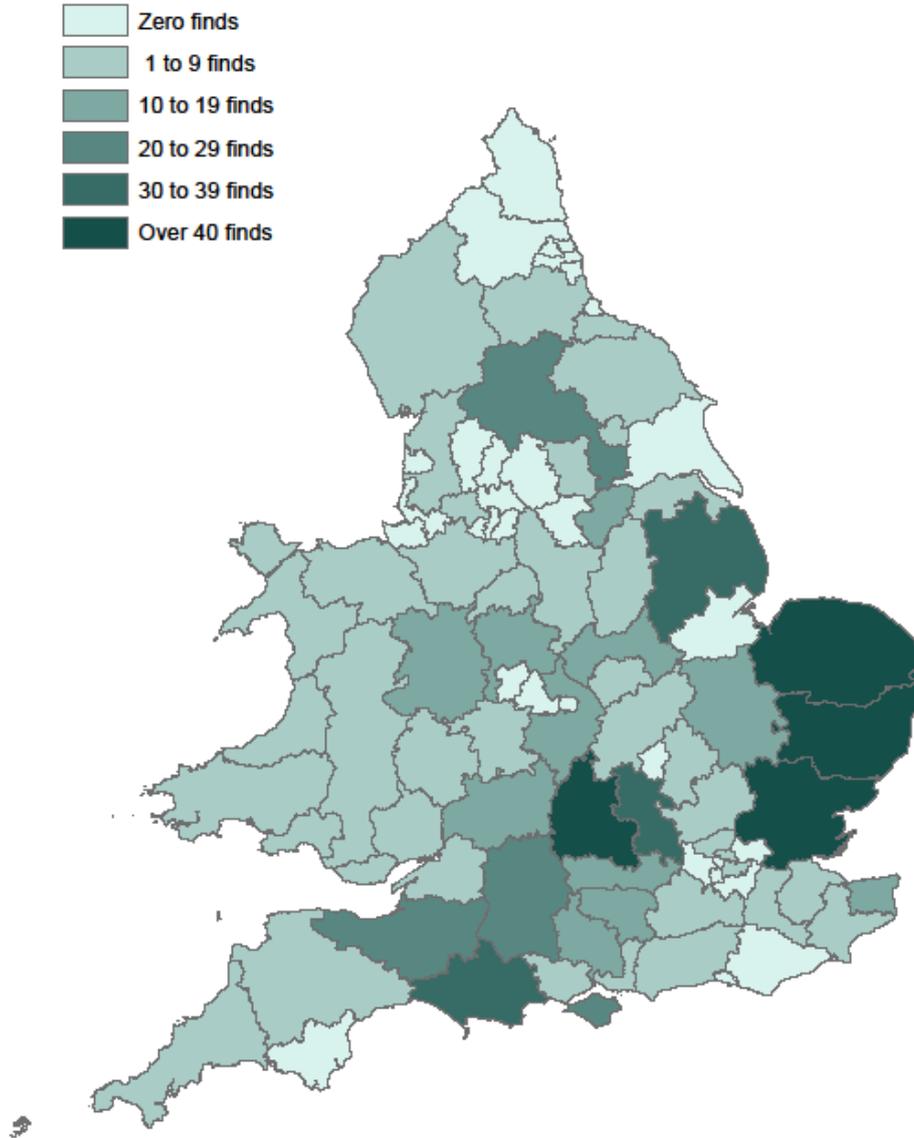
[www.gov.uk/government/organisations/department-for-culture-media-sport/series/treasure-and-portable-antiquities-statistics](http://www.gov.uk/government/organisations/department-for-culture-media-sport/series/treasure-and-portable-antiquities-statistics)

**Figure 7: Finds reported to coroners, treasure inquests held under the Treasure Act, and proportion of treasure verdicts returned, 2004-2015<sup>28</sup>**



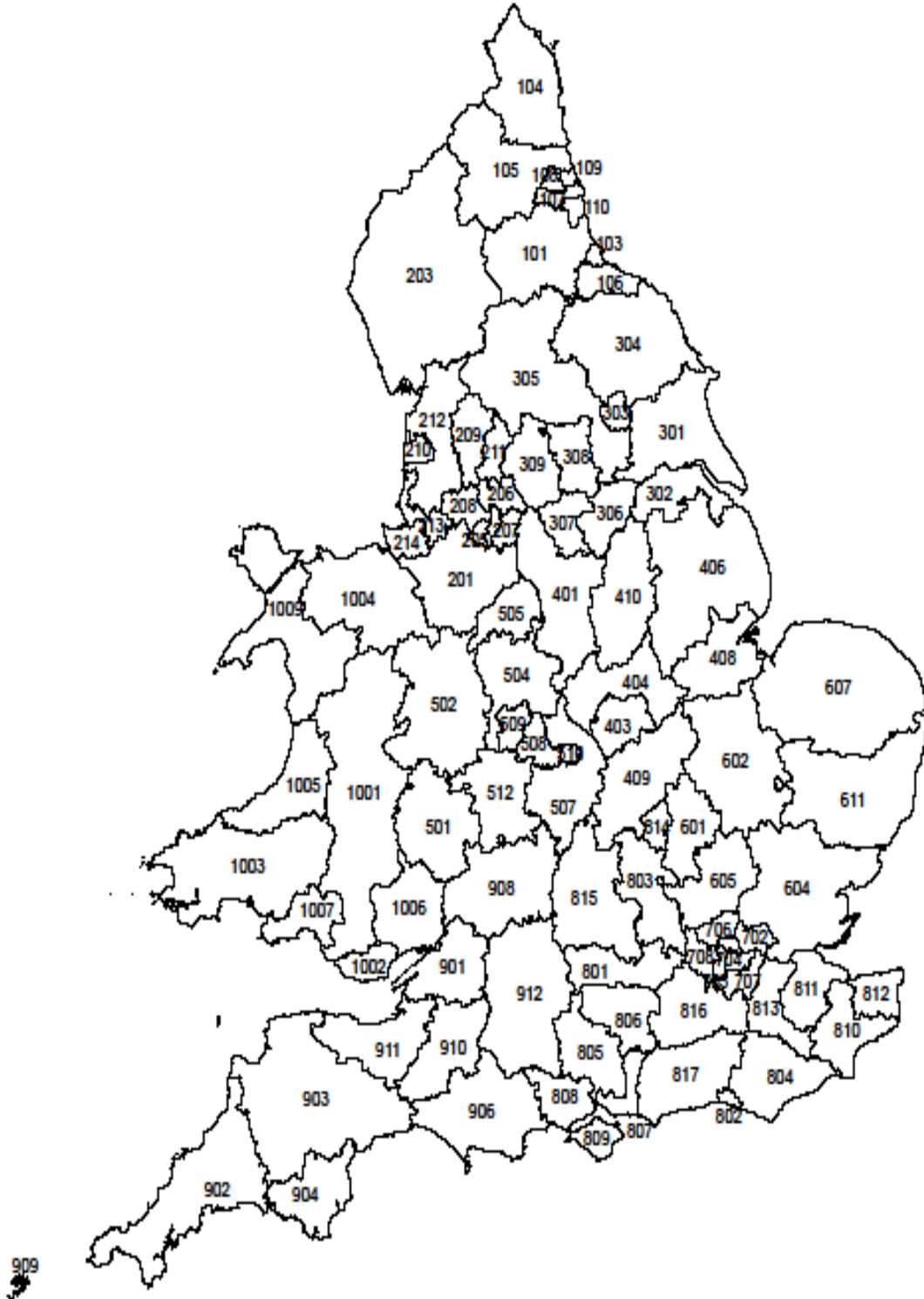
<sup>28</sup> This chart does not include reported findings under "Treasure Trove"

**Map 6: Number of treasure finds reported to coroners, England and Wales, 2015**



Thirty-one coroner areas had no treasure finds reported to them. Norfolk had the highest number of treasure finds at 97.

# Annex A: Map of coroner areas in England and Wales, 2015



Key to coroner areas

## Coroners Statistics 2015

### North East

101 – County Durham and Darlington  
103 – Hartlepool  
104 – North Northumberland  
105 – South Northumberland  
106 – Teesside  
107 – Gateshead and South Tyneside  
108 – Newcastle upon Tyne  
109 – North Tyneside  
110 – Sunderland

### North West

201 – Cheshire  
203 – Cumbria  
205 – Manchester (city)  
206 – Manchester North  
207 – Manchester South  
208 – Manchester West  
209 – Blackburn, Hyndburn and Ribble Valley  
210 – Blackpool and Fylde  
211 – East Lancashire  
212 – Preston and West Lancashire  
213 – Sefton, Knowsley and St Helens  
214 – Liverpool and the Wirral

### Yorkshire and the Humber

301 – East Riding and Hull  
302 – North Lincolnshire and Grimsby  
303 – York City  
304 – North Yorkshire - East  
305 – North Yorkshire - West  
306 – South Yorkshire - East  
307 – South Yorkshire - West  
308 – West Yorkshire - East  
309 – West Yorkshire - West

### East Midlands

401 – Derby and Derbyshire  
403 – Leicester and South Leicestershire  
404 – North Leicestershire and Rutland  
406 – Central Lincolnshire  
408 – South Lincolnshire  
409 – Northamptonshire  
410 – Nottinghamshire

### West Midlands

501 – Herefordshire  
502 – Shropshire, Telford and Wrekin  
504 – Staffordshire South  
505 – Stoke-on-Trent and North Staffordshire  
507 – Warwickshire  
508 – Birmingham and Solihull  
509 – Black Country  
510 – Coventry  
512 – Worcestershire

### East of England

601 – Bedfordshire and Luton  
602 – Cambridgeshire and Peterborough  
604 – Essex  
605 – Hertfordshire

607 – Norfolk  
611 – Suffolk

### London

701 – City of London [not visible]  
702 – East London  
703 – Inner London North  
704 – Inner London South  
705 – Inner London West  
706 – North London  
707 – South London  
708 – West London

### South East

801 – Berkshire  
802 – Brighton and Hove  
803 – Buckinghamshire  
804 – East Sussex  
805 – Central Hampshire  
806 – North East Hampshire  
807 – Portsmouth and South East Hampshire  
808 – Southampton and New Forest  
809 – Isle of Wight  
810 – Central and South East Kent  
811 – Mid Kent and Medway  
812 – North East Kent  
813 – North West Kent  
814 – Milton Keynes  
815 – Oxfordshire  
816 – Surrey  
817 – West Sussex

### South West

901 – Avon  
902 – Cornwall  
903 – Exeter and Greater Devon  
904 – Plymouth, Torbay and South Devon  
906 – Dorset  
908 – Gloucestershire  
909 – Isles of Scilly  
910 – Eastern Somerset  
911 – Western Somerset  
912 – Wiltshire and Swindon

### Wales

1001 – Powys, Bridgend & Glamorgan Valleys  
1002 – Cardiff and Vale of Glamorgan  
1003 – Carmarthenshire and Pembrokeshire  
1004 – North Wales (East and Central)  
1005 – Ceredigion  
1006 – Gwent  
1007 – Swansea and Neath Port Talbot  
1009 – North West Wales

## Annex B: Details of recent coroner area amalgamations

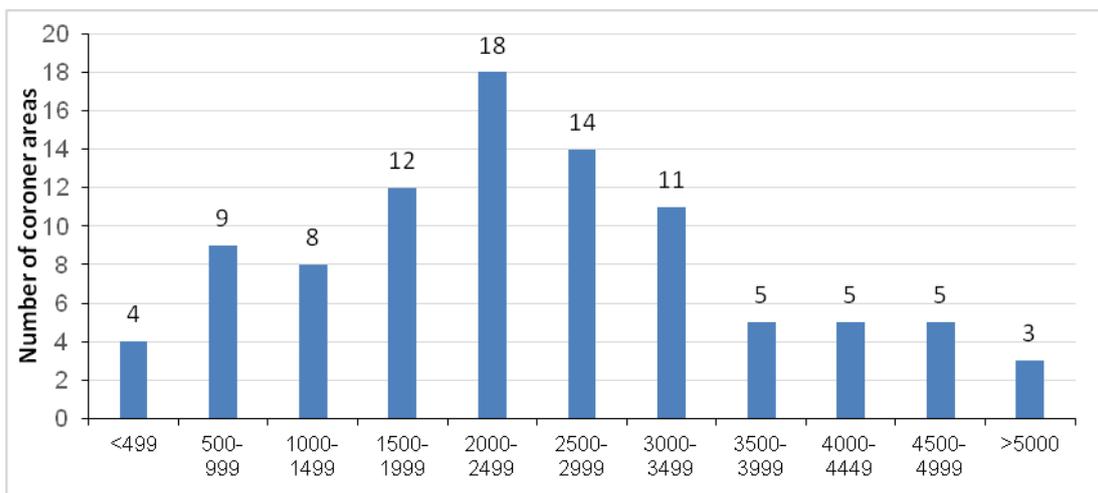
The following table summarises the coroner area amalgamations that have occurred since the 2014. This bulletin uses the coroner areas shown below that were formed in 2015 to breakdown the figures. Additionally, one of the 2016 amalgamations, has also been included in this report. A 2015 data return was received from Somerset coroner area, even though this area did not officially come into force until 1<sup>st</sup> April 2016. Therefore it was not possible to report on East Somerset and West Somerset coroner areas individually.

<b>Date effective</b>	<b>Previous coroner area</b>	<b>New coroner area</b>	<b>Nature of merge</b>
01-Jan-15	North and West Cumbria; South and East Cumbria	Cumbria	2 into 1
02-Apr-15	Liverpool; the Wirral	Liverpool and the Wirral	2 into 1
01-Aug-15	North and East Cambridgeshire; South and West Cambridgeshire; Peterborough	Cambridgeshire and Peterborough	3 into 1
01-Apr-16	East Somerset; West Somerset	Somerset	2 into 1
01-Apr-16	Cornwall; the Isles of Scilly	Cornwall and the Isles of Scilly	2 into 1
01-Apr-16	Cardiff and Vale of Glamorgan; Powys, Bridgend & Glamorgan Valleys;	South Wales Central	2 into 1

## Annex C: Further analysis of deaths reported to coroners

The number of deaths reported to coroners in 2015 varied by coroner area – from 14 in the Isles of Scilly to 6,869 in Essex. The number of deaths reported in each area will be affected by its size, population and demographic breakdown so comparisons of deaths reported to the coroner across coroner areas should be treated with caution.

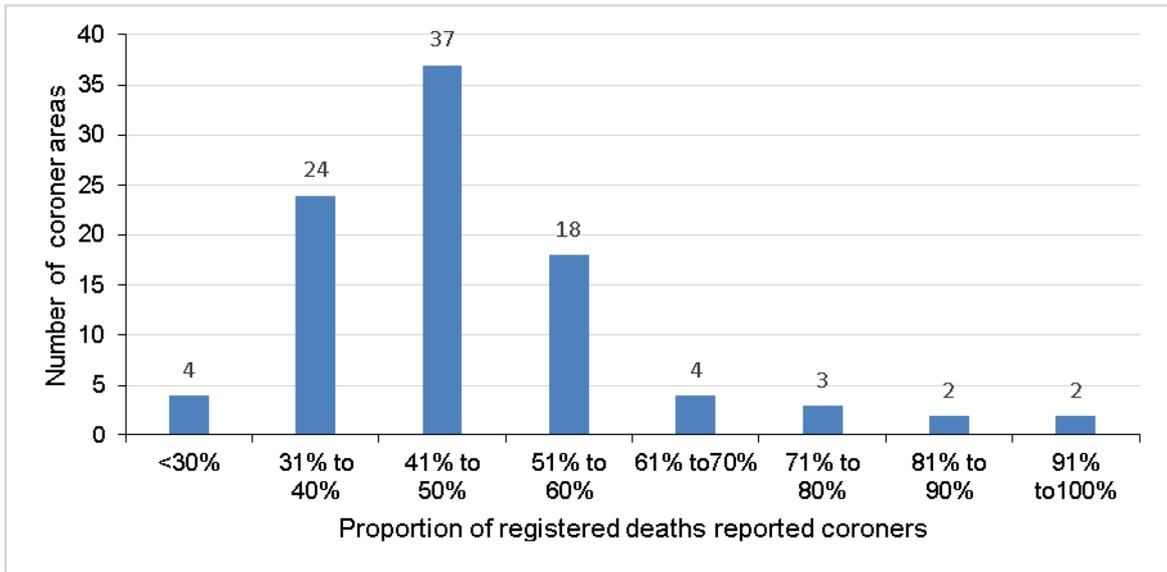
**Figure C1: Number of deaths reported to coroners, 2015**



When looking at the number of deaths reported to coroners in 2015 as a proportion of registered deaths<sup>29</sup>, which should allow for differences in population characteristics, there is still a wide variation across coroner areas e.g. 26% in Rutland and North Leicestershire compared with 92% in Stoke-on-Trent and North Staffordshire.

<sup>29</sup> As the ONS death registration figures are based on area of usual residence whereas the coroners' figures are based on the area where a person died, these figures should be used with caution. For example, the coroner office for the City of London shows a distorted figure of 476% due to the low levels of residence and high level of commuters.

**Figure C2: Deaths reported to coroners in 2014 as a proportion of registered deaths<sup>30,31</sup>**



<sup>30</sup> Provisional figure based on ONS monthly death registration figures for 2015

<sup>31</sup> Data for the City of London has been excluded from this analysis due to the small size of this coroner area. The total number of coroner areas shown in Figure C2 is therefore 93.

## Explanatory notes

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods, and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

The data analysed in this publication are based on annual returns from coroners. Thanks are due to coroners and their staff for their work in preparing these returns.

### **Quality and consistency of the statistics**

The figures presented in this report are collected via statistical returns completed by coroners. For the calendar year 2015, all coroner area returns were received electronically. The process by which coroners provide their returns can vary according to the case management system they use. Many coroners use a system provided by an external contractor, while other coroners use alternative computer systems or a paper-based system. Although care is taken in completing, analysing and quality-assuring the data provided on the statistical returns, the figures are, of necessity, subject to possible inaccuracies inherent in any large-scale collection of this type. Every effort is made, however, to ensure that the figures presented in this publication are accurate and complete.

Returns are individually quality-assured and validated in a process that highlights inconsistencies between years, and between areas. Checks are made to ensure that each return is arithmetically correct, e.g. subtotals and overall totals are correctly summed. Unusual or outlying values found within returns are queried with the data supplier, to confirm whether these are correct, or that an error exists in the information provided which requires amendment.

There were two coroner areas where data discrepancies from the 2015 data returns were unresolvable at the time of publication. East Sussex and Plymouth, Torbay and South Devon coroner areas. Both reported discrepancies when reporting the number of post-mortems by type, whether by standard and non-standard rate and by gender and inquest situation of the case. Following discussions with these coroner areas we took the post-

mortem by gender and inquest, to be the correct official figure for these areas.

Coroners are independent office-holders, and there is considerable variation in the way each coroner's area is structured and managed, and in the mechanisms they have in place for discharging their duties under the Coroners Act. From a statistical perspective one of these differences relates to the way they approach the handling of "NFA" cases.

Many deaths referred to coroners require no further action being taken by them – these are known as "NFA" cases. These are deaths reported to coroners where there was no inquest, no post-mortem, and no certificate was issued by the coroner for registration or any other purpose. The statistics for 1995 onwards include all NFA cases within the figures for deaths reported that required neither an inquest nor a post-mortem. Prior to 1995, however, some coroners did not report some or all of their NFA cases in their annual statistics (figures for some earlier years are shown in Table 2), and the inclusion of all NFA cases in the statistics addressed this inconsistency in reporting.

Despite the inclusion of all NFA cases in the statistics since 1995, there may still however be some differences between coroners as to which cases they consider constitute a substantive "reported death" (and are therefore reported in their statistics) where little or no action is required on their part and no post-mortem or inquest is held. As such, the statistics reflect those cases which each individual coroner considers to be a death reported to them, and the figures for different coroner areas can be compared on this basis.

### **Timeliness of inquests**

For the purpose of determining the timeliness of inquests, the time taken to conduct an inquest is deemed to be from the day the death was reported to the coroner until either (a) the day the inquest is concluded by the delivery of a verdict or (b) the day the coroner certifies that an adjourned inquest will not be resumed.

The average time for an inquest to be conducted is estimated in the following way: Coroners are asked in their annual return to state how many inquests were concluded within certain time periods. There are five time bands, which are: within one month; 1-3 months; 3-6 months; 6-12 months; and over 12 months. All the inquests falling within a time-band are then assumed to have been completed at or near the mid-point of the various time-bands for the purposes of calculating the average, although inquests within the "under one month" band are assumed to have taken 3 weeks for this purpose of this estimation, and those inquests taking over a year to conclude were deemed to have taken 18 months, although the time-band itself is open-ended. Numbers are then aggregated and the average figure (in weeks) calculated in the normal way.

Only deaths occurring within England and Wales are included in the calculation. Statistics are not collected on the time taken for inquests where the death occurred outside England and Wales. Deaths occurring abroad are often significantly delayed because of the difficulty, for example, of obtaining reports from other countries.

### **Revisions to statistics for previous years**

The estimated figure for the number of registered deaths in 2014 which was derived for the purposes of Table 2 in last year's edition of this bulletin has now been replaced by an actual figure subsequently published by the Office for National Statistics.

### **Symbols and conventions**

The following symbols have been used throughout the tables in this bulletin:

n/a = Not applicable

- = Zero

.. = No data available

(p) = provisional data

(r) = Revised data

### **Further notes**

Prior to 1 June 2005, policy responsibility for coroners lay with the Home Office, but on that date it passed to the Department for Constitutional Affairs as part of machinery of government changes following the 2005 general election. Responsibility now lies with the Ministry of Justice, which was created on 9 May 2007.

Prior to the transfer of responsibility, the Home Office published statistical bulletins based on coroners' annual returns, from 1980. The last four bulletins published in the Home Office Statistical Bulletin series were as follows: for year 2003, bulletin 9/04; for 2002, bulletin 6/03; for 2001, bulletin 3/02; and for year 2000, bulletin 7/01. These may be found at:

[webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/hosbarchive.html](http://webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/hosbarchive.html)

Editions of this bulletin for years up to and including 2009, published by the Ministry of Justice, the Department for Constitutional Affairs, and the Home Office, were entitled "Statistics on deaths reported to coroners, England and Wales, (year)".

## Contacts

Current and previous editions of this publication are available for download at:

[www.gov.uk/government/collections/coroners-and-burials-statistics](http://www.gov.uk/government/collections/coroners-and-burials-statistics)

The spreadsheet file of the statistical tables referred to in this bulletin is also available for download from this address, along with the CSV file and the Coroners Statistical Tool spreadsheet.

Press enquiries should be directed to the Ministry of Justice press office:

Tel: 0203 334 3529

Email: [Sebastian.Walters@justice.gsi.gov.uk](mailto:Sebastian.Walters@justice.gsi.gov.uk)

Other enquiries about these statistics should be directed to:

### **Tara Rose**

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102 Petty France

London

SW1H 9AJ

Email: [statistics.enquiries@justice.gsi.gov.uk](mailto:statistics.enquiries@justice.gsi.gov.uk)

A copy of the data collection form which was sent to coroners may be obtained via the contact details above.

General enquiries about the statistical work of the Ministry of Justice can be e-mailed to: [statistics.enquiries@justice.gsi.gov.uk](mailto:statistics.enquiries@justice.gsi.gov.uk)

Other National Statistics publications, and general information about the official statistics system of the UK, are available from [www.statistics.gov.uk](http://www.statistics.gov.uk).

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