CORONERS' COURTS

A Guide to Law and Practice

THIRD EDITION

Christopher Dorries OBE
HM Senior Coroner South Yorkshire (West)

Contributors

Belinda Cheney
Assistant Coroner Cambridgeshire South & West
Assistant Coroner Surrey
Assistant Coroner Northamptonshire

Dr Alan Fletcher
Consultant Emergency Physician
and Lead Medical Examiner (Sheffield)

ME Hassell
HM Senior Coroner Inner North London

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1

THE CORONER

The Office of Coroner 1.01
- Introduction 1.01
- Creation of the office 1.06
- The medieval coroner 1.10
- Early duties 1.15
- Development of the system 1.22
- Modern developments 1.28
- Recent years 1.35
- Modern review of the coroner system 1.38
- The Shipman Inquiry 1.41
- Subsequent moves towards reform 1.44
- The 2009 Act 1.46
- Charters and guides 1.51
- Terminology 1.53

The Independence of the Coroner 1.55
- The importance of independence 1.55
- The local authority 1.59
- Central government 1.63
- The Chief Coroner 1.66

Qualification and Appointment 1.72
- Qualification 1.72
- Appointment of a senior coroner 1.80
- Removal from office and complaints 1.86
- Resignations 1.89
- Salary arrangements 1.91
- Part-time senior coroners 1.94
- Appointment and duties of assistant coroners 1.96
- The Courts and Legal Services Act 1990 1.101
- Immunity 1.104

Financing and Staffing 1.108
- Payments by councils 1.108
- Staffing 1.117

Coroners' Areas 1.120
- Statistics 1.120
- Division of a county 1.123

The Coroner's Officer 1.125
- Introduction 1.125
- Civilianization 1.130
- Manner of work 1.133
- Training and COASA 1.139

> The coroner was the people's judge, the only judge the people had the power to appoint. The office has been specially instituted for the protection of the people.[1]

The Office of Coroner

Introduction

This chapter gives the reader some background knowledge of the office of coroner and an understanding of the coroner's role within the legal system. **1.01**

[1] Dr Thomas Wakley (Coroner 1839–62).

1.02 The office of coroner, as we now understand it within the English legal system, is virtually unique even though medico-legal officials with the title 'coroner' exist in a number of countries.

1.03 Many nations had the English legal system imposed during the days of Empire and thus acquired the office of coroner. However, just as the work of the coroner has changed out of all recognition here over the last 150 years, the overseas coroners developed their own roles in different directions. In many countries, 'coroners' are now actually more akin to our forensic pathologist. Even Scotland, with its separate laws, has nothing similar to the English and Welsh coroner.[2]

1.04 As a judicial officer,[3] the coroner is almost unique within our own legal system, having the role of an 'inquisitor' rather than simply presiding over court proceedings.

1.05 An understanding of the modern coroner and inquest system requires a knowledge of the long history of the office, which predates much of our judicial system. Some readers may also appreciate an understanding of the coroner's appointment, administration, and genuine independence.

Creation of the office

1.06 The first clear evidence of the office of coroner dates back to the reign of Richard I in 1194, although the post might have earlier origins. As a Norman, Richard was primarily interested in his rights to Saxon England as a source of finance.

1.07 Justice had largely depended previously upon the whim of the feudal lords and the King's sheriffs, who were generally corrupt and inefficient. Richard consolidated his hold upon the undeveloped country by controlling the administration of justice, at the same time seizing the opportunity to raise money. In doing so he created an official who had both financial and judicial responsibilities to the Crown. The Articles of Eyre,[4] issued in September 1194, first outlined the office of coroner in a form recognizable today and decreed:

> In every County of the King's Realm should be elected three Knights and one Clerk to keep the pleas of the Crown.

1.08 In Latin the title was *custos placitorum coronae*[5] and it is not difficult to see how the post-holder became known as the 'crowner' and subsequently 'coroner'. The office holder was responsible for examining cases of sudden death—and a much wider range of tasks on behalf of the Crown.

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[2] Although Scotland did have coroners in pre-Reformation times.

[3] Coroners are increasingly referred to simply as a judge rather than the more old-fashioned terminology of 'judicial officer'. See *Forrest v The Lord Chancellor and The Lord Chief Justice* [2011] EWHC 142 (Admin) which is further referred to at paragraphs 1.61 and 1.111. <http://www.bailii.org/ew/cases/EWHC/Admin/2011/142.html> (accessed 18 March 2014).

[4] Articles were a pronouncement of royal powers.

[5] 'Keeper of the Pleas of the Crown'.

The coroner was elected by a meeting of the Freemen of the County, fostering independence of established authority. The unique independence of the coroner remains a key feature of the modern inquest system and an important safeguard for society. **1.09**

The medieval coroner

The role of the early coroner was that of an independent and reliable revenue collector for the King, acting as a check on the power of the sheriffs and feudal lords. The office was unpaid and the requirement of knighthood implied a man of stature with significant financial resources. **1.10**

The coroner's most important task was the investigation of sudden death, a potent source of revenue for the Crown. There was a rigid procedure upon the finding of a body and any failure to follow this exactly was punishable by a fine. **1.11**

In this early period, much of the justice system was taken up with compensation for the victim or the raising of revenue for the Crown. Any object causing death, known as a deodand, would form part of this financial aspect. An early function of the coroner was to monitor this process and make sure that the King received his proper share. **1.12**

The coroner was also required to keep records of the financial benefits accruing from the administration of justice. Whilst not generally responsible for the actual seizure of sureties and possessions from convicted felons or outlaws, the coroner had to ensure that such monies were properly taken and held until the King's Justices visited the area on circuit. This would occur infrequently, commonly every seven years. On the arrival of the court, the Coroner's Rolls (ie records) would be presented and the administration of justice could proceed. **1.13**

The role of the King's Justices at that time was more than simple punishment of offenders. Justice was a form of general taxation upon the inhabitants. One example was the 'murdrum'[6] fine, imposed originally by William the Conqueror to protect his fellow Normans in an unfriendly Saxon environment. When a violent or unexpected death occurred, the person finding the body was responsible for raising the 'hue and cry'. This would bring the death to the attention of the coroner, who would ride out immediately to where the body lay and gather a jury of men from the area. Unless it could be *proven* that the body was that of a Saxon, the deceased would be presumed to be Norman. The coroner would record details of the event and the murdrum would eventually be imposed upon the locality. This punishment was invariably harsh and proved a valuable source of revenue to the Crown. **1.14**

Early duties

Consequently the coroner has always had a specific role in the investigation of violent or unexplained death. The coroner had to attend and make inquiries before the body could be removed for burial. **1.15**

[6] Said to be the origin of the word 'murder'.

1.16 Although it was not intended that the coroner should sit as a judge to dispense justice, this became a common occurrence. The Magna Carta of 1215 curtailed the practice by proclaiming: 'No sheriff, constable, coroner or other of our bailiffs, shall hold the pleas of the Crown'.

1.17 Besides keeping accurate records, in order that no-one would escape paying the sums due, the early coroner had a variety of other duties. These included dealing with suspects and criminals who had taken sanctuary within a church. Sanctuary provided only temporary refuge but one way to escape justice permanently was to 'abjure the realm'. This meant making a confession to the coroner in a formal procedure at the end of the 40 days' sanctuary. The coroner would then arrange seizure of the man's land and goods for the Crown, pending the next visit of the Justices. The criminal, wearing sackcloth and carrying a cross, had to leave the country by an allotted port, at least until the crime was forgotten. Sanctuary was abolished in 1624.

1.18 Strangely, the early coroner was also connected with the barbaric practice of trial by ordeal. The suspected criminal would have to prove his innocence by a task such as picking up a red hot bar without suffering any burns, the principle being that God would protect the innocent from harm. The coroner would be present to record details of the event and preserve any forfeited property for the Crown.

1.19 As society became more civilized, the emphasis of the coroner's role changed to that of a medico-legal witness viewing victims of crime, from ravished women to those alleging a wounding. The coroner had to bear witness and record injuries so that this evidence could be presented to the King's Justices in due course. The coroner also took sureties from those suspected of the crime to ensure that they appeared to answer the allegations. Since they frequently failed to appear, this was another good source of income for the Crown.

1.20 In 1275 the Statute of Westminster, the first enactment to set out the duties of the coroner, was passed. It is sometimes argued that this was both the first and last defining legislation, as everything that followed, until the Coroners and Justice Act 2009 has been a consolidation in one form or another.

1.21 The development of an improved and more regular system of justice[7] eventually led to a decline in the coroner's direct involvement in the enforcement of criminal law. By 1500, the most significant task left for the coroner was the investigation of sudden death.

Development of the system

1.22 The Coroner's Act[8] of 1751 was the first effort to provide a realistic reward for the duties of the office and also allowed for the removal of a neglectful coroner.

[7] The Justice of the Peace Act 1360 established the early magistracy.
[8] 25 Geo 11 c29.

However, there remained considerable disagreement between coroners and the authorities over whether particular cases merited an inquest, and therefore payment. The minutes of Doncaster Town Council[9] record a number of instances where the coroner's fees were considered and rejected including a decision in 1843:

> It was ordered that the coroner's charge of £2.6s.8d. on the inquest held on the body of Mrs Sarah Hall be not allowed, the coroner not having taken a view of the body as by law required.

1.23 Nonetheless, the coroner held an important position within the county as regards law and order, a situation not without peril. In 1832 Thomas Badger, coroner for the Rotherham and Sheffield district of Yorkshire, was called upon to read the formal terms of the Riot Act from the steps of Sheffield Town Hall during a terrible disturbance which ended in the deaths of six rioters. The rioters then set upon Badger who received a severe beating, although he survived to serve another 31 years in office.[10]

1.24 The increasing complexity of society necessitated proper records of births and deaths, resulting in the Births and Deaths Registration Act of 1836. As the desirability of inquiries into the circumstances of a death became apparent, the role of the coroner began to grow in importance once more. The Act provided that there could be no burial without either a registrar's certificate or a coroner's order and required the coroner to inform the registrar of the verdict in all inquests.

1.25 In the same year legislation[11] was passed giving coroners power to require a doctor to perform an examination and/or attend at court to give evidence as to the cause of death. From this time onwards the coroner's inquiry could properly be regarded as a medico-legal investigation with at least the prospect of increased detection of homicide.

1.26 The early practice of appointment of the coroner by way of an election (originally by the freeholders of the county) continued. The Lowe Committee in 1860[12] recommended that the process should be as similar as possible to the election of a Member of Parliament.[13]

1.27 The gradual transition in the eighteenth century from feudalism to the development of early industrialization was also bringing a reconstruction of the law. As

[9] Jenny Moran, 'By the instigation of the Devil: The Doncaster Coroner's Records' in B. Elliot (ed), *Aspects of Doncaster No. 1* (Barnsley: Wharncliffe Publishing Limited, 1997).

[10] Obituary of Thomas Badger from the records of a local newspaper.

[11] An Act to provide for the Attendance and Remuneration of Medical Witnesses at Coroner's Inquests 1836.

[12] Parliamentary Select Committee on the Office of Coroner 1860.

[13] In 1826, rival candidates for a jurisdiction in the East Riding of Yorkshire brought nearly 2,000 freeholders to the Castle Yard at York for the election. The following year in Lincoln, candidates organized torchlight processions led by bands through crowded streets.

the possibilities of unnatural death increased, so the value of the coroner became more apparent and the coroner's court developed as a forum at which wider issues concerning conditions and accountability could be raised following an individual death.

Modern developments

1.28 The modern coroner is a creation of the County Coroners Act of 1860 and the Coroners Act of 1887. These Acts established a system of payment for coroners and to some extent clarified their role in relation to the investigation of certain classes of death. The 1887 Act consolidated earlier law into the structure for our present system, removing the traditional prominence of the Crown's financial interests and emphasizing the modern concept of an investigation into the cause and circumstances of a death. The Act also prohibited the holding of inquests in public houses, a development marking a more judicial approach to the investigative process.

1.29 The increasing sophistication of society brought new challenges for the coroner. In August 1886, Mrs Bridget Driscoll became the first victim of the motor car when she died from head injuries having been struck down near the gateway of Crystal Palace in London.[14] At the inquest, the coroner expressed the hope that such an event should never occur again.[15]

1.30 The Local Government Act of 1888 abolished the election of coroners by the freeholders of the county, providing instead that they be appointed by the local authority (see paragraphs 1.59–1.62).

1.31 By 1926 the police service had developed sufficiently to take full responsibility for investigating homicides. The Coroners (Amendment) Act of 1926 reduced the coroner's duties in the detection of crime by requiring an adjournment of the inquest until the conclusion of indictable criminal proceedings. This moved the focus of the coroner's work to the non-homicidal, but nevertheless unnatural, death with which we are familiar today. However, the coroner still retained the power to commit a person for trial on a charge of murder, manslaughter or infanticide.

1.32 The 1926 Act also introduced a requirement for the coroner to have a legal or medical qualification.

1.33 The number of coroner's jurisdictions was significantly reduced over time, the Wright Committee of 1936[16] having observed that many part-time coroners, because of the small size of their jurisdictions, had little experience in the conduct of their duties. It was suggested that this should be remedied by merging small

[14] Mrs Driscoll was a pedestrian—the first recorded accident that resulted in the death of the driver was at Grove Hill in Harrow on 25 February 1899.

[15] Approximately 2,000 deaths now occur on British roads each year.

[16] Departmental Committee on Coroners 1936 (Cmnd 5070).

jurisdictions. At that time there were 309 coroners jurisdictions, by 2014 there were only 99.

1.34 The Brodrick Committee, appointed in 1965 to review death certification and the role of coroners, proposed many improvements.[17] Unfortunately, although both Wright and Brodrick had recommended significant changes, their reports were largely shelved.

Recent years

1.35 The Criminal Law Act 1977 excluded the question of criminal liability from the purposes of the inquest. This brought to an end the coroner's major role in the detection of crime and removed, except in cases of contempt, the coroner's power of committal. The Act also replaced the verdicts of murder, manslaughter, and infanticide by the single verdict of 'unlawfully killed', emphasizing the neutral role of the inquest. The number of inquests in which juries need be summoned was also substantially reduced, most noticeably by removing the requirement for cases of road traffic deaths.

1.36 The Coroners Act of 1980 made a significant change to the everyday work of the coroner. Previously, jurisdiction over a body had been determined by actually viewing it, a remnant of the medieval necessity for the coroner to ride out and view the body *in situ* before it could be taken for burial. With the continual increase in reported deaths,[18] this was finally recognized as impractical and the modern concept of jurisdiction arising from the presence of a body lying within the coroner's geographical area was introduced.

1.37 The Coroners Act 1988 followed a Law Commission Report[19] and was merely a consolidation of the Acts of 1887 (itself a consolidation Act), 1890, 1926, 1954, and 1980. Being a consolidation, no improvement of the existing law was possible. It was said that the 1988 Act 'demonstrates, on a small scale, all the worst aspects of the modern consolidating statute'.[20]

Modern review of the coroner system

1.38 In January 2001 the Home Office set up a fundamental review of the coroner and death certification systems ('the Review') under the chairmanship of Mr Tom

[17] Report of the Committee on Death Certification and Coroners: Sept 1971 (Cmnd 4810).

[18] Reported deaths rose from 53,000 in 1920 to 222,700 in 2012, being approximately 46% of all registered deaths. The number of inquests concluded dropped from 31,500 in 1920 to 22,700 in 1997 but rose again to 30,123 by 2012, approximately 14% of the total deaths reported to coroners. *Ministry of Justice Statistics Bulletin* May 2013. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199793/coroners-statistics-bulletin-2012.pdf> (accessed 18 March 2014).

[19] Law Com No. 167; Cm 178.

[20] Law Society Gazette; 11 January 1989.

Luce. Announcing the Review team membership in July 2001, the Home Office minister said:

> Coroner arrangements and the inquest system have laboured for many years under antiquated legal provisions which were never designed to meet the demands of today's society.
>
> Public expectations, both in terms of public service and the product of coroners' inquiries, have run well ahead of what coroners can currently deliver. This fundamental overhaul is essential if we are to modernise the coroner system.

1.39 The Review was welcomed by coroners, used to making a system work which had not been subject to major revision since the reign of Queen Victoria. The government promised 'a root and branch review' to ensure the needs of the 21st century were met.

1.40 The Review report[21] was published in June 2003, declaring that 'neither the certification nor the investigation system is "fit for purpose" in modern society. Both need substantial reform'. But the report went on to say:

> We agree that the people working within the system often manage to produce better results than could reasonably be expected from the obsolete and flawed structures through which they work. It is to their credit that things are not worse. The challenge now is to provide structures which support them better and give the public services which reliably safeguard their interests.

The Shipman Inquiry

1.41 Shortly after Harold Shipman's conviction in January 2000, the Health Secretary announced an independent inquiry to establish what changes to the current system were necessary to safeguard patients in the future. Phase One of the inquiry reported in the summer of 2002 on how many patients Shipman killed and by what means.

1.42 Phase Two of the inquiry undertook to look at different aspects of practice to ensure that such events could not reoccur. Stage Two of this phase[22] looked at death and cremation certification, including the role of the coroner and the investigation of sudden death, reporting in July 2003, only a month after the Coroner Review.

1.43 The Shipman Inquiry made substantial proposals for change which were not entirely consistent with the proposals of the Coroner Review. The government sought further advice from Tom Luce on how the differing views might best be

[21] Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003. June 2003 Cm 5831. The full report is available at <http://webarchive.nationalarchives.gov.uk/20131205100653/http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf> (accessed 18 March 2014).

[22] The various reports of the Shipman Inquiry can still be found at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251078/6159.pdf> (accessed 18 March 2014).

reconciled and subsequently published a position paper in March 2004,[23] setting out their aspirations for reform. Sadly, even at that stage, it was indicated that reforms needed to be 'affordable within existing resources'. For a service already recognized as under-resourced, this was an almost impossible challenge and many felt that the prospects of any meaningful reform had gone.

Subsequent moves towards reform

1.44 After the 2005 general election, responsibility for coroner reform moved from the Home Office to the then Lord Chancellor's Department,[24] creating understandable delay. It became clear that the government could not fully support the cost of the proposals in the 2004 position paper and there followed a period of rationalizing good intentions against likely funding. The government set out its plans in a draft Bill, published for consultation in June 2006, which received parliamentary scrutiny from the Constitutional Affairs Select Committee.

1.45 Following an extended consultation period and last-minute withdrawal from the Queen's Speech in 2007 (due to the extra parliamentary time required for debating the increasingly difficult economic situation), the legislation was finally brought forward in the 2008–09 session. By this time, and to guarantee a place in the legislative programme, the text of the Bill was reduced (although without significantly affecting intentions) and put in as Part 1 of a Bill originally dealing with a range of criminal justice issues, making the Coroners and Justice Bill.

The 2009 Act

1.46 Part 1 of the Bill (the coronial provision) was subject to many hours of parliamentary debate. Much of the focus was on controversial clauses about 'private inquests', inserted because of a disclosure problem which had arisen in one particular case involving state secrets. However, there was considerable interest in the changes brought forward to improve the coroner and death certification systems. On the latter, the Bill did not change in substance during its passage, although several amendments were made; for example, clarifying issues on leadership of the respective systems and detaching treasure investigations from mainstream work. In general, there was parliamentary consensus about the value of the legislation.

1.47 On receiving Royal Assent in November 2009, the Coroners and Justice Act 2009 was created with an intended commencement for most coronial provisions of April 2012.

[23] Reforming the Coroner and Death Certification Service—a position paper. Cm 6159. March 2004. Available at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251078/6159.pdf> (accessed 18 March 2014).

[24] Which became the Dept for Constitutional Affairs and subsequently the Ministry of Justice in May 2007.

1.48 There followed consultation on several aspects of the policy which required secondary legislation, ie Statutory Instruments forming rules and regulations which would give detail to the principles in the Act. The Ministry of Justice published a consultation paper in March 2010 but the situation changed with the formation of a coalition government in May 2010, whose prime remit was to make substantial reductions to existing public expenditure. In such a financial climate, the new costs associated with full implementation of the legislation were not considered to be a priority.

1.49 The government subsequently announced an intention to remove the Chief Coroner and appeal provisions from the Act by means of the Public Bodies Bill.[25] The appeal provisions were to be abandoned altogether whilst many of the intended duties of the Chief Coroner would be divided between the senior judiciary and the Ministry of Justice. However, following defeat on the point in the House of Lords, in November 2011 the government retracted its intention to remove the post of Chief Coroner.[26]

1.50 The current legislation governing the role of the coroner takes the form of:

- The Coroners and Justice Act 2009 ('the Act')
- The Coroners (Investigations) Regulations 2013 ('the Regulations')
- The Coroners (Inquests) Rules 2013 ('the Rules')
- The Coroners Allowances, Fees and Expenses Regulations 2013 ('the Fees Regulations')

which all came into force on 25 July 2013.[27]

Charters and guides

1.51 In 1999 the Home Office provided coroners with a model charter[28] intended to promote broad consistency in the way the service is delivered in different jurisdictions. It was accepted that each jurisdiction had a background of different circumstances, workloads, and support arrangements, necessitating local management and decisions. Consequently a model charter which could be adapted to local conditions was thought to be the most effective manner of achieving stability in service delivery.

1.52 In 2012 the Model Charter was replaced by a Charter for Coroner Services setting out the service standards that bereaved family members, other 'interested persons', and witnesses in a coronial inquiry should expect to receive (eg time limits for certain actions, disclosure of documents prior to inquest, etc).[29] In 2014 the Charter

[25] More commonly known as 'the bonfire of the quangos'.
[26] See paragraphs 1.66–1.71 as to the appointment and duties of the Chief Coroner.
[27] Save for a few enabling clauses of the Act and provisions allowing an inquest to be held outside the coroners area which had all come into effect earlier.
[28] Home Office Circular 46/1999.
[29] <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283939/guide-to-coroner-service.pdf> (accessed 15 April 2014).

was re-written to make it compatible with provisions in the new Act, Rules and Regulations. It was re-issued as the Guide to Coroner Services ('the Guide') under s 42 of the Act (Guidance by the Lord Chancellor). It therefore has statutory authority as to how the coroner system is expected to operate in relation to bereaved people—s 42(2).

Terminology

1.53 The new Act introduced a change of terminology. Rather than coroner, deputy coroner and assistant coroner we now have a senior coroner for each 'area' (rather than district) with a number of assistant coroners. In a few areas, mainly those which previously had a full-time deputy coroner, there is also at the direction of the Lord Chancellor an area coroner[30] assisting the senior coroner.

1.54 For the avoidance of complication, this text uses the words 'coroner' or 'coroners' when referring to those of any title and the specific title only when necessary.

The Independence of the Coroner

The importance of independence

1.55 The coroner remains an independent judicial officer, responsible to the Crown, who can be removed from office only by the Lord Chancellor with the agreement of the Lord Chief Justice for incapacity or misbehaviour.[31]

1.56 The autonomy of the office is an important safeguard for society and a key element in the investigation of death. Overt independence is a cornerstone of the inquest, for the coroner may need to investigate a death involving almost any recognized authority—police, government, NHS, or local council.

1.57 Nonetheless, coroners cannot operate in a vacuum and need administrative support from local government, as well as the manpower and investigative abilities of the police. The coronial link with central government is now much reduced[32] but the Ministry of Justice retains responsibility for coroner policy. However, it is important that the provision of these services by police and local authority is carried out in such a way that the coroner remains unconstrained in both actions and decisions.

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[30] Para 2 of Schedule 3.

[31] There would be an investigation under the judicial conduct investigations procedure. See paragraphs 1.86–1.88.

[32] Because of the creation of the post of Chief Coroner (see paragraphs 1.66–1.71) who has taken over many of the issues which required action or approval by the Secretary of State under the Coroners Act 1988, such as authorization of an inquest in the absence of a body (see paragraphs 2.49–2.52).

1.58 There is clearly also a responsibility on coroners not to act in such a way that their independence and impartiality may be called into question.[33]

The local authority

1.59 Before the County Councils Act of 1888 the coroner had to negotiate financial arrangements with the Justices for the area. This was unsatisfactory and the 1888 Act made attempts to regularize the position. In doing so it placed the coroner, as a judicial officer, in the unique position of obtaining a salary and the expenses of office through the local authority.

1.60 Now, by s 24 of the Act, the relevant local authority must secure the provision of whatever officers and other staff are needed by the coroner to carry out their functions, insofar as staff are not provided by a police authority. Further the authority must provide and maintain appropriate accommodation. In deciding what is appropriate, either in terms of staff or accommodation, the local authority must take into account the views of the coroner.

1.61 The fact that local authorities are responsible for appointing and funding the coroner may give rise to the misconception that the coroner is an employee of the authority. In fact, having appointed the coroner, the local authority has no further control over the post-holder and no influence on the way in which the work is undertaken:

> Certain things are beyond contention. The coroner is a judge and neither [the local authority] nor anyone else, save a properly constituted court of appeal or review, has the least business interfering with his judgments or how he arrives at them. His independence as a judge is a matter of constitutional guarantee. Nothing could be more elementary.[34]

Further, the Chief Coroner's guidance (No. 6) on the appointment of coroners[35] is unequivocal:

> It should be noted that local authorities 'appoint' coroners but they do not 'employ' them. This is an important distinction. Once appointed a coroner becomes and remains an independent judicial office holder. Local authorities pay the coroner's salary or fees and agree other terms and conditions (the Chief Coroner is consulting on a template as guidance). But there is no contract of employment between local authority and coroner. Coroners should not be equated in financial or other terms with chief officers.

1.62 Providing the coroner is acting properly the costs of office cannot be denied or challenged. The system is well established in practice but the success with which it

[33] For example, in 1982 a whole-time coroner was said to have appeared as an expert forensic witness for the police in a criminal prosecution. The Secretary of State and Lord Chancellor expressed concern that a coroner, as a judicial officer, should engage in any activity which may give rise to a suspicion of partiality in the exercise of his judicial duties or raise doubts as to his independence.

[34] *Forrest v The Lord Chancellor and The Lord Chief Justice* (n 3) at para 27. It was also held at para 30 that whilst the local authority is obliged to meet the expenses of the coroner's office, the expenditure must be reasonable—see also paragraph 1.111.

[35] <http://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/> (accessed 30 June 2014).

operates varies considerably between areas. Finance of the coroner is further discussed at paragraphs 1.108–1.116 et seq.

Central government

1.63 Prior to the 2009 Act, coroners had regular, if limited, contact with the Ministry of Justice, the government department concerned with coroner policy. For example, applications for an order allowing the holding of an inquest in the absence of a body, required the approval of the Secretary of State. Such applications are now authorized by the Chief Coroner[36] and there is less requirement for direct contact between individual coroners and the Ministry. Similarly, the Chief Coroner now has responsibility for training arrangements rather than a committee established by the Ministry although day-to-day control of training events has been passed to the Judicial College.[37]

1.64 Many of the other functions previously falling on the Ministry in respect of setting fees, etc (for post-mortem examinations, for witness attendances or for the supply of documents) are now set out in regulations made by the Lord Chancellor under Schedule 7 of the Act.

1.65 The Ministry of Justice was always careful to point out that coroners are independent judicial officers, with a responsibility to the Crown rather than government, and that ministers have no authority to intervene or comment upon the way in which a coroner conducts inquiries in any individual case.

The Chief Coroner

1.66 The post of Chief Coroner is a role created by s 35 and Schedule 8 of the Act, the appointment being made by the Lord Chief Justice after consultation with the Lord Chancellor.

1.67 The Chief Coroner is head of the coroner system,[38] assuming overall responsibility and providing national leadership. Nonetheless, the Chief Coroner does not have day-to-day control of individual coroners or their investigations although a major part of the role is setting national standards and providing support, leadership, and guidance for coroners.

1.68 Beyond this, the main responsibilities of the Chief Coroner are:

- improving the consistency of standards between coroners (s 36(3)) to which end a number of law sheets and guidance notes have been published;[39]

[36] See paragraph 1.66.

[37] The Judicial College, previously known as the Judicial Studies Board, is responsible for the training of all judges.

[38] The 'coroner system' is defined in s 48 of the Act as 'the system of law and administration relating to investigations and inquests under this Part [of the Act]'.

[39] It is plain that the Chief Coroner considers consistency and reducing delays as amongst his top priorities. As regards consistency, a number of 'law sheets' and 'guidance notes' are being issued,

- taking steps to reduce unnecessary delays (s 36(4)(a));
- approving coroner appointments with the Lord Chancellor (para 1 of Schedule 3);
- making regulations and putting arrangements in place for training coroners, officers and staff (s 37);
- keeping a register of investigations lasting more than twelve months[40] (s 16);
- monitoring investigations into the deaths of service personnel (s 17);
- overseeing transfers of cases between coroners (s 2) and directing coroners to conduct investigations (s 3);
- directing a coroner to hold an investigation in England/Wales notwithstanding that the death occurred abroad and the body was returned directly to Scotland (s 13);[41]
- where appropriate, requesting the Lord Chief Justice to nominate a judge to conduct an investigation into a particular death (para 3 of Schedule 10);
- providing an annual report on the coroner system to the Lord Chancellor (which will be laid before parliament) (s 36);
- monitoring reports to prevent future deaths (para 7 of Schedule 5).

1.69 The Chief Coroner will also be consulted by the Lord Chancellor in relation to any guidance issued about the way in which the coroner system is expected to operate.

1.70 Regulation 25 of the Regulations allows the Chief Coroner to require information from a coroner in relation to an investigation conducted by that coroner.

1.71 The Chief Coroner is based at the Royal Courts of Justice and supported by his own team within the Judicial Office, using ancillary aspects (eg Human Resources or media office) of the Judicial Office as needed. The role is not currently full-time, the Chief Coroner also sitting as a judge in the Central Criminal Court. However, the Chief Coroner also sits as a Judge of the High Court on some judicial reviews of inquest decisions.

Qualification and Appointment

Qualification

1.72 To be appointed as coroner under the Act (whether senior coroner, area coroner, or assistant coroner), an applicant must:[42]

- be under the age of 70;
- satisfy the 'judicial eligibility criteria' on a five-year basis;
- have the Lord Chancellor and Chief Coroner consent to their appointment.

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which are available at <http://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/> (accessed 30 June 2014).

[40] This will only relate to deaths occurring after the Act was brought into force (25 July 2103).

[41] Which will generally only apply to service deaths. The Lord Advocate must notify the Chief Coroner that it is appropriate for such an investigation to take place.

[42] Schedule 3 of the Act made under s 23.

1.73 The 'judicial eligibility criteria' was introduced by s 50 of the Tribunal, Courts and Enforcement Act 2007 and effectively means (in this case) that the applicant must have been qualified as a solicitor, barrister, or Fellow of the Chartered Institute of Legal Executives[43] for the required period of five years and has 'gained experience in law' for the same period.[44]

1.74 The five-year required period runs from the time that the applicant's name was first entered on the Roll of Solicitors ('the Roll') under s 6 of the Solicitors Act 1974, or from completion of pupillage if a barrister, subject to alternative provision where the person was not required to undertake pupillage—see s 51 of the Tribunals, Courts and Enforcement Act 2007.

1.75 The Ministry of Justice view seems to be that whilst a solicitor applicant for a coroner post must be on the Roll at the time of appointment, there is no specific requirement to remain on the Roll thereafter, although it may be better to do so. There is certainly nothing in the 2009 Act to require a solicitor coroner to remain on the Roll after appointment. A part-time coroner who has a legal practice is, of course, in a different position.

1.76 Gaining experience in law is defined in s 52 of the same Act by an extensive list of 'law-related activities' which, beyond the obvious such as 'practice or employment as a lawyer', includes teaching or researching law. It matters not whether the law-related activity was done full-time or part-time,[45] for remuneration or otherwise, or was done in the UK or elsewhere.[46]

1.77 A medical qualification does not fulfil the judicial eligibility criteria and doctors may no longer be appointed as a coroner.[47] However, the restriction applies to an *appointment* under the 2009 Act and thus does not affect those doctors appointed under the Coroners Act 1988—although a doctor previously appointed as an assistant deputy under the 1988 legislation (and thus automatically an assistant coroner

[43] By virtue of the Judicial Appointments (Amendment) Order 2013 (SI 2013 No. 3022), Fellows of the Chartered Institute of Legal Executives hold a relevant qualification in relation to the judicial appointment eligibility condition and, on meeting the five-year qualification period, are eligible to be appointed as senior coroners, area coroners, and assistant coroners. Subject to holding appropriate advocacy certification from the Institute, they also have rights of audience at an inquest—see paragraphs 7.55–7.59.

[44] Prior to 1926, the only requirement for a coroner was to be a 'fit person' which led to some strange appointments. In 1819 Thomas Mandall, a plumber, was appointed coroner of Strafforth and Tickhill (Rotherham) and combined this duty with his family business for the next 31 years. In Doncaster, the charter of Edward IV for the borough (1467) authorized whoever held the position of Mayor to act as coroner, a power which was not abolished until the Municipal Corporations Act of 1835.

[45] Unless, by s 52(3), the engagement was negligible in terms of the amount of time.

[46] This appears to be an anomaly—the applicant must have been entered on the Roll of Solicitors for five years, the reference to s 6 of the Solicitors Act 1974 seeming to restrict this to solicitors in England and Wales. But the five years of experience can be gained outside the UK.

[47] As at 1 January 2014 there were 97 senior coroners, of whom approximately five were medically rather than legally qualified but about the same number again were both legally and medically qualified.

under the new legislation) would not now be able to apply for a post as senior coroner, whether in the same area or elsewhere.[48]

1.78 The coroner is no longer required to live within the area. In earlier times, when ownership of land within the appropriate area was a qualification for appointment, some coroners are said to have fulfilled this by the ownership of burial plots. Whether this was a macabre sense of humour or simply a cheap and effective way of meeting the qualification must remain a matter of conjecture.

1.79 Under para 4 of Schedule 3 of the Act, persons holding office as a local authority councillor or who have held such office within the previous six months cannot be appointed as a coroner[49] within the same local authority area. A person holding office as a coroner must vacate the position immediately if they become a councillor for the local authority.[50]

Appointment of a senior coroner

1.80 By para 1 of Schedule 3, a senior coroner is appointed by 'the relevant authority', that is, either the single local authority for the coroner area or the lead authority nominated between themselves where there is more than one.[51] The Lord Chancellor and Chief Coroner must consent to the appointment.[52]

1.81 Thus, despite reform, the coroner is still chosen by the members of the local authority, in effect the local population still selecting their coroner through their own elected officials.[53] However, the power of the local authority is simply to appoint the coroner and they do not have the power to remove or restrict the term of office. Beyond that, subject to the other provisions of the Act, the coroner holds office on whatever terms are from time to time agreed between the coroner and the relevant authority.[54]

1.82 The practicalities of appointment have created many difficulties. As a local authority may only appoint a new coroner once in 20 years, there was rarely a local precedent, but the Chief Coroner has now issued detailed guidance[55] which will promote consistency of practice and is taking an active part in the appointment process. To a great extent the appointment of assistant coroners must now follow the same process.[56]

[48] On the other hand, it is thought that a medically qualified coroner whose area was to be merged with another would be eligible to apply (if necessary) for the same post in the newly merged area.
[49] Whether as senior coroner, area coroner, or assistant coroner.
[50] Para 11 of Schedule 3.
[51] Para 3 of Schedule 2.
[52] Para 1 of Schedule 3.
[53] See paragraph 1.26.
[54] Para 19 of Schedule 3. See also paragraph 1.61.
[55] Chief Coroner's guidance (No. 6) on the appointment of coroners. The Chief Coroner's guidance and law sheets are available online (n 39).
[56] See paragraphs 1.96–1.100.

1.83 The members of the local authority sitting on the appointment panel will inevitably have a limited understanding of the role of the coroner or the qualities necessary in such a person. For this reason it was common that an experienced coroner would be present at the appointment panel in an advisory capacity. The Chief Coroner has taken over this role and nominated a small number of senior coroners to assist him in this task.

1.84 It is now usual for a person appointed as senior coroner, particularly to a whole-time appointment, to have had some substantial experience as an area or assistant coroner.

1.85 There is no longer a specific appointment of Coroner of the Queen's Household, this post having been abolished by s 46 of the Act.

Removal from office and complaints

1.86 Para 13 of Schedule 3 of the Act (by virtue of s 23) gives the Lord Chancellor (with the agreement of the Lord Chief Justice) the power to remove a senior coroner, area coroner or assistant coroner from office for incapacity or misbehaviour.

1.87 Para 14 also provides for any coroner to be subject to the disciplinary provisions of Chapter 3 of Part 4 of the Constitutional Reform Act 2005, which includes the power for the Lord Chief Justice to issue reprimands. In effect this places senior, area, and assistant coroners[57] within the disciplinary arrangements that apply to all other judiciary.

1.88 Whilst the Judicial Conduct Investigations Office[58] deals with complaints about the personal conduct of the judiciary, it does not have remit to consider complaints about a court decision or case management.

Resignations

1.89 By para 12 of Schedule 3 to the Act, a coroner can resign his or her office at any time by giving notice in writing to the relevant authority for the area. There is no longer a requirement on a senior coroner to remain in post until the vacancy has been filled (which was presumably unenforceable in any event) but the resignation does not take effect until accepted. The local authority must nominate the area coroner (if there is one) or one of the assistant coroners to act as senior coroner during the vacancy.

1.90 Para 10 of Schedule 3 also introduces a new retirement age of 70 for coroners. However, this only applies to coroners appointed under the provisions of the 2009 Act and not to those who originally held office under the 1988 Act. There remains no mandatory retirement age for those appointed under the 1988 Act.

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[57] Previously the coroner had the responsibility of disciplining or revoking the appointment of his or her deputy and assistant deputy coroners.

[58] See <http://judicialconduct.judiciary.gov.uk/index.htm> (accessed 26 March 2014).

Salary arrangements

1.91 Under Part 15(2) of Schedule 3 of the Act, the senior coroner and any area coroner are paid an annual salary by the relevant council at a rate fixed by agreement between the coroner and that authority.

1.92 This gives the misleading picture of the coroner working for the council, and of each coroner negotiating with their local authority. However, the reality at present is that salary negotiations generally take place nationally.

1.93 The coroner's salary is therefore paid by the local authority, out of the Council Tax Collection Fund, although the expenses of maintaining the coroner's office are taken into account when the government's contribution to the authority (the Revenue Support Grant) is set.

Part-time senior coroners

1.94 Some senior coroners attend to their duty on a part-time basis[59] as the number of deaths within the area is below the recognized whole-time caseload of approximately 2,000 deaths per year. Most part-time coroners are solicitors in private practice and many use the facilities of their own office for the administrative work.

1.95 The salary scales for coroners contain specific provision for the payment of part-time coroners according to their annual caseload. There should also be agreement between the coroner and the relevant local authority as to reimbursement of the operational expenses per death – the cost of secretarial assistance, office overheads and the like. The figure which local authorities are prepared to pay by way of reimbursement varies considerably from area to area.

Appointment and duties of assistant coroners

1.96 In terms of area assistant coroners, the Lord Chancellor may require the relevant local authority to appoint:

- one or more area coroners (effectively full-time salaried deputies but this is likely to be quite rare)
- a minimum number of assistant coroners (that is, the more common situation of a fee paid part-time deputy), leaving the maximum number of assistant coroners for discussion between the senior coroner and the authority. In recent years there was encouragement to appoint a number of deputies in an effort to ensure business continuity in the event of a flu pandemic but the pressure may now be in the opposite direction to encourage regularity of sitting and avoid wasted training costs.

[59] Around half of coroner areas remain part-time as at January 2014.

1.97 In either case the Lord Chancellor and Chief Coroner must consent to the appointment.[60] The local authorities duty to appoint clearly ends the (arguably anachronistic) practice of a coroner having sole control over the appointment of his or her own deputies.

1.98 Any person appointed as an area or assistant coroner must be qualified to act as coroner in their own right (ie must be qualified as a solicitor or barrister, etc with a minimum of five years' post-qualification experience).[61] When acting on the senior coroner's behalf, the assistant coroners have the same jurisdiction as the coroner and will sign documents in their own name.

1.99 By para 8(1) of Part 3 to Schedule 3 of the Act, an area or assistant coroner may perform any functions of the senior coroner:

- during a period when the senior coroner is absent or unavailable, or
- at any other time with the consent of the senior coroner.

1.100 Although para 8(1)(b) now clarifies the point, the 2002 case of *Commissioner of Police for the Metropolis*[62] held that the equivalent wording in the 1988 Act to the current para 8(1)(a) was:

> perfectly capable of bearing the meaning of 'lawful absence from performance of his normal duties', for example because of the carrying out of other coronial work. Such an interpretation is consistent with the objectives of the statute, which must include the just and expeditious disposal of the work of the coroner.

The Courts and Legal Services Act 1990

1.101 By s 75 of the Courts and Legal Services Act 1990[63] a whole-time coroner (being one of the holders of office listed in Schedule 11 of the Act) is prohibited from:

- providing any advocacy or litigation services in any jurisdiction;
- providing any conveyancing or probate services;
- carry on any notarial activities (within the meaning of the Legal Services Act 2007);
- practising as a barrister, solicitor, public notary or licensed conveyancer or be indirectly concerned in such a practice;
- practising as an advocate or solicitor in Scotland;
- acting for remuneration as an arbitrator or umpire.

1.102 This comprehensive ban on extraneous legal work for holders of full-time judicial office is plainly designed to prevent any conflict of interest or similar situation arising. Of course, no such ban could be applied to the holders of a part-time

[60] See para 5 of Schedule 3 of the Act.
[61] See paragraphs 1.72–1.79.
[62] *Commissioner of Police for the Metropolis v HM Coroner [Inner London South]* (2003) All ER 585.
[63] As amended by the Legal Services Act 2007.

appointment who have to be particularly aware of the possibility of an allegation of bias or improper conduct.[64] The question of bias generally is dealt with more fully at paragraphs 6.45–6.47.

1.103 Section 75 of the Courts and Legal Services Act is concerned with holders of judicial office of all types and does not have regard for the prospect that a coroner may still be medically rather than legally qualified if appointed under the 1988 Act. Thus there is no bar to a medically qualified coroner undertaking any medical work, even within the area. Good sense would obviously dictate that caution needs to be applied.

Immunities

1.104 Historically the coroner was entitled to various privileges or immunities. These included immunity from arrest on civil (as opposed to criminal) process when engaged in the course of coronial duties.[65] However civil arrest is virtually unknown in modern times.

1.105 Of greater importance is the general rule that no action will lie against a judge for any matter done by him in the exercise of judicial functions—in this context the definition of judge includes a coroner. Thus no action for libel can be taken against a coroner in respect of anything said during an inquest. There is no test of reasonableness or good faith for this immunity but it does not extend beyond the court door or the end of the actual proceedings.

1.106 It is likely that a coroner deciding within the office which cases require a post-mortem examination and/or inquest is immune from civil proceedings for a decision made in good faith.

1.107 Coroners, as with most other holders of judicial office, are now eligible for jury service following the 2003 Criminal Justice Act.

Financing and Staffing

Payments by councils

1.108 Section 24 of the Act requires the relevant local authority to:

- secure the provision of whatever officers and other staff are needed by the coroners for that area to carry out their functions—but only to the extent that such officers and staff are not provided by a police authority;

[64] It was reported that a solicitor/coroner (part-time) was called before the Solicitors Disciplinary Tribunal in 1995 and reprimanded for opening an inquest as coroner and later acting as advocate for an interested party, although having first transferred the case to another jurisdiction.

[65] *Callaghan v Twiss* (1847) 9 Irish Law Reports 422.

- provide or secure the provision of accommodation appropriate to the needs of those coroners in carrying out their functions;
- maintain, or secure the maintenance of that accommodation—other than where this is the responsibility of another.

1.109 In deciding how to fulfil these requirements, the local authority must take into account the views of the senior coroner for the area.

1.110 The issue of costs incurred by the coroner has caused problems for several centuries. It continues to provoke furore from time to time, particularly as the overall budget for local authorities diminishes in real terms year by year.

1.111 In the continuing climate of financial stringency, it is hardly surprising that local authority officers look for coroners to cut their 'budget' in the same way as any other area. The difficulty is that as independent judicial officers, coroners cannot easily be bound by a budget in respect of operational matters. It would be wholly improper for a coroner to be influenced in necessary judicial decisions by thoughts of whether funds could run to a post-mortem examination or the attendance of an expert witness at an inquest.[66] Equally, as a guardian of public money, the coroner must not act in a profligate or insensitive manner:

> It is true that the arrangements for funding the coronial service in England and Wales are to some extent wrapped in history. It is possible to envisage circumstances in which the responsible local authority and the Coroner may have different views, perhaps very different views, as to the propriety of this or that item of expenditure, or as regards an order or direction given to a member of staff. If such differences could not be settled—I apprehend that would only arise in an extreme case—their ultimate arbiter would no doubt be the High Court, presumably in judicial review proceedings. Plainly the High Court would be acutely alive to the high importance of the Coroner's judicial independence.[67]

1.112 In terms of actual expenses, Part 1 of Schedule 7 to the Act provides that a juror is entitled to claim loss of earning and expenses of attending court. Part 2 makes similar provision for payment of allowances to witnesses attending court, persons who produce documents, etc under a Schedule 5 order, or those who provide evidence in the form of a written statement. Police officers, prison officers and prisoners are specifically excluded. Part 3 makes provision for payments to those making post-mortem examinations under section 14.

1.113 The Fees Regulations set out the fees payable for those outlined in paragraph 1.112 in a Schedule. The Fees Regulations also require the corner to provide accounts of expenditure to the local authority and, notably, that the coroner must advise the local authority of any unusual fee or expense likely to be incurred (regulation 7).

[66] The situation may be very different in terms of funds that were not for directly operational matters, for example the redecoration of an office.

[67] *Forrest v The Lord Chancellor and The Lord Chief Justice* (n 3) at para 32.

1.114 Part 3 also provides that a local authority may issue a schedule of fees, allowances and expenses that may be properly paid or incurred by the coroner in the performance of his or her functions—other than the fees or allowances mentioned at paragraph 1.112.

1.115 Schedule 7 also provides that regulations may be made in respect of fees payable by an 'interested person' for disclosure of documents after an inquest.

1.116 Para 9(3) of Schedule 7 makes clear that references to the reimbursement of expenses incurred includes provision of an indemnity for costs reasonably incurred in proceedings and associated damages or costs.

Staffing

1.117 Staffing arrangements vary widely between coroner's areas, dependent not only upon the caseload but also the different practices that have developed in each area over the years. In each area there will be administrative staff and usually at least one coroner's officer (ie those carrying out the day-to-day handling of investigations into deaths on behalf of the coroner). However, in practice there may be no clear dividing line between these two types of work.

1.118 The role of the coroner's officer, and issues of civilianization, are more fully discussed at paragraphs 1.125–1.141.

1.119 The administrative staff in a coroner's area are usually employees of the local authority or, in a smaller area, may be the staff of the solicitor's firm where the coroner practices. The coroner's officers might also come from the local authority, or may be either serving police officers or police civilian employees. This raises two difficulties. First, given the ambiguous links with the local authority and the police, exercising day to day control over staff who are neither employed by nor responsible to the coroner can create problems. Secondly, the coroner may have to run an office with personnel from two very different organizations, often with divergent structures, hours, and facilities, and even dissimilar IT equipment.

Coroners' Areas

Statistics

1.120 The Ministry of Justice Statistics Bulletin[68] for 2012 refers to 499,326 deaths in England and Wales of which 46% (227,721) were reported to coroners.

[68] Ministry of Justice Statistics Bulletin May 2013: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199793/coroners-statistics-bulletin-2012.pdf> (accessed 18 March 2014).

Post-mortem examinations were held in 94,814 cases (41.6% of reported deaths) and there were 32,542 inquests opened (14% of reported deaths) but only 30,123 closed.[69]

1.121 There were 99 coroner areas in England and Wales as at 1 January 2014, with 97 senior coroners because two senior coroners each hold two areas. Approximately half of the senior coroners are part-time. Of these, around five hold office solely by virtue of a medical qualification, another five being dual-qualified.

1.122 By Schedule 2 of the Act, the Lord Chancellor may make orders altering coroner areas, having consulted appropriately. It is increasingly common that adjoining smaller areas are merged upon the retirement of one of the office holders.

Division of a county

1.123 Each area forms part of a county (or in a few cases the whole of a county), but in some places the county council no longer exists. Accordingly, one of the City or Metropolitan Borough Councils within the county is designated as the 'relevant council' for the appointment and funding of the coroner.[70] This authority recovers a proportion of its expenditure from the other councils within that area.

1.124 The new Act has no provision similar to s 4(5) of the 1988 Act which made clear that where a county is divided into coroner's districts, each coroner, although appointed to a particular district, was able to act as coroner for the whole administrative area. This was occasionally helpful, when the police or a transplant coordinator needed to refer a matter urgently, and neither the relevant coroner nor deputies were available immediately, they could contact an adjoining coroner within the same county. Whilst s 3 of the new Act empowers the Chief Coroner to direct the transfer of cases between areas, this is unlikely to help in urgent circumstances. One answer might be that adjoining areas seek to appoint the neighbouring senior coroner as an assistant coroner.

The Coroner's Officer

Introduction

1.125 There remains no statutory provision for this post. Almost the only mention of coroner's officers falls within s 24, which requires the local authority to provide sufficient officers and staff, except where such are provided by a police authority.[71]

[69] Note that the number of inquests continues to rise gradually, having increased three percentage points between 2002 and 2012.

[70] Para 3 of Schedule 2 to the Act.

[71] Section 37 of the Act also makes reference to the Chief Coroner's ability to make regulations about the training of coroners, their officers and other staff. See paragraph 1.141.

1.126 The duties of the coroner's officer have evolved in different ways in the various jurisdictions over many years, and the way in which the task is performed now differs markedly between areas. Nonetheless, the importance and responsibility of the coroner's officer most certainly should not be underestimated.

1.127 A 2002 Home Office working party to examine the role of coroner's officers[72] noted that there were then 430 coroners officers, of which 394 were full-time. This figure seems unlikely to have changed significantly over the intervening years, although it may be falling in reality as vacancies are not always filled. The report provided a helpful overview of the work undertaken by officers without seeking to reach any conclusion about responsibility for the post or make recommendations. The government of the day decided that general changes to present arrangements would not be justified in advance of the outcome of the Fundamental Review[73] and such changes have never materialized.

1.128 Coroner's officers are likely to experience considerable emotional pressure in their work. Whilst the coroner is generally insulated from direct contact with grieving relatives, and has the formality of the court as support, the officer may spend the entire day dealing with telephone calls or visits from the suddenly and traumatically bereaved. The post therefore calls for a strong, yet tactful and empathetic, character.

1.129 The nature of the coroner's work is particularly complex, which presents a considerable challenge to the new coroner's officer. The trainee must spend much time understanding medical phraseology, and gaining experience generally, before being able to have a meaningful conversation with a doctor reporting a death—or explaining a cause of death to a family. This was recognized in the report of the Shipman Inquiry,[74] which suggested that recruitment policies be changed to reflect the relevance of medical knowledge and experience to the work of the coroner's officer.

Civilianization

1.130 Traditionally the coroner's officer was an experienced police constable on permanent secondment, but civilianization of police administrative posts has also affected coroners. Generally the civilian coroner's officer remains an employee of the police service, but in a number of areas the post has been transferred into local authority responsibility.[75]

[72] Report on the provision of coroner's officers: August 2002, distributed in Home Office Circular 46/2002.

[73] See paragraphs 1.38–1.40.

[74] At para 19.137—suggestions for transitional arrangements pending the development of a new system—see paragraphs 1.41–1.43.

[75] In 2012 the Ministry of Justice noted that approximately 90% of coroners officers were provided by the police. Pandemic Influenza—guidance on the operation of the coroner system in England and Wales: Ministry of Justice June 2012.

1.131 The Association of Chief Police Officers has maintained for some time that the police service should not be providing and paying for coroner's officers. Some local authorities have shown reluctant acceptance of this point in principle but there remains widespread disagreement about funding. The new Act makes no move towards clarifying this issue.

1.132 Perhaps rather surprisingly, there have been moves in one or two areas to outsource the tasks of the Coroner's Officers to private companies. It is very difficult to see how this could be acceptable to families or others concerned in the process—for example, when an employing company is under scrutiny from the coroner's office because they also provide custody services and there has been a death in the cells or in transit.

Manner of work

1.133 A coroner with a large area may have a number of officers dealing with different geographical areas. In some areas the officer is personally responsible for attending the scene of a sudden death, taking initial details and making arrangements for the removal of the body. Where necessary there will be a search made for evidence (eg a suicide note). If there are suspicions about the death, police colleagues would immediately be called in to perform a more detailed investigation. However, in routine cases it is generally sufficient for the officer to obtain an understanding of the circumstances surrounding the death and the basic medical history, particularly whether the deceased has seen a doctor in recent weeks. The officer may then liaise with the deceased's GP to establish whether the doctor is able to issue a medical certificate of cause of death.

1.134 In other areas, the officer will spend the whole day within the office, receiving reports from hospital doctors, GPs, and uniform or CID officers about deaths. In deaths that the coroner decides[76] necessitate a post-mortem examination, the officer will liaise with the pathologist and the mortuary, this may include arrangements for a formal identification of the body. The officer also plays a significant part in the process mandated by regulations 14 and 15 of the Regulations in which the family are told of any tissues retained at autopsy and their wishes as to disposal are noted (see paragraphs 5.103–5.112).

1.135 Where investigations are not proceeding to inquest, the officer (or in some areas the administrative staff) will prepare the appropriate disposal form for the coroner to sign. All of this involves much liaison with the relatives of the deceased, sometimes made more difficult by disagreement between different elements of the family. The officer must be capable of explaining the cause of death given by the pathologist or certifying doctor in terms that the relatives can understand.

[76] The coroner cannot delegate judicial functions to an officer (regulation 7). Decisions to hold an investigation, post-mortem examination or inquest are all judicial decisions.

1.136 At the same time, the officer must be capable of recognizing issues needing further investigation when listening to what the family have to say. The officer will also be in regular contact with funeral directors, registrars, or the press, and may well be responsible for arranging a jury when required.

1.137 If the death necessitates an inquest, the officer will either take, or more likely arrange for, statements from witnesses. In due course the officer will prepare a statement for the coroner to use at the opening of the inquest, setting out the result of the initial inquiries and confirming that a proper identification of the body has been made. In some areas the officer will give oral evidence at the opening of the inquest.

1.138 At a later stage the officer will ensure that all relevant information is available for the coroner to choose which witnesses are required at the inquest. Arrangements will then be made to ensure those witnesses are told of the date, as well as relatives and other interested parties. Finally, at the inquest itself the officer will organize the court for the coroner, possibly acting as both clerk and usher.

Training and COASA

1.139 Training now falls under the responsibility of the Chief Coroner. By s 37 of the Act, the Chief Coroner may (with the agreement of the Lord Chancellor) make regulations about the training of coroners, their officers and other staff. This includes the type, amount and frequency of such training. The explanatory notes to the Act indicate that this is designed to ensure that all those working within the coroners' service apply best practice, relevant guidelines and standards issued under s 42 (for example) and other developments in legislation.

1.140 A Coroner's Officers Association was formed in 1997 and attracted a sizeable membership. More recently (2011), the name was changed to the Coroners' Officers and Staff Association[77] to reflect the inclusion of coroner's administrative staff. The Association continues to hold training sessions and seminars—which were initially the first national effort to provide education or standards for officers.

1.141 In the report of the Shipman Inquiry,[78] the importance of appropriate and proper training for officers was recognized:

> Training should be provided for coroner's officers and coroner's liaison officers. The work of the Coroner's Officers Association should be funded, supported, and expanded upon. The Association should be encouraged to develop protocols of good practice.

[77] Email address: <secretary@coasa.org.uk>.
[78] At para 19.139.