# Still the "forgotten service"? An empirical study of coroners' backgrounds, attitudes and experiences in England and Wales.

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“I, Terence Joseph McGuinness, confirm that the work presented in my thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.”

## Abstract

Coroners play a vital role in the administration of justice and hold an office of great antiquity. Yet little is known about who coroners are or how they see their role in the justice system, and their contribution has long been overlooked in legal scholarship. This research aimed to address these knowledge gaps by (1) producing a detailed demographic profile of the coronership; (2) understanding coroners' attitudes towards their role in the administration of justice; and (3) comparing coroners' experience of their working lives with those of other judges. An anonymous, voluntary online survey of coroners was conducted to achieve this.

This thesis presents the findings from the Coroner Attitude Survey 2020, the first major quantitative survey of the backgrounds, attitudes and experiences of all coroners in England and Wales. It had an extremely high response rate (100% of senior coroners, 100% of area coroners and 85% of assistant coroners) and mirrored a survey of judges in the courts and tribunals of England and Wales, which enabled direct comparisons between coroners and these other judicial office holders.

Key findings of this research revealed that:

- While coroners do not reflect the population of England and Wales in terms of either gender or ethnicity, it is no longer a "self-perpetuating group".
- Coroners have a strong personal attachment to being part of the coronership, but they feel detached from the rest of the judiciary.
- Coroners see their most important functions as providing answers to the public on cause of death and preventing further deaths.
- While most coroners believe the inquest can be a cathartic process, they disagree with therapeutic approaches taken in recent high profile death inquiries.
- While coroners see the creation of a Chief Coroner as beneficial, most feel further change is necessary, including a unified, national coroner service.

## Impact statement

This research has the potential for high impact at academic, judicial and government policy levels.

Before this research there were no available statistics on the composition of the coronership; this thesis provides the first detailed demographic profile of the 21st century coroner service. This research significantly advances understanding of coronial law and practice, setting out coroners' attitudes to a range of important aspects of the inquest, including the inquest's purpose, the efficacy of reports to prevent future deaths and the appropriateness of coroners assisting the deceased's family during the hearing. The thesis also sets out coroners' attitudes to their job and to their working conditions and compares them with the views of the judges of the courts and tribunals judiciary. As a result, this research will equip central government and local authorities for the first time with solid, evidence-based knowledge about coroners that can guide future policy making and funding decisions. Similarly, the Chief Coroner will benefit from considering the findings set out in this research when issuing or revising guidance to coroners, designing coronial training syllabuses, reporting on coroners' needs to the Lord Chancellor and advocating on coroners' behalf to local authorities.

In terms of legal scholarship, there have been relatively few academic studies touching upon the work of the coroners of England and Wales. While much is known and has been written about the judges of the courts and tribunals judiciary, judicial studies as a discipline has not yet considered the coroner. This is the first study to take coroners themselves as its focus, and the wealth of information it has produced fills a sizeable gap in knowledge, providing baseline data that will assist further research into this jurisdiction. The methodological approach adopted – a self-administered attitudinal survey – allows for the empirical element of this research to be repeated in the future. By expanding the data set to create a longitudinal study, this would allow researchers to discover whether the diversity of the coronership and coroners' attitudes to key aspects of their working lives change over time.

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**Table of Contents**

## List of figures

## List of tables

# Chapter 1 Introduction

On 17 July 2016, 15-year-old Natasha Ednan-Laperouse travelled from London with her father and a friend for a short holiday in Nice. At Heathrow Terminal Five she purchased an artichoke, olive and tapenade baguette from Pret a Manger. Allergic to sesame, Natasha had checked the ingredients before buying and felt reassured by the lack of specific allergen information. The sandwich packaging did not state that the dough contained sesame. Having eaten the baguette, Natasha developed an anaphylactic reaction during the flight to Nice. Despite her father administering adrenaline via two EpiPen injections and the best efforts of a doctor who was a fellow passenger, Natasha died in hospital in Nice shortly after landing.

The West London Coroner's Office commenced an investigation into the death. Following a week-long inquest held in September 2018, HM Assistant Coroner Séan Cummings made a number of findings.[1] He was concerned that allergens were not labelled adequately or clearly on Pret a Manger packaging. He said that Pret was "evading the spirit" of the Food Information Regulations 2014, which were then framed in such a way as not to impose full food labelling requirements on small, independent sandwich shops. Having heard expert evidence on the emergency treatment of anaphylactic reactions, the coroner described the 16mm length of EpiPen needles as "inherently unsafe"[2] and also expressed concerns as to the adequacy of the dose of adrenaline they administer.

Speaking to the media at the close of the inquest Natasha's father, Nadim Ednan-Laperouse, said:

> "Our beloved daughter died in a tragedy that should never have happened. If Pret a Manger was following the law, then the law was playing Russian Roulette with our daughter's life. It's clear that the food labelling laws as they stand today are not fit for purpose and it's now time to change the law.

[1] Regulation 28 report of Assistant Coroner Sean Cummings following the inquest into the death of Natasha Ednan-Laperouse, 8 October 2018 <https://www.judiciary.uk/publications/natasha-ednan-laperouse/> accessed 14 September 2022.

[2] The coroner criticised the use of needles which accessed only subcutaneous tissue and not muscle. In the "Emergency treatment of anaphylactic reactions: Guidelines for healthcare providers", the preferred needle length is 25 mm for adrenaline injectors to access muscle in most people (ibid).

> Natasha's inquest should serve as a water shed moment to make meaningful change and to save lives."[3]

The coroner agreed that action was necessary in order to prevent further deaths. He sent a Report on Action to Prevent Future Death to the chief executive of Pret a Manger, to the Medicines and Healthcare products Regulatory Agency, to the chief executive of Pfizer (makers of the EpiPen) and to the Secretary of State for the Department for the Environment, Food and Rural Affairs. They were all given 56 days to respond.[4] The Secretary of State replied on 27 November 2018, stating that an urgent review of allergen information provision for food was underway. The Medicines and Healthcare products Regulatory Agency wrote to the coroner two days later, addressing his concerns as to needle length and the adequacy of the adrenaline dose in an EpiPen.[5] The Pret CEO, Clive Schlee, published a number of statements on his blog setting out Pret's plan for ensuring allergen safety.[6] Regulations introduced by the Government in response to its review of allergen information provision – known as "Natasha's law"[7] – came into force in October 2021 and require food businesses to include full ingredients labelling on foods pre-packed for direct sale.

The inquest into Natasha's death is a good example of a coronial investigation establishing the facts of an alarming fatality and issuing a report based on the lessons learned so as to prevent further loss of life. Coroners in England and Wales undertake such work every day.[8] However, while coroners' investigations feature regularly in the

[3] 'Natasha Ednan-Laperouse's father says labelling laws 'played Russian Roulette with daughter's life'' (*ITV News*, 28 September 2018) <https://www.itv.com/news/2018-09-28/pret-inquest-death-teenager-natasha-ednan-laperouse-allergy/> accessed 14 September 2022.
[4] <https://www.judiciary.uk/wp-content/uploads/2018/10/2018-0279-Response-by-Department-for-Environment-Food-Rural-Affairs.pdf> accessed 14 September 2022.
[5] <https://www.judiciary.uk/wp-content/uploads/2018/10/2018-0279-Response-by-MHRA.pdf> accessed 14 September 2022.
[6] <https://www.pret.co.uk/en-gb/prets-next-steps-on-allergy-safety> accessed 7 August 2019.
[7] 'Natasha's legacy becomes law' (GOV.UK, 5 September 2019) <https://www.gov.uk/government/news/natashas-legacy-becomes-law> accessed 14 September 2022.
[8] Maria Voisin, HM Senior Coroner for the Avon area, is currently conducting an inquest into the death of Celia Marsh, whose fatal reaction to eating a Pret 'vegan' sandwich that contained traces of dairy protein occurred 15 months after Natasha Ednan Laperouse's death in Nice. Steven Morris, 'Woman Died after Eating "Vegan" Pret a Manger Wrap, Inquest Told' *The Guardian* (London, 6 September 2022) <https://www.theguardian.com/uk-news/2022/sep/06/woman-died-after-eating-vegan-pret-a-manger-wrap-inquest-told> accessed 14 September 2022.

local and national press, their role in the justice system is not well understood by the public and is neglected by government.[9]

The office of coroner is one of the oldest judicial posts in England and Wales, dating back to September 1194[10], although its role has changed repeatedly and significantly over eight centuries. Given the "great antiquity"[11] of the office of coroner, it is somewhat surprising that, in comparison to other judicial offices in England and Wales, the coroner's contribution to the administration of justice has been the subject of limited scholarship.[12]

This research seeks to address this lacuna. It has three key aims:

(1) to produce an extensive and up-to-date profile of the composition of the coronership in England and Wales;
(2) to understand these coroners' attitudes towards their role in the administration of justice; and
(3) to reveal their experiences of important aspects of their working lives.

A further aim is to compare coroner attitudes and experiences with those of the judges of the courts and tribunals judiciary of England and Wales, from which coroners have always been excluded. The following research is an empirical, quantitative study based on an attitudinal survey of coroners ("the Coroner Attitude Survey"). The survey is the second ever conducted with coroners in England and Wales[13] and the first undertaken in this century and on this larger scale.

[9] Constitutional Affairs Committee, 'Reform of the Coroners' System and Death Certification' (2006) HC 902–I 3; Justice Committee, 'The Coroner Service' (House of Commons 2021) HC 68 4.
[10] Christopher P Dorries, *Coroners' Courts: A Guide to Law and Practice* (Third edition, Oxford University Press 2014) para 1.06-1.08 The first coroners were independent revenue collectors rather than judicial officers.
[11] *Regina v HM Coroner for North Humberside ex p Jamieson* [1995] QB 1, 11 (Sir Thomas Bingham MR).
[12] It is important to note two key practitioners' texts that contain a wealth of information on coronial law and practice. The first and most significant work is Jervis on Coroners, now in its 14th edition and described by the Lord Chief Justice as "the bible of the coronial jurisdiction": Paul Matthews (ed), *Jervis on Coroners* (14th edition, Sweet & Maxwell 2020) vii; The second text, a more recent title published by the Legal Action Group charity, is written primarily for inquest advocates representing the bereaved: Leslie Thomas and others, *Inquests: A Practitioner's Guide* (Third edition, Legal Action Group 2014).
[13] One previous study of the coroner service, conducted in 1997 on behalf of the Home Office (then the government department with responsibility for the coroner service), used a similar research method, namely a postal questionnaire, to survey not only coroners but also officials from local

### 1.1 Coroners' investigations and inquests

Coroners investigate deaths where they have reason to suspect that the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in state detention.[14] The investigation seeks to ascertain who the deceased was and how, when and where he or she came by his or her death.[15] The coroner must "seek out and record as many of the facts concerning the death as [the] public interest requires".[16] Coroners' investigations are not litigation. They are neither criminal proceedings nor civil proceedings. In the coroner's court there are no trials. There are not even parties: rather, there are "interested persons".[17] Proceedings are essentially – even if not entirely – inquisitorial in nature.[18]

The inquest is the final stage of a coroner's investigation. Unlike a trial in the civil or criminal courts, it is a fact-finding exercise led by the coroner, more akin to a "short but rigorous public enquiry".[19] It is not subject to the strict rules of evidence that govern witness testimony in trials, and the procedural safeguards that may be applicable to criminal or civil proceedings do not apply. The inquest is not concerned with attributing blame; its findings must not appear to determine any question of criminal liability on the part of a named person, or civil liability.[20] This is not to suggest the inquest cannot find fault. It is the coroner's duty to ensure that the relevant facts are "fully, fairly and fearlessly investigated" and "exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity".[21] As "the public interest may require criticisms to be made"[22], the inquest can and must identify where things went wrong but may not imply liability in doing so. Neither the coroner nor the

government and police forces. Roger Tarling, 'Coroner Service Survey' (Home Office, Research and Statistics Directorate 1998).

[14] Coroners and Justice Act 2009, s 1.

[15] Coroners and Justice Act 2009, s 5(1).

[16] *R v South London Coroner, ex p Thompson* (1982) 126 SJ 625 (Lord Lane CJ).

[17] See the Coroners and Justice Act 2009, s 47(2) for a list of those who qualify to be an interested person at an inquest.

[18] In *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, Lord Bingham recognised at [26] the "hybrid procedure" of the coroner's court, which is "not purely inquisitorial or purely adversarial".

[19] Thomas and others (n 12) 39.

[20] Coroners and Justice Act 2009, s 10(2).

[21] *Jamieson* (n 11) 26 (Sir Thomas Bingham MR).

[22] Thomas and others (n 12) para 17.113.

jury, if there is one,[23] may express any opinion on any matter other than the identity of the deceased and the facts of the death.[24]

In 2020, the year the Coroner Attitude Survey was conducted, 205,438 deaths were reported to coroners in England and Wales[25] (34% of all the registered deaths that year[26]). Because of differences in the size, population and demographic background of coroner areas, the number of deaths reported to coroners in that year varied greatly across England and Wales – from as few as 239 in the City of London coroner area to 6,880 in the Hampshire, Portsmouth and Southampton area (the largest number for any coroner area in that year). The number of reported deaths that require a full investigation with an inquest is a small proportion of the overall numbers reported. Many cases reported to the coroner service are signed off by a coroner after preliminary enquiries are made as being deaths from natural causes (with or without a post-mortem examination[27]). In these cases, a formal investigation is not required by law, and therefore there is no inquest. Inquest cases represented 16% of all deaths reported to coroners in 2020; this amounted to 31,991 inquests opened by coroners that year.[28]

Most inquests are relatively quick, uncontentious hearings. Many last for just a few hours, sometimes less, and are conducted by a coroner sitting alone and without live witness testimony. However, others are much longer, contentious affairs, particularly when the circumstances suggest a breach by state agents of the deceased's right to life.

[23] An inquest must be held with a jury if the coroner has reason to suspect (a) that the deceased died while in custody and that the death was violent or unnatural or the cause of death is unknown, (b) that the death resulted from an act or omission of a police officer in the purported execution of his or her duty, or (c) that the death was caused by a notifiable accident, poisoning or disease (Coroners and Justice Act 2009, s 7(2)). An inquest may also be held with a jury if the coroner thinks there is sufficient reason for doing so (s 7(3)).
[24] Coroners and Justice Act 2009, s 5(3).
[25] Statistics on the work of the coroner service are published yearly by the Ministry of Justice: 'Coroners statistics 2020: England and Wales' <https://www.gov.uk/government/statistics/coroners-statistics-2020> accessed 14 September 2022.
[26] All deaths in England and Wales must be registered with the Registrar of Births and Deaths (Births and Deaths Registration Act 1953, s 15).
[27] Post-mortem examinations were held for 79,357 deaths reported to coroners in 2020, representing 39% of all deaths reported. The proportion of post-mortems ordered by coroners varied from 16% of deaths reported in the Staffordshire South coroner area to 63% in the North Yorkshire (Eastern) area. 'Coroners statistics 2020: England and Wales' (n 25).
[28] The number of inquests opened as a proportion of deaths reported in 2020 varied across England and Wales, from 2% in the Newcastle upon Tyne coroner area to 37% in Gwent. Most coroner areas (63 of the 85 coroner areas) held inquests for between 10% and 20% of all deaths reported.

In such "article 2 cases"[29] the coroner may call many witnesses to give live evidence to the inquest, and lawyers will also ask questions on behalf of sometimes numerous interested persons. It is not uncommon for such proceedings to become fraught and emotionally charged, despite the best efforts of the coroner. Some deaths, such as a violent or unnatural death in a prison or where the deceased died after contact with the police, require the coroner to sit with a jury. There were 239 inquests held with juries in 2020 (representing 1% of all inquests) – a decrease of 55% compared to 2019. Holding inquests with juries during the COVID-19 pandemic presented some unique challenges due to social distancing requirements.

### 1.2 Contribution of this research

In evidence to the House of Commons Constitutional Affairs Committee in 2006, Tom Luce, who chaired the committee that conducted the last system-wide review of the coroner service in 2003[30], painted a gloomy picture of the death certification and investigation systems in England and Wales:

> "the systems in England and Wales have been for decades a forgotten service. They are staffed in the main by people of competence and integrity, but their structures are obsolete, they have historically received only modest support from Governments and until recently they engaged little public and political attention."[31]

Luce's committee's review was one of four major government-sponsored reviews of the workings of the coroner service in just 70 years.[32] Despite this level of attention,

[29] Inquests into such deaths are typically termed "article 2 cases", referring to the right to life enshrined in the European Convention on Human Rights. Convention jurisprudence states that article 2 imposes on Council of Europe member states a procedural obligation to initiate an effective public investigation by an independent official body into any death occurring in circumstances in which it appears that one or more of the substantive obligations to protect life have been, or may have been, violated and it appears that agents of the state are, or may be, in some way implicated. In England and Wales, the coroner's inquest is the means by which the UK ordinarily discharges this procedural obligation. In other European states that do not have the coronial tradition of death investigation, the procedural obligation is satisfied through criminal or civil proceedings, or a combination of both.

[30] The Luce Review Committee, 'Death Certification and Investigation in England, Wales and Northern Ireland the Report of a Fundamental Review 2003' (2002) Cm 5831.

[31] Constitutional Affairs Committee (n 9) para 13.

[32] Robert Wright, 'Report of the Departmental Committee on Coroners' (HM Stationary Office 1936) Cmd 5070; Norman Brodrick, 'Report of the Committee on Death Certification and Coroners' (HM Stationary Office 1971) Cm 4810; The Luce Review Committee (n 30); Dame Janet Smith, 'The Shipman Inquiry. Third Report, Death Certification and the Investigation of Deaths by Coroners' (HM Stationary Office 2003) Cm 5854.

there has been relatively little empirical research on the coroners of England and Wales. In their recent call for sustained academic focus on coronial law and practice, Bray and Martin pointed out how the comparative lack of attention is surprising, highlighting the "growing social attention to death generally" and more frequent "discussions around end of life wishes and options."[33] Even allowing for the fact that deaths investigated by coroners are a "distinct category of death" [34] for which people cannot prepare, the paucity of research on the coroners of England and Wales and their role in the administration of justice is odd given the attention paid by the media to inquests into deaths in custody or in hospitals, or those which result from police and military operations.

Why have such cases not piqued the interest of a greater number of researchers? In these cases, coroners are often confronted with very complex questions of law and some of the most challenging fact-finding exercises faced by judicial decision-makers. Coroners must handle competing pressures – the bereaved family's desire for "justice", society's need for accountability, witnesses' need for procedural fairness – all while walking the tightrope of not appearing to determine liability. When, in the wake of a tragedy, politicians and voices from civil society call for "lessons to be learned", it is usually a coroner who is tasked with identifying those lessons. But even the confluence of two major and highly critical reviews of the coroner service at the start of the century[35] did not prompt a new research agenda focussing on their role and work.

This research has produced unique knowledge about the attitudes and experiences of coroners. It is the first study to reveal coroners' attitudes to the reforms introduced by the Coroners and Justice Act 2009 and by the Chief Coroners – especially important as the long-awaited review of the revised coroner service, announced by the government in 2015[36] and which had sought coroners' views on these changes, will now never be published.[37] This research also presents coroners' attitudes to significant

[33] Rebecca Scott Bray and Greg Martin, 'Introduction: Frontiers in Coronial Justice – Ushering in a New Era of Coronial Research' (2016) 12 103, 103.
[34] ibid.
[35] The Luce Review Committee (n 30); Smith (n 32).
[36] Ministry of Justice news story, 'Review of coroner services launched', 15 October 2015 <https://www.gov.uk/government/news/review-of-coroner-services-launched> accessed 14 September 2022.
[37] 'The Coroner Service: Government Response to the Committee's First Report' (House of Commons 2021) HC 675 3.

proposals made in two recent reports commissioned by the government in which the coroner service featured prominently. In her review of deaths and serious incidents in police custody, Dame Elish Angiolini added her voice to those who have called for radical reform of the coroner service, recommending the creation of a single, unified service covering all of England and Wales.[38] Bishop James Jones examined the experiences of the bereaved families at the fresh inquests into the deaths at Hillsborough Stadium and recommended changes to how coroners accommodate the needs of grieving relatives.[39] The Coroner Attitude Survey explored both matters with coroners.

In addition to the insight it provides into coroners' attitudes and experiences, the research also provides the first detailed picture of coroners' demographics and backgrounds. The House of Commons Justice Committee's 2021 inquiry into the coroner service noted "no statistics are available on the diversity of coroners".[40] This research addresses that knowledge gap with a detailed insight into the personal and professional backgrounds of coroners. It also responds to considerable anecdotal evidence that coroners feel underappreciated by government and overlooked by their peers in the courts and tribunals judiciary.

### 1.3 Previous research on coroners

The key theme that emerges from a review of the previous research conducted on the work of coroners in England and Wales is the wide variation in the practices of coroners and of inquest conclusions. This body of work is epitomised by recent studies conducted by Maxwell Mclean, whose 2017 research found that different coroners presented with identical information as to a death may make very different choices at each stage of the investigation process.[41] This research followed an earlier analysis of

[38] Dame Elish Angiolini, 'Report of the Independent Review of Deaths and Serious Incidents in Police Custody.' (Home Office 2017).
[39] James Jones, '"The Patronising Disposition of Unaccountable Power": A Report to Ensure the Pain and Suffering of the Hillsborough Families Is Not Repeated' (House of Commons 2017) HC 511.
[40] Justice Committee (n 9) para 26.
[41] Maxwell Mclean, 'Contradictory Coroners? Decision-Making in Death Investigations' (2017) 70 Journal of Clinical Pathology 787. Mclean sent all 92 senior coroners a web link to three different clinical scenarios. Each scenario had nine consistent categories of information, such as cause of death and the deceased's medical history. Coroners were asked to indicate an inquest conclusion using free text and to provide comments. Computer software allowed Mclean to see how participants made use of the information provided (e.g. the order the information was accessed and the frequency with which

Ministry of Justice data on inquest conclusions across all coroner areas in the 10 year period 2001-2010.[42] While individual coroner areas remained consistent over time in the conclusions reached, there was a wide variation *between* coroner areas in terms of conclusions. The authors felt this variance may result from the individual decision-making styles of coroners rather than representing a reliable picture of local patterns of death. They also found evidence of coroners taking a "gendered approach" to their decision-making during investigations: "fewer women were reported to the coroner, fewer women proceeded to inquest and fewer women at inquest were considered to have died unnaturally".[43] Some coroners, "especially gendered" in their approach, were "consistently more likely to favour a particular verdict according to the sex of the deceased".[44] Mclean argued that such idiosyncrasy leaves coroners "vulnerable to the criticism that they represent a 'post-code lottery'"[45] as to the service they provide.

This criticism was previously levied by Roberts, Gorodkin and Benbow, who had sought to determine how coroners approach investigations into deaths that fall in the "grey area between those that are clearly natural and those that are unnatural".[46] The responses to their questionnaire showed considerable variation in the way coroners

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participants returned to one category of information). Whilst the 35 participating coroners' decision-making processes were found to be very similar, they came to widely different results on the basis of identical information. (There was a response rate of 36%). Some indicated that no further investigation of the hypothetical death was necessary; others who felt an inquest was necessary proposed numerous alternative conclusions.

[42] Maxwell Mclean, Jason Roach and Rachel Armitage, 'Local Variations in Reporting Deaths to the Coroner in England and Wales: A Postcode Lottery?' (2013) 66 Journal of Clinical Pathology 933.

[43] ibid 936. The issue of a "gendered approach" also arose in earlier research but with some conflicting findings. A 1997 study by Neeleman and Wessely found that coroners were more likely to arrive at an open conclusion rather than one of suicide when the deceased was a woman ('Changes in Classification of Suicide in England and Wales: Time Trends and Associations with Coroners' Professional Backgrounds' [1997] 27 Psychological Medicine 467). However, a 1995 study by O'Donnell and Farmer found a "consistent gender bias" of "suicide conclusions being returned in a greater proportion of inquests on women in every court" ('The Limitations of Official Suicide Statistics' [1995] 166 British Journal of Psychiatry 458). In addition, Salib's 1997 study of the North Cheshire Coroner suggested that men were more likely to have a suicide verdict returned than women ('Coroner's Verdicts in the Elderly: A Suicide or an Open Verdict?' [1997] 12 International Journal of Geriatric Psychiatry 481), but in 1999 Sampson and Rutty found no such gender bias in south Yorkshire during the period of their research ('Under-Reporting of Suicide in South Yorkshire [West]: A Retrospective Study of Suicide and Open Verdicts Returned by HM Coroner, 1992–1997' [1999] 6 Journal of Clinical Forensic Medicine 72).

[44] ibid. For example, men were over-represented in deaths given a conclusion of industrial disease or suicide, while women were over-represented in narrative verdicts and conclusions of accident.

[45] Mclean (n 41) 790.

[46] ISD Roberts, LM Gorodkin and EW Benbow, 'What Is a Natural Cause of Death? A Survey of How Coroners in England and Wales Approach Borderline Cases' (2000) 53 Journal of Clinical Pathology 367.

approach such borderline cases.[47] The authors warned that the consequences of the variation in approach included confusion for medical professionals, further distress for the bereaved and "gross distortions"[48] of the mortality statistics.

This concern for the accuracy of the mortality statistics has prompted the work that forms the bulk of the empirical scholarship on coroners: analysis of their decisions as to conclusion at inquests into self-inflicted deaths. There is a widely held belief that the suicide statistics are inaccurate and misleading.[49] Most fingers of blame have pointed at the standard of proof required for a conclusion of suicide, which until July 2018 was much higher than that required for other conclusions such as accidental death.[50] It is thought that many deaths that received an open conclusion[51] at inquest were in fact suicides.[52] The increasing use by coroners of narrative conclusions at the end of inquests has also impacted upon the suicide statistics.[53] A number of researchers have sought to identify what factors influence coroners' decision-making in cases of

[47] They sent to all coroners in England and Wales sixteen clinical scenarios, which were based on cases from their personal experience that had given them particular difficulty and fell close to the borderline between natural and unnatural causes of death. The deaths fell into three groups: postoperative, a combination of trauma and disease, and infectious disease. For each scenario the coroners were asked to provide a verdict with an explanation. 45% of coroners responded.
[48] Roberts, Gorodkin and Benbow (n 46) 373.
[49] See, for example, Ian O'Donnell and Richard Farmer, 'The Limitations of Official Suicide Statistics' (1995) 166 British Journal of Psychiatry 458.
[50] In *R (Maughan) v HM Senior Coroner Oxfordshire and others* [2018] EWHC 1955 (Admin) the Divisional Court found that the standard of proof for a conclusion of suicide is the civil standard of proof, i.e. the balance of probabilities. This important judgment overturned the received wisdom as set out in all practitioner texts, the Chief Coroner's Guidance and Form 2 to the Coroner (Inquest) Rules 2013 that suicide must be proved to the criminal standard, i.e. beyond a reasonable doubt.
[51] An open conclusion is arrived at in the absence of sufficient evidence to prove another conclusion. When a coroner or jury returns an open conclusion, the inquest has failed to establish to the necessary standard of proof how the deceased came by his or her death.
[52] Jan Neeleman and Simon Wessely, 'Changes in Classification of Suicide in England and Wales: Time Trends and Associations with Coroners' Professional Backgrounds' (1997) 27 Psychological Medicine 467; Jan Neeleman, Vivienne Mak and Simon Wessely, 'Suicide by Age, Ethnic Group, Coroners' Verdicts and Country of Birth: A Three-Year Survey in Inner London' (1997) 171 The British Journal of Psychiatry 463.
[53] Chris Hill and Lois Cook, 'Narrative Verdicts and Their Impact on Mortality Statistics in England and Wales' [2011] Health Statistics Quarterly; Basingstoke 81. They noted that the ONS is now working with coroners to find ways of recording information from narrative conclusions to allow for more accurate coding of cause of death. R Carroll and others, 'Impact of the Growing Use of Narrative Verdicts by Coroners on Geographic Variations in Suicide: Analysis of Coroners' Inquest Data' (2012) 34 Journal of Public Health 447. The authors warned that frequent use of narrative conclusions may lead to an underestimation of suicide and called for local data on the incidence of suicide to be treated with caution.

suspected suicide.[54] The key finding of the largest of such studies was the considerable variation in coroners' conclusions.[55]

It has also been suggested that coroners are uninterested in the production of accurate suicide statistics, prioritising instead the needs of bereaved families.[56] In the absence of a clearly defined, statutory purpose for the coroner's investigation of death, two recent PhD theses have explored with coroners what they believe to be the main objective for their role. Edward Kirton-Darling's 2016 thesis focussed on the centrality of the bereaved family to the contemporary inquest.[57] He argued that the prominent role for the family of the deceased in modern death investigation reveals contrasting tensions in the coroner's court, between, on the one hand, demands of the narrow, prescriptive law and on the other, calls for the process to be meaningful and participative, even therapeutic. He conducted loosely structured interviews with eight senior coroners. While he did not seek to produce generalisable results, his interviewees consistently indicated that an interest in the therapeutic possibilities of the inquest – the processing of grief by achieving explanation, certainty and closure – was entirely proper.[58]

Catherine McGowan's 2012 PhD thesis posed the question: what is the purpose of the coroner?[59] She conducted semi-structured, qualitative interviews with 32 coroners[60],

[54] Emad Salib, 'Coroner's Verdicts in the Elderly: A Suicide or an Open Verdict?' (1997) 12 International Journal of Geriatric Psychiatry 481; KR Linsley, Kurt Schapira and TP Kelly, 'Open Verdict v. Suicide – Importance to Research' (2001) 178 The British Journal of Psychiatry 465; D Stanistreet and others, 'Accident or Suicide: Predictors of Coroners' Decisions in Suicide and Accident Verdicts' (2001) 41 Medicine, Science and the Law 111.
[55] Bret S Palmer and others, 'Factors Influencing Coroners' Verdicts: An Analysis of Verdicts given in 12 Coroners' Districts to Researcher-Defined Suicides in England in 2005' (2015) 37 Journal of Public Health 157.
[56] Gordon Tait and Belinda Carpenter, 'Suicide, Statistics and the Coroner: A Comparative Study of Death Investigations' (2015) 51 Journal of Sociology 553. The authors interviewed six coroners in one English region. They concluded: "…most coroners feel under no obligation to make their findings amenable to the production of accurate and useful suicide statistics. Most see their task as a fundamentally administrative function concerning the management of particular kinds of death, as well as helping families deal with the passing of a loved one. They do not see their job as making life easy for those charged with turning such deaths into meaningful numbers."
[57] Edward Kirton-Darling, 'Looking for Justice: The Family and the Inquest' (University of Kent 2016).
[58] ibid 147.
[59] Catherine R McGowan, 'Frustration of Purpose: Public Health and the Future of Death Investigation in England & Wales.' (London School of Hygiene & Tropical Medicine 2012).
[60] Of the 32 coroners interviewed by McGowan, 29 were male and three were female. All regions of England and Wales were represented: one coroner worked in the North East, six in Yorkshire & Humberside, one in the East Midlands, two in East Anglia, two in London, four in the South East, four in the South West, three in the West Midlands, seven in the North West, and two in Wales. ibid 130.

who were asked to state and describe their purpose. The interviews revealed no consensus.[61] While the coroners all identified strongly with a single purpose, that purpose varied from coroner to coroner. Helping the bereaved family was the first or only purpose indicated by 46.9% of coroners; public health and safety was next, cited as the first or only purpose by 18.8%. Surprisingly, these two purposes were referenced by only 53.1% and 50% of coroners respectively.[62] McGowan's research was conducted at the end of a previous era in coronial justice and published just before the coming into force of the Coroners and Justice Act 2009 and the reforms introduced by the first Chief Coroner, Sir Peter Thornton KC. These changes do not undermine her compelling case that the contemporary coroner service lacks a clear purpose, but it is rooted in an earlier era.[63]

McGowan's PhD research is one of only two studies in the past 40 years that have specifically asked coroners to state the purpose of their work. The other, a sociological study of how coroners construct accounts of sudden death, also found differences between coroners.[64] In an earlier and quite different era in coronial law to that in which McGowan worked, John Fenwick interviewed 15 coroners from five counties in the north of England between 1978 and 1979 as part of his own PhD research.[65] He found significant variation in coroners' attitudes, not just in relation to the "manifestly 'discretionary' areas of coroners' work" but also as to "ostensibly straightforward, clear-cut legal terms such as court-of-record."[66]

Criminology provides the one other critical body of work touching upon the work of coroners. Criminologists have not focussed directly on coroners but have instead assessed the significance of inquests in the state's response to certain categories of death (e.g. investigations of deaths in custody or deaths that followed police contact).

[61] ibid iii.
[62] ibid 132–133.
[63] McGowan's thesis concludes with a call for the formalisation of the fundamental purpose of the coroner as a facilitator of public health.
[64] John Fenwick, 'Accounting for Sudden Death : A Sociological Study of the Coroner System' (University of Hull 1984).
[65] Those interviewed included both full and part-time coroners covering both urban and rural areas.
[66] Fenwick (n 64) 96.

The key theme of this scholarship is that the coroner's inquest has served to protect the state and maintain the reputation of its agents.[67]

### 1.4 The key questions addressed by this research and the approach followed

This research took the coroners themselves as its focus. It first set out to answer the question: who are the coroners of England and Wales? It sought to identify coroners' personal and professional backgrounds, their motivations for becoming coroners and how their backgrounds and career paths compare with the judges of the courts and tribunals judiciary. It also examined how coroners understand their role in the administration of justice and their attitudes to the recent changes in their service. In

[67] It is seen in the influential article by members of the Warwick Inquest Group, reporting their experience observing a 1984 inquest into a controversial death at a Coventry police station. The authors argued that the construction of an "official discourse" at such inquests suppressed contrasting accounts of angered communities. (Warwick Inquest Group, 'The Inquest as a Theatre for Police Tragedy: The Davey Case' (1985) 12 Journal of Law and Society 35). Two decades later, Goldson's analysis of the language used in official reports of investigations into the deaths of child prisoners led him to describe the coroner's inquest as an "institutional symbol of denial", producing "officially sanctioned knowledge" that painted limited, even misleading pictures of deaths in order to protect institutions and ideologies from the danger of scrutiny. From attending inquests, interviewing bereaved families and studying official files and transcripts of inquest proceedings, criminologists have argued that some coroners colluded in ascribing violent tendencies to the deceased, characterising them as "anti-police" or part of a dangerous movement, or as "troubled" in order to minimise or justify the force used against them by state agents. Inquests' emphasis on the deceased's individual health problems, vulnerability or personal weakness produced accounts of death that describe isolated tragedies rather than further evidence of a systemic failure. (Barry Goldson, 'Fatal Injustice: Rampant Punitiveness, Child Prisoner Deaths, and Institutionalized Denial-A Case for Comprehensive Independent Inquiry in England and Wales' (2006) 33 Social Justice 52). Criminologists have also touched upon the personal views of coroners in office in the 1970s and 1980s. Scraton and Chadwick described the evidence of the Coroners' Society to the 1980 Home Affairs Committee inquiry into deaths in police custody as coming from the same standpoint as that of bodies representing police and prison officers, noting their "close ideological association on law and order issues". (Phil Scraton and Kathryn Chadwick, 'Speaking Ill of the Dead: Institutionalised Responses to Deaths in Custody' (1986) 13 Journal of Law and Society 93). Similarly, Beckett highlighted how some coroners saw fit to comment upon the moral worthiness of the deceased and the bereaved family. (Clare Beckett, 'Deaths in Custody and the Inquest System' (1999) 19 Critical Social Policy 271). Much of this criminological scholarship predates the Human Rights Act 1998 and the 2004 House of Lords judgment in *Middleton* that significantly widened the scope of inquests into deaths in which the right to life may have been breached. It does not touch upon the reforms introduced since 2013 by the first and second Chief Coroners and a number of its criticisms, primarily those relating to the extent of bereaved families' involvement and the sufficiency of the airing of their concerns, have been answered at least partially in recent years. However, Baker's more recent study of narrative conclusions – in which he sought to shine a light on how the coronial system constructs accountability in cases of deaths following police contact – suggests the character of the deceased is still a battleground at these contentious inquests. (David Baker, Deaths after Police Contact: Constructing Accountability in the 21st Century (Palgrave Macmillan 2016)). Similarly, the earlier criticism that the coroner's investigation is "profoundly circumscribed" by legislation remains relevant, with the inquest's narrow remit described as a "problem endemic in the role of the coroner". (James Mehigan, 'Deaths after Police Contact: Constructing Accountability in the 21st Century' (2018) 28 Policing and Society 503).

recent years, a number of well-funded and high-profile inquiries have set new standards and raised expectations of death investigation[68]; as a result, this research also explored how coroners perceive the preventative and therapeutic potential of their work. The final central focus of this empirical research was coroners' relationships with the rest of the judiciary, the legal profession and central and local government.

This thesis begins with an historical analysis of the changing role of the coroner over time – and how this moulded the coroner's court into a unique and independent tribunal. This is followed by a structural analysis of the political significance of the contemporary coroner service that highlights not only the guarantees of independence found in law but also the internal factors that impact upon coroners' status and role perception. The thesis then examines how well the coroner service fulfils the two functions said to be the key purposes of the coroner in the 21st century, before exploring the different conceptions of justice that may be served by the coroner's investigation. A survey (the Coroner Attitude Survey) sought empirical information on coroners' backgrounds, attitudes and experiences. The survey picked up on a number of the themes that emerged from the review of coronial history and from the discussions as to the purpose of a coronial investigation and the form of justice coroners' deliver. These include the continual reinvention of the coroner's role and the different attempts at defining its ultimate purpose; the tensions between the legal limits of an investigation into a death and coroners' desire to aid the bereaved; the lack of uniformity in coroners' practices; and coroners' relationships with local government and other holders of judicial office. The survey results were then compared with those of the UK Judicial Attitude Survey 2020, which explored a number of similar issues with salaried judges in the courts and tribunals judiciary.[69]

This research was conducted at the Judicial Institute at University College London, the UK's only centre of excellence dedicated to research, teaching and policy engagement on the judiciary. The Coroner Attitude Survey built upon and was run alongside the

[68] Examples include the fresh inquests into the deaths that occurred in the Hillsborough Stadium disaster and the public inquiry into the Manchester Arena Bombing.
[69] Cheryl Thomas, '2020 UK Judicial Attitude Survey: England and Wales Courts and UK Tribunals' (UCL Judicial Institute 2021) <https://www.judiciary.uk/wp-content/uploads/2021/02/JAS-2020-EW-UK-TRIBS-8-Feb-2021-complete.pdf> accessed 14 September 2022.

UK Judicial Attitude Survey in 2020[70], covering all salaried judges in England and Wales, Scotland and Northern Ireland. The UK Judicial Attitude Survey, run periodically since 2014, is the only current longitudinal study of the working lives of judges anywhere in the world. The Coroner Attitude Survey was the first time coroners were surveyed as part of this larger project.

### 1.5 The structure of this thesis

Chapter 2 describes the medieval origins of the coroner and charts the office's changing role and turbulent relationship with government and other judges over the centuries. Chapter 3 sets out the structure of the coroner service in the 21st century and its place in the legal system of England and Wales. Using Guarnieri and Pederzoli's *The Power of Judges*[71] as a framework, it considers the factors, both external and internal, that shape the current service's political significance. Chapter 4 discusses the key purposes of the 21st century coroner, identifies aspects of coronial law and practice that may undermine coroners' efforts towards fulfilling these functions, and considers the forms of justice that coroners work to deliver. Chapter 5 sets out the research methods adopted in this thesis and sets out how the Coroner Attitude Survey was designed and implemented.

Chapters 6, 7 and 8 present the results of the survey. Chapter 6 answers the question: "who are the coroners of England and Wales?". Chapter 7 examines coroners' views as to their purpose, their thoughts on reforms to the coroner service and their views on different approaches to their work and to inquests. Chapter 8 explores coroners' attitudes to their place in the judiciary of England and Wales and their attitudes to aspects of their working lives, comparing their views with those of judges in the courts and tribunals judiciary of England and Wales.

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[70] Cheryl Thomas, '2014 UK Judicial Attitude Survey: Report of Findings Covering Salaried Judges in England & Wales Courts and UK Tribunals' (UCL Judicial Institute 2015) <https://www.judiciary.uk/wp-content/uploads/2015/02/jac-2014-results.pdf> accessed 14 September 2022; Cheryl Thomas, '2016 UK Judicial Attitude Survey: Report of Findings Covering Salaried Judges in England & Wales Courts and UK Tribunals' (UCL Judicial Institute 2017) <https://www.judiciary.uk/wp-content/uploads/2017/02/jas-2016-england-wales-court-uk-tribunals-7-february-2017.pdf> accessed 14 September 2022; Thomas, '2020 UK Judicial Attitude Survey: England and Wales Courts and UK Tribunals' (n 69).

[71] Carlo Guarnieri and Patrizia Pederzoli, *The Power of Judges: A Comparative Study of Courts and Democracy* (CA Thomas ed, Oxford University Press 2002).

Chapters 9, 10 and 11 discuss the results of the survey. Chapter 9 discusses the importance of the profile of the composition of the coronership set out in Chapter 6 and its implications for the level of public confidence in coroners. Chapter 10 considers coroners' attitudes to whether the inquest can be a cathartic process for those affected by a death and to four methods used in recent, high profile death investigations to facilitate closure for the bereaved. Chapter 11 addresses the question of whether there should be a unified national coroner service and discusses how the debate is advanced by the important new knowledge provided by the Coroner Attitude Survey. Finally, Chapter 12 provides a series of policy recommendations for how coroners could be bolstered in their work and sets out proposals for further research in this under-developed area of legal scholarship.

# Chapter 2 A fossil of legal history

This chapter sets out the historical development of the office of coroner in England and Wales, from its medieval foundations to the 21st century. It has been likened to a fossil "bear[ing] the layers of almost every era of legal history from feudal policing to 19th century statehood construction and 21st century human rights culture".[72] Thomas et al have argued that an understanding of the wider historical, social and political processes associated with inquests is important for those practising in this area of law.[73] The coroner's independence over such a long period of time has led to a unique tribunal, the nature of which "cannot be readily appreciated simply by recourse to the various Coroners Acts and statutory instruments".[74] They contend that the uniqueness and independence of the coroner's court continues to influence how coroners exercise their authority. This chapter argues that the long history of the office of coroner in England and Wales has a direct bearing on how today's coroners exercise their investigatory powers and broad discretion, and that this history is important to take into account in any exploration of the attitudes and experiences of today's coroners.

## 2.1 Medieval origins

The origin of the office of coroner is usually traced to the Articles of Eyre[75] of September 1194 and the subsequent election in every English county[76] of three knights and one clerk to serve as *custos placitorum coronae* or "keepers of the pleas of the Crown". This significant reorganisation of local administration was driven by the Crown's need for much greater efficiency in recording the details of matters related to criminal justice; this was a potential source of revenue for the Crown as a felon's property was forfeited to the king.[77] Richard the Lionheart's participation in the Third Crusade and the hefty ransom paid for his freedom had left England's treasury in dire need of funds. The larcenous local officials who had performed the coroner's duties

[72] Thomas and others (n 12) para 2.50.
[73] ibid 2.1.
[74] ibid.
[75] Articles were pronouncements of royal powers.
[76] The office of coroner was introduced in Wales following the Edwardian Conquest of 1283.
[77] KJ Kesselring, 'Felony Forfeiture in England, c.1170–1870' (2009) 30 The Journal of Legal History 201.

before 1194 were no longer trusted with the task.[78] Royal advisor and Chief Justiciar Hubert Walter hoped the election of eminent men[79] to the new office would act as a check on sheriffs' corruption and that their singular mission would benefit both local judicial efficiency and royal revenue.[80]

The first coroners were not tasked with hearing and determining a case but with keeping records for the next visit to the county by the king's itinerant justices, known as the General Eyre. Seven years would commonly pass between such visits on circuit.[81] Upon the arrival of the court, the coroner would present his rolls for inspection and the General Eyre could proceed to levy justice. The 7th edition of *Jervis on Coroners* states that the 13th century coroners' rolls suggest there was less concern with bringing a felon to justice than with securing his chattels for the king.[82] Deaths of the king's subjects represented a loss of taxation revenue from the deceased. Coroners therefore investigated unnatural and suspicious deaths so that, in the event of a crime, this loss could be mitigated by the forfeiture of felons' goods. Any item found to have caused the violent death of one of the monarch's subjects was declared a *deodand* – a gift to God, taken by the king – and forfeited by its owner if he could not pay a fine equal to its value. Coroners also assessed the value of estates and ensured that land owed to the Crown did not pass to others. An important further duty was to investigate finds of objects that might be treasure trove, an important source of revenue to the Crown in medieval times. The coroner was tasked with determining when, where and in what circumstances the object had been found, the identity of the person who found it, and whether it was indeed treasure trove and thus property of the Crown.[83] Severe penalties were imposed on those who attempted to conceal such finds.[84] The coroner's first role was therefore a financial one.

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[78] RF Hunnisett, *The Medieval Coroner* (Cambridge UP 1961) 3.
[79] The office of coroner existed for 757 years before the first female coroner, Lilian Hollowell, was appointed in 1951. ('Who Was the First British Woman Coroner?' First Women, 17 March 2021, <https://first-women.com/2021/03/17/who-was-the-first-british-woman-coroner/> accessed 20 September 2021. The first female coroner in Wales, Mary Hassall, was not appointed until 2005 <http://news.bbc.co.uk/1/hi/wales/4153094.stm> accessed 14 September 2022.
[80] Hunnisett (n 78) 3.
[81] Dorries (n 10) para 1.13.
[82] Sir John Jervis and F Danford Thomas, *Sir John Jervis on the Office and Duties of Coroners* (Seventh edition, Sweet & Maxwell 1927) 5.
[83] AG Guest and Paul Matthews, 'The Coroner', *The Law of Treasure* (Archaeopress Publishing Ltd 2018) 87.
[84] ibid.

## 2.2 Coroners' early role in criminal justice

But medieval coroners also played an important role in criminal justice by hearing appeals[85] and the confessions of felons. Dorries states that, while it had never been the intention for coroners to dispense justice as judges, it became a common occurrence.[86] Chapter 24 of Magna Carta (1215) sought to curtail the practice: "No sheriff, constable, coroners, or other royal officials are to hold lawsuits that should be held by the royal justices".[87] Despite this prohibition, some coroners continued to conduct trials in the medieval county court, sitting with, and sometimes without, sheriffs.[88] Coroners also performed tasks of an executive character alongside their judicial functions; the range of administrative duties included executing the king's writs in place of the sheriff and summoning juries to assess compensation for land taken.[89]

The role of the jury in coroners' investigations was established at an early stage. By 1250 Bracton had recorded the duty on coroners to summon a jury from the neighbouring townships to assist in investigating deaths and reports of possible treasure trove:

> "…as soon as they have their order from the bailiff of the lord king or from the responsible men of the district, they ought to go to those who have been slain or wounded or drowned or have met untimely deaths, or to where there has been housebreaking or where it is reported that treasure has been found, at once and without delay to the place where the dead man has been found, and on their arrival there to order four, five or six of the neighbouring vills to come before them at once and by their oath hold an inquest."[90]

[85] This was not an appeal as we understand it today but rather an accusation of a felony. Originally it was the victim of a crime (or his or her family) who had the responsibility of finding the felon and bringing him or her to justice. This process was called appeal against felony and the coroner operated as a check on this system: Jervis and Thomas (n 82) 5.
[86] Dorries (n 10) para 1.16.
[87] British Library, English translation of Magna Carta, 28 July 2014 <https://www.bl.uk/magna-carta/articles/magna-carta-english-translation> accessed 1 April 2022.
[88] Jervis and Thomas (n 82) 7.
[89] ibid.
[90] Henry de Bracton, *De legibus et consuetudinibus Angliae* (1250), Samuel E Thorne translation, Vol.2, 342, <http://amesfoundation.law.harvard.edu/Bracton/Unframed/English/v2/342.htm#TITLE300> accessed 14 September 2022. A "vill" is a small collection of houses.

Hunnisett's 1961 study of the medieval coroner emphasises that the coroner's jurisdiction was limited at a very early stage as a result of the significant failure to define the coroner's role beyond the limited instruction to "keep the pleas of the Crown".[91] Despite the potential scope of such a wide brief, felonies became the only Crown pleas to attract coroners' attention. Before long, it was only homicide and suicide with which coroners were really concerned. According to Hunnisett, by the time the first comprehensive list of the coroner's duties appeared in the 1276 statute *De Officio Coronatoris*, "an immense gap" had already emerged between what coroners were said to do and the tasks actually performed. His history asserts that the statutes and law books of the 13th century paint a picture of coroners' work that is misleading in its breadth.

Despite this early restriction of the coroner's purview, the coroner remained a leading figure in the county or borough and was second in importance only to the sheriff in local government. While the office of coroner was created to act as a check on the sheriff, until the 15th century coroners were subordinate to the sheriff.[92] Sheriffs played an important role in the election of coroners and sometimes intervened in their work. According to Hunnisett, while there was no part of the coroner's duties from which the sheriff could be excluded, nearly the whole range of the sheriff's activities were outside the scope of the coroner's remit.[93]

In the fourteenth and fifteenth centuries, the decline in the work of the medieval county court and the rise in importance of the offices of escheator[94] and keeper (later justice) of the peace reduced the role of the coroner (and also further diminished the prestige and power of the sheriff). Escheators, the local officials responsible for upholding the king's rights as feudal lord, gradually assumed sole responsibility for appraising and taking possession of land and chattels belonging to outlaws and victims of homicide and suicide.[95] This all but ended coroners' financial activities. The wide jurisdiction of the new Justices of the Peace and their assumption of duties previously performed by coroners also eventually ended coroners' direct involvement in the enforcement of

[91] Hunnisett (n 78) 4–5.
[92] ibid 196.
[93] ibid 195–6.
[94] Escheat is the common law doctrine under which the property of a deceased person transferred to the Crown if the deceased left no heirs. Escheators were appointed in each county to manage escheats.
[95] Hunnisett (n 78) 197–198.

the criminal law. The Coroners Act of 1509, requiring coroners to view the body of someone "slain, drowned or otherwise dead by misadventure", saved the office from becoming obsolete.

### 2.3 Coroners in the early and late modern period

Little has been written on the role and work of the coroner in the sixteenth and seventeenth centuries. One relatively recent study by Loar[96] argues that the coroner's inquest retained its importance in early modern England, playing a "pivotal role" [97] in the judicial system. The majority of prosecutions for homicide proceeded to trial in the criminal courts on the basis of indictments issued by inquest juries in coroners' courts.[98] At trial, assize judges probably saw the indictments issued by coroners' juries as deserving greater weight than those of grand juries.[99] Loar's assessment of the importance of coroners in this period also relied on Havard's assertion that "the higher courts attached greater authority to a coroner's inquisition than to proceedings [in preliminary examinations] before the Justices of the Peace."[100]

The mid-18th century saw the publication of the first manual specifically for coroners. Published in 1756, "The Coroner's Guide"[101] set out the criteria for appointment to the office of coroner in the 18th century. This practitioner text, the authorship of which is unknown, said that coroners were to be good and lawful men, knowledgeable, capable and diligent in performing their office.[102] In his study of how coronial manuals helped

[96] Carol A Loar, '"Go and Seek the Crowner": Coroners' Inquests and the Pursuit of Justice in Early Modern England' (PhD, Northwestern University 1998).
[97] ibid 42.
[98] ibid 102.
[99] ibid 133. Criminal trial in the courts of assize followed the issuing of an indictment against the accused. Indictments were mostly issued by grand juries. A grand jury was made up of between 12 and 23 men. Its role was to determine whether *prima facie* evidence existed to bring a charge. It was separate from the jury of 12 men which determined the accused's guilt or innocence following trial in the court of assize. However indictments could be also issued by a coroner's jury following an inquest following a death.
[100] JDJ Havard, The Detection of Secret Homicide: A study of the Medico-Legal System of Investigation of Sudden and Unexplained Deaths (Macmillan & Co 1960) 16, as cited in Loar (n 96) 43.
[101] Anon., The Coroner's Guide: or, the office and duty of a coroner: containing variety of precedents, and proper instructions for executing the said office. Compiled from the best authorities (London: printed by Henry Lintot, Law-Printer to the King's most Excellent Majesty; for John Worrall, at the Dove in Bell-Yard near Lincoln's Inn, 1756), as cited in Marc Trabsky, 'The Coronial Manual and the Bureaucratic Logic of the Coroner's Office' (2016) 12 International Journal of Law in Context; Cambridge 195, 205.
[102] Trabsky (n 101).

shape the office of the modern coroner, Trabsky explains how the various handbooks published throughout the 19th century were increasingly full of "questions of technical knowledge, administrative procedure and bureaucratic governance".[103] For Trabsky, the "technology" of these texts professionalised the role of the coroner.

As society became more complex during the late-18th and 19th century, the role of the coroner grew in significance again "after several centuries as a rather unimportant appendage of criminal law."[104] Much of local administration was not ready for the population boom and the phenomenon of urbanisation caused by industrialisation. The rise in the death rate and high infant mortality during the Industrial Revolution made reliable records of births and deaths an imperative. The accompanying demands for improved social welfare, labour rights and public health standards led to increased government oversight and new social institutions. The government created new Inspectorates of Anatomy (1832), Factories (1833) and Prisons (1835), and coroners' inquests complemented the work of these new bodies. Dorries explained that:

> "[a]s 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 a death."[105]

According to Sim and Ward, in the 19th century the pressure on coroners to expose abuses in institutions came not only from the powerful in central government. The election of coroners by county freeholders, the informality of their courts and the inclusion of the working class on their juries[106] imbued some coroners' inquests with a "popular flavour".[107] Increasingly they came to be seen as a forum in which the most marginalised in Victorian society – the families of prisoners and paupers – could challenge the practices of the powerful.[108]

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[103] ibid.
[104] Joe Sim and Tony Ward, 'The Magistrate of the Poor? Coroners and Deaths in Custody in Nineteenth-Century England' in Catherine Crawford and Michael Clark (eds), *Legal Medicine in History* (Cambridge University Press 1994) 245.
[105] Dorries (n 10) para 1.27.
[106] Unlike in other courts, in the 19th century there was no property qualification for serving on a coroner's jury.
[107] Sim and Ward (n 104) 246.
[108] ibid 263.

## 2.4 19th century challenges to new assertions of coronial power

During the 19th century coroners saw off challenges to their authority and to the existence of their office from other important Victorian office holders. County magistrates were under pressure to reduce costs at a time when "legislation and growing social pressures for reform were continually adding to county expenses".[109] As they struggled to afford new prisons, asylums and a police force, the magistrates preferred to cut inquest costs rather than to tackle other areas of public spending.[110]

The zeal with which certain coroners used new powers to pursue their investigations of deaths in the new prisons or in hospitals and workhouses drew the ire of the magistrates and poor law guardians. Thomas Wakley, perhaps the most famous of Victorian coroners, directed that all deaths in custodial settings - prisons, police stations, workhouses and asylums - be reported to him. This approach heeded the call previously made by the Lancet, the medical journal he founded, for inquests to be held into all hospital deaths so as to expose "the ignorance, negligence or misconduct of public functionaries".[111] Wakley viewed the coroner's role as a distinctly public office: "[T]he 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 people".[112]

This commitment, and the loss of life that accompanied the construction of passenger railways, led Wakley and a small number of like-minded coroners to impose a much more exacting scrutiny on workplace deaths as well. While most investigations into occupational deaths remained routine, predictable affairs,[113] Cawthon describes how "[t]he families of some workers who died on the job gradually began to find justice in an unexpected quarter – coroners' inquests".[114] The power imbalance between the railway companies and bereaved families and the lack of any relief for relatives of workplace accident victims led these coroners to adopt an innovative and controversial

[109] Pamela Fisher, 'The Politics of Sudden Death: The Office and Role of the Coroner in England and Wales, 1726-1888' (Thesis, University of Leicester 2007) 151.
[110] ibid 152.
[111] Lancet, 2 (1827-28), 532, as cited in Sim and Ward (n 104) 249.
[112] Dorries (n 10) 1.
[113] Elisabeth Cawthon, 'Thomas Wakley and the Medical Coronership–Occupational Death and the Judicial Process' (1986) 30 Medical History 191, 193.
[114] ibid 192.

tactic. Their "weapon of choice"[115] was the ancient *deodand*[116], resurrected and now imposed as a compensatory and punitive measure through which inquest juries could condemn railway companies' shoddy practices or negligence. This was a significant appropriation of power and one which forced industry to take inquests seriously: "large scale employers such as railway and steamship operators feared the unpredictability of self-conscious and increasingly sophisticated coroners' courts".[117] However the deployment of the deodand was not simply retrospective. Coroners' ambitions included prevention. As Cawthon states, "to attempt to guarantee the safety of employees and passengers on steam-powered vehicles was a logical step for coroners' courts".[118]

The growing boldness of radical coroners and their juries in levying deodands of many hundreds of pounds upon the operators of the railways and steamships infuriated the bosses and incensed the High Court judges who were quick to strike down such impositions.[119] Given the already strained relations between coroners and magistrates, it prompted both national and local attempts to limit coroners' powers. Cawthon highlights how a "combination of outraged lawyers, employers and judges got the ear of Parliament in the matter", which passed the Deodands Abolition Act in 1846.[120] Meanwhile the "ongoing clashes between Wakley and the magistrates"[121] culminated in a report of the Middlesex Justices in 1851, which called for the abolition of the coroner's office and, pending the transfer of their powers to Justices of the Peace, restrictions as to when they should open an inquest into a death. Sim and Ward refer to the report's criticisms of coroners' juries' "interference" and "irrelevant questions".[122] Other counties followed Middlesex's lead. While Wakley's dedication was not matched by most of his peers, Cawthon notes that "his defiance of local magistrates seemed to spread to other coroners"[123] and by 1850 *The Times* described the coroner as "eminently the magistrate of the poor".[124] Fisher explains how "the

[115] Elisabeth Cawthon, 'New Life for the Deodand: Coroners' Inquests and Occupational Deaths in England, 1830-46' (1989) 33 The American Journal of Legal History 137, 143.
[116] See Chapter 2.1 above.
[117] Cawthon (n 115) 146.
[118] ibid 142.
[119] The High Court's supervisory authority over coroners is discussed in the following chapter.
[120] Cawthon (n 115) 147.
[121] Fisher (n 109) 165.
[122] Sim and Ward (n 104) 254.
[123] Cawthon (n 115) n 16.
[124] Fisher (n 109) 147.

varying appetite among county magistrates to restrict the number of inquests held, the range of different strategies in use and the individual views of coroners on how their office should be performed" led not only to a reduction in the number of inquests being held but to a "complex national picture in which virtually every county was operating its own unique system".[125]

A further threat to coroners' independence came via the Royal Commission established in 1858 to "Inquire into the Costs of Prosecutions and Expense of Coroners' Inquests", which made the radical proposal that the *police* decide when the coroner holds an inquest.[126] Such a change would have dramatically reduced the work of coroners, who strongly criticised the proposal. According to Fisher, coroners used their political savvy and good connections to prevent the abolition of their role.[127] However, Sim and Ward place more emphasis on the "sheer ineptitude of the magistrates' tactics"[128] in their campaign to curb coroners' influence. For example, during a time of heightened political concern about infanticide (stoked by the nascent sanitary movement), the magistrates' obstruction of coroners' investigation of child deaths appeared to undermine their efforts.

The struggle with the magistracy was settled in the coroners' favour by the 1860 report of the Parliamentary Select Committee on the Office of Coroner, chaired by Robert Lowe MP.[129] It rejected the Royal Commission's proposal for police to decide when inquests were to be held. It encouraged the holding of inquests, recommending that coroners be paid a salary (rather than a fee per inquest) to be revised periodically according to the average number of inquests held by each coroner in the previous five years.[130] It recommended that inquests be held in all cases of sudden or accidental deaths. William Farr, writing in the Registrar General's report, stated that such an expansion in coroners' work was necessary "for the denunciation of the guilty, for the

[125] ibid 176.
[126] Royal Commission to Inquire into the Costs of Prosecutions and Expense of Coroners' Inquests, BPP 1859 (Session 2) XIII.
[127] Fisher (n 109) 182.
[128] Sim and Ward (n 104) 256.
[129] Select Committee on Office of Coroner, BPP 1860 (193) XXII.
[130] Sim and Ward (n 104) 257.

comfort of the innocent, and for the information of the public, who should be taught the nature and extent of the dangers that surround them".[131]

### 2.5 The start of the modern era: Coroners Act 1887

The recommendations of the Select Committee eventually made it into the statute books through the Coroners Act 1887 and the Local Government Act 1888. The Local Government Act secured coroners' independence from the influence of the magistrates by transferring responsibility for their election and salary to local authorities. As Sir Thomas Bingham (as he was then) stated in *Regina v HM Coroner for North Humberside ex p Jamieson*: "it was with the Coroners Act 1887 that the office moved into the modern era".[132] The Act provided the blueprint for today's coronial jurisdiction. It emphasised the modern concept of an investigation into the cause and circumstances of a death[133]; it established a system of payment for medical witnesses[134]; and it relieved the coroner of some archaic duties (such as the holding an inquest into the death of royal fish[135]). While the Act ended the traditional prominence of the Crown's financial interests in coroners' work, it continued the coroner's long jurisdiction since 1276 "to inquire of treasure which is found, who were the finders and who were suspected thereof".[136] Such inquiries were no longer conducted for the royal revenue but rather to ensure the preservation for the nation of objects of historical, cultural or archaeological interest.[137]

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[131] Registrar General, Nineteenth Annual Report, PP 1857-8, XXIII, 1, 198.
[132] *Regina v HM Coroner for North Humberside ex p Jamieson* [1995] QB 1, 11 (Sir Thomas Bingham MR).
[133] Coroners Act 1887, ss 3 and 4.
[134] Coroners Act 1887, s 22.
[135] Coroners Act 1887, s 44. Whales and sturgeon are royal fish and belong to the Crown if taken in the seas around Britain. Historically the Crown received income from the prerogative rights relating to royal fish, which is why the medieval coroner had an interest in their being caught.
[136] Coroners Act 1887, s 36, derived from the 1276 statute *De Officio Coronatoris*, 4 Edw. 1. According to Matthews (n 12, para 16-02), there was no consensus amongst English jurists as to the meaning of treasure trove, with various definitions offered over the centuries. The definition offered by Coke in The Third Part of the Institutes of the Laws of England (1644, p 132) was eventually preferred by the Court of Appeal, over three hundred years later, in *Attorney-General of the Duchy of Lancaster v G. E. Overton (Farms) Ltd.* [1982] 2 WLR 397: "Treasure trove is when any gold or silver, in coin, plate, or bullyon hath been of ancient time hidden, wheresoever it be found, whereof no person can prove any property, it doth belong to the king, or to some lord or other by the kings grant, or prescription."
[137] Guest and Matthews (n 83) 88.

## 2.6 An end to the coroner's role in criminal and civil proceedings

What remained of the coroner's duties in the detection of crime was reduced further by the requirement in the Coroners (Amendment) Act 1926 that an inquest be adjourned until the conclusion of indictable criminal proceedings. By this time in the early 20th century, the police service was deemed sufficiently developed to take full responsibility for the investigation of crime. As a result, the coroner's focus shifted from homicide to the investigation of other unnatural deaths.

The coroner's impact on civil proceedings was also curtailed in the early part of the 20th century. The 1936 Departmental Committee on Coroners, appointed by the Home Secretary and chaired by Lord Wright, criticised the tendency of coroners "to go beyond the mere investigation of the facts of an unnatural death and to deal with questions of civil or criminal liability for the consideration of which the coroner's court is ill-equipped".[138] The report concluded that there was no authority for seeking to use inquests in order to elicit facts that have a bearing on civil liability[139] and recommended the establishment of a rules committee to protect people from this practice. This eventually led to the first Coroners Rules[140], introduced in 1953, which included a prohibition on the determination of questions of civil liability. The 1953 Rules were later consolidated by the Coroners Rules 1984[141], which determined the scope and limitations of inquests for the next quarter century. Thomas et al, writing in 2014, bemoan this legacy which meant that "Edwardian ideals of a gentleman's reputation and good governance outweighed the broader priority of rendering the conduct of public authorities in the modern world more accountable".[142]

Continuing concern about the coroner's jurisdiction led the Home Secretary in 1965, Frank Soskice, to appoint a Home Office committee under the chairmanship of

[138] Wright (n 32) para 60.
[139] ibid 111–112.
[140] SI 1953/205. Cabinet papers (seen by the researcher at the National Archives) show the reason for the inaction was uncertainty as to how to address the main problem which occasioned the setting-up of the Wright Committee, namely, coroners' treatment at inquests of those suspected of crime. The government took the view that this primary problem was not one easily solved by legislation, but it was aware that the Lord Chancellor and Home Secretary were "open to justifiable criticism" if the recommendation of introducing Coroners Rules was not implemented.
[141] SI 1984/552.
[142] Thomas and others (n 12) para 2.15.

Norman Brodrick QC (the Brodrick Committee) to review the law and practice relating to death certification, coroners and coroners' courts.[143] The review was prompted by a report entitled "Deaths in the Community", published in 1964 by the British Medical Association, which argued that the existing law failed to ensure that causes of death were established with sufficient accuracy.[144] It suggested that a consequence of such deficiencies was the danger that homicides might go undetected. Reporting in 1971[145], the committee acknowledged the public interest a coroner's inquiry may serve in determining the medical cause of death, allaying rumour and suspicion and drawing attention to the existence of circumstances which, if not remedied, might lead to further deaths. However, the committee also found the coroner had become an "isolated individual"[146] struggling to adequately exercise his or her functions and lacking a "clear idea of their role in contemporary society".[147] It highlighted the tendency of coroners to "take death as it comes"[148], conducting limited inquiries into the immediate circumstances of each individual case rather than more exacting investigations into modern health hazards or other sources of danger. The committee said the wide discretion and limited oversight enjoyed by coroners had led to variations in both standards and procedures.[149]

The Brodrick Committee's report criticised the role of a coroner's jury in attributing criminal responsibility. It recommended that in the future "the function of an inquest should be simply to seek out and record as many of the facts concerning the death as the public interest requires, without deducing from these facts any determination of blame".[150] Four years later, the jury at the inquest into the 1974 death of Sandra Rivett concluded that she had been murdered by Lord Lucan, who the coroner then committed to the Crown Court for trial. This prompted the government to act upon the Brodrick Committee's recommendation, and in 1977 the power of a coroner or an inquest jury

[143] Brodrick (n 32).
[144] ibid ix.
[145] The length of time taken by the Brodrick Committee was noted by coroners. Gavin Thurston, coroner for Westminster, jokingly referred to the six years as "waiting for Brodot". Gavin Thurston, 'The Brodrick Report, an Appreciation' (1972) 40 Medico-Legal Journal 27.
[146] Brodrick (n 32) para 11.39.
[147] ibid 11.40.
[148] ibid.
[149] ibid 11.41.
[150] ibid 16.40.

to charge a person with homicide was abolished.[151] After 700 years, this brought an end to the major role of the coroner in the administration of criminal justice. It was reflected in the concomitant change in coronial language, with the introduction of the neutral term of "unlawfully killed". The conclusion of unlawful killing can be returned by a coroner or jury only if a criminal offence of murder, manslaughter or infanticide was committed.[152] No conclusion of unlawful killing may name the person responsible[153], but that person must still be capable of being identified whether by name, description or otherwise, as the person who caused the death.[154]

The coroner's jury itself survived, but this was not a foregone conclusion. Until 1926 all inquests were held with a jury. The Coroners (Amendment) Act 1926 allowed coroners to sit without a jury unless there was reason to suspect any of four occurrences:

(i) the deceased came by his/her death by murder, manslaughter or infanticide;
(ii) that the death occurred in prison or in such circumstances as to require an inquest under any Act other than the Coroners Act 1887;
(iii) that the death was caused by an accident, poisoning or disease, notice of which was required to be reported to a government department;
(iv) that the death occurred in circumstances the possible recurrence of which would be prejudicial to the health and safety of the public or any section of the public.[155]

The Brodrick Committee had recommended that these mandatory provisions be repealed and that coroners be given a total discretion on whether to sit with a jury.[156] It thought it important to retain the jury but only for its symbolism and to add legitimacy to the conclusion of the coroner.[157] This recommendation was welcomed

[151] Criminal Law Act 1977, s 56(1). Lord Lucan was the last person to be committed for trial in the Crown Court following an inquest.
[152] *R (on the application of Wilkinson) v HM Coroner for the Greater Manchester South District* [2012] EWHC 2755 (Admin).
[153] *R v West London Coroner, ex p Gray* [1988] 1 QB 467 at 477.
[154] *R (on the application of Anderson) v HM Coroner for Inner North Greater London* [2004] EWHC 2729 (Admin) at [21].
[155] Coroners (Amendment) Act 1926, s 13.
[156] Brodrick (n 32) para 16.49.
[157] ibid.

by some coroners. The then Westminster Coroner described it as "indisputable that juries make no contribution to most inquests, as normally only one conclusion is possible"[158] and stated "most [coroners] will hope that the use of juries will disappear."[159] Wells explains how the "increasingly subservient role given to the inquest […] appeared to suggest that inquest juries would quietly fade away altogether."[160] However, in 1980 the family of Blair Peach successfully challenged the decision of the West London coroner not to sit with a jury at the inquest into Peach's death.[161] Peach, a teacher and anti-racism activist, had died following an Anti-Nazi League demonstration in Southall, during which he was hit on the head, probably by a member of the Metropolitan Police's Special Patrol Group.[162] Wells argues that the Court of Appeal's broad interpretation of "prejudicial to the health and safety of the public or any section of the public" "disposed of any threat to the survival of the compulsory coroner's jury".[163] She points out that, shortly after the judgment, the government legislated for procedures similar for those for juries in the Crown Court.[164]

Writing in 1994, Sim and Ward noted how the coroner's inquest, "long regarded as a quiet and curious backwater of the English legal system"[165], had once again become the subject of considerable controversy. The debate mirrored that of the mid-19th century: whether the coroner's inquest had any role in securing political or legal accountability for deaths in custody. Thomas et al have described how political and societal changes, an increasing assertiveness on civil rights and an accompanying defensiveness by public authorities led coroners' courts to become "sites of intense legal and political conflict from the 1980s onwards".[166] For Matthews, many inquests had become "battlegrounds more bitter than any litigation."[167] It was not just bereaved

[158] Thurston (n 145) 30.
[159] Thurston (n 145).
[160] Celia Wells, 'Inquests, Inquiries and Indictments: The Official Reception of Death by Disaster' (1991) 11 Legal Studies 71, 74–75.
[161] *R v Hammersmith Coroner, ex p Peach* [1980] 1 QB 211.
[162] David Renton, 'The Killing of Blair Peach' (2014) 36 *London Review of Books* <https://www.lrb.co.uk/the-paper/v36/n10/david-renton/the-killing-of-blair-peach> accessed 13 September 2022.
[163] Wells (n 160) 75.
[164] Coroners Juries Act 1983, ss 1-3.
[165] Sim and Ward (n 104) 245.
[166] Thomas and others (n 12) para 2.25.
[167] Paul Matthews, 'What Is the Coroner For?' (1994) 110 Law Quarterly Review 536, 537. Matthews offered an explanation as to why some bereaved families sought to push the coroner beyond establishing the bare facts: "For one thing, they take place much sooner after the death than any civil action would, when feelings are still running high. For another, the family or friends usually have no

families who sought to take on the state at inquests. Wells recounts how the rebellious juries at the inquests following the *Herald of Free Enterprise* disaster (1987), the Glanrhyd Bridge collapse (1988) and the Clapham rail crash (1990) were each "undaunted in refusing to follow the cautious approach of the coroner"[168], ignoring directions that they were not to determine civil or criminal liability. Nevertheless, the general trend throughout the 20th century was towards limited inquiries that rarely ventured beyond the immediate facts of a death. Coroners restricted themselves to noting the means by which the deceased died and were generally unwilling to investigate wider contributory factors. This approach is best summed-up in the 1995 judgment of the Court of Appeal in *R v HM Coroner for North Humberside, ex p Jamieson*. Lord Bingham, then Master of the Rolls, wrote: "the task [of the coroner or coroner's jury] is not to ascertain how the deceased died, which might raise general and far-reaching issues, but 'how . . . the deceased came by his death,' a more limited question directed to the means by which the deceased came by his death".[169] Thomas et al are critical of how coroners and judges preferred highly circumscribed inquests, likening it to an "attempt to judicially control the inquest forum".[170] This may appear to be an odd charge given that the coroner is a judge with sole responsibility for conducting his or her inquest, but Thomas et al clearly prefer the approach adopted by Wakley and the more independently-minded coroners of the 19th century.

## 2.7 The coroner service in the 21st century

The deficiencies of the coronial system at the start of the 21st century were laid bare in two reports published in 2003: the Third Report of the Shipman Inquiry[171], chaired by Dame Janet Smith, and the report of Tom Luce's fundamental review of death certification and investigation in England, Wales and Northern Ireland (the Luce Review).[172] Both reports painted a picture of an inadequate, neglected service

information provided to them in advance of the hearing, as to what will be said by any of the witnesses (or indeed which witnesses will be called). This state of ignorance is shared by all the other 'interested persons' (including anyone whose conduct might be criticised), but in the case of family and friends it often fuels mistrust, and sometimes creates suspicion of a 'cover up'."

[168] Wells (n 160) 76.

[169] *R v HM Coroner for North Humberside and Scunthorpe ex p Jamieson* [1995] 1 QB 1, 26.

[170] Thomas and others (n 12) para 2.30. They point a finger of blame at the "unjustified suspicion that families only used the inquest system as a 'fishing expedition' for civil actions".

[171] Smith (n 32).

[172] The Luce Review Committee (n 30).

requiring significant reform and investment. Three decades on from the publication of the Brodrick Report, both the Luce Review team and Dame Janet Smith found there to be no consensus as to coroners' priorities nor clarity as to the purpose of an inquest. The coroner service lacked leadership,[173] was "isolated from the mainstreams of medicine and justice administration"[174] and presided over proceedings that "fall below modern judicial standards of openness, fairness and predictability".[175] The deficiencies were such that Smith considered whether she ought to recommend the abolition of the coronial system. In explaining why she had decided against such a drastic step, she noted the English and Welsh public's affection for the office: "the tradition of the coroner's inquest is so well rooted in this country that most members of the public would regret its loss".[176]

According to the Luce Review, the "root cause" of the problems (which were the result of coroners' lack of training, poor support and limited resources) lay in how the police and local authorities viewed the coroner's office:

> "It is perceived as a small independent judicial service, outside the effective scope of their influence and with little relevance to the crime prevention and law enforcement responsibilities of the police or the preoccupying service delivery priorities of local government in education and other large public services."[177]

Both reports recommended that the coroner service cease to be the responsibility of local government and both argued for a single, national coroner jurisdiction, which the Luce Review said should be "re-sited within national justice services".[178] According to Luce's committee:

> "The coroner service is essentially a judicial, investigative and public safeguarding or regulatory service, which should in all its functions work to judicial standards. It is more likely to develop such standards reliably and consistently if it has a structure similar to and linked with those of

[173] ibid 17; Smith (n 32) paras 82, 91.
[174] The Luce Review Committee (n 30) 17; Smith (n 32) para 7.41, 7.44.
[175] The Luce Review Committee (n 30) 17; Smith (n 32) para 7.64.
[176] Smith (n 32) para 19.11.
[177] The Luce Review Committee (n 30) 182.
[178] ibid; Smith (n 32) para 19.15.

> mainstream judicial services, which are organised into national jurisdictions and are led by the higher judiciary."[179]

Submitting his committee's report to the government, Luce noted that in the preceding three-quarters of a century governments had twice commissioned similar fundamental reviews of the coronial jurisdiction, in 1936 and 1965 (Wright and Brodrick respectively). He expressed the hope of his committee that their conclusions would not suffer the same neglect as those of the Wright Committee and Brodrick Report.[180]

As these reports were being written, the courts were grappling with the question of whether the regime for holding inquests established by the Coroners Act 1988 and the Coroners Rules 1984 met the requirements of the European Convention on Human Rights. This litigation, arising out of an inquest into the suicide of Colin Middleton, a serving prisoner, reached the House of Lords in 2004.[181] In the case of *R (Middleton) v HM Coroner for West Somerset*, the Law Lords considered the adequacy of the coronial regime summarised in *Jamieson* and concluded that in some cases it did not meet the requirements of article 2 of the Convention.

Article 2[182] imposes two types of obligations on member states. First there are substantive obligations not to take life without justification and to establish a framework of laws, procedures and means of enforcement to protect life. But there is also a procedural obligation to initiate an effective public investigation by an independent official body into any death occurring in circumstances in which it appears that one or other of the substantive obligations may have been violated and it appears that agents of the state may be implicated.[183] To meet the procedural requirement of article 2, an inquest ought ordinarily to culminate in an expression,

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[179] The Luce Review Committee (n 30) 182.
[180] The Luce Review Committee (n 30). Letter to Hilary Benn MP.
[181] *R (Middleton) v HM Coroner for West Somerset* [2004] 2 AC 182.
[182] Article 2 ECHR: 1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
(a) in defence of any person from unlawful violence;
(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection."
[183] *McCann and others v UK* (1995) 21 EHRR 97, [161].

however brief, of the jury's conclusion on the disputed factual issues at the heart of the case.[184]

Lord Bingham, now the senior Law Lord, considered in *Middleton* that only one change was needed to make coronial law in England and Wales Convention-compliant. Coroners and their juries should interpret the statutory question of how the deceased came by his or her death "in the broader sense previously rejected [by the Court of Appeal in *Jamieson*], namely as meaning not simply 'by what means' but 'by what means and in what circumstances'."[185] *Middleton* was an important judgment; it widened significantly the scope of inquests into deaths occurring in circumstances in which it appears that one of the state's substantive obligations may have been violated and that agents of the state may be implicated. Greater rigour and a more searching inquiry are now required of coroners in cases where the state may bear some responsibility for the death.

It was not long before the impact of this ruling was seen by the public. An inevitable consequence of British involvement in the wars in Afghanistan and Iraq was a surge in coroners' inquests into battlefield casualties. The bodies of servicemen who died in the conflict were returned to the UK via the RAF base at Brize Norton in West Oxfordshire, meaning the responsibility for investigating the deaths fell to the Oxfordshire coroner. To help tackle the backlog of inquests that quickly developed, Andrew Walker, then a deputy coroner in London, was drafted in to conduct the inquests into the deaths of dead soldiers. Relying on the Law Lords' decision in Middleton to conduct thorough investigations, Walker swiftly developed a reputation in the press as a "thorn in the side" of the military and government.[186] At a time of public disquiet in the UK over the adequacy of the body armour provided to British troops and "friendly fire" deaths involving the American military, Walker was lauded in the press as an "unlikely hero" to service families, willing to challenge those in power on behalf of grieving parents, widows and girlfriends.[187] These inquests are a

[184] *R (Middleton) v HM Coroner for West Somerset* [2004] 2 AC 182, [20].
[185] ibid, [35].
[186] Angela Balakrishnan, 'An outspoken critic of the MoD', *The Guardian* (11 April 2008) <https://www.theguardian.com/uk/2008/apr/11/military.defence> accessed 14 September 2022.
[187] Marcus Dunk, 'An unlikely hero: The coroner Labour is trying to gag from criticising the MoD', *Daily Mail* (London, 18 March 2008) <https://www.dailymail.co.uk/news/article-539108/An-unlikely-hero-The-coroner-Labour-trying-gag-criticising-MoD.html> accessed 14 September 2022.

more recent example of the legal and political conflict that Thomas et al say became more common in coroners' courts in the 1980s and 1990s. In Walker's vocal criticism of both the UK and American governments there are echoes of his Victorian forebears' efforts on behalf of the families left bereaved by railway deaths and industrial accidents. Like those cases, the Afghanistan and Iraq inquests are evidence of the trust placed in coroners by sections of the public who feel shut out by the response of the powerful to their loved ones' deaths. As one mother told the Guardian newspaper, "He's the only man who has tried to help us. The British government and the Americans have only let us down".[188]

## 2.8 Coroners and Justice Act 2009: a national head for the coroner system

In its response to the Luce Review and Dame Janet Smith's reports, the government accepted "the irrefutable case for reform".[189] Writing the foreword to a Home Office position paper, the then Home Secretary, David Blunkett, acknowledged that the coroner system relied on "outdated" practices and "archaic" funding arrangements, and that the experience of bereaved families varied widely according to where the coroner's investigation took place.[190] The Government initially envisaged a reformed coroner system that would operate nationally under the leadership of a Chief Coroner. It proposed a more professional service, operating consistently across England and Wales and subject to a system of inspection and oversight to attain high standards.[191] It would be judicially independent but supported by an advisory "Coronial Council" and bolstered by closer links to other relevant professionals.

Despite widespread agreement on the need for improvement, reform was not introduced swiftly. Thomas et al criticised how "it took just short of ten years for a new statutory regime to come into force".[192] It is not as if the question of judicial reform was not on the government's mind during this time. This decade saw a major

[188] Mark Townsend, 'Why won't the US tell us how Matty died?', *The Guardian* (London, 4 February 2007) <https://www.theguardian.com/uk/2007/feb/04/iraq.military> accessed 14 September 2022.
[189] 'Reforming the Coroner and Death Certification Service: A Position Paper' (Home Office 2004) Cm 6159 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/251078/6159.pdf> accessed 14 September 2022.
[190] ibid.
[191] ibid 10.
[192] Thomas and others (n 12) para 2.45.

restructuring of the justice system, with the establishment of the Supreme Court[193], the assumption by the Lord Chief Justice of the Lord Chancellor's judicial functions[194], the creation of the Judicial Appointments Commission[195] and the unification of the tribunals[196] under the leadership of a new Senior President of Tribunals.[197] The pressing need for reform of the death investigation system and the continuing isolation of coroners, highlighted by both the Luce Review and by Smith, were not enough to include coroners in the government's thinking during these years of sustained legislative attention on the judiciary. The eventual changes were also limited. When a draft bill was published in June 2006, the Constitutional Affairs Committee accused the government of having "ignored the recommendations of both the Shipman Inquiry and the Luce Review".[198] It predicted that any improvements that might come about as a result of the limited reforms "will be threatened by the paucity of resources which are likely to be devoted to this important area."[199] In the end the Coroners and Justice Act 2009 introduced only one of the major recommendations set out in the two reports: the office of Chief Coroner became a national head of the coroner system in England and Wales. Even this single step was very nearly not taken. Sir Peter Thornton received his letter of appointment as the first Chief Coroner on 6 May 2010, the day of the general election that removed from power the Labour government that had enacted this significant reform.[200] In further evidence of where the coroner service falls on the list of government priorities, the incoming coalition administration deemed the post of Chief Coroner to be too expensive and added it to its list of offices selected for abolition.[201] It was saved from this "bonfire of the quangos" by the House of Lords. Following lobbying by the Royal British Legion, the scale of peers' opposition to the move eventually resulted in a government U-turn.[202] Having "listened to and reflected on the concerns raised across Parliament, by families and by other groups, […] that a

[193] Constitutional Reform Act 2005, s 23.
[194] ibid, s 7.
[195] ibid, s 61.
[196] Tribunals, Courts and Enforcement Act 2007, s 3.
[197] ibid, s 2.
[198] Constitutional Affairs Committee (n 9) 3.
[199] ibid 215.
[200] Sir Peter Thornton, 'Annual Conference: The Coroners' Society of England and Wales' (*Courts and Tribunals Judiciary*, 9 November 2012) para 5 <https://www.judiciary.uk/announcements/chief-coroner-speech-coroners-society-conference-21092012/> accessed 14 September 2022.
[201] Public Bodies Act 2011, sch 1.
[202] 'Clarke U-turn over scrapping of chief coroner', *BBC News* (22 November 2011) <https://www.bbc.co.uk/news/uk-politics-15847352> accessed 14 September 2022.

single figure needs to be responsible for the coroner system"[203], the then Justice Secretary Ken Clarke announced he would, after all, implement the office of the Chief Coroner. There had been no such national post in the over 800-year history of the coroner's office.

But the national, unified coroner service recommended by both the Luce Review and by Smith was not introduced. The government rejected the Constitutional Affairs Committee's criticism and expressed confidence it could couple "the best features of a national structure, headed by a Chief Coroner, with the best features of local service delivery".[204] This would "ensure responsiveness to local circumstances and help to build strong local partnerships with other services".[205] This was a disappointment to both local authorities and to coroners. The Local Government Association described the arrangement of coroners being accountable only to the senior judiciary while being funded by local taxpayers as "an outdated anomaly".[206] The Honorary Secretary of the Coroners' Society, Victor Round, said the society had hoped to see a national system and "had almost got to the stage of assuming it would happen".[207] He said coroners were "a bit shaken to find that we still have the old battles to fight."[208]

## 2.9 The relevance of coronial history

The website of the Coroners' Society of England and Wales puts the reforms of the Coroners and Justice Act 2009 in their historical context, highlighting the importance of the history of the office to coroners:

> "The Office of Coroner has survived for over eight hundred years by evolving to meet the changing needs of the society that it is there to serve, and it continues to welcome any beneficial and positive changes which

[203] ibid.
[204] 'Reform of the Coroners' System and Death Certification: Government Response to the Constitutional Affairs Select Committee's Report' (Department for Constitutional Affairs 2006) Cm 6943 8.
[205] ibid.
[206] Constitutional Affairs Committee (n 9) para 93.
[207] ibid 100.
[208] ibid.

> will enable it to develop and build on the service it provides to the public in general and the bereaved in particular."[209]

In his 2012 address to the Coroners' Society, Sir Peter Thornton referred to and endorsed coroners' appreciation of their history: "One coroner impressed me when he said: 'I have a deep affection for the office'. And so you should, rightly so. It is an office of great veneration and continuing importance."[210]

Coroners appear unwilling to divest themselves of their history and are proud of their enduring status as officers of the Crown. When the first Chief Coroner pointed out that coroners had become "creatures of statute" under the 2009 Act and questioned coroners' entitlement to continue calling themselves "HM Coroner" in light of the Act's silence on the question of whether the office is held under the Crown, he urged coroners not to be troubled about the change in nomenclature under review.[211] However, in the general introduction to the 13th edition of *Jervis on Coroners*, the key practitioner text used in the Coroners' Court, Professor Paul Matthews, himself a coroner, argued that the coroner's position as an officer of the Crown "is even stronger than before".[212] He stressed how the Act had neither expressly nor impliedly changed coroners' status, and he pointed to how appointments, "previously made by local authorities alone, must now be approved by both a senior minister of the Crown, the Lord Chancellor, and the Chief Coroner".

## 2.10 Summary

This chapter has provided an overview of the long history of the coroner. It traced how the role has changed since its inception. It described how the political significance of the coroner has waxed and waned over the centuries. And it has highlighted coroners' uneasy relationships with politicians and other judicial office holders as their investigations and desire to do justice have come up against legal limits and financial constraints. These remain live issues today as an increasingly professionalised but still atomised coronership contends with a new centralised direction and scarce local

[209] Coroners' Society of England and Wales <https://www.coronersociety.org.uk/the-coroners-society/history/> accessed 14 September 2022.
[210] Thornton, 'Annual Conference' (n 200).
[211] 'The Chief Coroner's Guide to the Coroners and Justice Act 2009' (Chief Coroner 2013) para 35.
[212] Matthews (n 12) para 1.15.

resources. The role of contemporary coroners, their political significance and the nature of the justice they provide are discussed over the following chapters, starting with an overview of the coroner service in the 21st century.

# Chapter 3 The 21st century coroner service and its political significance

This chapter introduces the new structure of the 21st century coroner service and its place in the legal system of England and Wales. It sets out the formal, prescribed guarantees of coroners' independence alongside the procedures for their recruitment, training and discipline. These structural factors are known to affect the political significance of judicial decision-makers, as demonstrated in Guarnieri and Pederzoli's *The Power of Judges*[213], and this chapter analyses how the 21st century changes to the coroners service may have affected its political significance. These structural changes also form an important backdrop to understanding the views of today's coroners about recent reforms to the coroner service and the working lives of coroners, all of which are explored in the Coroner Attitude Survey.

## 3.1 The structure of the new coroner service

Despite its limitations, the Coroners and Justice Act 2009 made important changes to the coroner service in England and Wales (most of which were introduced in July 2013). The most significant reform was the introduction of national leadership for all coroners in the shape of the office of Chief Coroner.

### 3.1.1 The Chief Coroner

Pursuant to the calls for a "more focussed, professional and consistent approach to coroners' investigations"[214], the Chief Coroner has the statutory power to provide guidance, set standards and develop training for coroners and their staff.[215] Other duties include directing investigations to be undertaken,[216] monitoring certain investigations and coroners' reports,[217] overseeing the transfer of cases between coroners,[218] keeping a register of lengthy investigations[219] and reporting annually to

[213] Guarnieri and Pederzoli (n 71).
[214] Smith (n 32) para 9.69.
[215] Coroners and Justice Act 2009, ss 17 and 37.
[216] ibid, s 13.
[217] ibid, sch 5 para 7(3).
[218] ibid, s 3.
[219] ibid, s 16.

the Lord Chancellor.[220] The Chief Coroner may also conduct investigations and inquests himself.[221] Increasingly often, the Chief Coroner also sits as a judge of the Administrative Court in judicial reviews of coroners' decisions – a development welcomed by the senior judiciary.[222] Separate from coroners' investigations, the Chief Coroner also plays an important role in the appointment of coroners; this represents the first time that a member of the courts and tribunals judiciary has been able to influence this process.[223]

The creation of the office of Chief Coroner also resulted in the emergence of an institutional hierarchy in the coroner service. The Coroners and Justice Act 2009 assigned responsibility for the appointment of a Chief Coroner to the Lord Chief Justice, thus giving the head of the judiciary a greater degree of control over the work of coroners. As the office of Chief Coroner has been described as "the cornerstone of the coroner system",[224] it is perhaps surprising that the Act does not actually require the Lord Chief Justice to appoint someone to the role. The Lord Chief Justice has a discretion as to whether to appoint someone and sets the length of the term of office. Political involvement is not wholly absent: the Act mandates that the Lord Chancellor be consulted on any Chief Coroner appointment and on the length of the term. To date, the three people to have held the post of Chief Coroner have been drawn not from the ranks of senior coroners but from the courts and tribunals judiciary. Sir Peter Thornton KC, the first Chief Coroner, was a Senior Circuit Judge at the time of his appointment.[225] His successor, His Honour Judge Mark Lucraft KC, was a Circuit Judge at the time of his appointment and continued to sit as a judge at the Central Criminal Court throughout his time as Chief Coroner.[226] The current Chief Coroner,

[220] ibid, s 36.
[221] ibid, sch 10 para 1.
[222] *R (Silvera) v HM Senior Coroner for Oxfordshire* [2017] EWHC 2499 (Admin) [41] (Charles J): "The Chief Coroner for England and Wales has sat as a member of the Court in a number of the cases to which we were referred relating to the decisions of Coroners. Where, as here, the challenge does not engage any of the duties of the Chief Coroner of England and Wales as such it seems to me that this is both appropriate and helpful."
[223] Discussed below in Chapter 3.3.
[224] Matthews (n 12) para 2.48.
[225] Since stepping down as Chief Coroner, Sir Peter Thornton KC has sat as an assistant coroner, including hearing the renewed inquests into the deaths caused by the 1974 Birmingham pub bombings.
[226] In April 2020, still during his tenure as Chief Coroner, His Honour Judge Lucraft KC was appointed Recorder of London, the most senior judge at the Old Bailey.

His Honour Judge Thomas Teague KC, is also a circuit judge.[227] The legislative intention that coroners be tied more closely to the courts and tribunals judiciary is evidenced by the fact that in all three appointment processes for Chief Coroner only High Court or Circuit Judges under the age of 70 were eligible for appointment; the post is closed off to coroners. However, the Act allows for the appointment of one or more Deputy Chief Coroners and permits the appointment of senior coroners to this role. Derek Winter, the Senior Coroner for the Sunderland Coroner Area, was (alongside Her Honour Judge Alexia Durran) the first to be appointed to this post, both taking office in January 2019.[228]

### 3.1.2 The reorganisation of the coroner service

Prior to the 2009 reorganisation of the coroner service, there had been three types of coroner:

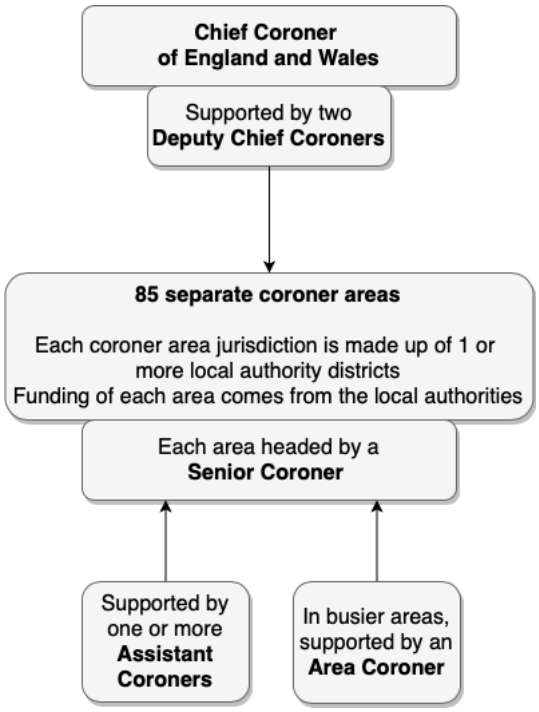
(1) District (formerly "County") Coroners, appointed by the local authority and supported by a Deputy Coroner and sometimes one or more assistant deputies;
(2) Coroners by virtue of their office (coroners *ex officio* such as the Lord Chief Justice and Justices of the High Court); and
(3) Franchise Coroners, all but extinct by 2013.[229]

Under the Coroners and Justice Act 2009, the old "coroner districts" became "coroner areas", encompassing one or several local authority districts. Each coroner area is headed by a Senior Coroner supported by one or more part-time Assistant Coroners.

[227] 'Appointment of new Chief Coroner' (Courts and Tribunals Judiciary, 22 December 2020) <https://www.judiciary.uk/announcements/appointment-of-new-chief-coroner> accessed 14 September 2022.
[228] 'Appointment of Deputy Chief Coroners' (Courts and Tribunals Judiciary, 14 January 2019) <https://www.judiciary.uk/announcements/deputy-chief-coroner-appointments/> accessed 10 May 2022.
[229] Franchise coroners were not elected by the freeholders of a county but were appointed by a lord or other person having the right to appoint a coroner for "any town corporate, liberty, lordship, manor, university or other place". Aside from the office of 'King's coroner', which still survives but exercises no coronial functions, the Coroner of the Queen's Household was the only franchise coroner remaining in 2013.

In busier coroner areas the Senior Coroner may also have a deputy (termed an "Area Coroner" in the Act) to share his or her workload.[230] Figure 1 sets out the new structure.

**Figure 1 Structure of the coroner service after the Coroners and Justice Act 2009**

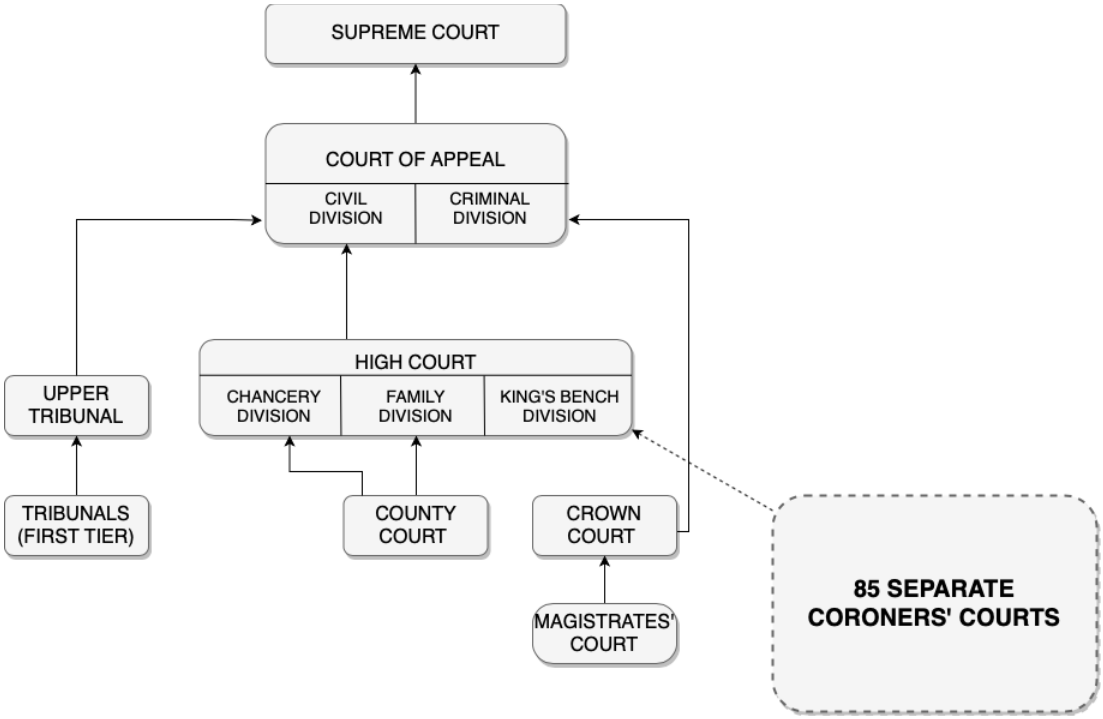



As discussed in Chapter 2, the principle of neighbourhood justice has always been a prominent feature of the coroner service, and the 2009 Act did not replace its local structure with the single, unified coronial jurisdiction as recommended by the Luce Review and by Dame Janet Smith (and to a lesser degree by the Brodrick Committee three decades earlier). As Figure 1 shows, the coroner service continues to be delivered in 85 separate coroner areas across England and Wales, funded and supported by the relevant local authorities.

[230] The distinction between the posts of Area Coroner and Assistant Coroner is somewhat confusing. Like their Assistant Coroner colleagues, Area Coroners may also work part-time. There is no difference in powers between Area Coroners and Assistant Coroners, and nothing to prevent a Senior Coroner from delegating decisions as to the distribution of work to an Assistant Coroner rather than an Area Coroner. However the Chief Coroner's aspirational document "A Model Coroner Area" suggests that where there is an Area Coroner, the Senior Coroner's administrative workload should be shared with the Area Coroner by agreement (see Report of the Chief Coroner to the Lord Chancellor, Fifth Annual Report 2017-18, Annex B).

The 2009 Act also did not bring coroners' courts inside the system of courts and tribunals comprising HM Courts and Tribunal Service (HMCTS). Seventeen years on from the Luce Review, the coronial system remains fragmented and still outside "the mainstream judicial services."[231] As Figure 2 shows, the 85 separate coroners' courts remain apart from all other courts and tribunals, with coronial investigations entering the system only when the King's Bench Division of the High Court is asked to judicially review a decision of a coroner.

**Figure 2 The coroner service in the judicial system of England and Wales**




So not only are coroners still set apart from the rest of the judiciary, they remain separate from each other. Early in his tenure as Chief Coroner, Sir Peter Thornton described coroners as remaining "locked away in their own little worlds, in their own particular corners of the administration of justice".[232]

[231] The Luce Review Committee (n 30) 182.
[232] Sir Peter Thornton, 'Howard League Parmoor Lecture 2012: The Coroner System in the 21st Century' (*Courts and Tribunals Judiciary*, 25 October 2012) <https://www.judiciary.uk/announcements/coroner-system-21st-century-chief-coroner-speech-25102012/> accessed 14 September 2022.

However, it would be wrong to say that the Act left the coroner service's territorial dimension untouched. Since the implementation of the Act, the number of coroner areas in England and Wales has been reduced from 110[233] to 85. The intention is that this number will be reduced further over the next few years as the Lord Chancellor and Chief Coroner pursue the aim of creating coroner areas of roughly equal size and workload. The Ministry of Justice and Chief Coroner have a target of a reduction to around 80 coroner areas in the short to medium term and 75 areas in the longer term. Their view is that each coroner area should have approximately 3,000-6,000 reported deaths each year, with a full-time Senior Coroner in post.[234] Smaller coroner areas have been merged to increase not only efficiency and cost-effectiveness at a local level,[235] but also greater consistency in inquest approach and outcomes across coroner areas.[236] Reform is also driven by the desire for greater parity across coroner areas in terms of the special work arising from deaths in prisons, major hospitals, mental health institutions or at airports.

A clearer break with strict territorial jurisdiction may be seen in another innovation of the first Chief Coroner, namely the creation of a specialist cadre of coroners whose members are trained to conduct investigations and inquests into the deaths of service personnel on active service. Two further cadres have since been created with specialism in the investigation of mass fatality incidents and the identification of victims of disasters, such as the March 2015 crash of Lufthansa Germanwings Flight 4U9525 in the French Alps. The members of these cadres are not bound by territorial constraints and can travel to conduct inquests in other coroner areas. Thornton claimed the creation of such specialist groups was made possible by "the greater flexibility in the new Act over coroner areas and the possible movement of coroners by way of an extended transfer system".[237]

Furthermore, in guidance issued to local authorities in 2020 the second Chief Coroner, His Honour Judge Lucraft KC, emphasised that the responsibilities of senior coroners

[233] This itself was a marked reduction from the number in the 1980s, before local authorities sought to reduce costs through merging their areas upon the retirement of coroners.
[234] Mark Lucraft, 'Chief Coroner's Annual Report 2017-18' (2018) 57.
[235] Sir Peter Thornton, 'Chief Coroner's Annual Report 2013-14' (2015) para 40.
[236] Mark Lucraft, 'Chief Coroner's Annual Report 2016-17' (2017) para 26.
[237] 'Guidance No.7 A Cadre of Coroners For Service Deaths' (Chief Coroner 2013) para 8.

extend beyond their own coroner areas to encompass regional and national duties that underpin the structure and organisation of the coroners' service in England and Wales:

> "These roles include training and development of those who work in the coroner service, being members of specialist cadres, and attending meetings, seminars and events where explanation as to the role of the coroner is needed to support bereaved people and others who interface with the coroner service."[238]

This guidance suggests the development of a system not previously known to the coroner service. In her 2012 thesis on the purpose of the coronial investigation, written at the end of the previous era in coronial law, McGowan describes how one coroner she spoke to "balked at my referring to coroners as operating as part of a 'system' *per se* suggesting that the term implies a level of cohesion and organisation that did not, in fact, exist."[239]

## 3.2 Relationship between coroners' courts and the wider judiciary

### 3.2.1 No appeal route

It is striking that there is no statutory appeal from the coroner's court. Coroners' decisions are therefore insulated from challenge to a much greater degree than those of most other judges. As coroners' decisions are not routinely appealed, this means that opportunities for judicial direction from the High Court are relatively rare. Two consequences are notably apparent in the coroners' system. First, as noted in Chapter 1, there have been many findings of inconsistency between coroner areas in terms of coroners' decision-making. Second, as noted in Chapter 2, throughout the 1980s and 1990s inquests were often marked by "political conflict" as the bereaved saw the coroners' court as a venue where they could assert their civil and human rights.[240] The lack of an appeal route will have contributed to the sense that the coroner's inquest was independent.

[238] 'Guidance No.6 The Appointment of Coroners' (Chief Coroner 2020) para 3.
[239] McGowan (n 59) 109.
[240] Thomas and others (n 12) para 2.25.

In 2009, Parliament recognised the absence of a "simple appeal route for bereaved families and other interested persons"[241] and provided for a new right of appeal to the Chief Coroner in section 40 of the Coroners and Justice Act. Under this provision, the Chief Coroner's decision could thereafter be appealed to the Court of Appeal, on a point of law only. However, section 40 was never brought into force and was quickly repealed by the Public Bodies Act 2011.[242]

### 3.2.2 The breadth of coroners' discretion

A decision of a coroner may be challenged by an application for judicial review.[243] Applications are heard in the Administrative Court of the King's Bench Division. Only those with a sufficient interest in the coroner's decision will be given permission to apply.[244] This is a low hurdle, "designed only to exclude clearly unmeritorious, 'busybody' cases".[245] Applicants usually seek a quashing order to quash the challenged inquest and a mandatory order directing that a fresh inquest be held.[246] But here they must clear a high hurdle. The higher courts have emphasised repeatedly the wide discretion that Parliament has afforded coroners. Unlike proceedings in the Crown Court or County Court, the ambit of the coroner's investigation and inquest is determined not by parties or interested persons but by the coroner.[247] In a well-known passage in *Jamieson*[248], Lord Bingham said:

> "…the responsibility is [the coroner's]. He must set the bounds of the inquiry. He must rule on the procedure to be followed. His decisions, like

[241] Coroners and Justice Act 2009, Explanatory Notes, para 297.
[242] This decision was not without merit: "Section 40 covers every judicial decision that a coroner can make. If there is an appeal on everything the coroner says, we will have a very busy Chief Coroner and Deputy Chief Coroner because they have to rehear and re-adjudicate each and every decision." André Rebello, Oral evidence to the Justice Committee: The Coroner Service, HC 282 2020 [Q 1-26] Q22.
[243] In addition to judicial review, an inquest may also be challenged in the High Court under statutory powers (Coroners Act 1988 s 13) upon an application by or with the permission of the Attorney General. A challenge under the "Attorney General's Fiat" is of much narrower scope than judicial review. The High Court may order an inquest into a death if satisfied either that a coroner is refusing or neglecting to hold an inquest which ought to be held. Or where an inquest has been held, the High Court may order that a fresh inquest is necessary or desirable in the interests of justice. An applicant must first persuade the Attorney General to give his authority. Without this the case will not be considered by the High Court.
[244] Senior Courts Act 1981 s 31(3); CPR r 54.4.
[245] Matthews (n 12) para 19.37.
[246] *Halsbury's Laws*, 2010, vol 24, para 237.
[247] See *R v South London Coroner, ex parte Thompson* (1982) 126 SJ 625.
[248] *R v HM Coroner for North Humberside and Scunthorpe ex parte Jamieson* [1995] 1 QB 1, 26.

> those of any other judicial officer, must be respected unless and until they are varied or overruled."

The High Court will not act as a court of appeal. It will interfere only on "*Wednesbury*"[249] grounds, namely where the coroner has erred in law, has taken into account an irrelevant consideration or failed to take into account a relevant one, or has acted in a way in which no reasonable coroner would have acted.[250] The High Court has taken a "hands-off' approach, reiterating that coroners are best placed to make decisions in their courts. In terms of procedure at an inquest, Brooke LJ said in *Hay*[251]:

> "We are unwilling, for our part, to fetter the discretion of a coroner by being at all prescriptive about the procedures he should adopt in order to achieve a full, fair and thorough hearing."

As to decisions on the issues and possible conclusions that may be left to a jury, these are "very much a matter for the judgment of the […] coroner who has seen and heard the evidence tested to decide. An appellate court will rarely intervene."[252]

### 3.2.3 Judge-led investigations

Coroners may enjoy a wider discretion than circuit judges, but the difference in their relative status is very evident in another power granted to the Chief Coroner. The Chief Coroner may request that the Lord Chief Justice nominate a judge to replace a coroner in conducting an investigation into a person's death.[253] The Lord Chief Justice may nominate a judge of the High Court, a Circuit Judge or a retired judge of the Court of Appeal or High Court. In recent years this aspect of judicial control over coronial proceedings has been exercised in a number of particularly sensitive cases of national or public importance. Examples include the inquests into the deaths arising from the Westminster terror attack of 22 March 2017, the London Bridge and Borough Market

[249] *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223, 229.
[250] *R v Coroner for Exeter and East Devon, ex parte Palmer* [2000] Inquest LR 78 (CA) 9.
[251] *R v Coroner for Lincolnshire, ex parte Hay* (1999) 163 JP 666, [46].
[252] *R (Sreedharan) v HM Coroner for Greater Manchester [2013] EWCA Civ 181* (CA), [72]
[253] Coroners and Justice Act 2009, sch 10, para 3. The Lord Chief Justice must consult the Lord Chancellor before making a nomination.

terror attack of 3 June 2017, the Manchester Arena terror attack of 22 May 2017[254] and the terror attack at Fishmongers' Hall, London, on 29 November 2019.[255]

The limitations on coroners' ability to investigate certain politically sensitive deaths were laid bare in litigation arising from the investigation into the 2012 death of Alexander Perepilichnyy, a Russian national, near his home in Surrey.[256] In that case there were suspicions that the deceased had been killed by agents of the Russian state. The Home Secretary made an "unprecedented"[257] application to the High Court for an order permitting the non-disclosure of sensitive documents to the senior coroner on the ground that disclosure would damage the public interest. Mr Justice Cranston's ruling made clear that not only are Senior Coroners, as a category, not among those able to see sensitive material related to issues of national security, but that the Home Secretary can rely upon the assertion of a general policy not to provide coroners with such material and so does not have to provide any evidence that disclosure to a particular coroner will in itself result in a real risk of serious harm to national security.[258] He dismissed arguments advanced before the coroner that government policy allowed the executive branch to pick and choose the judicial office holder to conduct a coronial inquest. He said: "It is wrong to characterise the policy as somehow the Executive interfering with the judiciary. It is a pragmatic response to the very real practical problems when courts handle security and intelligence material."[259]

The consequence of the High Court allowing the Home Secretary's application was that the coroner's position in the inquest was untenable. As he could not discharge his obligation to conduct a full and fair investigation if unable to have sight of relevant, sensitive material, the Chief Coroner had to arrange for Mr Justice Hilliard, then the Recorder of London, to take over the inquest.

[254] The Manchester Arena inquests were subsequently turned into a public enquiry.
[255] The Lord Chief Justice nominated His Honour Judge Lucraft KC, then Chief Coroner of England and Wales, to conduct the inquests arising from the Westminster terror attack, from the London Bridge and Borough Market terror attack and from the Fishmongers' Hall terror attack. Sir John Saunders, a retired High Court judge was nominated to conduct the Manchester Arena inquests.
[256] *Secretary of State for the Home Dept v Senior Coroner for Surrey* [2016] EWHC 3001 (Admin).
[257] ibid [1].
[258] ibid [64]-[65].
[259] ibid [48].

Mr Justice Cranston referred in his judgment to advice issued to coroners by the first Chief Coroner in December 2014 entitled "Duty to Notify Chief Coroner in Certain Cases".[260] This guidance calls for coroners to inform him as early as possible of cases involving consideration of very sensitive material held by government agencies:

> "The Chief Coroner therefore needs to discuss this type of case with the senior coroner and any potential for investigation by a 'relevant judge' as early as possible. The Chief Coroner does not want to take interesting cases away from coroners, but there are some cases which, under the law as it stands, may require a judge to conduct the investigation. Otherwise the process of investigation by the coroner may be incomplete."[261]

Writing in the UK Inquest Law Blog, Bridget Dolan KC explained that in managing the disclosure of confidential security services material, the government had, as a matter of policy, adopted the distinctions between judicial offices drawn by the Regulation of Investigatory Powers Act 2000 (RIPA).[262] The provisions of that Act do not consider a coroner to be a "relevant judge", nor an inquest to be a "statutory inquiry". As a result, some material that can be disclosed to High Court and Circuit Judges cannot be seen by coroners.

The impact of this ruling on coroners' status has been described by Dolan as a "second blow" to coroners "still smarting from being described as holding 'a relatively lower judicial office' by Mr Justice Singh in the *Norfolk Coroner v AAIB* case last month." She drew attention to the fact that neither Mr Justice Cranston nor the Chief Coroner suggested another potential solution in cases where sensitive material does not fall under RIPA, which is that senior coroners could themselves undergo the security clearance process so that the government and intelligence agencies could be satisfied that coroners can be trusted.[263]

The Chief Coroner's power under schedule 10 is not the only means by which an inquest can be assigned to a member of the courts and tribunals judiciary instead of a

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[260] Now withdrawn but available at <http://ukinquestlawblog.co.uk/images/PDF/advicenotify.pdf> accessed 5 July 2022.
[261] ibid, para 20.
[262] Bridget Dolan, 'Inquests, Coroners and Secrets: The Latest Word' (*UK Inquest Law Blog*, 30 November 2016) <https://www.ukinquestlawblog.co.uk/inquests-coroners-and-secrets-the-latest-word/> accessed 14 September 2022.
[263] ibid.

coroner. The Chief Coroner's guidance on judge-led inquests acknowledges that "very occasionally it may be the case that for particular, case-specific reasons, it is prudent for a sitting or retired judge to sit as a coroner"[264]:

> "This may be because the investigation and inquest is very controversial or sensitive, or it has a difficult history which means that, looking at the case as a whole, the Chief Coroner decides to invite the relevant local authority to appoint a judge to sit as an assistant coroner."[265]

In these circumstances the relevant local authorities have appointed senior judges as assistant coroners to allow them to hear the inquests. This is not a new approach; Dame Heather Hallett, a Lady Justice of Appeal, acted as coroner at the inquests into the 52 deaths arising from the London terror attacks of 7 July 2005.[266]

The Chief Coroner's guidance closes with a statement that the complexity of a case or high level of media interest in an inquest is unlikely to be enough to persuade him to use his schedule 10 powers or to request a local authority to appoint a judge as an assistant coroner: "A coroner has the specialist skills to lead an investigation and inquest and this should only very rarely be replaced by another member of the judiciary."[267]

### 3.3 The recruitment of coroners

Prior to the Coroners and Justice Act 2009, in some areas of England and Wales the office of coroner was a closed shop. Dame Janet Smith's inquiry heard of a tradition in some coroner districts that the office passed from partner to partner within a single solicitors' practice – an arrangement that apparently survived into the 21st century.[268] District coroners appointed their deputies, who would then be the strongest candidates for appointment as district coroner in the future given their monopoly on experience

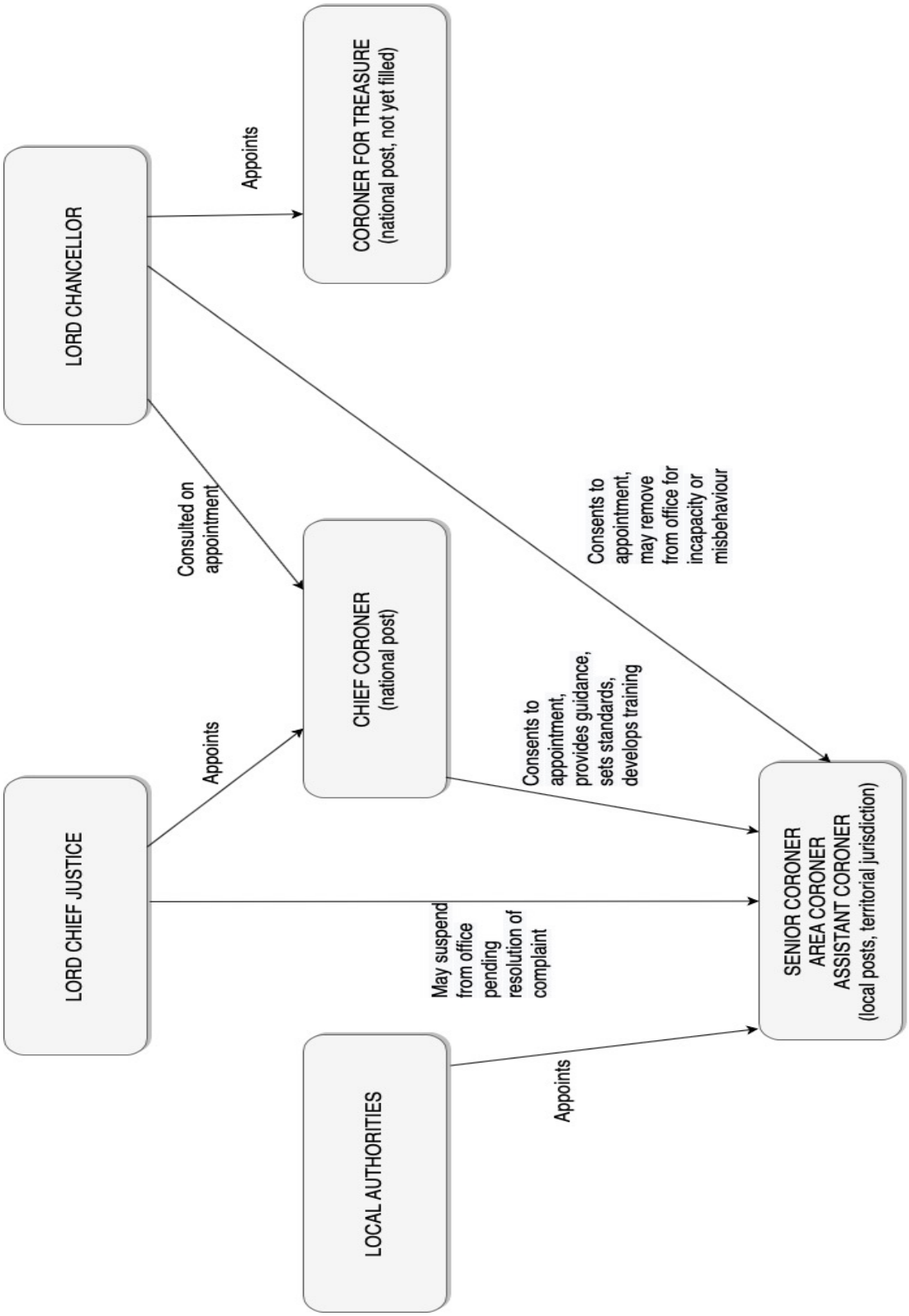
[264] 'Guidance No.30 Judge-Led Inquests' (Chief Coroner 2019) para 40.
[265] ibid.
[266] The Coroners' Society of England and Wales has highlighted how the judges in these inquests are granted "a legal team and vast resources, which the coroner can only look upon with envy. This raises the bar and expectations of the public from the coroner service." 'Written Evidence from The Coroners' Society of England & Wales' (Justice Committee, House of Commons 2020) COR0030 <https://committees.parliament.uk/writtenevidence/10556/pdf/> accessed 14 September 2022.
[267] 'Guidance No.30 Judge-Led Inquests' (n 264) para 46.
[268] Smith (n 32) para 7.4.

of coronial work. Smith concluded that, to a large extent, coroners in 2003 were still a "self-perpetuating group".[269]

Today, responsibility for the appointment of coroners is still a local matter, with the appointment of a Senior Coroner being a statutory obligation on local authorities.[270] However, under the 2009 Act no person may be appointed to any coronial office unless the Lord Chancellor and Chief Coroner both consent to the appointment (see Figure 3).[271] Previously there had been no such judicial veto on appointments. The Chief Coroner is not passive in exercising his discretion as to consent. Rather he has relied upon this provision of the Act to "involve himself at multiple steps in every appointment process."[272] The extent of the Chief Coroner's influence over the appointment of coroners may be seen in the guidance he has issued to local authorities. Setting out the "recommended procedure to ensure a smooth process when running an appointment campaign for senior, area and assistant coroners"[273], it starts by emphasising that the process is a matter for the local authority and that "each appointment will be their appointment".[274] However, the rest of the document makes clear the strong judicial control that now exists over coronial recruitment.

[269] ibid.
[270] Coroners and Justice Act 2009 sch 3 para 1 (1). Where a coroner area encompasses more than one local authority, the Senior Coroner is appointed by the 'relevant authority' as decided between them.
[271] Coroners and Justice Act 2009 sch 3 para 1 (3), para 2 (5).
[272] 'Guidance No.6 The Appointment of Coroners' (n 238) 8.
[273] 'Guidance No.6 The Appointment of Coroners' (n 238).
[274] ibid 2.

**Figure 3 Responsibility for appointment and removal of coroners (post CJA 2009)**



The Chief Coroner involves himself directly in every appointment of a Senior Coroner, either personally or through a nominee (an experienced Senior Coroner chosen by the Chief Coroner). The guidance dictates that local authorities notify the Chief Coroner's office of any forthcoming recruitment campaign. The Chief Coroner's office then sends to the local authority its "appointments pack", which includes the Chief Coroner's guide to eligibility and a draft advertisement including the job specification, scoring sheet and individual assessment form.[275] The guidance advises that these must be read carefully along with the guidance prior to commencing the recruitment campaign. Through the provision of such material the Chief Coroner frames the process at an early stage.

After a local authority draws up a shortlist of candidates, the Chief Coroner reviews all applications for three purposes.[276] First, he reviews to ensure no good candidate is overlooked for interview; if such a candidate is identified the Chief Coroner will recommend that that candidate be interviewed. Second, he reviews so as to be able to advise the local authority if he cannot consent to a shortlisted candidate's appointment. Thirdly, he reviews to ensure that both he and the Lord Chancellor have knowledge of the entire process and are satisfied with it, in order to inform their consent. Interviews take the form of a presentation and questions. The guidance recommends that the local authority sends a copy of the technical interview questions, indicator markers and any topics for presentations to the Chief Coroner's office. This is to ensure that the Chief Coroner is happy with the questions being put (and to avoid duplication of questions across coroner areas).

The Chief Coroner (or his nominee) will attend interviews but not ask questions or intervene. The Chief Coroner will also be present during evaluations of the candidates' interview performance but shall not cast a vote in the decision. The Chief Coroner has described his attendance or representation as "integral in preserving public confidence in the appointment process."[277] If a decision is taken to appoint a candidate, the Chief

[275] ibid 16.
[276] ibid 30.
[277] ibid 13.

Coroner (or nominee) will indicate whether he gives his consent, setting out his reasons. This will be repeated in writing as soon as reasonably practicable.

In a new procedure, possibly designed by the Chief Coroner to address the perception that coroners are not part of the "wider judicial family",[278] new Senior Coroners are sworn in at the Royal Courts of Justice in London by a senior appeal judge in the presence of the Chief Coroner.[279] This process is further evidence of an emerging hierarchy in the coroner service and of its closer ties to the courts and tribunals judiciary.

The Chief Coroner's role in the appointment of Assistant Coroners is more flexible because his direct involvement may not be possible in all cases due to the larger number of assistant coroner appointments. However, through running workshops for those lawyers interested in appointment as assistant coroners, the Chief Coroner maintains an influence over recruitment at the entry-level of the coroner service. The guidance calls for the involvement of the relevant area's Senior Coroner in the recruitment process, recommending that the local authority seek the Senior Coroner's advice and assistance on the need for and type of Assistant Coroner appointments and in selecting candidates for interview. It also proposes that the Senior Coroner should always sit as a member of the interview and decision panel. If the Chief Coroner or his nominee was unable to be present during the interviews, the local authority should provide the Chief Coroner with a written report about the application and interview process and its reasons for selecting the successful candidate(s). The Chief Coroner's guidance reminds local authorities that his consent to an appointment is not a foregone conclusion.[280]

The Chief Coroner's Third Annual Report 2013-14 claimed that local authorities have embraced their role in the reformed process with enthusiasm and described the competitions for appointment as "more open, transparent and fair".[281] The report pointed to the variety in appointees' backgrounds and experience as evidence of the process working well. In 2015-16 legal executives, first-tier tribunal judges,

[278] Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 21.
[279] ibid 40.
[280] 'Guidance No.6 The Appointment of Coroners' (n 238) para 46.
[281] Thornton, 'Chief Coroner's Annual Report 2013-14' (n 235) para 51.

magistrates' court legal advisers and managers within HM Courts and Tribunals Service were among those appointed to the post of Assistant Coroner.[282]

### 3.4 Coroners' training

While coroner training existed before the appointment of a Chief Coroner, it was not comparable to the advice and guidance given to other members of the judiciary.[283] Writing in 2003, Dame Janet Smith found that "to a very large extent, coroners are left to their own devices"[284]:

> "Until recently, there was virtually no training available for coroners. Prior to 1983, the Coroners' Society assumed sole responsibility for training but, since that time, the Home Office has also been involved. The extent of training was at first very limited and was not compulsory. About three years ago, however, the Coroners' Society urged the Government to allocate increased resources for training and matters have improved, but only slightly. Training is still not compulsory and, according to Mr Burgess, there are some senior coroners who never undertake the voluntary training that is available because they believe they know all that there is to know."[285]

There are significant differences between previous courses and the new regime. First, attendance at training is now compulsory. Second, training is no longer organised on an ad hoc basis by the Coroners Society of England and Wales or by the Home Office; it is now delivered under the auspices of the Judicial College of England and Wales that trains courts and tribunals judges and non-legal members in that jurisdiction. Thirdly, newly appointed coroners are expected to complete compulsory residential induction training (in addition to local "in-house" training) before they sit.[286] The Chief Coroner's guidance dictates that those who do not undertake the induction

[282] ibid 52.
[283] Smith (n 32) para 7.41.
[284] ibid.
[285] ibid 7.45.
[286] Training for newly appointed coroners covers all aspects of coronial law, practice and procedure and provides a basic understanding of medicine and human anatomy. 'Written Evidence from The Coroners' Society of England & Wales' (n 266).

training on appointment must be supervised while sitting as a coroner until it is complete.[287] Training is described as "an integral part of all appointments."[288]

After appointment, all coroners receive compulsory residential training each year. The Judicial College of England and Wales identifies those who fail to attend, and it is not uncommon for the Chief Coroner to contact individual coroners to ascertain the reason for their absence.[289] Attendance forms part of the annual appraisal scheme for assistant coroners introduced in 2019. Coroners may also choose to attend one-day courses organised by the Chief Coroner on specific topics. Previous one-day courses have focussed on investigations into deaths in prison, the deaths of children, mass fatality events and medical topics.[290]

Mentoring is also available for all coroners should it be required. Mentoring may be arranged at a coroner's request or where the Chief Coroner or a senior coroner believes it would assist the coroner. Mentors are senior coroners or others with considerable experience who volunteer for the role and who are approved by the Chief Coroner.[291]

### 3.5 Discipline and removal from office

The procedures in place for disciplining coroners suggest a high level of independence from both external and internal pressures. While local authorities appoint and pay coroners they do not employ them and have no say over their judicial decision-making. As the coroner's "independence as a judge is a matter of constitutional guarantee"[292], councils have no power to remove a coroner. As Figure 3 shows, only the Lord Chancellor, acting with the agreement of the Lord Chief Justice, may remove a coroner from office for incapacity or misbehaviour. The judicial disciplinary procedure of the Constitutional Reform Act 2005 has applied to all coroners, regardless of office, since July 2013.[293] Previously only district coroners were subject to the disciplinary arrangements under the 2005 Act; the disciplining (and potentially the removal from

[287] 'Guidance No.6 The Appointment of Coroners' (n 238) para 66.
[288] ibid.
[289] 'Written Evidence from The Coroners' Society of England & Wales' (n 266).
[290] Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 81.
[291] 'Guidance No.19 Mentors for Coroners' (Chief Coroner 2019) para 2.
[292] *Forrest v Lord Chancellor* [2011] EWHC 142 (Admin) [27].
[293] Matthews (n 12) para 2.97.

office) of deputies and assistant deputies was left as a local matter and responsibility lay with the district coroners.

The Lord Chancellor must comply with the "prescribed procedures" set out by the Lord Chief Justice to be followed in the investigation and determination of allegations of judicial misconduct. Some local authorities have expressed deep frustration with this arrangement. For example, Chinyere Inyama, the Senior Coroner for West London, remains in post despite years of complaints and a Parliamentary debate on the "terrible standards of service"[294] at the West London Coroner's Court. Unable to remove him from office, the London Borough of Hammersmith & Fulham, and the five other local authorities that appointed Mr Inyama in 2013, could only repeat their calls for him to resign, saying they remained "hugely disappointed" [295] with how complaints have been addressed by the Judicial Conduct Investigations Office.

All coroners are subject to the same disciplinary powers that fall short of removal from office that apply to other judicial holders. What amounts to incapacity or misbehaviour will depend on the facts of the case. However, it is clear that the bar is set high; there are very few recent examples of misbehaviour deemed worthy of removing a coroner from office. The most recent example concerned unreasonable behaviour on the part of the coroner, stemming from a mistaken perception of his relationship with his local authority.[296]

[294] HC Deb 16 December 2015 c596WH-612WH <https://hansard.parliament.uk/commons/2015-12-16/debates/15121636000001/WestLondonCoroner'SCourt> accessed 14 September 2022.
[295] Law Society Gazette, 'Conduct unbecoming', 22 January 2018, <https://www.lawgazette.co.uk/commentary-and-opinion/conduct-unbecoming/5064436.article>, accessed 14 September 2022.
[296] *Forrest v Lord Chancellor* [2011] EWHC 142 (Admin). The coroner had taken the view that his judicial independence would or might be usurped if his local authority's role was anything other than as funder of the local coroner service or if his staff (provided and paid for by the local authority) were under the control of anyone other than himself. He looked on the setting of a budget, even in relation to administration, as a fetter upon his jurisdiction. The High Court agreed with the conclusion of a review body that the coroner's view of the legal relations between himself, the local authority and his staff was both erroneous and unreasonable. His error had led him to act in a high-handed and aggressive manner which was not compatible with his continuing as a coroner.

### 3.6 Limits to the 2009 reforms

The most recent government-commissioned report[297] to touch upon the work of coroners suggested that the structural reforms of the Coroners and Justice Act 2009 do not go far enough. In her review of deaths and serious incidents in police custody, Dame Elish Angiolini highlighted how a lack of resources leaves coroners unable to initiate their own investigations "without complete reliance on third parties".[298] She described such dependency as unacceptable and said it "tests the viability of the Coroner's role as an inquisitorial judge."[299] She found "persistent inconsistencies in service"[300], which she said were inevitable given the "variance of skills and experiences brought to the role by coroners."[301] Concerned that some coroners lack the experience and expertise required to preside over death in custody inquests, she recommended the creation and training of a cadre of ticketed and specialist coroners"[302] to preside over such difficult cases. To address these issues, her report urged the government to consider again the creation of a single, unified coronial jurisdiction.

The first two Chief Coroners, Sir Peter Thornton KC and His Honour Judge Lucraft KC, both took the view that the new structure introduced from July 2013 has worked well in the main[303] (At the time of writing, His Honour Judge Teague KC has yet to issue an annual report). However, both Thornton and Lucraft also remained of the view that a national coroner service is necessary to meet the goals of the coroner system.[304] Thornton highlighted the impediment to collaborative working that is a feature of the present system:

> "A senior coroner is appointed by the local authority but not employed by them, so their line manager is the Chief Coroner, or possibly the Lord Chief Justice. Then you have coroners' officers, employed by the police. Their line manager is a detective sergeant, or some other officer. Then you have administrative staff, who are employed by the local authority, and

[297] Angiolini (n 38).
[298] ibid 16.40.
[299] ibid.
[300] ibid 222.
[301] ibid 16.68.
[302] ibid 16.77.
[303] Sir Peter Thornton, 'Chief Coroner's Annual Report 2015-16' (2016) para 23; Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 22.
[304] Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 15.

> line managed by someone there. So you have that peculiar triangle, and it only works if everybody is working together."[305]

The Chief Coroners' annual reports to the Lord Chancellor have highlighted a number of issues of concern, which both men believe flow from "the localised nature of the present service".[306] These include a failure by some police and local authorities to supply coroners with sufficient resources, causing coroners' officers stress and long-term sickness and leading to delays for bereaved families in the completion of investigations.[307] Many coroners in different parts of England and Wales struggle to obtain the regular services of pathologists, leading to further delays.[308] There is a variable service offered to Hindu, Jewish and Muslim communities anxious to abide by religious requirements as to preservation of the corporeal integrity of the body after death and early burial.[309] The salaries paid to Senior Coroners have varied widely, as do the methods and arrangements for payment.[310] Despite the agreement reached in 2018 between the Coroners' Society of England and Wales and the Local Government Association as to salaries, the level of fees paid to assistant coroners varies across areas.[311] There are two further serious problems with the current fragmented service. By tying a coroner's jurisdiction to geography, rural coroners, or those whose areas do not encompass a prison or large hospital, may have much less experience in investigating deaths involving possible breaches of the right to life. Secondly, the Chief Coroner does not have the resources to keep abreast of the work of so many

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[305] Sir Peter Thornton, 'Reforming the Coroner Service: Minutes of the All-Party Penal Affairs Parliamentary Group Held on 5th November 2013' (*Prison Reform Trust,* 5 November 2013) <http://www.prisonreformtrust.org.uk/PressPolicy/Parliament/AllPartyParliamentaryPenalAffairsGroup/Nov2013ReformingtheCoronerService> accessed 1 April 2022.

[306] Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 16; Thornton, 'Chief Coroner's Annual Report 2015-16' (n 303) para 17.

[307] Thornton, 'Chief Coroner's Annual Report 2015-16' (n 303) para 19.

[308] ibid 135; Both the first and second Chief Coroners expressed great concern over "seriously stretched" coronial pathology services: Mark Lucraft, 'Chief Coroner's Annual Report 2018-19 & 2019-20' (2020) para 103; In his 2015 report for the Home Office, Professor Peter Hutton warned that both forensic and non-forensic pathology services in England and Wales are "fragile, and corrective action needs to be taken now": Peter Hutton, 'Review of Forensic Pathology in England and Wales' (Home Office 2015) 2 <https://www.gov.uk/government/publications/review-of-forensic-pathology-in-england-and-wales> accessed 14 September 2022.

[309] Lucraft, 'Chief Coroner's Annual Report 2016-17' (n 236) paras 182–188. A notable case in point is that of the "cab rank" principle applied by the Senior Coroner for Inner North London, by which she refused to prioritise investigation of one death over any other on the basis of the religion of the deceased or bereaved family. The High Court found this policy to be unlawful: *Adath Yisroel Burial Society v HM Senior Coroner for Inner North London* [2018] EWHC 969 (Admin).

[310] Thornton, 'Chief Coroner's Annual Report 2015-16' (n 303) para 168.

[311] Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 172.

autonomous courts. As will be discussed in Chapter 4, the 2009 reforms do not address the long-held view[312] that lessons learned from investigations into deaths are insufficiently disseminated throughout England and Wales and themes and patterns of death that emerge across coroner areas are often overlooked.

### 3.7 The political significance of coroners

Despite these shortcomings, since July 2013 the coroner service has, as Thornton predicted[313], moved steadily towards a more integrated, flexible and transparent system. It is also a more professionalised service, and one under much greater judicial control. What has not changed are the expectations placed upon coroners: bereaved families still want accountability for wrongful death and concerned communities want risky or hazardous practices to be identified and brought to the attention of those who can make changes. How have the reforms set out above affected coroners' ability to further such positive societal change?

In their book *The Power of Judges*, Guarnieri and Pederzoli examined the increase in the political significance of courts in a number of western democracies in the late 20th century. Judges' political power increased as modern democracies entrusted them with "solv[ing] problems that other institutions are unable or unwilling to deal with effectively".[314] This phenomenon was defined by Vallinder as the "judicialization of politics".[315] Guarnieri and Pederzoli argued that the social and political significance of judges is conditional on the extent of their judicial independence. It is impossible to speak of an autonomous judicial intervention in politics without there being an independent judiciary made up of judges willing to intervene.[316] They highlighted how judges' independence and role perceptions – and thus their political significance – are shaped by factors internal to judiciaries.

[312] Helen Shaw and Deborah Coles, *Unlocking the Truth: Families' Experiences of the Investigation of Deaths in Custody* (Inquest 2007) 107.
[313] Thornton, 'Howard League Parmoor Lecture 2012: The Coroner System in the 21st Century' (n 232) para 27.
[314] Roger Cramton, 'Judicial Lawmaking and Administration in the Leviathan State' (1976) 36 Public Administration Review 551, quoted by Guarnieri and Pederzoli, 1.
[315] T Vallinder, 'When the Courts Go Marching In' in CN Tate and T Vallinder (eds), *The Global Expansion of Judicial Power* (New York University Press 1995) 13.
[316] Guarnieri and Pederzoli (n 71) 18.

Guarnieri and Pederzoli identified two main means by which political systems can influence their judges. The first "channel of influence"[317] is found in the structure of the judicial system, and there are two features that are relevant. The first structural control is jurisdiction: the types of cases judges are tasked with resolving. Judicial decisions that have a far-reaching scope are more likely to be politically significant.[318] When jurisdiction is concentrated in a unitary court system, judges tend to have greater political power. When it is fragmented across a plurality of different courts, each with their own separate hierarchies, the political impact of the judges' decisions is limited.[319] Guarnieri and Pederzoli asserted that "in principle, it is possible to assess the political significance of courts through an analysis of the types of controversies referred to them"[320], with the character of the parties the "reliable indicator of the nature and magnitude of the interests at stake".[321] For example, the social and political significance of a case brought by one private citizen against another can usually be distinguished from that of a dispute involving an arm of the state (e.g. a prosecution in the criminal courts or a judicial review challenge to a local authority). The potential implications of a case involving different parts of central government, or between government and devolved institutions, are different again.[322]

Applying this analysis to the coroner service, one's first thought might be that the coronership's political significance is limited. The "disputes" a coroner is tasked with resolving are the investigations of deaths that the coroner has reason to suspect were violent or unnatural, deaths where the cause is unknown and deaths that occurred while the deceased was in custody or state detention. While some inquests are socially or politically highly charged, the scope of coroners' investigations cannot be described as far reaching. The higher courts have repeatedly confirmed that coroners enjoy a wide discretion in conducting investigations, but they have also emphasised coroners' far more circumscribed jurisdiction. As will be discussed in Chapter 5, the higher courts have limited the extent to which coroners can investigate certain matters,

[317] ibid 80.
[318] ibid 79.
[319] ibid 78–79.
[320] ibid 80.
[321] ibid.
[322] LM Friedman, 'Trial Courts and Their Work in the Modern World' in LM Friedman and R Rehbinder (eds), *Zur Soziologie des Gerichtsver-fahrens* (Westdeutscher Verlag 1976), quoted by Guarnieri and Pederzoli, 80.

asserting that the inquest is not usually the right forum for resolving concerns about high level public policy.[323] For example, the second Chief Coroner relied on this case law when advising coroners at the height of the COVID-19 pandemic in April 2020 that "an inquest would not be a satisfactory means of deciding whether adequate general policies and arrangements were in place for provision of personal protective equipment (PPE) to healthcare workers in the country or a part of it."[324]

Furthermore, the coroner's jurisdiction is not concentrated in a unitary system but is fragmented across a plurality of courts. Many countries' judicial systems make some provision for "neighbourhood justice"; Chapter 2's review of coronial history made clear how this commitment to local ties still defines the coroner service in the 21st century. Guarnieri and Pederzoli would therefore likely agree with Thornton that coroners are "locked away in their own little worlds"[325] and conclude that such fragmentation curtails their influence and political significance.

However, if the nature and magnitude of legal proceedings can be seen in the character of the parties, it is surely significant that coroners' inquests can involve branches of the state and big business as well as individual grieving families. Such powerful interests always take such proceedings seriously: the campaign for bereaved families to be granted legal aid emphasises how the state is always well represented at an inquest when the actions or inaction of one of its agents is to be scrutinised by a coroner.[326] Here the terminology is also telling: the fact that there are no "parties" in an inquest, but rather "interested persons", underlines how the coroner's investigation is different from litigation. Unlike other judges who must wait for a party to commence proceedings, or who the government appoints to lead a public inquiry, coroners initiate their own investigations and remain wholly independent of all who appear before

[323] *Scholes v SSHD* [2006] HRLR 44, [69]; *R (Smith) v Oxfordshire Asst. Deputy Coroner* [2011] 1 AC 1, [81].
[324] 'Guidance No.37 COVID-19 Deaths and Possible Exposure in the Workplace' (Chief Coroner, 28 April 2020) para 13. This guidance was subsequently revised following a challenge from the campaigning charity INQUEST. The updated version removed the unconditional statement above and included the following caveat: "it is repeated that the scope of inquiry is a matter for the judgment of coroners, not for hard and fast rules."
[325] Thornton, 'Reforming the Coroner Service: Minutes of the All-Party Penal Affairs Parliamentary Group Held on 5th November 2013' (n 305) para 5.
[326] 'Now or Never! Legal Aid for Inquests' (INQUEST 2019) <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=a1ec7dcc-9ed6-405c-8af6-2639438e8d00> accessed 14 September 2022.

them. Parties might settle a case and a government may opt to close an inquiry, thus ending judicial involvement in litigation or in the public scrutiny of a matter, but at an inquest only the coroner may decide when his or her investigation is complete.

Finally, when considering the potential implications of a coroner's conclusion, it would be a mistake to overlook what MacMahon has termed the power of "soft adjudication".[327] The potential impact of coroners' conclusions led MacMahon to draw upon the literature on "soft law"[328] when describing their virtues. He identified two general lessons from that literature that are applicable to the work of coroners. First, despite being neither binding nor directly coercive, soft law may lead to beneficial change. Second, a major advantage of soft law's norms is that, unfettered by the procedural formalities of "hard law", they are more flexible and freer to pursue law makers' intent – or in the coronial context, the truth as to how a person came by his or her death. MacMahon described the inquest as an example of what he termed "soft adjudication". He defined soft adjudication as involving:

> "a formal pronouncement about a particular past event that lacks binding legal effect, though it may influence other legal decision makers and the public. Soft adjudication has the power to go beyond simple fact-finding: the decision maker, in an appropriate case, renders a normative judgment about responsibility for an event or the absence of responsibility."[329]

For MacMahon, the coroner's inquest "can be viewed as an information-gathering arm of the political process".[330]

The second structural control identified by Guarnieri and Pederzoli is in the relationship between first instance courts and appellate bodies, in particular the role appeal courts play in ensuring consistency in judicial decisions.[331] This is an important way in which the structure of a judicial system determines its judges' political significance. They recognised two models for structuring an appellate system: the

[327] Paul MacMahon, 'The Inquest and the Virtues of Soft Adjudication' (2015) 33 Yale Law & Policy Review 275, 317.
[328] MacMahon (n 327). MacMahon acknowledged that "soft law" is "notoriously difficult to define" but asserted that it is "generally used to refer to quasi-legal norms that lack fully binding force", existing "on a continuum between, on the one hand, hard law, and, on the other, mere political activity" .
[329] ibid 317.
[330] ibid 301.
[331] Guarnieri and Pederzoli (n 71) 80.

"coordinate" system, where most cases are dealt with by the lower and intermediate level courts and few cases are appealed all the way to the apex court, and the "hierarchical" system, where the supreme court re-examines a substantial number of lower-level decisions, enabling it to exercise control over the lower courts.[332] The authors saw the hierarchical model as increasing the judiciary's political significance as a strong decision-making court at the top maintains consistency in judicial decisions, producing a stable body of case law that citizenry can use as a point of reference.[333] The co-ordinate model, on the other hand, in promoting the autonomy of lower courts, has less internal consistency making litigation more likely and thus lessening the political impact of its judges' decisions. However, Guarnieri and Pederzoli do acknowledge Eckhoff's observation that this may strengthen the perception that individual, lower ranking judges are impartial and less influenced by senior judicial colleagues, which may enhance citizens' willingness to turn to the courts to pursue social goals.[334]

Applying this analysis to the coroner service, it is immediately apparent that coroners have great autonomy. Not only does England and Wales have a co-ordinate system with relatively few cases reaching the appeal courts, there is no formal appeal structure in coronial law. With an application for judicial review the only option, those who wish to challenge a coroner's decision must clear a high bar. Dame Janet Smith's third report noted that the absence of an appeal structure and the rarity of judicial review applications had left coroners effectively free to develop their own responses to the legislative provisions.[335] The Chief Coroner's law sheets and formal guidance are intended to address the caselaw lacuna and to achieve greater uniformity in approach across coroner areas. Nevertheless, as Chapter 2 showed, coroners have a long history of independence and 150 years after *The Times* described the coroner as "the magistrate of the poor"[336], there is strong evidence that bereaved families and concerned citizens still look towards the coroner's inquest as the place they will find justice. The tireless campaigning by the families of those killed in the *Marchioness*

[332] ibid 80–81.
[333] ibid 81.
[334] ibid; T Eckhoff, 'Impartiality, Separation of Powers, and Judicial Independence' (1965) 9 Scandinavian studies in law 11, 39.
[335] Smith (n 32) 16.
[336] Fisher (n 109) 147.

and Hillsborough Stadium disasters for full inquests into their loved ones' deaths led Wells to conclude that for the bereaved the inquest has acquired "an almost mythical status"[337] amongst accountability mechanisms. That this view of the inquest prevails was recognised by the mayor of London, Sadiq Khan, in his open letter to then Prime Minister Theresa May following her announcement of a public inquiry into the fire at Grenfell Tower on 14 June 2017. He wrote:

> "A view has taken hold in some quarters in the local community that a Public Inquiry is sub-optimal to an inquest, fuelling suspicion that this is being used to suppress the facts emerging. Part of the communication effort must therefore also involve explaining the merits of a Public Inquiry, how it will get to the truth and how it does not preclude an inquest at a later date if one is still necessary after the inquiry. In particular, families of loved ones must be reassured that the inquiry won't impede the formal recognition process of those who lost their lives. However, in order to avoid duplications of hearings, evidence and resources, it is vital that the inquiry deals fully with many of the issues that would arise at an inquest. The inquiry must be a thorough and detailed process which [sic] standards of representation, investigation, disclosure, evidence and questioning that are no less than would be provided at the most rigorous of inquests."[338]

According to Guarnieri and Pederzoli, the second channel by which political systems can influence their judges relates to judges' recruitment, training and the means of career advancement.[339] As these are so important in forming a judge's role perception, it is a more direct strategy of control. There are two basic models of judicial recruitment in western democracies – the "bureaucratic" model of the civil law tradition and the "professional" model that is characteristic of the common law tradition.[340] In the bureaucratic model, recruitment is usually direct from law school graduates who join the judiciary at the bottom rung with little or no previous professional experience. Through training and the criteria for promotion, such judiciaries have great latitude to mould recruits. The constant evaluation and

[337] Celia Wells, 'Inquiring into Disasters: Law, Politics and Blame' (1999) 1 Risk Management 7, 17.
[338] Mayor of London press release, 'Residents must be given their say in Grenfell Tower fire inquiry', 20 June 2017 <https://www.london.gov.uk/press-releases/mayoral/residents-say-in-grenfell-tower-fire-inquiry> accessed 14 September 2022.
[339] Guarnieri and Pederzoli (n 71) 80.
[340] ibid 20.

professional socialisation shapes recruits' role perceptions as they advance in their careers and affects their independence.[341]

The senior judiciary's capacity for internal control is much weaker in judiciaries formed by the professional model. These judges are, in contrast, usually recruited after accruing much experience in private practice. There are no set criteria for professional advancement and elevation to higher judicial office occurs much less frequently than in bureaucratic judiciaries. Guarnieri and Pederzoli explained how "lateral" recruitment from the ranks of legal professionals and the limited opportunities for promotion tend to weaken the senior judiciary's internal control. Judges appointed after time in private practice are, of course, shaped by the professions from which they are recruited and usually maintain ties with their former colleagues. Guarnieri and Pederzoli therefore stressed the need to identify such judges' reference groups – the professions from which they join the judiciary and whose values they import into the judicial system.

Approaching the coroner service from this viewpoint, it is easy to understand why Dame Janet Smith was concerned at how, in certain regions of England and Wales, the pool from which coroners were being recruited was sometimes as narrow as one local solicitors' firm. The revised coroner appointment process has sought to address this and the Chief Coroners' annual reports have documented their efforts to "ensure recruitment from the widest possible pool of most meritorious applicants".[342] However prior to this research, statistics on the diversity in coroners' professional backgrounds was unknown as was the impact of the new appointment process. The senior judiciary's capacity for internal control over coroners is also stronger in the revised procedures for coroner training, which is now very much "in-house" following the transfer of training responsibility from the Coroners' Society of England and Wales to the Judicial College of England and Wales.

To evaluate the degree of judicial independence, Guarnieri and Pederzoli argued that judicial recruitment and training must be considered alongside formal guarantees of judges' independent status. This is because "the way judges are recruited affects not

[341] ibid 19.
[342] Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 51.

only the social and professional composition of the bench but also the relationships that the judiciary establishes with other political actors."[343] Indeed, Guarnieri and Pederzoli claim a specific connection between status and recruitment patterns.[344] They argue it is also necessary to go beyond the institutional mechanisms for recruitment and to take account of those who can influence the process. Such analysis, they say, can reveal links between the judiciary and its environment which shape judges' subsequent role perceptions and conduct.[345] As discussed earlier in this chapter, the recruitment of coroners remains a matter for local authorities. But since July 2013, the process has been reformed significantly by the Chief Coroner who has introduced a high degree of judicial control. However this development has not weakened coroners' independence. On the contrary, the link between judicial status and recruitment patterns identified by Guarnieri and Pederzoli may be seen in the Chief Coroner's reminder to local authorities at the start of his guidance on recruitment that these appointments are unique amongst those of local government: "Once appointed a coroner becomes a judge".[346] Later in that document, stressing the need for confidentiality throughout the entire recruitment process for senior coroners, the Chief Coroner emphasises to local authorities that "these are high level appointments".[347] The Chief Coroner has sought to leave councils in no doubt that their influence over a coroner's judicial work begins and ends with their appointment of the coroner.

### 3.8 Summary

This chapter set out the structure of the contemporary coroner service and analysed how this may affect the political significance of coroners. Applying Guarnieri and Pederzoli's framework, this chapter examined not only the statutory and common law guarantees of independence but also internal factors that impact upon coroners' status and role perception. The revised procedures for coroners' appointment, training and discipline have undoubtedly brought coroners closer to the rest of the judiciary and increased the extent of the senior judiciary's influence on the service. On the one hand these efforts to "professionalise" the coroner service and raise standards invite greater

[343] Guarnieri and Pederzoli (n 71) 18.
[344] ibid 19.
[345] ibid.
[346] 'Guidance No.6 The Appointment of Coroners' (n 238) para 4.
[347] ibid 31.

prestige and respect; on the other they demarcate coroners' authority much more clearly. These important matters are explored in the Coroner Attitude Survey, which explores coroners' attitudes towards career advancement, judicial leadership in the coroner service and their status as coroners. In addition to reforming the structure of the coroner service, the 2009 Act also altered an aspect of coroners' jurisdiction – the type of disputes they are tasked with settling. (Here "disputes" includes not only the questions of who the deceased was and when, where and how the death occurred, but also the issue of whether action should be taken to prevent further fatalities). This too directly affects the political significance of the coroners' courts. The purposes to which coroners exercise their authority are the subject of Chapter 4.

# Chapter 4 The coroner service: purpose and forms of justice

According to the first Chief Coroner, Sir Peter Thornton KC, the coroner service in the 21st century provides justice for the public in two main ways:

> "First, the public, especially the bereaved, family and friends, need to know what happened, how the deceased came by his death. That applies particularly to deaths in custody or at the hands of an agent of the state, where there is a wider duty to protect citizens from the wayward or mistaken actions of the state and to expose wrongdoing and bad practice. But it applies equally to all deaths where there is a real element of uncertainty. The public need to know. They have a right to know."[348]

And the coroner service also provides public justice

> "… in preventing future deaths of a similar nature, something which families often feel passionately about. They say, and rightly say, our beloved should not have died in those circumstances, and what is more we do not want his death to be in vain; we do not want it to happen to anyone else in that same way."[349]

Both Thornton and His Honour Judge Lucraft KC, his successor as second Chief Coroner, have asserted "the essential concept that bereaved families must at all times be at the heart of the coroner process".[350] This had been a key proposal of the Luce Review in 2003, which noted that how relatives find out how a loved one died is key to how they deal with their own grief.[351] Yet there is a general belief that inquests can and do frequently disappoint families, who can sometimes feel let down by the conclusions reached by coroners or their juries.[352]

Starting with Thornton's formulation, this chapter first examines coroners' fact-finding and preventative efforts. It defines the justice that coroners provide to the public as accountability and argues that the coroner's court should be considered part of the system of administrative justice in England and Wales. The chapter then

[348] Thornton, 'Howard League Parmoor Lecture 2012: The Coroner System in the 21st Century' (n 232) para 46.
[349] ibid 51.
[350] Thornton, 'Chief Coroner's Annual Report 2013-14' (n 235) para 10; Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 11.
[351] The Luce Review Committee (n 30) 143.
[352] Thomas and others (n 12) 195.

considers the extent to which the structure, resources and legislation that shape the contemporary coroner service allow coroners to provide accountability in practice as well as in theory. Finally, the chapter discusses how coroners have sought to accommodate and address the specific needs of grieving relatives in their own formal court proceedings, and it considers the limits and difficulties they have encountered in doing so. This exploration of the purpose of and the justice provided by coroners' investigations provides an important framework to issues explored with current serving coroners in the Coroner Attitude Survey.

### 4.1 Fact-finding in public

The centrality of the coroner's fact-finding role was emphasised by Sir Thomas Bingham MR in *R v HM Coroner for North Humberside and Scunthorpe, ex p Jamieson*:

> "It is the duty of the coroner as the public official responsible for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory."[353]

The emphasis on public scrutiny highlights an important difference between coroners and the numerous ombudsmen and inquiries operating in England and Wales: the coroner's inquest is conducted wholly in public. Recent decisions of the High Court on applications for fresh inquests made following the discovery of new evidence are further reminders of the importance of public examination of the full facts of a death. Ordering fresh inquests into the Hillsborough Stadium disaster deaths, Lord Judge CJ thought it:

> "elementary that the emergence of fresh evidence which may reasonably lead to the conclusion that the substantial truth about how an individual met his death was not revealed at the first inquest, will normally make it

[353] *R v HM Coroner for North Humberside and Scunthorpe, ex p Jamieson* [1994] 3 WLR 82, 26 (Sir Thomas Bingham MR).

> both desirable and necessary in the interests of justice for a fresh inquest to be ordered."[354]

Even in a time of austerity and great constraints on the justice budget, it did not matter that the likely conclusion of fresh inquests would not differ from that of the first:

> "even when significant fresh evidence may serve to confirm the correctness of the earlier verdict, it may sometimes nevertheless be desirable for the full extent of the evidence which tends to confirm the correctness of the verdict to be publicly revealed."[355]

In 2017 the High Court held that where the discovery of new facts and evidence made it clear that the evidence heard by a coroner was insufficient to provide the full picture now available of the circumstances of a death, this can render the coroner's investigation insufficient through no fault of the coroner.[356] In such circumstances both the public interest and the interests of the bereaved families required that the evidence be heard at a fresh inquest. The High Court confirmed it was not incumbent upon those seeking a fresh inquest to show that the conclusions reached would likely be different.

Nor does the passage of even half a century vitiate the public interest in the full airing of the facts. Despite 53 years having passed since the original inquest into the death of murdered teenager Elsie Frost, which named Ian Bernard Spencer as her killer, in 2019 the High Court agreed with the deceased's brother that a new inquest was necessary given that the West Yorkshire Police now took the view that Elsie had been murdered by a different man, Peter Pickering.[357] Nor was the public interest lessened by the fact that the new inquest would be subject to limitations imposed by a modern legislative provision[358], prohibiting the formal pronouncement of criminal liability with which the original inquest concluded. The High Court accepted the submission that the *process* of public examination of the new evidence would achieve a sufficient resolution for the bereaved family after so many years.[359] It would be insufficient

[354] *HM Attorney General v HM Coroner for South Yorkshire (West)* [2012] EWHC 3783 (Admin), para 10.
[355] ibid.
[356] *HM Senior Coroner for the Eastern Area of Greater London v Whitworth and Kovari* [2017] EWHC 3201 (Admin), para 23.
[357] *Frost v HM Coroner for West Yorkshire (Eastern District)* [2019] EWHC 1100 (Admin), para 42.
[358] Coroners and Justice Act 2009 s 10.
[359] *Frost* (n 345) para 46.

simply to order the deletion of the name of Mr Spencer from the original record of Inquisition.[360]

That the public examination of the evidence is an end in itself is not readily appreciated by bereaved families, who, in their grief and confusion about coronial procedures, often bring to inquests expectations that cannot be met.[361] In ordering new inquests into the deaths of the Hillsborough Stadium disaster, Lord Judge CJ saw the vindication of the bereaved families as central to the interests of justice.[362] However, that vindication was to be found in their achievement of securing a fresh and fair investigation, not necessarily in its outcome. Justice in this context would be achieved through the inquests establishing in public the unvarnished truth, whatever that was to be:

> "This combination of circumstances, as we have narrated, makes inevitable the order for a new inquest. The interests of justice must be served. Within the limits of the coronial system, the facts must be investigated and reanalysed in a fresh inquest when, however distressing or unpalatable, the truth will be brought to light. In this way the families of those who died in this disaster will be vindicated and the memory of each victim will be properly respected."[363]

It is important to note at this point that the purposes of an inquest are not satisfied merely by the evidence being heard in public. In a 2003 case arising out of a death in prison, the Court of Appeal held that relevant facts found must also be identified in the coroner's or jury's conclusion:

> "If one of the purposes of an inquest is that culpable conduct should be 'exposed and brought to public notice', that will not satisfactorily be done merely by the hearing of 'very full' evidence of what occurred, a verdict of accidental death and a recommendation by the coroner to the prison governor. The jury must be given a proper opportunity to say, if they think it right to do so on the evidence which they have heard, that the death was

[360] ibid, para 49. It should be noted that the second Chief Coroner has recommended that the Coroners Act 1988, s 13 (as amended) be changed to give the High Court greater flexibility when it quashes an inquest. His Honour Judge Lucraft KC took the view that some s 13 cases could be sufficiently concluded without ordering a fresh inquest. He proposes an amendment that would allow the High Court to direct that the particulars of the Record of Inquest be amended: 'Chief Coroner's Annual Report 2017-18' (2018) para 192.
[361] Thomas and others (n 12) 195.
[362] *HM Attorney General v HM Coroner of South Yorkshire (West)* [2012] EWHC 3783 (Admin) [29], Emphasis added.
[363] ibid.

> contributed to by neglect, in the somewhat special sense of 'neglect' in this area of law."[364]

As Thomas et al have pointed out, "Inquests have been quashed by reason of the conclusion being inadequate, even where the investigation was exemplary."[365] The reason for this is twofold, matching Sir Peter Thornton's two-pronged explanation of how coroners provide justice. First, as noted by the Court of Appeal, addressing the public's need to understand what happened to the deceased will sometimes require more than a one or two word "short-form" conclusion, and the coroner or jury may have to go into some detail.[366] Second, the inquest conclusion has value in preventing further deaths of a similar nature. As Lord Woolf MR explained in *R v Inner South London Coroner ex p Douglas Williams*: "an inquest verdict can have a significant part to play in avoiding the repletion of inappropriate conduct and encouraging beneficial change."[367]

### 4.2 Prevention of further deaths

Where the facts established by an investigation give rise to a concern that further deaths may occur in the future if action is not taken, the coroner must report the matter to a person who the coroner believes may have power to take such action. This is why, at the end of his inquest into Natasha Ednan-Laperouse's death, the coroner wrote to the chief executive of Pret a Manger, to the Medicines and Healthcare products

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[364] *R (Davies) v HM Deputy Coroner for Birmingham* [2003] EWCA Civ 1739 [71].
[365] Thomas and others (n 12) para 17.149. One example of this is the House of Lords decision in Middleton [2004] UKHL 10.
[366] Coronial law permits two types of conclusion: "short-form" and "narrative". Short-form conclusions are one- or two-word labels for categories. The accompanying notes to Inquest Form 2 lists nine short-form conclusions: accident or misadventure; alcohol/ drug related; industrial disease; lawful/ unlawful killing; natural causes; open; road traffic collision; stillbirth; and suicide. Short-form conclusions make up the majority of all inquest conclusions. They are seen as having "the advantage of being simple, accessible for bereaved families and public alike, and also clear for statistical purposes" (Chief Coroner's Guidance No.17 'Conclusions: Short-form and Narrative', para 26). However, one defect of short-form conclusions is that they do not allow a coroner or jury to express their verdict on the disputed factual issues at the heart of the case. As an alternative or in addition to one of these short-form conclusions, a coroner or jury may record a narrative conclusion. There is no standardised format for a narrative conclusion, which can vary in length from a few sentences to a number of pages. A narrative conclusion provides a coroner or a jury with the opportunity to close an inquest with a statement of findings as opposed to merely attaching a label. By recording the factual details of a death, narratives "dovetail" with the inquest's purposes of public fact-finding and learning of lessons (David Baker, 'Deaths after Police Contact in England and Wales: The Effects of Article 2 of the European Convention on Human Rights on Coronial Practice' (2016) 12 162, 166).
[367] *R v Inner South London Coroner ex p Douglas Williams* [1999] 1 All ER 344 at 347-348.

Regulatory Agency, to the chief executive of Pfizer (who made the defective EpiPen) and to the Secretary of State for the Department for the Environment, Food and Rural Affairs. The prevention of further deaths has long been acknowledged as an important function of coroners' work but more recently it has been recognised as a central purpose of the inquest. In *R (Amin) v Secretary of State for the Home Department*, Lord Bingham said:

> "The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; *that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others*."[368]

The issuing of a Report on Action to Prevent Future Death ("PFD report") represents the most direct means by which a coroner can seek to fulfil this preventative purpose. As the key tool in the coroner's public health toolbox, a PFD report should be "clear, brief, focused, meaningful and, wherever possible, designed to have practical effect."[369] It is a common misconception that coroners make recommendations as to what ought to be done. This is not the case. PFD reports recommend only that action should be taken, not what that action should be. This is not a shortcoming. As pointed out by Lady Justice Hallett during the inquests into the London Bombing deaths of 7 July 2005, it is neither necessary nor appropriate for a coroner to identify the remedial action required.[370] Inquests are not public enquiries and as such PFD reports cannot be based upon a comprehensive understanding of all the relevant facts. Coroners lack the specialist knowledge of report recipients who are better placed to decide on what steps should be taken to prevent further fatalities.

When a report is sent to an organisation, the coroner strives to identify a relevant person with sufficient seniority to take the necessary remedial action.[371] Coroners must also send a copy of a report to the Chief Coroner and to any interested person (such as

[368] [2003] UKHL 51 [31], emphasis added.
[369] 'Guidance No.5 Reports to Prevent Future Deaths' (Chief Coroner 2020) para 5.
[370] Coroner's Inquests into the London Bombings of 7 July 2005, per Lady Justice Heather Hallett, Assistant Deputy Coroner for Inner West London, ruling of 6 May 2011, transcript page 15.
[371] 'Guidance No.5 Reports to Prevent Future Deaths' (n 369) para 35.

the bereaved family) who the coroner thinks ought to receive it.[372] So that wider lessons may be learnt, reports of concerns arising from deaths in prison are often also copied to HM Inspectorate of Prisons, the National Offender Management Service and to the Independent Advisory Panel on Deaths in Custody. Similarly, copies of relevant reports are often sent to the Department of Health, the Care Quality Commission and Department of Transport. Those to whom a PFD report is addressed must respond to the coroner within 56 days, either setting out a timetable for implementing changes or explaining why they propose to take no action.[373]

The potential of coroners' reports in protecting public health can be seen in the report issued by the Senior Coroner for Inner West London, Dr Fiona Wilcox, during her investigation into the deaths caused by the Grenfell Tower fire.[374] Despite the fact that the inquests are suspended pending the outcomes of the public inquiry into the fire and the police investigation, Dr Wilcox's concern for the health of survivors and first responders motivated her to issue a PFD report to the chief executive of NHS England.[375] Her report related not to fire prevention but risk evaluation and treatment for those who inhaled smoke and dust and mental health support for those suffering emotional trauma. Dr Wilcox warned that the "potential impact of this disaster is very wide ranging."[376] She was able to bring the multi-faceted needs of all involved in the tragedy to the attention of the NHS due to the flexibility of the law of PFD reports. Coroners are not restricted to matters arising from the evidence at an inquest;

[372] Coroners (Investigations) Regulations 2013, reg 28(4)(a). The Chief Coroner himself was the recipient of a PFD report in June 2019. At the conclusion of the fresh inquest into the death of Private Geoff Gray at Deepcut Barracks in 2001, HH Peter Rook KC urged the Chief Coroner to consider amending his guidance so that in cases of death from gunshot wounds, full consideration be given to the nature of the post-mortem examination to be carried out. See 'Geoff Gray Inquest: PFD report directed at the Chief Coroner' (*UK Inquest Law Blog*, 21 June 2019) <https://ukinquestlawblog.co.uk/rss-feed/130-pfd-report-to-chief-coroner> accessed 14 September 2022.
[373] Coroners (Investigations) Regulations 2013, reg 29(3)-(4).
[374] Amy Street, 'The Grenfell Tower Fire "Preventing Future Deaths" Report: The Breadth and the Limitations of PFDs' (*UK Inquest Law Blog*, 23 November 2018) <https://www.ukinquestlawblog.co.uk/grenfell-pfd-reports/> accessed 12 July 2022.
[375] Regulation 28 report of Senior Coroner Fiona Wilcox during the investigation into the deaths caused by the Grenfell Tower fire, 19 September 2018 <https://www.judiciary.uk/wp-content/uploads/2018/09/Grenfell-Tower-2018-0262.pdf> accessed 14 September 2022.
[376] ibid.

investigations need not be complete before coroners are empowered to act; and the future deaths envisaged need not be similar to the deaths under investigation.[377]

The coronial law as it stands today supports the coroner's work in saving lives to a greater extent than any previous iteration. The preventative function of an inquest was once manifested in inquest jury "riders" – the additional, often censorious opinion attached to the inquest verdict. While coroners discouraged juries from straying beyond their verdict, they recognised that "a rider or recommendation which contains reference to useful reforms may effect a public good if it reaches the proper quarter."[378] Over time juries' freedom to comment was increasingly circumscribed. The Coroners Rules 1953 permitted only those riders that may have prevented the recurrence of similar fatalities[379], and the Coroners (Amendment) Rules 1980 finally prohibited riders entirely.[380]

In their place came "Rule 43 reports", introduced by the Coroners Rules 1984. Rule 43 was a limited provision, giving coroners a power rather than a duty to make reports and requiring no response from the recipient of a report. Families were left in the dark as to what action, if any, had been taken in response to their loved one's death.[381] A study of the use of Rule 43 reports was undertaken between 2001 and 2003 as part of the Luce Review of death certification and investigation in England, Wales and Northern Ireland. It found a "significant disparity of practice" between coroners over whether and when they issued reports to prevent future deaths[382]:

> "about a third of the coroners in [the] sample made no recommendations at all during the previous year, one had made 60, nearly a quarter had made one or two, another quarter had made between three and six, and the remainder had made more."[383]

[377] Dorries (n 10) para 10.17.
[378] William Bentley Purchase, *Sir John Jervis on the Office and Duties of Coroners* (Eighth edition, London: Sweet & Maxwell 1946) 110.
[379] Coroners Rules 1953, rr 32, 34.
[380] Coroners (Amendment) Rules 1980, r 11.
[381] Deborah Coles and Helen Shaw, 'Learning from Death in Custody Inquests: A New Framework for Action and Accountability' (2012) 9 <https://www.inquest.org.uk/learning-from-deaths-in-custody> accessed 8 February 2021.
[382] The Luce Review Committee (n 30) 95.
[383] ibid 93.

Following successful lobbying by the charity INQUEST, the Labour government in 2007 moved to strengthen the preventative role of coroners. The then Minister of State for Constitutional Affairs, Harriet Harman MP, recognised how important it is for bereaved families that some good may come from their loved ones' deaths:

> "Families often express their wish that something positive might come out of a coroner's inquiry and hope that relevant agencies will take preventative action so that the death of their family member is not in vain. The increased focus on the ability to learn lessons, and to share information and best practice, will help families to achieve closure, as well as prevent future deaths, and address public interest issues about health and safety."[384]

Rule 43 was amended in July 2008, widening coroners' remit to make reports and imposing a requirement on recipients to send the coroner a written response within 56 days.[385] Coroner Christopher Dorries described the reforms of Rule 43 as "amongst the most important advances in coroner's law for the decade before the 2009 legislation came into effect in mid-2013."[386]

With the Coroners and Justice Act 2009, Parliament bolstered coroners' use of reports in two ways. It first emphasised the importance of the preventative function by upgrading the relevant provision, moving it from the Coroners Rules to part of the statute and strengthening its terms by replacing the coroner's power to issue a report with to a duty to do so when concerned. Secondly, in creating the post of Chief Coroner, Parliament provided a neglected service with much-needed leadership, guidance and support. Upon his appointment as the first Chief Coroner, Sir Peter Thornton undertook a review of the process of issuing preventative reports. He described the "great significance" of this aspect of coroners' work but noted the variance in coroners' practice and in the contents of reports.[387] He urged coroners to

[384] HC Deb 30 January 2007 c9WS.
[385] Coroners (Amendment) Rules 2008 (SI 1984/552).
[386] Dorries (n 10) para 10.13.
[387] Thornton, 'Annual Conference' (n 200) para 63.

issue more reports and published formal guidance[388] and a template report[389] to assist them in doing so.[390]

The Coroners (Investigations) Regulations 2013 replaced Rule 43 with fresh procedures which encouraged wide dissemination of the new PFD reports. Coroners' reports are now routinely published on the website of the courts and tribunals judiciary, accessible to all who may have an interest in them. The reports are categorised by type of death, allowing for much greater scrutiny of coroners' concerns and easier analysis of reports by coroner area and themes. The second Chief Coroner, His Honour Judge Lucraft KC, sought both additional resources to improve the platform on which reports are made available and further staff to assist in analysing trends in reports and responses to better understand the lessons learned from deaths.[391] This is important: since PFD reports deal with individual deaths, it is only through analysis of multiple reports that themes can emerge allowing for identification of systemic defects that may make further deaths more likely. While this approach represents an improvement on the previous regime, when there was no obligation on coroners to share the report with bereaved families, the Chief Coroner has yet to be granted the funding necessary for this work.

### 4.3 Justice as accountability

In his evidence to the House of Lords Select Committee on the Inquiries Act 2005, Sir Stephen Sedley included the coroner's inquest as one of the components of the system of administrative justice in England and Wales, alongside the unified courts and tribunals, public inquiries, ombudsmen and auditors.[392] Of these other institutions, the inquest has most in common with the public inquiry. In seeking to identify the type of

[388] 'Guidance No.5 Reports to Prevent Future Deaths' (n 369).
[389] 'Reports to Prevent Future Deaths Template Form' (Courts and Tribunals Judiciary) <https://www.judiciary.uk/wp-content/uploads/2013/09/guidance-no-5-reports-to-prevent-future-deaths-annex.doc> accessed 14 September 2022.
[390] The Chief Coroners' commitment to maximising the learning opportunities created by coroners' investigations may be seen in the proposal that coroners raise concerns even when the duty to make a PFD report does not arise. When matters revealed by the evidence are of concern but unlikely to lead to further deaths, coroners are encouraged to write to the relevant person or organisation. 'Guidance No.5 Reports to Prevent Future Deaths' (n 369) para 37.
[391] Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 88.
[392] 'Written and Corrected Oral Evidence to the Select Committee on the Inquiries Act 2005' 407 <https://www.parliament.uk/globalassets/documents/lords-committees/Inquiries-Act-2005/IA_Written_Oral_evidencevol.pdf> accessed 14 September 2022.

justice provided by the coroner's court, the overlap between the two is significant. Both are inquisitorial proceedings that (a) seek to establish the facts; (b) ensure accountability by identifying any wrongdoing or blameworthy conduct, prioritising the learning of lessons over the casting of blame; (c) aim to restore public confidence and allay disquiet; (d) provide an opportunity for catharsis; and (e) discharge the investigation obligations on the state imposed by article 2 of the ECHR.[393]

Considering the different roles of the institutions that make up the system of administrative justice in England and Wales, Elliot differentiated the work of the courts and tribunals, which he labelled "legal-judicial control of government", from the "non-legal" forms of accountability provided by public inquiries and ombudsmen. Elliot overlooked the coroner's court[394], so one could ask: into which of these broad categories of administrative justice does the coroner's inquest fall? The High Court has given short shrift to any suggestion that the coroner's office is not judicial.[395] But inquest conclusions and coroners' reports create only very limited legal obligations. Nevertheless, securing accountability is central to the modern coroner's work. The Judicial Committee of the House of Lords in *Amin* emphasised the European Court of Human Rights jurisprudence that interprets article 2 ECHR as requiring investigations of death to feature a sufficient level of public scrutiny so as to "secure accountability in practice as well as in theory."[396]

The literature on the role played by the courts of England and Wales in achieving accountability is situated almost completely in the context of constitutional law. It addresses the role of the courts and tribunals judiciary, ombudsmen and public inquiries but fails to consider the coroner's court as a site of justice or injustice. Nevertheless, and its narrow jurisdiction notwithstanding, on a daily basis the inquest plays its part in securing accountability in England and Wales. Public bodies (and

[393] Jason Beer (ed), *Public Inquiries* (Oxford University Press 2011) para 1.02-1.09.
[394] He also did not consider auditors. Mark Elliott, 'Ombudsmen, Tribunals, Inquiries: Re-Fashioning Accountability Beyond the Courts' in Nicholas Bamforth and Peter Leyland (eds), *Accountability in the Contemporary Constitution* (Oxford University Press 2013) 245.
[395] *Forrest v Lord Chancellor* [2011] EWHC 142 (Admin) [27]: "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."
[396] *R v Secretary of State for the Home Department, ex p Amin* [2004] 1 AC 653 [20].

private companies and citizens) frequently turn up to the coroner's court to give their accounts of how deaths occurred and to make submissions on whether or not remedial change is needed. The inquest into the death of Natasha Ednan-Laperouse due to allergens in her Pret a Manger sandwich is a good example of this.

Scholarship on accountability may have neglected the inquest but the work of the modern coroner is encompassed by the various definitions it offers of an accountability inquiry. For example, Turpin and Tomkin's definition of accountability as entailing both "explanatory" and "amendatory" obligations[397] neatly matches Thornton's two-part definition of the coroner's justice work as public fact-finding and prevention. Of the four types of accountability mechanism at work in the British constitution identified by Oliver,[398] it could be argued that elements of three are reflected in the coroner's inquest. The first, *political accountability to politicians,* as manifested in minsters' accountability to Parliament, does not encompass the work of coroners (though coroners do occasionally give evidence to select committee inquiries, most recently in 2020 to the Justice Committee's inquiry into the coroner service). But the presence of the coroner's jury is a reminder of the second of Oliver's types of accountability mechanism: *public accountability owed to the general public or interested sections of it*. As Thomas et al put it, "[the jurors'] presence provides a powerful symbolic and historical indication that the ordinary peers of the deceased are anxiously inquiring into the facts of his or her death."[399] The third, *legal accountability of public bodies to the courts,* surely extends beyond the courts and tribunals judiciary to include coronial proceedings. One need only look at the inequality of arms at inquests between the taxpayer-funded lawyers for state agencies and the often unrepresented bereaved to see how the state will defend its position following a death. Similarly, Oliver's fourth type of accountability, the *administrative accountability of public bodies to non-governmental ombudsmen,* is reflected in those same public bodies' subsequent and corresponding explanations and reassurances offered to the

[397] Colin Turpin and Adam Tomkins, 'Parliament and the Responsibility of Government', *British Government and the Constitution: Text and Materials* (6th edn, Cambridge University Press 2007) 566.
[398] Dawn Oliver, *Government in the United Kingdom : The Search for Accountability, Effectiveness, and Citizenship* (Open University Press 1991) 23–27.
[399] Thomas and others (n 12) para 16.1.

coroner (not to mention coroners' near-complete reliance on ombudsmen's reports on deaths occurring in state custody).

What does accountability mean in the coronial setting? As Elliot has noted, accountability is "a protean concept", carrying radically different meanings depending on the context.[400] Elliot maintains that it can however be calibrated, and its different senses identified. This can be done by considering three things:

1) the subjects that may form the focus of an accountability inquiry;
2) the criteria or standards by reference to which the inquiry proceeds;
3) the purposes that might be served by the inquiry.[401]

Applying this formulation to coronial investigations, the subject of coroners' inquiries are violent or unnatural deaths, those where the cause of death is unknown and those that occurred while the deceased was in custody or otherwise in state detention.[402] The criteria by reference to which a coronial investigation is evaluated can be both legal – the standards developed by the higher courts in the exercise of their judicial review function and by the European Court of Human Rights – and administrative – the policies produced by various arms of the state so as to comply with the legal standards or in response to a previous coroner's report.[403] While the purpose of the coronial inquiry is narrow – determining who the deceased was and when, where and how he or she came by his or her death – it too falls within the ambit of accountability enquiries, which "can be, and are, undertaken for a number of purposes."[404]

Despite the statutory prohibition on inquest findings casting blame, the coroner's court is still an accountability institution. Elliot acknowledges that the notion of accountability is often equated with culpability, but "just as ministerial accountability is about far more than the circumstances in which ministers should resign, so may accountability inquiries be conducted for ends other than the delivery of a scalp."[405]

[400] Elliott (n 394) 234.
[401] ibid.
[402] Coroners and Justice Act 2009, s1 (2).
[403] David Baker, *Deaths after Police Contact: Constructing Accountability in the 21st Century* (Palgrave Macmillan 2016) 79–80.
[404] Elliott (n 394) 234.
[405] ibid.

Two of these ends listed by Elliot are the important functions highlighted by Thornton as the means by which coroners deliver justice: catharsis by authoritatively establishing what actually happened and the learning of lessons.[406]

It is odd that Elliot omitted the coroner's court from his consideration of accountability construction beyond the courts and tribunals system. He identifies "several senses in which inquiries occupy a different niche from courts and tribunals"[407] and these distinguish inquest proceedings too. Like an inquiry chairman, a coroner can ask questions about the wisdom of policy choices pertinent to a death that would be beyond the remit of a court engaged in judicial review. As the courts "necessarily deal with individual, isolated challenges"[408], so too a coroner's investigation is limited by looking only at individual deaths. But, where relevant to the circumstances of a death, a coroner *can* go further and consider a series of administrative actions. And just like many inquiries, lesson-learning is a central purpose of the inquest. For Elliot, inquiries are thus capable of "supplying a more explicitly political (albeit non-partisan) form of accountability"[409] through examining matters "in a way that potentially contributes to political discourse, and to the evaluation of government, at a deeper level."[410] As Natasha Ednan-Laperouse's inquest proved, a coroner's inquiry can also prompt political action and debate and bring attention to the effectiveness of systems. For MacMahon, the inquest "can be viewed as an information-gathering arm of the political process".[411]

Significantly, there is one way in which Elliot differentiates inquiries from the courts and tribunals system that does *not* apply to the work of the coroner's court. Elliot highlights how litigation is usually initiated by individuals whereas inquiries are created by a minister and thus owned by the government. Coroners' investigations are different to both as they are initiated by the coroner who remains independent both of the interested persons at the inquest and of government. As the coroner strives to provide justice, the inquest offers the possibility of avoiding the shortcomings of the

[406] ibid 235.
[407] ibid 250.
[408] ibid 250.
[409] ibid 251.
[410] ibid 251.
[411] MacMahon (n 327) 301.

adversarial system and represents an investigation free of the suspicion of government control.

### 4.4 Securing accountability in practice

MacMahon has argued that the seeming toothlessness of the coroner's inquest is in fact a strength in terms of delivering accountability, one which has led him to argue for the revival of the inquest in the United States as an institutional response to custodial deaths:

> "Because they impose neither punishment nor liability, inquests operate relatively unencumbered by the restrictive procedures entailed by adversarial proceedings. For this reason, they can aim more squarely at establishing the truth, and so have the potential to uncover more information and issue more accurate judgments at lower cost. […] [I]nquests can do things that adversarial litigation is not designed to do: to help the deceased's family come to terms with the death, and to warn the broader community of the dangers of deadly activities while suggesting precautions."[412]

This is true in theory but the reality of the coronial jurisdiction in England and Wales means that accountability is not always achieved in practice.

#### 4.4.1 The pressure of resources

The coroner service featured prominently in Dame Elish Angiolini's Independent Review of Deaths and Serious Incidents in Police Custody.[413] Her review was commissioned in 2015 by the then Home Secretary, Theresa May MP, after meeting with the families of Sean Rigg and Olaseni Lewis, both of whom died having been restrained by police officers. Angiolini found "a coronial system under great pressure of resources and that is 'ad hoc', largely dependent on a 'grace and favour' relationship with other agencies".[414] The financial strain under which some coroners work was evidenced by reports of some having to rely on other agencies to help with photocopying for disclosure at inquests. In cases of death in custody or following

[412] ibid 278.
[413] Angiolini (n 38).
[414] ibid 16.14.

police contact, the coroner "relies heavily on the IPCC",[415] with the final IPCC report often forming "the backbone of evidence at the Inquest".[416] Some coroners reported that they would like to conduct their own enquiries into such deaths but lacked the resources and investigative personnel that would enable them to do so. For Angiolini this state of affairs renders the coroner's own investigative role "largely reactive to the adequacy and outcome of the investigations of others".[417] It creates a "real vulnerability"[418] for coroners as their ability to satisfy their legal obligations is so dependent on the timeliness and quality of outside help. She made the following warning:

> "The extent of the dependency of the Coroner on the efficacy of the other main participants is not acceptable and tests the viability of the Coroner's role as an inquisitorial judge. If the inquisitorial nature of the Coroner's role is to be more than superficial until the Inquest hearing commences, the Coroner must be capable of initiating his or her own investigations without complete reliance on third parties."[419]

Coroners are wholly dependent on local authorities for their resources. Across England and Wales, "there is no uniformity or consistency in the way in which the coroner is resourced or supported".[420] Some senior coroners have the benefit of a large team of coroners' officers and support staff while others do not. The variation in approach between local authorities means that in coroner areas of relatively similar sizes, the number of coroners' officers ranges from two to 11. The Chief Coroner has highlighted that "many coroner areas have been neglected for years in the provision of resources".[421] However, the resource problem is greater than simply having to work to a tight budget. Coroners who spoke to the Angiolini review also felt that there was a "constant pressure on them to make savings".[422] As a judge, a coroner does not need to seek his or her local authority's permission for spending. However the obligation to inform the council of any "unusual" expenditure[423] has made some coroners reluctant

[415] Independent Police Complaints Commission, the predecessor of the Independent Office for Police Conduct (IOPC).
[416] Angiolini (n 38) para 16.10.
[417] ibid 16.15.
[418] ibid.
[419] ibid 16.40.
[420] ibid 16.12.
[421] Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 17.
[422] Angiolini (n 38) para 16.13.
[423] ibid 16.34.

to instruct an expert for an inquest. While this is "not universal"[424] – some coroners will instruct their own experts if they feel there are additional lines of enquiry – Angiolini was alarmed that a local authority would query the need for expert evidence and opinion. She took the view that "such behaviour could be a clear interference in the work of judicial officers".[425]

### 4.4.2 The toothlessness of coroners' reports

Elliot argued any effective accountability institution must possess two general characteristics, the first of which is that it must first be independent from the body or bodies being held to account.[426] The dependency identified by Angiolini undermines coroners' independence, with a consequent impact upon their ability to provide justice as accountability in each and every case in which resource constraints impact upon the thoroughness of their investigation. The second general characteristic identified by Elliot is that the accountability institution must also have clout: "effective accountability being impossible if the output of the process is so readily dismissible as to have no meaningful impact."[427] Coroners' reports themselves are largely toothless. Their legal force is limited to imposing a requirement for a response. The coroner has no further power to act, even if he or she deems the content of a response to be inadequate or the recipient fails to respond at all. The only real force of coronial reports is their "name and shame" value.[428] This is a long-standing issue limiting the effectiveness of coroners' reports. In a 2012 report the charity INQUEST gave the example of HMP Styal[429] where six women died in the 12 months between August 2002 and 2003.[430] A coroner's report made following an earlier death at the prison in 2001 had called for the creation of a detoxification unit to care for female prisoners withdrawing from drugs. However, action was not taken until after the sixth death, over two years after the report was issued.[431]

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[424] ibid 16.33.
[425] ibid 16.34.
[426] Elliott (n 394) 235.
[427] ibid 246.
[428] Amy Street (n 374).
[429] A closed-category prison and Young Offender Institution in Cheshire.
[430] Coles and Shaw (n 381) 11.
[431] More recently, in May 2017, an ultimately unsuccessful High Court challenge prompted by the high rate of self-inflicted deaths at HMP Woodhill highlighted the limited effectiveness of coroners' reports in preventing deaths in prison. In *R (Scarfe & Ors) v Governor HMP Woodhill* [2017] EWHC

Evidence of inaction following a coroner's report perhaps can best be seen in the case of the Grenfell Tower fire. On 3 July 2009 six people died in the high-rise fire at Lakanal House in Camberwell, South London. Following the inquests into their deaths the coroner wrote to the Secretary of State for Communities and Local Government on 28 March 2013 to highlight her concerns from matters raised in evidence.[432] These concerns included the advice given to residents of high rise residential buildings in case of fire; the national guidance as to firefighting in high rise buildings; fire risk assessments in high rise residential buildings; the installation of sprinklers in high rise residential buildings; and the Building Regulations guidance on the fire protection properties of materials incorporated into the fabric of a building. Little action was taken in response to the coroner's potentially life-saving report in the four years between its issue and the further deaths of 72 people in the Grenfell Tower fire of 15 June 2017.[433]

Like coroners, ombudsmen also lack powers to compel a response from government. However, ombudsmen's reports are usually implemented by public bodies – testament, Elliot said, "to the fact than an accountability institution can have considerable impact without possessing legal powers of enforcement."[434] Of course, just like with coronial reports issued after inquests, the higher profile cases are a different matter.

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1194 (Admin) relatives of deceased prisoners sought a declaration that HMP Woodhill and the Secretary of State for Justice had breached their duties to protect prisoners. At the time of the claim there had been eighteen self-inflicted deaths in HMP Woodhill since 2013, with five self-inflicted deaths at the prison in 2015 and seven in 2016. Because they all occurred at the same prison, all the inquests were conducted by the same coroner, HM Senior Coroner for Milton Keynes. In a PFD report issued in 2015 this coroner had expressed concern as to the prison's response to his earlier reports: *"my concern is that reports and recommendations of the Ombudsman and indeed my own Preventing Future Deaths Reports have not been implemented by Woodhill prison and there needs to be an urgent review as to why the necessary measures to prevent suicides from recently admitted prisoners have not been implemented".* However HMP Woodhill had, without exception, accepted all of the recommendations made by the coroner and the Prisons and Probation Ombudsman about the need for compliance with Prison Service Instructions relevant to suicide prevention. The High Court took the view that the deaths arose from the individual errors of prison officers rather than flaws in the prison's system. When the scope for individual mistake is so substantial, coronial reports can only go so far in effecting meaningful change.

[432] Rule 43 report of Assistant Deputy Coroner Frances Kirkham following the inquests into the deaths caused by the Lakanal House fire, 28 March 2013 <https://www.lambeth.gov.uk/sites/default/files/ec-letter-to-DCLG-pursuant-to-rule43-28March2013.pdf> accessed 14 September 2022.

[433] The initial response of Eric Pickles MP is available on the GOV.UK website: Ministry of Housing, Communities and Local Government, 'Lakanal House: response to Coroner's recommendations', 6 June 2013 <https://www.gov.uk/government/publications/lakanal-house-response-to-coroners-recommendations> accessed 14 September 2022.

[434] Elliott (n 394) 246.

Ombudsmen's recommendations for change attract greater resistance when the issues involved are wide-ranging and their chances of implementation depend largely on "the extent of public, political and media sympathy for the plight of the relevant victims of maladministration."[435] But they do not suffer from one problem encountered by coroners: recipients of their reports know what they have received and understand how the ombudsman's role relates to their own. Research in the healthcare context by Claridge et al found the role of the coroner was not clear even to senior staff in the NHS, some of whom did not understand what was expected of them following receipt of a coroner's report.[436]

### 4.4.3 A preference for "technocratic" language

Writing almost two years before the Grenfell Tower fire, Kirton-Darling criticised coroners' preference for focussing their reports on the technical details of deaths and warned that their decision to exclude political issues could lead to a "vacuum of accountability."[437] (He asked rhetorically what Thomas Wakley and his fellow radical coroners of the mid-nineteenth century would have made of the Chief Coroner's preference for "technocratic moderation over perhaps more meaningful language" [438] in coroners' PFD reports[439]). Kirton-Darling pointed to how a dispute between the Labour-led London Borough of Southwark and the Conservative Secretary of State for Communities and Local Government meant neither accepted responsibility for the lack of necessary inspections being conducted in all of the Lakanal House flats.[440] Kirton-Darling argued that the coroner's decision to ignore this political context undermined "the possibility of achieving accountability through either rule setting or through meaningful explanation or justification after the inquest."[441] A decade later, Sir Martin

[435] ibid 247.
[436] Tanya Claridge, Gary Cook and Richard Hale, 'Organizational Learning and Patient Safety in the NHS: An Exploration of the Organizational Learning That Occurs Following a Coroner's Report under Rule 43' (2008) 14 Clinical Risk 8.
[437] Kirton-Darling (n 57) 70.
[438] ibid 75.
[439] Kirton-Darling had in mind the guidance that "coroners should at all times use moderate, neutral, well-tempered language, befitting a judge" and refrain from saying "I am appalled": 'Guidance No.5 Reports to Prevent Future Deaths' (n 369) para 31.
[440] The council's response to the coroner said it had no right to enter those private flats that had been bought by former council tenants under the Thatcher government's Right to Buy scheme (RtB); the government's reply reasserted the autonomy of RtB lessees. This was the latest in a long-running dispute between a Conservative-dominated central government and a Labour-controlled local government over access to RtB properties.
[441] Kirton-Darling (n 57) 70.

Moore-Bick's inquiry into the Grenfell disaster now seeks to fill the accountability gap.

### 4.4.4 Coroners' reports get overlooked

Nor is the coroner system in England and Wales set up to maximise coroners' preventative potential. Angiolini also found that the potential of PFD reports is undermined by the lack of a structure that ensures the message is heard:

> "Such reports are not routinely disseminated to organisations or individuals who should or must be made aware of the terms and implications of the report (although all are published online by the Chief Coroner). For example, there is no mechanism for these reports to be routinely sent to police forces or the College of Policing which would be in a position to consider whether the report's conclusions should inform their national training."[442]

Similarly Ferner et al's 2018 study of PFD reports issued following inquests into deaths from medicines also found that the effectiveness of reports was hampered by their not being addressed as a matter of course to a central authority with the power to implement nationwide change.[443]

### 4.4.5 No review of responses to coroners' reports

Angiolini identified a further weakness in the lack of any review of organisations' responses to coronial recommendations, without which "it is difficult to know if action is taken in response to reports, training materials are being updated, or even if there is the most cursory awareness of the Coroner's findings."[444] This finding endorsed that of INQUEST, which has long stressed how important it is that there be an effective mechanism for monitoring action taken in response to a report, particularly where the report reveals serious and systemic problems within an institution that could lead to further deaths.[445] It also chimed with the observation made by Bishop James Jones in his 2017 government-commissioned, independent report on the experience of the

[442] Angiolini (n 38) para 16.67.
[443] Robin E Ferner, Craig Easton and Anthony R Cox, 'Deaths from Medicines: A Systematic Analysis of Coroners' Reports to Prevent Future Deaths' (2018) 41 Drug Safety 103.
[444] Angiolini (n 38) para 16.67.
[445] Coles and Shaw (n 381) 11.

Hillsborough families.[446] He saw the Chief Coroners' "considerable leadership" on coroners' preventative function stymied by a lack of resources preventing his office assessing the adequacy of responses to PFD reports.[447] After examining some 500 PFD reports, Ferner et al concluded that it is "difficult to judge whether responses have been reasonable, proportionate and effective."[448] Despite the significant improvement in public access to reports, responses are rarely published online.

In his evidence to the Justice Committee in August 2020, coroner André Rebello went as far as saying the new regime for reports is "not as useful as it used to be under the 1988 Act". He pointed out that previously the Ministry of Justice "had civil servants who drafted annual reports that pulled out themes so that everybody could see the issues of the day".[449] While the Ministry was "well-funded with regard to writing these themed reports, […] the Chief Coroner has not been given that wherewithal, and since we have had the Chief Coroner those [thematic] annual reports have not been published. That is very sad."[450]

### 4.4.6 The narrow parameters of coroners' investigations

The coroner's investigation is also "profoundly circumscribed"[451] by legislation. One important restriction is that the inquest must keep to the facts of the particular death under investigation. This focus on individual cases prevents coroners taking a wider view. In her analysis of New Zealand's coronial jurisdiction, Moore said it was essential that coroners be able to draw upon the findings of previous inquests: "Although the community can learn from one death, when a greater number of deaths with common circumstances are identified, the potential to learn is greater."[452] The preventative potential of reports produced in such isolation is likely to be limited.

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[446] Jones (n 39).
[447] ibid 64.
[448] Ferner, Easton and Cox (n 443).
[449] 'Oral Evidence to the Justice Committee: The Coroner Service, HC 282' Q4.
[450] 'Oral Evidence to the Justice Committee: The Coroner Service, HC 282' (n 449) Q19.
[451] Barry Goldson, 'Fatal Injustice: Rampant Punitiveness, Child Prisoner Deaths, and Institutionalized Denial-A Case for Comprehensive Independent Inquiry in England and Wales' (2006) 33 Social Justice 52.
[452] Jennifer Moore, *Coroners' Recommendations and the Promise of Saved Lives* (Edward Elgar Publishing 2016) 183.

### 4.4.7 Variation in coroners' practice

It is important to note that Bishop Jones also found the potential of PFD reports to be undermined by coroner inconsistency: "I have been told by the legal representatives of families that PFD reports are currently under-utilised and that practice among coroners as to the circumstances in which they make PFD reports varies considerably."[453] Inconsistency in coroners' practice in issuing reports is not new. Coles and Shaw's analysis of the old Rule 43 reports found that while some coroners adopted a "dynamic approach" to using their power, others would decline to issue reports if told by the relevant authorities that the matters had been addressed.[454]

However, such under-reporting may also be as a result of the structure of the current coroner service. Moore's 2016 study of New Zealand coroners – who are empowered to go beyond expressing concerns and may make recommendations as to what should be done – found that most New Zealand coroners want to be able to base their recommendations for change on evidence but are often unable to draw on scientific expertise due to financial constraints and staff shortages.[455] As previously discussed, Angiolini saw the limited resources available to coroners in England and Wales as restricting their access to such specialist opinion.[456] Here a contrast can be drawn with the coroners of Victoria, Australia, who have the support in developing recommendations for preventing further deaths from the Coroners Prevention Unit – a specialist, multi-disciplinary team drawing on law, medicine, public health and the social sciences to provide coroners with expert assistance.[457]

## 4.5 Other purposes of the coroner's inquiry

Section 5 of the Coroners and Justice Act 2009 states that the purpose of a coroner's investigation is to ascertain who the deceased was and how, when and where the deceased came by his or her death.[458] However, it does not state the reason *why*

[453] Jones (n 39) 64.
[454] Coles and Shaw (n 381) 10.
[455] Moore (n 452) 178.
[456] Angiolini (n 38) para 16.13.
[457] Coroners Court of Victoria <https://www.coronerscourt.vic.gov.au/about-us/our-people/court> accessed 14 September 2022.
[458] And the particulars (if any) required by the Births and Deaths Registration Act 1953 to be registered concerning the death.

answers to these questions are sought. Nor did the Coroners Act 1988 or antecedent legislation address this issue. In his evidence to the Constitutional Affairs Committee in 2006, Michael Burgess, the coroner for Surrey and the Queen's Household, explained:

> "…it is necessary to understand what the coroner's function is and currently in statute that is not clear. All we have got is that we are to hold inquests and those inquests are expected to find certain things as proved or not as the case may be."[459]

In the absence of a statutory definition of purpose there have been varying and numerous suggestions as to the purposes of the coroner service. The Brodrick Committee identified the following grounds of public interest which they believed that a coroner's inquiry should serve: [460]

> "(i) To determine the medical cause of death;
> (ii) To allay rumours or suspicion;
> (iii) To draw attention to the existence of circumstances which, if unremedied, might lead to further deaths;
> (iv) To advance medical knowledge;
> (v) To preserve the legal interests of the deceased's person's family, heirs or other interested parties."[461]

The Luce Review recommended that the purposes of the coronial death investigation service be:

> "(a) to satisfy the public that there is an independent and professional process for scrutinising deaths of uncertain cause or circumstances, for scrutinising all deaths of people detained by the state or dying at the hands of state agents, or otherwise in situations of special vulnerability or where special vigilance is required;
>
> (b) to help families understand the causes and circumstances of the death of the family member where these cannot be resolved through other processes;

[459] Constitutional Affairs Committee, *Reform of the coroners' system and death certification*, HC 902–II, 1 December 2006, Q1.
[460] Matthews (n 12) para 1.26.
[461] The first three of these grounds were cited with approval by the Court of Appeal in *R v HM Coroner for North Humberside and Scunthorpe ex p Jamieson* [1994] 3 WLR 82.

> (c) to contribute along with other public services and agencies to the avoidance of preventable deaths."[462]

When Dame Janet Smith turned to address the coroner service's purpose, she listed a disparate number of aims including the prevention of crime, assisting the bereaved, public reassurance, the prevention of further deaths and a public health role.[463]

As noted in Chapter 1, only two studies in the past 40 years have sought to learn coroners' views as to purpose of their work. Fenwick's interviews with 15 coroners in the late 1970s revealed significant variation in their attitudes on this.[464] He summarised their divergent views as to the purpose of the inquest as (1) the public "ventilation" of the circumstances of a death; (2) detecting any criminal involvement; (3) a public advocate role, making recommendations about any health hazards, and (4) clearing suspicion and stopping misinformed gossip.[465] Thirty years later, McGowan categorised coroners' responses into seven categories:

> "providing a service/closure for families; facilitating public health and safety; detecting homicide; public reassurance; meeting the obligation of Article 2 of the ECHR; acting as a check on the military; and defining a purpose was not necessary."[466]

It is only relatively recently then that aiding the bereaved has been recognised as a purpose of the coronial investigation. While Chapter 2 showed that coroners have long sought to give succour to the bereaved, it was not identified as a coronial purpose by the Brodrick Committee in 1976 or by the coroners who spoke to Fenwick a few years later. But it was identified by the Luce Review and Dame Janet Smith at the start of this century and by the coroners interviewed by McGowan and Kirton-Darling[467] ten years later.

[462] The Luce Review Committee (n 30) 72.
[463] Smith (n 32) para 19.13.
[464] Fenwick (n 64) 96.
[465] ibid 96.
[466] McGowan (n 59) 148.
[467] E.g., Kirton-Darling (n 57) 170–171.

### 4.6 Therapeutic jurisprudence

The question of why the deceased died is asked by both the coroner and by the family and friends left behind, but, as Kathryn Schulz, writing in the *New Yorker*, put it:

> "the causes that count as good answers are irreconcilably different. […] As the bereaved, we ask because we want to know if a loved one suffered or was at peace, or if her death was meaningful, or whether we could have prevented it, or how the universe could have permitted it. On all those questions, a death certificate is mute."[468]

Deaths that are subject to coronial investigation[469] are, by their nature, particularly painful for the bereaved. Reviews of coronial law in England and Wales have long recognised the potential for its procedures to compound grief and exacerbate trauma at each stage of the process. In 2003 the Luce Review recognised how much information there is for a bereaved family to absorb in the immediate aftermath of learning of a loved one's death and the challenge this poses to the human and professional skills of the coroner's officer.[470] Dame Janet Smith recorded how a coroner's automatic following of "procedures" without thought as to the consequences caused distress to relatives of the victims of Harold Shipman.[471] Conducting her independent review of deaths in police custody 13 years later, Angiolini heard from families who had not been informed that a post-mortem examination was being conducted, let alone told of their right to attend.[472] Angiolini also emphasised that the inquest hearing itself can be damaging for unsupported bereaved families:

> "In many cases the grief and trauma of losing a loved one is compounded by the confusion and bewilderment of the unfamiliar, formal and sometimes hostile atmosphere of the Coroner's court. Without help and support the inquest may be an intimidating experience."[473]

[468] Kathryn Schulz, 'Final Forms' *The New Yorker* (7 April 2014) <https://www.newyorker.com/magazine/2014/04/07/final-forms> accessed 14 September 2022.
[469] Deaths that are violent or unnatural, or where the cause is unknown, or that occurred while the deceased was in custody or otherwise in state detention.
[470] The Luce Review Committee (n 30) 144.
[471] Smith (n 32) 278–279.
[472] Angiolini (n 38) para 16.20.
[473] ibid 16.45.

Chief Coroners Thornton and Lucraft both took steps to address this problem in England and Wales. Consideration of the experiences of bereaved families and how to deal with the vulnerable now feature in coroners' compulsory training[474] and formal guidance issued to coroners reminds them of families' particular needs.[475] Both men emphasised how the issuing of a PFD report is of value to bereaved families, who hope that some positive change may result from their loved one's death.[476] When an inquest gives rise to concerns but the duty to issue a report does not arise, the Chief Coroner's guidance that coroners may raise such concerns in a letter provides another means of assuaging family anxieties.[477]

There is also evidence of informal moves by individual coroners to soften the blow felt by bereaved families at inquests. Examples of such "trauma informed practice"[478] include allowing bereaved families to display a photograph of the deceased at the start of the inquest and to provide the court with a pen portrait of the deceased. They do not provide evidence relevant to the questions the coroner or jury must answer but are used to reassure and engage bereaved families. At the fresh inquests into the deaths of the Hillsborough Stadium disaster in 2014, the coroner, Lord Justice Goldring, said the short biographical statements provided in court by the families underlined the "individual tragedies" of the disaster.[479] In his report on the Hillsborough families' experiences of the inquest process, Bishop James Jones said the coroner's decision to allow families to show photographs and to provide pen portraits "helped to put the families at the heart of proceedings" and was "important and therapeutic" for the

[474] Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 64.
[475] See, for example, Chief Coroner's Guidance No.5: Reports to Prevent Future Deaths, para 2; Chief Coroner's Guidance No.9: Opening Inquests, para 9; Chief Coroner's Guidance No.22: Pre-inquest Review Hearings, para 11.
[476] Thornton, 'Howard League Parmoor Lecture 2012: The Coroner System in the 21st Century' (n 232) para 51; Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) 62.
[477] Frances McClenaghan, 'No PFD – what about a Paragraph 37 Letter?' (*UK Inquest Law Blog*, 6 April 2016) <http://www.ukinquestlawblog.co.uk/rss-feed/53-no-pfd-what-about-a-paragraph-37-letter> accessed 14 September 2022. See Chief Coroner's Guidance No.5: Reports to Prevent Future Deaths, para 37. The duty to issue a report arises when anything revealed by the coroner's investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and the coroner believes that action should be taken to eliminate or reduce the risk of death created by such circumstances: Coroners and Justice Act 2009, sch 5, para 7 (1).
[478] Ian Freckelton, 'Minimising The Counter-Therapeutic Effects Of Coronial Investigations: In Search Of Balance' (2016) 16 QUT Law Review 4, 5.
[479] 'Hillsborough disaster inquests hear first pen portraits of the 96 FA Cup semi-final victims', *Liverpool Echo*, (Liverpool, 3 April 2014) <https://www.liverpoolecho.co.uk/news/liverpool-news/hillsborough-disaster-inquests-hear-first-6916754> accessed 14 September 2022.

bereaved families.[480] He called on the Chief Coroner to ensure that the opportunity is offered to families at all inquests. Since the Hillsborough inquests these practices have been adopted by some (but not all) coroners and used at the public inquiry into the Grenfell Tower disaster.[481]

Such steps are in line with the principles of "therapeutic jurisprudence" (though coroners in England and Wales are yet to use this term). Writing in 1992, David Wexler defined therapeutic jurisprudence as:

> "[…] the study of the role of the law as a therapeutic agent. It looks at the law as a social force that, like it or not, may produce therapeutic or anti-therapeutic consequences. Such consequences may flow from substantive rules, legal procedures, or from the behaviour of legal actors (lawyers and judges). In other words, one may look at the law itself as being a therapist—or at least a therapeutic agent or tool."[482]

Coroners in Australia are well aware of the anti-therapeutic potential of their procedures. Research conducted in England and Australia has highlighted how, during each stage of a coroner's investigation of a death, there are numerous ways in which the bereaved family can be adversely affected.[483] Australian coroners responded to these studies by proposing the incorporation of therapeutic principles into their work. In 2007 the Victorian State Coroner called on his fellow coroners to add "the human dimension" by enhancing the information provided to families, providing greater sensitivity in communication and reducing formality in court.[484]

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[480] Jones (n 39) 62.
[481] Owen Bowcott, 'All inquiries should use Grenfell's tributes model, charity says', *The Guardian*, (London, 30 May 2018) <https://www.theguardian.com/uk-news/2018/may/30/all-inquiries-should-use-grenfell-tributes-model-charity-says> accessed 14 September 2022.
[482] David B Wexler, 'Putting Mental Health into Mental Health Law' (1992) 16 Law and Human Behavior 27, 32; Belinda Carpenter and others, 'When Coroners Care Too Much: Therapeutic Jurisprudence and Suicide Findings' (2015) 24 Journal of Judicial Administration 172, 173.
[483] Daniel Harwood and others, 'The Grief Experiences and Needs of Bereaved Relatives and Friends of Older People Dying through Suicide: A Descriptive and Case-Control Study' (2002) 72 Journal of Affective Disorders 185; Lucy Biddle, 'Public Hazards or Private Tragedies? An Exploratory Study of the Effect of Coroners' Procedures on Those Bereaved by Suicide' (2003) 56 Social Science & Medicine 1033; Victorian Parliament Law Reform Committee, 'Coroners Act 1985: Final Report' (Government Printer 2006).
[484] Graeme Johnstone, 'Adding the Human Dimension: The Future and a Therapeutic Approach to the Independent Work of the Coroner' (Paper presented at the Asia-Pacific Coroners Society Conference, Hobart, November/December 2007) as quoted by Ian Freckelton, 'Minimising The Counter-Therapeutic Effects Of Coronial Investigations: In Search Of Balance' (2016) 16 QUT Law Review 4, 9.

However, some Australian coroners believe that therapeutic jurisprudence can go further; not only can it mitigate the adverse effects of a coronial investigation, but it can allow coroners to help proactively the bereaved deal with their grief so as to reach acceptance and closure. In 2008 Michael King, the coroner for Geraldton in Western Australia, published an influential paper calling on coroners to take inspiration from restorative justice and the methods of "problem-solving courts".[485] Such alternatives to the traditional, adversarial approach to legal problems addressed, he argued, the issues underlying the legal dispute and did so in a way that did not aggravate the conflict. Proposing a model for how coroners could adopt a problem-solving approach to death investigation that drew on mediation and restorative justice, King envisaged coroners leading a multi-disciplinary team of professionals with input from the family in order to achieve case-management by consensus. Involving the various interested persons in the process from an early stage would, he claimed, benefit both the investigation and the chance for therapeutic outcomes.[486] He believed coroners are well suited to this task, describing their work as "intimately connected with wellbeing".[487]

While acknowledging the many ways in which the coroner's investigation can produce anti-therapeutic consequences, Freckelton too underlined the potential for the role of the coroner to produce and maximise therapeutic outcomes:

> "At its best, the coronial process can facilitate understanding of the circumstances of a death, forgiveness for error or fault, and adoption of better and safer processes with the potential to avoid deaths occurring in comparable circumstances – something positive can emerge from tragedy."[488]

In their 2015 study of reluctance on the part of coroners in Australia and England to return conclusions of suicide, Carpenter et al highlighted how some coroners "appear to be functioning as an informal therapeutic filter"[489], processing the facts of a death

[485] Michael S King, 'Non-Adversarial Justice and the Coroner's Court: A Proposed Therapeutic, Restorative, Problem-Solving Model' (2008) 16 Journal of Law and Medicine 442.
[486] ibid 449.
[487] ibid 445.
[488] Freckelton (n 478) 22.
[489] Carpenter and others (n 482) 173. Carpenter et al conducted semi-structured interviews with six coroners in one English region and with five coroners working in and around an Australian state capital.

in a manner that mitigates the emotional impact and deflects social stigma. Coroners interviewed in both jurisdictions spoke of going beyond the letter of the law to help families find closure and catharsis.[490]

The study found that coroners have incorporated therapeutic jurisprudence principles in two primary ways.[491] Firstly, through the adoption of practices and techniques that recognise the need for sensitivity and through which the coroner's court is an environment facilitating closure rather than exacerbating grief and distress. Coroners' desire to soften the blow of a suicide conclusion led them to include "legally meaningless statements within findings to decrease the shame and guilt for families" (e.g. "while the balance of his mind was unsound").[492] The interviewed coroners also spoke of their "non-statutory functions" as including helping families find closure. The coroners' willingness to go beyond their relatively narrow judicial duty reminded Carpenter et al of Rottman and Casey's observation that "the orientation underlying therapeutic jurisprudence directs the judge's attention beyond the specific dispute before the court and toward the needs and circumstances of the individuals involved in the dispute."[493] Secondly, they saw therapeutic jurisprudence in action in the coroners' understanding of the need for "timely and sensitive communication" with traumatised families. Carpenter et al noted how these coroners' commitment to giving a voice to the bereaved represents a break with conventional legal communication that traditionally "has largely not been concerned with the emotional, behavioural or cognitive processes of communication".[494]

However, therapeutic jurisprudence acknowledges that concern for the well-being of the bereaved family does not trump the coroner's primary responsibilities. The coroner must still conduct a rigorous inquiry, seeking out and recording as many of the facts concerning the death as the public interest requires. A family's opposition to a conclusion of suicide is not a licence for coroners to write fiction. As André Rebello told the House of Commons Justice Committee, "when you call relevant evidence and adjudicate upon it, the evidence is what it is. We cannot make things up to appease

[490] ibid 178.
[491] ibid 5.
[492] ibid 6.
[493] David Rottman and Pamela Casey, 'Therapeutic Jurisprudence & the Emergence of Problem-Solving Courts' (2000) 9 Corrections Forum 28; as quoted in: Carpenter and others (n 482) 76.
[494] Carpenter and others (n 482) 9.

people".[495] In her submission to the Luce Review's consultation, Selena Lynch, the Senior Coroner for Inner South London, stated:

> "....the review team have properly recommended putting bereaved people at the centre of a reformed inquest process. However, the interests of justice must be paramount. Many families are divided, and those cases involving more than one death involve families with different needs. Some families may have reasons to encourage, or to avoid, the exposure of certain facts."[496]

Nor does therapeutic jurisprudence relegate fairness to a secondary thought. The goals of therapeutic justice must be met within the constraints of procedural justice. Submissions to the Luce Review sought to remind the review team that "there are frequently other participants than the family with an equal right to fair and objective treatment – doctors and nurses in healthcare settings, prison staff, and the drivers of trains used as a means of suicide, for example."[497]

Freckelton has emphasised the importance of coroners taking account of these other actors' therapeutic needs too. He pointed to a 2011 qualitative study undertaken for the Coronial Council of Victoria that sought the views of those who had experienced involvement in a death and a subsequent coronial investigation as part of their employment.[498] The study, conducted by Sweeney Research, was limited to one jurisdiction and 19 people, but for Freckelton the results were "striking".[499] Interviews conducted with members of the police, emergency services, social services and medical and mental health services revealed feelings of responsibility towards the deceased and of grief and loss. These feelings were exacerbated by involvement in the inquest. Questioning was seen as accusatory and any sense of guilt or self-doubt that respondents may have had was intensified.[500] Respondents described the process to be adversarial and spoke of feeling that their role was to exonerate themselves rather than simply to give their account.[501] They also reported feeling additional pressure due to

[495] 'Oral Evidence to the Justice Committee: The Coroner Service, HC 282' (n 449) Q5.
[496] The Luce Review Committee (n 30) 142.
[497] ibid 143.
[498] Sweeney Research, 'A qualitative research report for the Coronial Council of Victoria' (Report, 2011), as quoted in Ian Freckelton, 'Minimising The Counter-Therapeutic Effects Of Coronial Investigations: In Search Of Balance' (2016) 16 QUT Law Review 4, 13
[499] Freckelton (n 478) 13.
[500] Sweeney Research (n 498).
[501] ibid.

the presence of the deceased's family, particularly when they believed the family to be angry over the death or seeking accountability.[502]

As a result, Freckelton proposed that coroners might defuse tensions – and even enable rapprochement – by extending to other interested persons the opportunity now commonly afforded to family members to express how the death has affected them personally.[503] He approved of the availability of grief counselling services for family members at some coroners' courts and argued that such assistance should be offered to all who have the potential to be affected by the coroner's investigation.[504]

Freckelton also called attention to other participants' fear of the potential consequences of the coroner's findings, e.g. consideration by prosecutors of criminal charges or a civil claim for damages brought by the deceased's family.[505] Delays in the investigation are therefore detrimental to witnesses as well as to the family. He also highlighted how psychological damage from involvement in a death can deprive people such as police officers, doctors or train drivers of the ability to return to their work at the same performance level as before, or lead to depression and even suicidality.[506] This potential is not lessened by the intense scrutiny of some inquests and the range of media now available to those with an interest in discussing the death. Acknowledging that instantaneous social media can facilitate accurate reporting, Freckelton nevertheless asked how coroners can keep their proceedings "a dignified search for the truth, rather than a vehicle for media which frequently will focus upon blame and fault-finding".[507]

Therapeutic jurisprudence calls on coroners to strike a careful balance. They should seek to facilitate closure for the family of the deceased while limiting the potential adverse effects of proceedings on other participants, all the while maintaining the integrity of their investigations and fulfilling their fact-finding and public health roles. A good example of a coroner weighing the potential benefit and counter-therapeutic effects of witnesses' live evidence can be seen in the litigation arising from the inquest

[502] ibid.
[503] Freckelton (n 478) 27.
[504] ibid 28.
[505] ibid 18.
[506] ibid.
[507] ibid 21.

into the death of Mrs Ann Maguire, a Leeds school teacher murdered in her classroom by a 15-year-old pupil in April 2014.[508] The High Court upheld the coroner's decision not to call other pupils to give live evidence at the inquest. The deceased's widower had wanted these pupils called so that the inquest could hear evidence as to students' understanding of the school rules relating to weapons in school and whistleblowing. The minutes of the Pre-Inquest Review, quoted in the judgment of Holroyde J, reveal the coroner's balancing exercise:

> "11.2 The Coroner concluded that it was important to be proportionate and fair to all involved in this tragic incident, when setting the bounds of the inquiry. As it was often said 'no-one is on trial at an inquest' there was a legitimate concern that calling potentially vulnerable young people to question them in a way which may connote blame on their part for not having reported matters within their knowledge, ran the risk of exacerbating the trauma which all IPs recognised had been experienced by the pupils involved. The information which the pupils could provide had been assembled in the investigation carried out by the police (albeit that further questions could always be asked). The balance of benefit and risk was such that, in his judgment, the risk of inflicting psychological harm on the pupils to be called was foreseeable, whereas the benefit was small."[509]

The Court of Appeal dismissed an appeal in this case and endorsed the coroner's approach. Commenting on this case, barristers Amy Street and Bridget Dolan KC noted how it is unusual for witness safeguards to be used in the coroners' courts.[510] This is perhaps surprising given that they are now a common feature of criminal and family proceedings in England and Wales.[511] Street and Dolan pointed out how coroners rarely apply the lessons learned in these other jurisdictions about how to achieve best evidence from a vulnerable witness. They argue that:

> "without a structure in which to frame the potential need for special measures, accompanied by a formally agreed understanding between the

[508] *R (Maguire) v Assistant Coroner West Yorkshire* [2017] EWHC 2039 (Admin).
[509] ibid, at [24].
[510] Bridget Dolan and Amy Street, 'Protecting Vulnerable Witnesses in Coroners Courts' (*UK Inquest Law Blog*, 5 June 2018) <https://www.ukinquestlawblog.co.uk/protecting-vulnerable-witnesses-in-coroners-courts/> accessed 14 September 2022.
[511] The Youth Justice and Criminal Evidence Act 1999 introduced a range of measures that can be used to facilitate the gathering and giving of evidence by vulnerable and intimidated witnesses. The measures are collectively known as "special measures".

> court and the advocates, the court process risks traumatising (or re-traumatising) those vulnerable persons who are asked to give evidence."[512]

They recommended that coroners make much greater use of the "ground rules hearings" commonly used by the criminal and family courts to make directions for the fair treatment and effective participation of vulnerable witnesses.[513] This would allow consideration in advance of an inquest as to how best to accommodate a vulnerable witness' particular needs. They also called for wider use of the Advocate's Gateway guidance on questioning vulnerable witnesses.[514]

## 4.7 Summary

This chapter identified the two means by which the contemporary coroner provides justice: establishing for the bereaved family and the wider public the facts of a death and highlighting dangers in order to prevent further deaths. It argued that this is a form of administrative justice – accountability –which coroners, given their independence and non-adversarial role, ought to be well placed to deliver. The chapter then reviewed how the current reality of the coroner service challenges coroners' ability to provide such justice in practice as well as in theory. It concluded with a discussion of how some coroners have looked beyond the four discrete questions that legislation tasks them with answering, hoping to lessen the impact of their proceedings on the bereaved family. The importation of therapeutic techniques into death investigation processes in Australia and, more recently, in England raises the possibility of the emergence of a further and novel role for the coroner. All of these issues were explored with coroners in the Coroner Attitude Survey, and the following chapter sets out the methodology of that survey.

[512] Bridget Dolan and Amy Street (n 510).
[513] ibid.
[514] The Advocate's Gateway provides practical, evidence-based guidance on questioning vulnerable witnesses and defendants. It is provided by the Inns of Court College of Advocacy.

# Chapter 5 Research methods

This chapter sets out the challenges that can be encountered when conducting research with "elites" such as coroners and why the particular method of an attitude survey was utilised to answer the research questions. It then sets out how the Coroner Attitude Survey was developed, how the survey itself was constructed, how it was conducted and, finally, how the data were analysed.

## 5.1 Research aims and "elites" research

This research had three key aims:

(1) To produce an extensive, up-to-date profile of the composition of the coronership in England and Wales;
(2) To understand the attitudes of coroners towards their role in the administration of justice; and
(3) To discover coroners' experience of important aspects of their working lives and to compare them with the experiences of judges of the courts and tribunals judiciary.

This then is a study of the backgrounds, attitudes and experiences of members of an "elite" group. Hoffmann-Lange defined elite research as:

> "Elite research studies the characteristics of politicians and other holders of leadership positions in powerful public institutions and private organizations who are distinguished by their regular participation in (political) decision making."[515]

She classified four substantive areas of elite research.[516] First, social background studies, which collect data on the regional origins, religious affiliation, socio-economic background and educational history of members of elite groups. This allows us to compare their social backgrounds to those of other elites or those of the general population. It allows the researcher to determine important prerequisites of elite

[515] Ursula Hoffmann-Lange, 'Methods of Elite Research', *The Oxford Handbook of Political Behavior* (Oxford University Press 2007) 910.
[516] ibid 911.

careers. Second, elite research encompasses the study of elite career paths: "the more or less structured patterns of professional advancement that eventually lead into elite positions".[517] Third, research into elites includes attitudinal studies and analysis of the activities and values of members of elite groups. Fourth, elite research includes exploration of the interactions between elite groups, which can reveal the extent of an elite group's access to central political decision makers, as well as shedding light on how closely integrated the group is with other elites. The specific research questions this thesis addresses for coroners touch upon all four areas of elite research.

## 5.2 Research questions

The specific research questions examined in this thesis[518] address three broad themes related to coroners in England and Wales:

(1) The social backgrounds and career paths of coroners;
(2) Coroners' attitudes to their role; and
(3) Coroners' attitudes to the wider judiciary, legal profession and the government.

Each of the specific research questions falling under these three themes are set out below.

### *Coroners' social backgrounds and career paths*

- What are the social and professional backgrounds of coroners?
- What motivates people to become coroners?
- How do coroners' social backgrounds and career paths compare with those of the courts and tribunals judiciary?

### *Coroners' attitudes to their role*

- How do coroners in England and Wales understand their role in the administration of justice?

[517] ibid 912.
[518] The Coroner Attitude Survey included more questions than are explored in this thesis. A final report covering the whole survey was submitted to the Chief Coroner in October 2021. It is currently unpublished.

- How do coroners perceive the preventative and therapeutic potential of their work?
- How do coroners feel about changes in the coroner service?

*Coroners' attitudes towards judges, the legal profession and government*

- Do coroners feel part of the judiciary of England and Wales?
- Do coroners feel valued by the courts and tribunals judiciary, the legal profession and government?
- Do coroners feel supported by their local authorities?

As noted in the introduction, until now the social and professional backgrounds of coroners have not been known, with no statistics on diversity of coroners available.

The research also sought to learn coroners' attitudes to their role. As discussed in Chapters 2 and 4, there is little consensus as to coroners' priorities and doubts have been expressed as to the effectiveness of coroners' fact-finding and reports. As high-profile inquests and inquiries set new standards in accommodating the grief of bereaved families, it is surprising that so few empirical studies have sought the views of coroners themselves.

As discussed in Chapter 3, the last decade has seen unprecedented reform of the coroner service with the creation of the post of Chief Coroner, the emergence of an institutional hierarchy and the reorganisation and mergers of coroner areas. But coroners' views on the reforms to their service were unknown. The importance of this aspect of the research increased during the writing of this thesis. The government's decision not to publish the findings of its review of the operation of the Coroners and Justice Act reforms meant that coroners' views on the changes introduced by the 2009 Act and by the Chief Coroner would otherwise continue to remain unknown.

In addition, as the links between the courts and tribunals judiciary and the coronership are continuing to be strengthened, the research also sought to understand the extent to which coroners see themselves as judges and as part of the wider judiciary of England and Wales. And as funding and administrative support for the coroner service remain

the responsibilities of local authorities, the survey also sought to understand the coroners' relationship with and attitudes toward local government.

### 5.3 Research approaches

The aims of this research called for a methodological approach that would reach all coroners in the jurisdiction, facilitate their engagement and allow for easy collection of the information. An online self-administered survey was the best means of achieving this. Surveys are "ideal methods"[519] for discovering people's attitudes towards different aspects of social life and their data can provide a detailed description of a population on a number of variables. A quantitative survey also promised to provide baseline information that would provide a platform for further empirical research on coroners.[520]

A series of qualitative interviews would not have been able to cover as wide a range of issues with as many coroners given the time and resource constraints, nor could the data have been generalised to all coroners. In addition, coroners' status as members of an elite group meant that using qualitative interviews as the primary research method would be a challenging process. In a 2018 article on conducting interviews with judges, Nir listed a series of hurdles a researcher needs to clear to get access to prospective elite interviewees. They included respondents' hesitancy due to privacy concerns; distrust of the research process; time constraints; perceptions of risk of harm; fear of professional repercussions; and general disinterest in the subject.[521] As coroners are obliged to maintain the principles of judicial independence, impartiality and integrity, it was thought that recorded interviews may make some coroners reluctant to participate, even if assured that their answers were anonymised. One of the coroners

[519] Wing Hong Chui, 'Quantitative Legal Research' in Wing Hong Chui and Mike McConville (eds), *Research Methods for Law* (Edinburgh University Press 2017) 62.
[520] The website of the Coroners' Society of England and Wales provides a tool by which users can search for their local coroner, available at <https://www.coronersociety.org.uk/coroners/>, accessed 14 September 2022. It provides the names and contact details of coroners in each coroner area. However, the information is limited. It is left to each society member to update his or her details. It does not indicate whether senior or area coroners work on a full- or part-time basis, nor does it say how often assistant coroners sit. As it also includes coroners who have retired, it cannot be relied upon as an accurate list of all those currently working in the coroner service. It provides no insight into coroners' professional backgrounds.
[521] Esther Nir, 'Approaching the Bench: Accessing Elites on the Judiciary for Qualitative Interviews' (2018) 21 International Journal of Social Research Methodology 77, 79.

who agreed to be interviewed during the exploratory research stage of this thesis warned this would be an issue for senior colleagues.

As the focus of this research is exploring coroners' backgrounds, attitudes and experiences, rather than what coroners *do,* it was not deemed necessary to include observations at inquests as a secondary research method. An oft-cited advantage of observations is the insight into the process and setting of the research subject's work. It is said that while a researcher may learn the "formal language" through studying relevant texts such as legislation or official reports, observation often offers the best means of learning what Bryman has termed "the 'argot' – the special uses of words and slang – that is important to penetrate the culture."[522] However, as a barrister with much experience working in the coroners' courts, this researcher has been able to bring his knowledge of and familiarity with the culture and language of inquests to the overall design of this research and specific content of the survey.

### 5.4 The wider context: the UK Judicial Attitude Survey

This is the first major quantitative survey of coroners' backgrounds, attitudes and experiences. A more limited survey was conducted by Tarling in 1997 on behalf of the Home Office[523]; while that survey sought some background information on coroners – age, sex and whether their professional qualification was in law or medicine – its main focus was on the organisation of each of the then 148 coroner districts. While this thesis' survey of coroners is new, it built upon and was run in conjunction with the UK Judicial Attitude Survey (the UK JAS), an existing longitudinal study of the courts and tribunals judiciary of England and Wales, Scotland and Northern Ireland.[524] The UK JAS is conducted by the UCL Judicial Institute on behalf of the Lord Chief Justice of England and Wales, the Lord President of Scotland and the Lord Chief Justice of Northern Ireland and has been run periodically since 2014. The UK JAS assesses courts and tribunals judges' attitudes in key management areas including the experience of being a judge, morale, working conditions, remuneration, training and

[522] Alan Bryman, *Social Research Methods* (5th edition, Oxford University Press) 493.
[523] Tarling (n 13).
[524] Thomas, '2014 UK Judicial Attitude Survey: Report of Findings Covering Salaried Judges in England & Wales Courts and UK Tribunals' (n 70); Thomas, '2016 UK Judicial Attitude Survey: Report of Findings Covering Salaried Judges in England & Wales Courts and UK Tribunals' (n 70); Thomas, '2020 UK Judicial Attitude Survey: England and Wales Courts and UK Tribunals' (n 69).

personal development, retention and leadership, and had been conducted in 2014 and 2016. In 2020, the survey of coroners that forms part of this thesis was conducted alongside the third running of the UK JAS. A key aim of this thesis was to understand how coroners' attitudes compared with those of judges in the courts and tribunals judiciary, and it was important that the methodological approaches aligned. The UK JAS is both a quantitative and qualitative survey, enabling judges to answer questions with set answer options (therefore providing quantitative data) as well as free text answers (providing additional qualitative data to these questions). The Coroner Attitude Survey that formed the empirical part of this research mirrored that approach and provided a series of corresponding questions, thereby enabling results for both judges and coroners to be compared. However, a number of questions in the Coroner Attitude Survey were necessarily distinct from the question in the UK JAS, as they explored key areas of importance for the coroners service.

## 5.5 Preliminary research

### 5.5.1 Background research

The first step taken to identify the issues that merited inclusion in the survey was to examine official reports touching upon the work of the coroner: the two reviews of the coroner service conducted by the Luce Review[525] and Dame Janet Smith[526], the 2006 report of the Constitutional Affairs Committee,[527] the 2017 report of Dame Elish Angiolini[528] and the Chief Coroners' annual reports to the Lord Chancellor since 2014. The evidence submitted by coroners to these inquiries was summarised in the reports of the Luce Review, Smith and Angiolini and published in full by the Constitutional Affairs Committee[529], thus providing a degree of insight into coroners' views on specific issues of importance. In noting the changes being made to the coronial jurisdiction, the Chief Coroners' annual reports highlighted areas of potential interest on which to seek coroners' views.

[525] The Luce Review Committee (n 30).
[526] Smith (n 32).
[527] Constitutional Affairs Committee (n 9).
[528] Angiolini (n 38).
[529] Available at <https://publications.parliament.uk/pa/cm200506/cmselect/cmconst/902/902we01.htm>, accessed 14 September 2022.

Discussions were also held with Rebecca Roberts, then Head of Policy at INQUEST, a charity that monitors the investigation of deaths in state custody and of those where state or corporate accountability is in question. The purpose of this background research was to learn what INQUEST saw as the most pressing issues in contemporary death investigation, and to discuss the recent survey of senior coroners conducted by the Ministry of Justice as part of its review of legal aid for inquests.[530]

### 5.5.2 Informal interviews

The next step in planning the survey was to undertake informal but in-depth, qualitative interviews with a small group of coroners in order to inform the content of the survey and to identify any issues important to coroners that may not have been apparent from analysis of the material referred to above. It was also hoped that the coroners' answers to questions would highlight particular terms or phrases that could be used in the design of the survey, so that respondents would feel the survey's questions, and the range of answer options, were relevant and comprehensive.

Three interviews were conducted: the first with an assistant coroner in the north west of England with three years' experience; the second with an assistant coroner in the south east of England with much experience of conducting article 2 inquests with juries; and the third with a senior coroner in the north west of England. Initial contact with the senior coroner was made through a formal letter. As the two assistant coroners are professional acquaintances from this author's time in practice, contact was made via email. The letter and emails set out the aims of the research, explained the purpose of the requested interview and guaranteed anonymity. As the inclusion of information on sponsorship and endorsement has proven effective in improving response rates,[531] the letter and emails also stated the research was being undertaken at the UCL Judicial Institute, was supported by a Faculty of Laws Research Scholarship and was being supervised by Professor Cheryl Thomas KC, director of the UCL Judicial Institute,

[530] Ministry of Justice, Review of Legal Aid for inquests, 7 February 2019 <https://www.gov.uk/government/publications/review-of-inquests> accessed 14 September 2022.
[531] Stefaan Walgrave and Jeroen K Joly, 'Surveying Individual Political Elites: A Comparative Three-Country Study' (2018) 52 Quality & Quantity 2221, 2227.

and Professor Nigel Balmer. The coroners were assured that the interview would last no more than one hour.

As the research had specific goals at the outset, the interviews were semi-structured, asking the coroners for their experiences of and attitudes to particular issues while giving them the opportunity to explain what they see as important. An interview guide was used to structure the interviews. This was revised after each interview with interesting matters raised by one interviewee incorporated into the questions asked in the subsequent interview.

One interview was conducted via Skype, another by telephone and one was conducted face-to-face. It was proposed that interviews would be in person at a time and location that suited interviewees. However, the use of Skype and the telephone were suggested by the participating coroners. Using Skype and the telephone was convenient for the coroners, it easily allowed for last-minute adjustments to the scheduling of the interviews when necessary, and there were also obvious time and costs savings as it was not necessary to travel for the interviews.[532]

The interviews were not recorded or transcribed. As the purpose of these interviews was to inform the content of a quantitative survey rather than stand as the main empirical research of this study, it was decided that a guided interview was more likely to produce a more open discussion than a formally recorded interview. It was felt that the use of a recording device may undermine reassurances as to the confidentiality and anonymity of responses. While a complete and precise account of each interview was not deemed to be necessary, it was nevertheless important to make a detailed note of each interview. This was made easier by the use of the detailed interview guide. Under each topic heading, the guide listed a series of words that were possible or expected answers and which could also be used as prompts during the interview. If the interviewee deemed something to be relevant or unimportant, this was recorded by placing a tick or a cross by the word. Such an approach required less writing and allowed concentration on the matters raised by interviewees that were not anticipated and on the language they used.

[532] Bryman (n 522) 492.

The semi-structured background interviews offered a detailed insight into the reality of a coroner's working day and indicated the variety and depth of coroners' feelings on issues such as administrative support and the pressures of the job. The interviews also helped in identifying the issues that merited inclusion in the survey. Those that coroners deemed to be of less importance were taken into consideration when deciding whether certain questions could be removed from the final survey to avoid it becoming excessively lengthy.

### 5.5.3 Formal permission and the Survey Working Group

Coroners were not included in the UK Judicial Attitude Surveys in 2014 and 2016. While this research wished to explore themes specific to coroners and their work, the methodological approach chosen offered an opportunity to seek coroners' attitudes on many of the issues the rest of the judiciary had been asked about in previous versions of the UK JAS and would be asked about in the UK JAS 2020. This in turn offered an opportunity to obtain the Chief Coroner's support for this research; running a Coroner Attitude Survey alongside the UK JAS would enable the Chief Coroner to show coroners that they too were now included in the survey of the entire judiciary. The inclusion in the survey of questions relevant to the Chief Coroner's work also meant that the Coroner Attitude Survey would be helpful to the Chief Coroner in fulfilling his own responsibilities. An approach was therefore made to the Chief Coroner's Office asking if the Chief Coroner would be interested in running a bespoke Coroner Attitude Survey alongside the planned UK JAS 2020. The Chief Coroner was interested and agreed to lend his support to this research. This support took the form of providing his input on the existing UK JAS questions that would be relevant to coroners, helping to convene a Survey Working Group and crucially providing his direct support in encouraging all coroners in England and Wales to complete the survey when it was launched.[533]

With the support of the Chief Coroner, a Survey Working Group was convened. The formation of a Survey Working Group was an important part of the design of the UK JAS in 2014, 2016 and again in 2020, and the Chief Coroner recognised the importance

[533] The survey therefore became a service evaluation conducted at the request of the Chief Coroner. As such, it fell within UCL's exemptions for research requiring formal ethical approval <https://ethics.grad.ucl.ac.uk/exemptions.php> accessed 14 September 2022.

of involving serving coroners in the framing of coroners' survey questions. He asked two senior coroners and a member of his office to be part of the group, along with this author and the Director of the UCL Judicial Institute, Professor Thomas. The Survey Working Group met twice. It provided feedback on an early draft of the survey, discussed issues relating to coroners' working lives that merited inclusion and considered how questions should be framed to ensure that the survey made sense to respondents, maximising the chances of a high participation rate.

## 5.6 The Coroner Attitude Survey

### *Sample group*

The approach was to reach as many coroners as possible rather than to rely on a representative sample. As the total number of coroners in office in May 2020 was not a matter of public record, the Chief Coroner's Office provided information on the number and status of all senior coroners, area coroners and assistant coroners as of 1 May 2020. This was important in order to calculate an accurate response rate to the Coroner Attitude Survey. As of 1 May 2020, there were a total of 406 coroners in England and Wales. There were 75 senior coroners, 30 area coroners and 301 assistant coroners (five of whom were acting up as senior coroners). This represented the survey's target population.

**Table 1 Coroners in post on 1 May 2020**

| | Number of coroners |
|---|---|
| Senior coroner | 75 |
| Area coroner | 30 |
| Assistant coroner | 301 |
| **Total** | **406** |

### *Survey design and composition*

As an aim of this thesis was to compare the Coroner Attitude Survey results to those of the UK JAS 2020, it was important to replicate not only question wording but also aspects of visual design and layout of the questions.[534]

The Coroner Attitude Survey comprised a brief introduction followed by 60 questions across 13 sections. The questions encompassed issues of salary, resources, leadership and future planning. These matters formed an integral part of the UK JAS and were of particular interest to the Chief Coroner on whose support this survey relied. This thesis sets out and discusses the results of only some of the survey's sections.[535] A copy of the Coroner Attitude Survey may be found at Appendix 1.

**Section 1: Your judicial role**. This section covered:

- Coroner post
- Part-time or full-time status
- Fee-paid or salaried
- Era of first appointment
- Length of time in office
- Any other judicial post held?

[534] Don A Dillman, *Internet, Phone, Mail, and Mixed-Mode Surveys: The Tailored Design Method* (Fourth edition, Hoboken, New Jersey : Wiley 2014) 107.
[535] A final report covering the whole survey was submitted to the Chief Coroner in October 2021. It is currently unpublished.

**Section 2: Working conditions**. This section sought coroners' attitudes as to:

- Working conditions
- Case and non-case workloads
- Importance of various aspects of working arrangements

**Section 3: Welfare**. Coroners were asked about:

- Personal security
- Significant sources of stress
- Reasonable adjustments for declared disabilities

**Section 4: Salary and pensions**. This section sought coroners' views on their:

- Pay and pension (this question tailored to whether a coroner was salaried or fee-paid)
- Income compared with earnings prior to appointment as a coroner (salaried coroners)

**Section 5: Resources and digital working**. Coroners were asked to assess:

- A range of IT and digital resources
- Quality and functionality of electronic systems

**Section 6: Training and personal development**. This section covered:

- Satisfaction with aspects of coroners' work
- Range and quality of training
- Areas on which coroners would welcome training

**Section 7: Change in the coroner service**. This section sought to learn:

- Extent to which the job has changed since first appointment
- Views on change

- Extent of concern on a range of issues affecting coroners, including lack of a national coroner service

**Section 8: Future planning**. Coroners were asked:

- Whether they might consider leaving the coroner service in the next five years
- Factors that would make them more likely to leave the service
- Factors that would make them more likely to remain in the service

**Section 9: Being a member of the coroner service**. This section covered:

- Extent to which coroners feel valued by a range of groups
- Whether coroners feel respected by society at large
- Coroners' personal attachment to the coroner service
- Coroners' membership of the judiciary of England and Wales
- Whether coroners consider themselves to be judges

**Section 10: Inquests and the coroners' role**. This section covered:

- Coroners' most important functions
- Use of special measures, ground rules hearings, and juries
- Appropriateness of "therapeutic jurisprudence" techniques
- Views on conducting inquests and the role of the coroner

**Section 11: Joining the coroner service**. Coroners were asked:

- Whether they would still have applied for their post if they had known what they know now
- Why they would encourage suitable people to apply to become coroners
- Why they might discourage people from applying to become coroners

**Section 12: Leadership**. This section sought coroners' views on:

- Taking on leadership responsibilities

- Their immediate leadership judge
- The impact of the Chief Coroner

**Section 13: General information**. This section sought to learn basic demographic information and the professional backgrounds of respondents:

- Main geographic region where they sit
- Legal role before appointment
- Sex
- Age group
- Family/ caring responsibilities
- Education
- Ethnic group

### *Software used*

The survey was created and run using the online survey tool Opinio. Opinio is a web-based survey tool which provides a framework for authoring and distributing surveys as well as a range of reporting facilities. It is available free of use to all UCL staff and postgraduate students. The survey tool provides a number of question types including multiple choice, rating, drop-down lists, numeric, matrix, essay and open-ended. Surveys can be delivered either by open-access or by invitation to a specified list.[536]

Opinio was preferable to other online survey tools as it offers a range of reporting functions and pays greater attention to the respondent interface and to the visual impact of the survey than that offered by alternative survey tools. Importantly, an Opinio survey can be accessed and completed just as easily via a browser on a mobile phone or tablet as on a desktop or laptop computer, allowing respondents to complete them at a convenient time. This survey tool was also used in the UK JAS in 2014 and 2016, so its reliability for this type of survey with judicial elites had already been proven.

[536] <https://www.ucl.ac.uk/isd/opinio> accessed 14 September 2022

### *Methodology of survey*

In online surveys there are two main approaches to question design: the open-ended question, where there are no limitations placed on how respondents can answer, and the closed-ended question, where respondents are asked to select their answer from a range of proffered options. The latter approach was preferred due to the important limitations of open-ended questions. In a self-administered survey such as this one, respondents are more likely to skip an open-ended question than a closed-ended question as they require more effort to answer.[537] As some types of respondents are more likely than others to skip such questions, issues of non-response bias then arise.[538] These problems are exacerbated when a sizeable number of respondents are completing the survey on a mobile phone, on which typing long responses is not as easy.[539]

The online survey has a number of advantages over the postal survey or email survey.[540] Firstly, online survey software allows for a greater range of options for the design of the survey. Using filter questions lessens the risk of respondents inadvertently missing relevant follow-on questions. Using an online survey also precludes the need to code respondents' answers as these can be downloaded to a database automatically, minimising the risk of errors in data entry. A further important benefit of the online survey over the email survey is that it instils a greater confidence in respondents that their answers are truly anonymous and treated confidentially.[541]

Previous research of elites has suggested that item non-response may be a problem as elites are more likely than other types of respondents to pick and choose which questions to answer.[542] But Walgrave and Joly note that online surveys are deemed to be superior to postal questionnaires as respondents may be more comfortable divulging sensitive information on a computer than on paper.[543]

[537] Dillman (n 534) 110.
[538] ibid.
[539] ibid.
[540] Bryman (n 522) 230–231.
[541] ibid 236.
[542] Walgrave and Joly (n 531) 2233.
[543] ibid.

In addition, since this research was reliant upon the good will and support of the Chief Coroner's office, it was important not to impose too heavy a burden upon it, such as the distribution of hard copy questionnaires to all 406 coroners.[544] The use of an online survey required only a brief message by email with a direct link to the survey.

## 5.7 Methodological limitations

It is important to recognise that the methodological choices made during this research bring limitations that qualify the findings. There are of course disadvantages to using online surveys. They are restricted to those with access to the internet, they can have a lower response rate than for postal questionnaires and respondents may have heightened concerns as to the confidentiality and anonymity of their responses.[545] The proliferation of online surveys also presents a risk that potential respondents will be asked so often to complete surveys that they decline to participate.[546] Nevertheless, none of these were major concerns in this research. Coroners are expected to be computer literate,[547] and they routinely communicate with medical professionals,[548] administrative support staff[549] and the Chief Coroner[550] via email. To encourage potential respondents to participate, a detailed statement was included at the start of the survey which set out the aims of the research and the work of the UCL Judicial Institute. It also explained how the survey was designed and administered using a reliable and secure software tool that would guarantee the confidentiality and anonymity of answers.

This was not a longitudinal study. Given the limited time frame of doctoral research, it was not possible to measure coroners' attitudes over time in order to detect whether their views changed or hardened with experience. In order to refute the "wide spread criticism that elite studies are of only descriptive value", Hoffmann-Lange has argued that comparative and longitudinal surveys are needed before we can attempt to answer

[544] The UCL Judicial Institute had no requests for a paper survey when conducting the first UK Judicial Attitude Survey in 2014 and dispensed with this option in 2016 and 2020.
[545] Bryman (n 522) 235–236.
[546] Mick P Couper, 'Web Surveys: A Review of Issues and Approaches' (2000) 64 The Public Opinion Quarterly 464, 465.
[547] Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 20.
[548] ibid 139.
[549] ibid 22.
[550] 'Guidance No.5 Reports to Prevent Future Deaths' (n 369) para 48.

important theoretical questions associated with elites.[551] This may be possible should the Coroner Attitude Survey feature again in future iterations of the UK JAS.

There are also disadvantages to using "closed-ended" questions in an online survey such as this one. The strength of the open-ended question is that respondents have the freedom to answer how they wish,[552] and so there is the possibility the researcher may find out more than he or she anticipated. Closed-ended questions, on the other hand, "stop the conversation and eliminate surprises".[553] This research sought to address this through the addition of optional text boxes throughout the survey, allowing respondents to expand on their attitudes. However, the extent to which optional text boxes make up for the loss of insight from responses to open-ended questions is limited. As Dillman noted, respondents are more likely to select the categories provided than to type their own responses.[554]

It is also important to keep in mind the limitations of attitudinal surveys. We do not know how incentivised coroners were to be honest in their answers to questions, or how their attitudes translate into judicial behaviour.

### 5.8 Survey implementation

One week before the launch of the survey, the Chief Coroner emailed all coroners in England and Wales to announce that they would soon be invited to take part in the first Coroner Attitude Survey. A copy of the Chief Coroner's email may be found at Appendix 2. The email provided coroners with information about the UCL Judicial Institute and the UK JAS, provided an overview of the topics that the survey would ask about and sought to reassure coroners that their answers would be completely anonymous.

The survey was launched by the Chief Coroner on 27 May 2020. He sent an email to all coroners that included a link to the online survey. He again explained that the survey

[551] Hoffmann-Lange (n 515) 925.
[552] Dillman (n 534) 110.
[553] Susan Ferrell, 'Open-Ended vs. Closed-Ended Questions in User Research' (*Nielsen Norman Group*, 22 May 2016) <https://www.nngroup.com/articles/open-ended-questions/> accessed 1 April 2022.
[554] Dillman (n 534) 113.

would run alongside the UK JAS 2020 and that it was the first time that coroners were included in the project. He requested that all coroners take the time to complete it. A copy of the Chief Coroner's email may be found at Appendix 3.

During the survey period the Survey Working Group monitored the response rate and any feedback from coroners. One coroner member of the Working Group reported that despite the guarantees of anonymity on the first page of the survey, some colleagues were concerned that they could still be identified by their answers. It was also noted that many assistant coroners were not working at that point in time due to the COVID-19 pandemic, and as such may not be checking their coroner emails often. To address these two issues the Working Group contacted the Chief Coroner's Office, suggesting that a further email be sent to all coroners emphasising that the researcher would conduct no multifactor analysis that might allow for identification of respondents and that the results of the survey would be presented at an aggregate level. A message to this effect was sent from the Chief Coroner on 5 June 2020, 10 days into the survey. When the response rate of assistant coroners remained low (63%) compared with area coroners and senior coroners, an email was sent by the Chief Coroner to assistant coroners only on 17 June 2020, reminding them of the link to the survey and requesting that they complete it.

The survey closed on 22 June 2020 at the end of the day. A final reminder was sent to all coroners by the Chief Coroner's Office that morning to remind those who had yet to complete the survey that it would close at midnight. To encourage those coroners who had yet to complete the survey, this email provided the response rates for each coronial office and also the response rates for the UK JAS 2020 in England and Wales, Scotland and Northern Ireland.

### 5.9 Response rate

The survey had an overall response rate of 89%: it was completed by 100% of senior coroners and area coroners and 85% (257) of assistant coroners.

**Table 2 Coroner Attitude Survey 2020 response rate**

| | Coroners in post May 2020 | 2020 CAS number of responses | 2020 CAS response rate |
|---|---|---|---|
| Senior coroners* | 75 | 75 | 100% |
| Area coroners | 30 | 30 | 100% |
| Assistant coroners** | 301 | 257 | 85% |
| **Total** | **406** | **362** | **89%** |

* Includes the Chief Coroner and two Deputy Chief Coroners

** Includes five assistant coroners acting up as senior coroners at the time of the survey

Such response rates are rare and significant. Survey response rates above 60 percent are now "the exception rather than the rule".[555] A recent study of the response rates of online surveys in education-related research found the average response rate is 44.1%.[556] The response rate for the Coroner Attitude Survey means its findings have a high level of reliability, reflecting the views of the vast majority of coroners in England and Wales.

### 5.10 Approach to analysis

The raw survey data was first produced in a Microsoft Excel file. The data was then cleaned. Duplicate lines of data (from respondents having started the survey only to abandon it in order to complete it on another occasion) were deleted, as were the small number of survey responses that had been abandoned after the first few questions. A decision was made to recode some respondents' answers to the question of whether they were a salaried full-time coroner, salaried part-time coroner or a fee paid coroner. This was only done where the rest of the respondent's answers made it clear that he or

[555] Scott Keeter, 'Evidence About the Accuracy of Surveys in the Face of Declining Response Rates', *The Palgrave Handbook of Survey Research* (Springer International Publishing 2017) 19.
[556] Meng-Jia Wu, Kelly Zhao and Francisca Fils-Aime, 'Response Rates of Online Surveys in Published Research: A Meta-Analysis' (2022) 7 Computers in human behavior reports 100206.

she had made an error in answering this question.[557] The cleaned dataset was then converted into an SPSS file and SPSS was used to code and analyse the survey data.

This thesis does not include an analysis of every question included in the Coroner Attitude Survey. It instead focuses on the questions relevant to the three key aims of this thesis as set out in the first section of this chapter. In order to produce an extensive profile of the composition of the coronership in 2020, it was necessary to include the first five questions in the survey on respondents' current coronial posts and the questions of the final section relating to their personal (Q54-58) and professional (Q51-53) backgrounds. Questions relating to the functions of the coroner (Q37), on the appropriateness of therapeutic jurisprudence techniques (Q39) and on various aspects of the inquest (Q38 and Q40) were important to include in order to understand how coroners see their role in the administration of justice. To understand coroners' working lives, the questions on change in the coroner service (Q26-27), on training and personal development (Q23-25) and on the Chief Coroner's leadership (Q49) were included in the analysis. In order to be able to compare coroners' attitudes with those of the judges of the courts and tribunals judiciary, this thesis also focussed on the survey questions on coroners' commitment to their job, their attachment to the coroners' service and to the wider judiciary (all Q36) and the extent to which they feel valued (Q34). The questions on working conditions, welfare, salary and pensions, resources and digital working, and future planning were deemed to be beyond the scope of this research.

Having identified the questions relevant to this thesis, the data from each question were first subject to univariate analysis that produced results for all coroners combined. Bivariate analysis that sorted the data according to coroner post was then carried out. Finally, some survey questions were subject to further bivariate analysis. Coroners' answers to questions about the type of legal engagement they were in prior to appointment as a coroner (Q52), the period of their first appointment (Q3) and the main geographic region where they sat (Q51) allowed for more detailed bivariate

[557] E.g., three assistant coroners (who are fee-paid rather than salaried) were acting as senior coroners at the time they completed the survey. They were treated as senior coroners and fee-paid, even though all senior coroners are salaried.

analysis that explored whether these factors were correlated with specific attitudes of coroners. For example:

- The functions coroners deemed to be their most important were analysed by period of first appointment and by professional background;
- Coroners' views on the extent of change in the coroner service since their first appointment as a coroner were analysed by the period of first appointment;
- Coroners' views on the effectiveness of PFD reports was analysed by region;
- The extent to which coroners felt valued by their local authorities and by central government was analysed by region;
- The availability of training opportunities was analysed by region;
- Whether coroners considered themselves to be judges and whether they felt part of the judiciary of England and Wales were both analysed by region and by professional background.
- Coroners' attitudes on the usefulness of sitting with a jury were also analysed by the frequency with which they sit with juries.

While the survey was completed by all senior coroners and area coroners and by 85% of assistant coroners, not every question was answered by all respondents. Therefore, in the following chapters, the number of responses is provided for each question covered in the analysis.

### 5.11 Summary

This chapter identified the research questions the Coroner Attitude Survey sought to answer and set them in the wider research context of the UK Judicial Attitude Survey. It explained why an online survey was the research method chosen and described how the survey was designed and implemented. Finally, it explained how the results were analysed. The following three chapters set out specific results from the survey.

# Chapter 6 Who are the coroners of England and Wales?

In its May 2021 report on the coroner service, the House of Commons Justice Committee was unable to comment upon the diversity of coroners as "no statistics are available".[558] In contrast there is a wealth of information on diversity in the courts and tribunals judiciary. In 2020 and 2021 the Ministry of Justice published a bulletin presenting the latest statistics on judicial diversity for England and Wales.[559] The bulletin covers courts and tribunals judges, non-legal members of tribunals and magistrates. The GOV.UK website also provides an "interactive dashboard" allowing users to explore the data in greater detail.[560] Coroners are not included in either. Nor were they included in the 2017 NatCen survey of newly appointed judges in the UK that included questions on the judges' age, gender, ethnicity, region and professional background.[561]

The research findings from the Coroner Attitude Survey (the CAS) that are presented in this chapter therefore set out the first in-depth analysis of the composition of the contemporary coroner service and of the background characteristics of coroners in England and Wales.[562] Given the extremely high response rate to the survey and the scope of demographic questions asked, these findings present the first ever in-depth analysis of who makes up the coroner service in England and Wales. They confirm that while there is now a greater variety in coroners' legal backgrounds and experience, the service still falls a long way short of reflecting the ethnic diversity of the population of England and Wales and, despite progress in the recruitment of women, there remains a gender imbalance. However, this lack of ethnic and gender diversity is starker in some regions than in others, and it is clear that progress in increasing some

[558] Justice Committee (n 9) para 26.
[559] Ministry of Justice, 'Judicial diversity statistics' (4 September 2020) <https://www.gov.uk/government/collections/judicial-diversity-statistics> accessed 14 September 2022.
[560] ibid.
[561] Tim Buchanan, 'Survey of Newly Appointed Judges in the UK 2017' (NatCen Social Research 2018) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/748593/161018_Final_report_-_NatCen.pdf> accessed 7 March 2020.
[562] As discussed in Chapter 5 above, while Tarling's 1997 Home Office sponsored survey of coroners sought information on the age, gender and professional background of coroners, his report offered only a brief, high level summary of some of the data collected and contained no analysis.

aspects of diversity has been made since changes to the coroner appointment process were introduced in July 2013.

### 6.1 Demographic factors examined

The CAS asked coroners about a range of demographic factors. Table 3 sets out the number of coroners who answered the relevant survey question.

**Table 3 Demographic factors examined in the Coroner Attitude Survey and the response rate of coroners**

| Demographic factor | Number of coroners who answered |
|---|---|
| Geographic region of England and Wales[563] | 330 |
| Age[564] | 325 |
| Date of first appointment to the coroner service[565] | 353 |
| Gender[566] | 326 |
| Ethnicity[567] | 322 |
| Disability[568] | 347 |
| Education[569] | 301 |
| Professional background[570] | 331 |

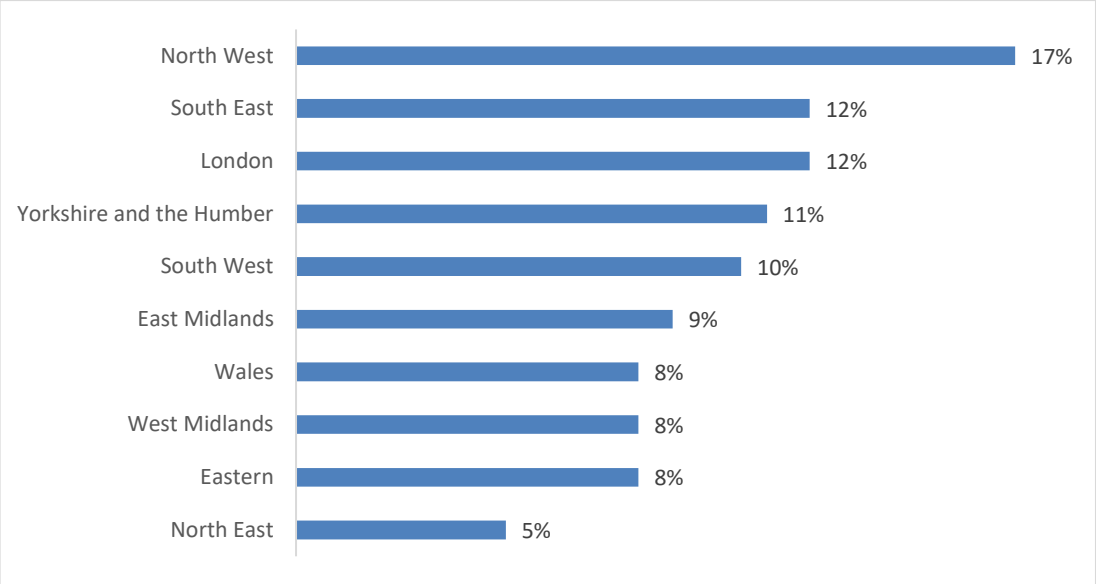
### 6.2 Regional representation and coroner demand

The CAS asked coroners to identify the main geographic region in which they sit. A total of 330 coroners answered this question. As may be seen in Figure 4, coroners are relatively evenly distributed across the regions of England and Wales. While London and the South East has the highest concentration of coroners, the North West is the

[563] Q.51.
[564] Q.55.
[565] Q.3.
[566] Q.54.
[567] Q.58.
[568] Q.16.
[569] Q.57.
[570] Q.52 and Q.53.

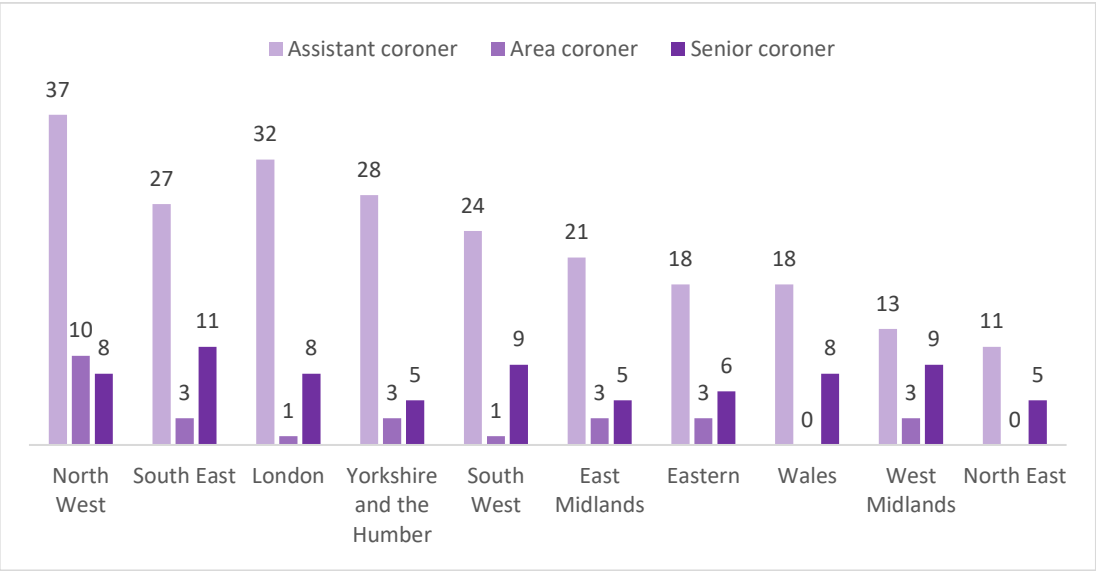
individual region with the largest proportion of coroners (17%). The North East has the smallest proportion of coroners (5%).

**Figure 4 Regional distribution of coroners (n=330)**



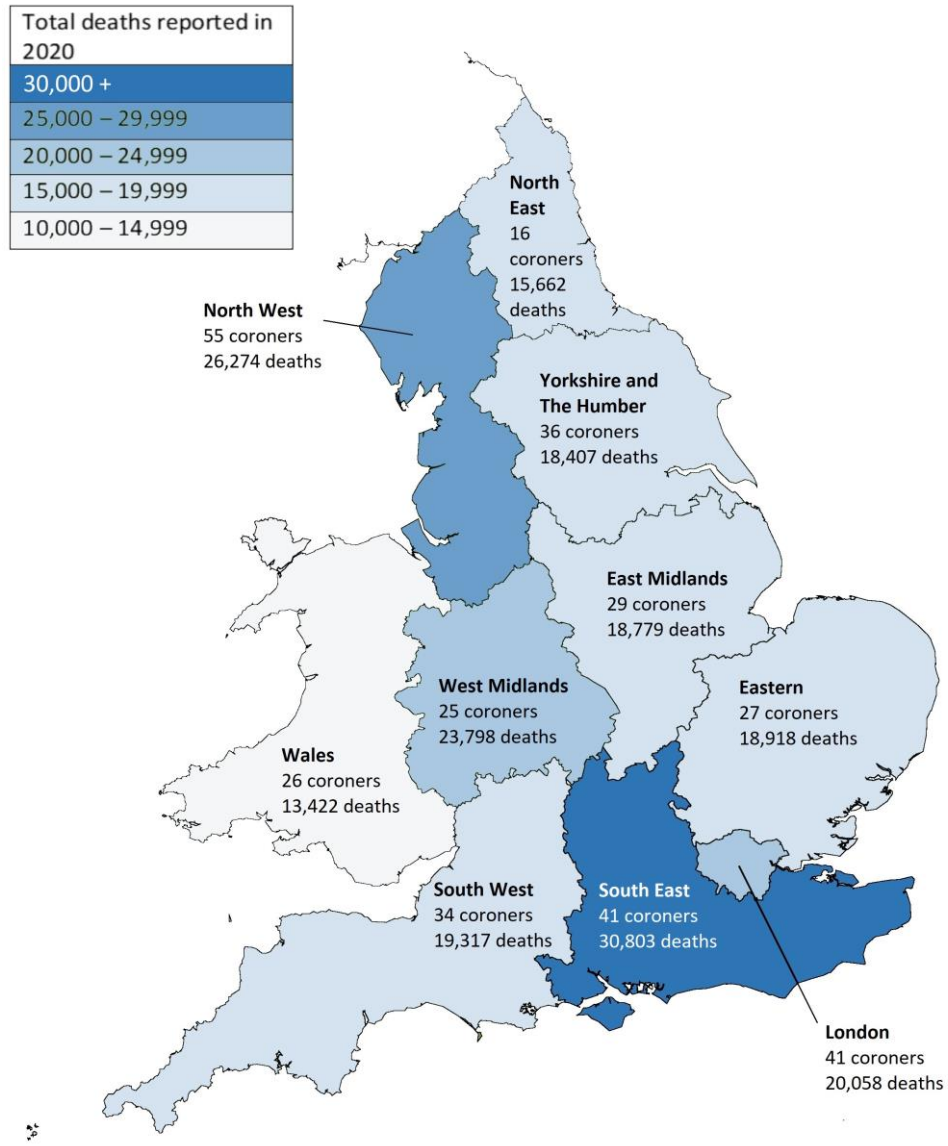

The CAS revealed differences across the regions in the distribution of different coroner posts. Figure 5 shows the South East has the highest number of senior coroners (11) and the North West has the highest number of area coroners (10) and of assistant coroners (37).

**Figure 5 Regional distribution of coroners by post (n=330)**



However, as Figure 6 shows, the distribution of coroners across England and Wales does not correspond to the number of deaths reported to coroners in each region. The South East is the region with the highest number of deaths reported to coroners in 2020 (30,803). However, that region's total of 41 coroners was only five more than that of Yorkshire and the Humber (36), where the number of deaths reported in 2020 was 60% that of the South East region (18, 407).

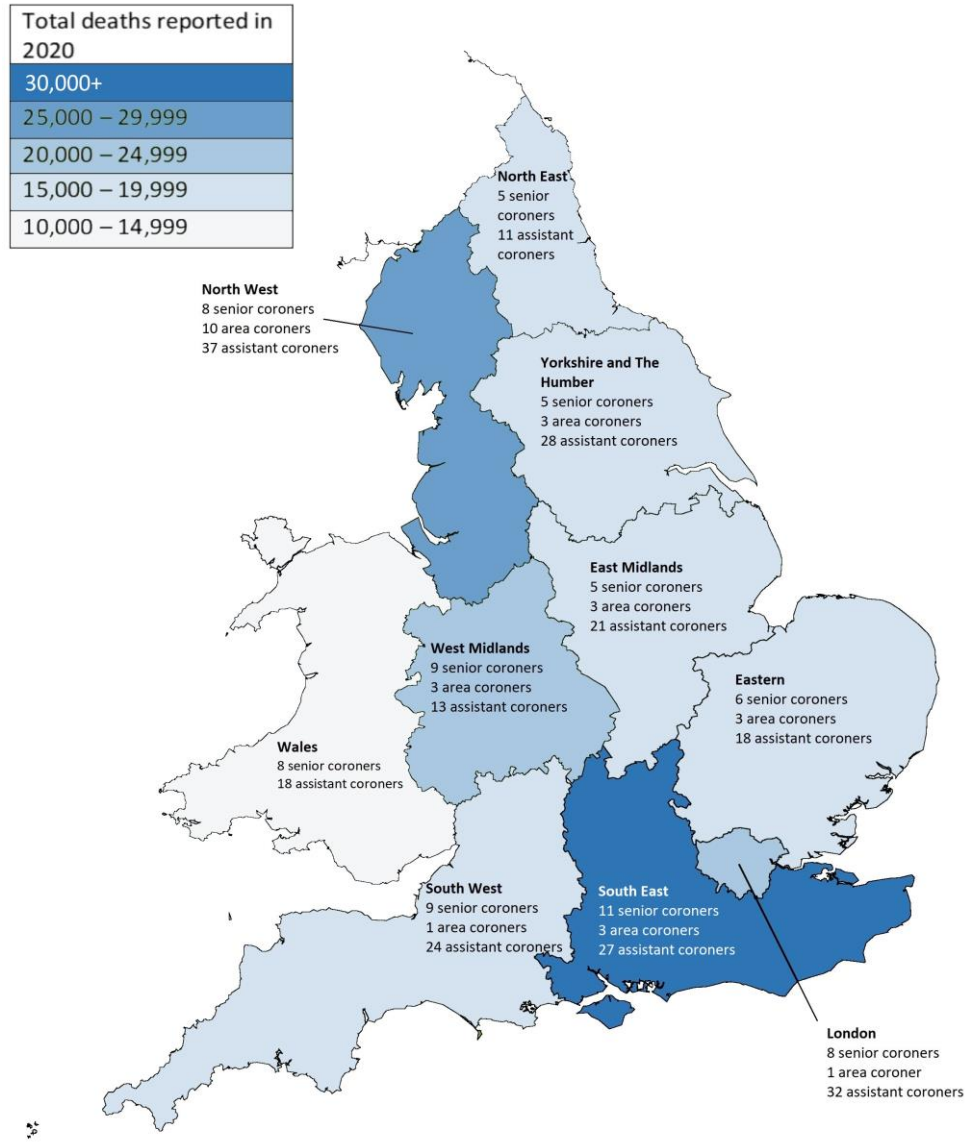
**Figure 6 Total number of coroners by geographic region and total deaths reported by region (n=330)[571]**




[571] Data as to number of deaths reported taken from *Coroner Statistics Annual 2020, England and Wales* (Ministry of Justice/ Office of National Statistics). Map of the regions of England and Wales adapted from that used in *Suicides in England and Wales: 2019 registrations* (Office of National Statistics), 1 September 2020.

When examining the individual coroner posts by region, there are also imbalances between the number of types of coroners in each region and the regional distribution of reported deaths. For example, there are quite substantial variations in the number of area coroners in England and Wales. There were a total of 30 area coroners in post when the survey was conducted, but a third of this cohort worked in one region – the North West. In contrast, there were only three area coroners appointed in the South East and only one in London.

**Figure 7 Coronial offices by main geographic region where coroners sit (n=328)**



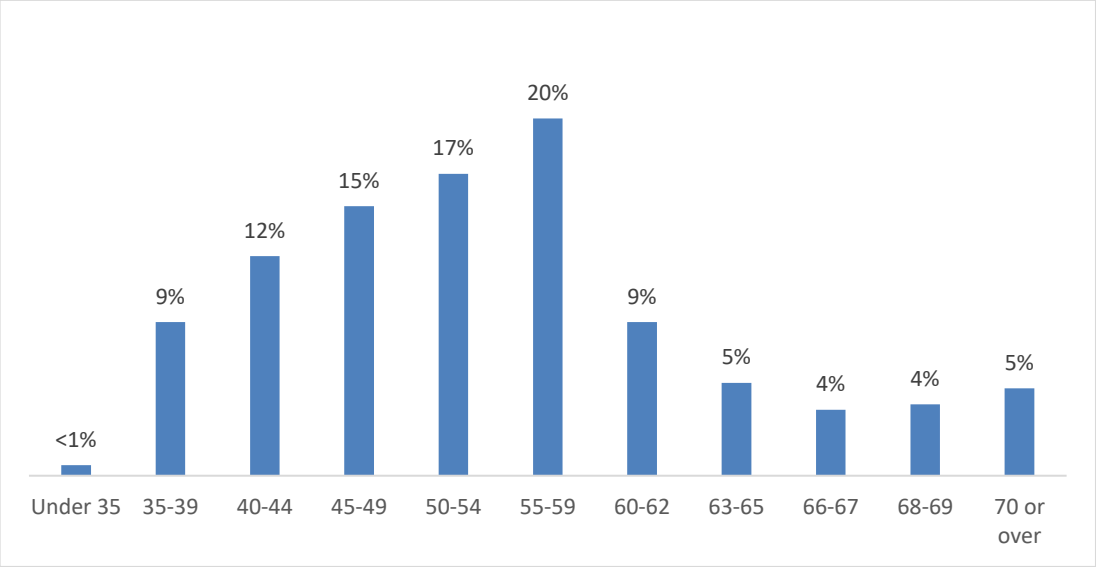
### 6.3 Age

Most coroners are mid and late-career professionals, with 64% aged 50 or above:

- 36% are under 50
- 37% are between 50 and 59
- 27% are 60 or above

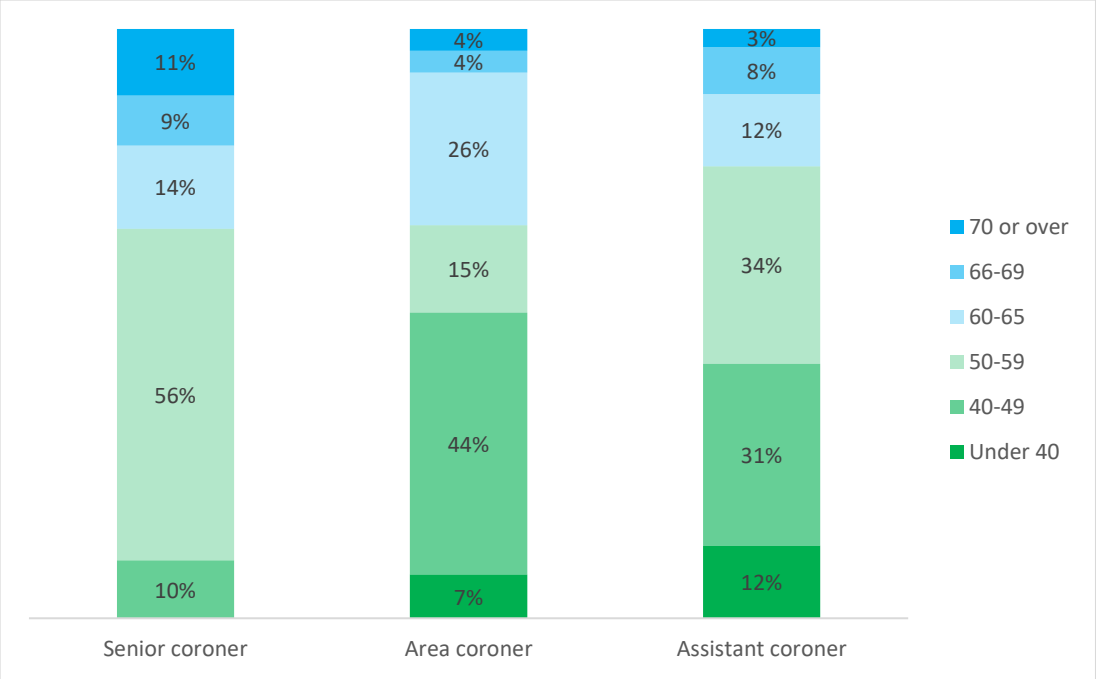
There are 16 coroners aged 70 or above.

**Figure 8 Coroner age distribution (n=325)**




The CAS revealed differences in age across coroner post, as shown in Figure 9. As senior coroners are appointed only after a substantial period of time in practice, it is not surprising that the vast majority of them are over 50 years of age. Nor is it surprising that a significant minority of assistant coroners are under 50, given that the part-time post is the entry position into the coroner service. Area coroners, effectively the deputies in each coroner area, have the highest representation of younger coroners, with over half under 50.

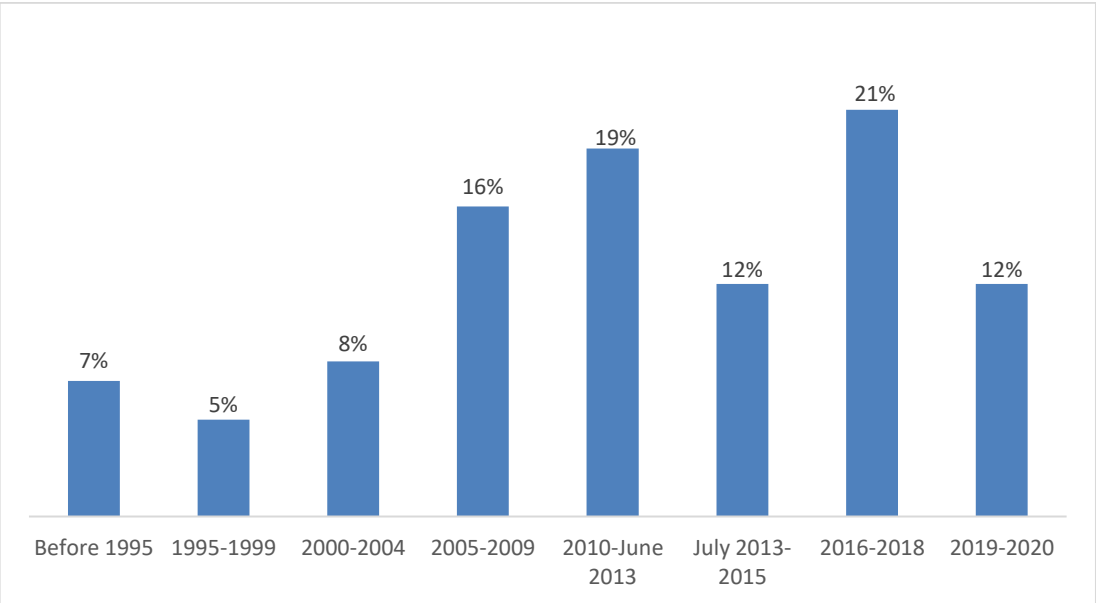
**Figure 9 Coroner posts by age (n=325)**




## 6.4 Date of first appointment

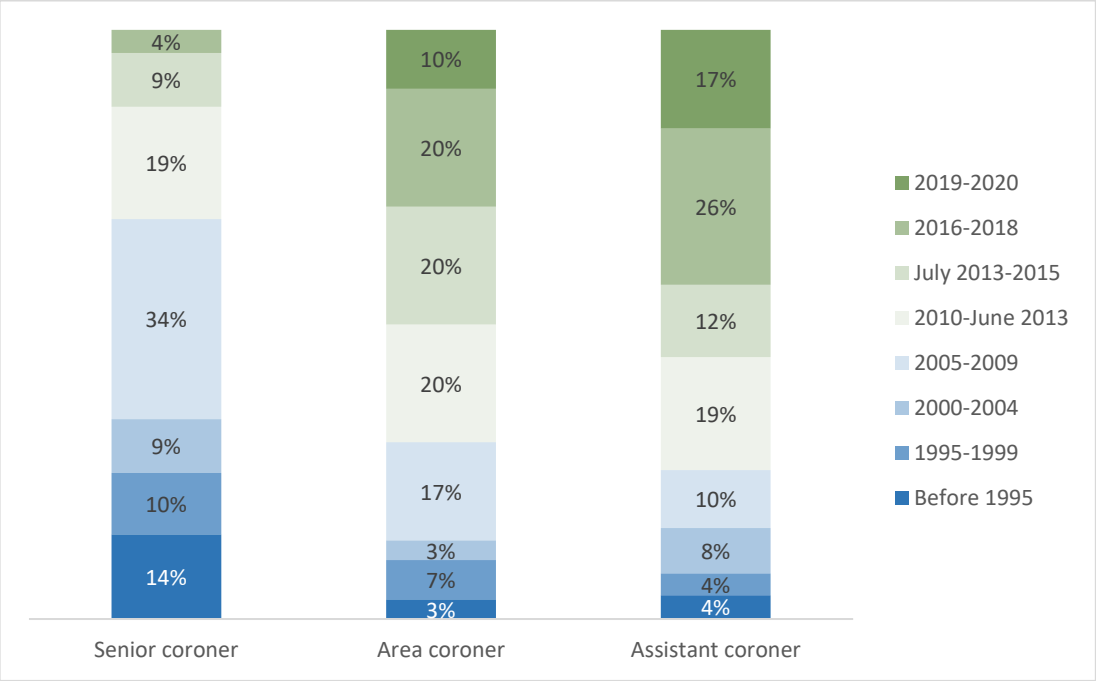
The CAS asked coroners for the date of their first appointment to a coronial post. The survey data revealed that just under half of all coroners (45%) have joined the coroner service since the first Chief Coroner reformed the appointment process beginning in July 2013 (Figure 10).

**Figure 10 Date of first appointment: all coroners (n=353)**



Whereas most senior coroners (67%) were appointed to their first coronial post before 2010, 43% of assistant coroners joined the coroner service in the past five years and almost three quarters (74%) since the introduction of the first Chief Coroner's reforms to recruitment and training (Figure 11).

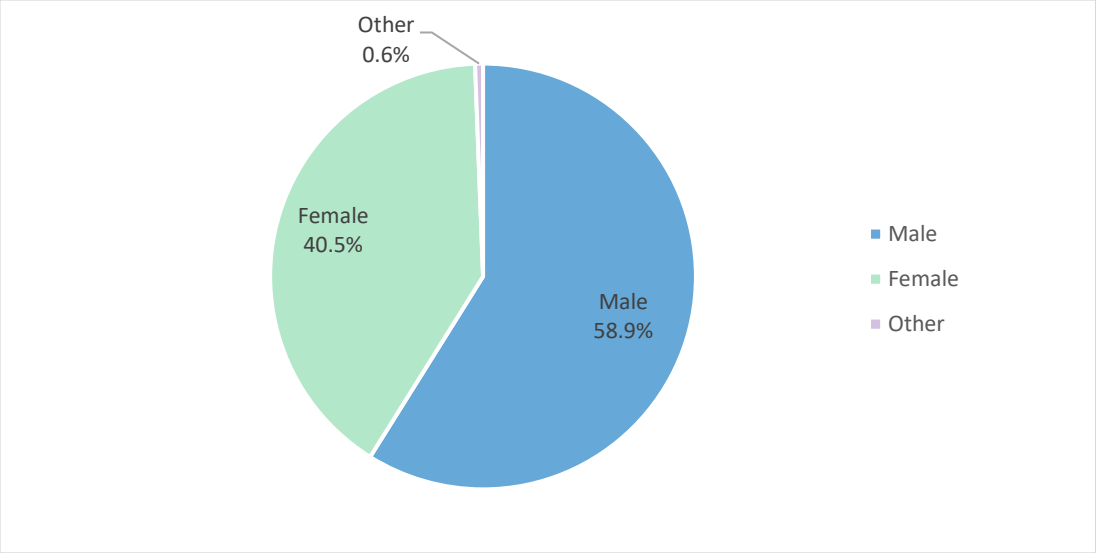
**Figure 11 Date of first appointment, by post (n=353)**




## 6.5 Gender

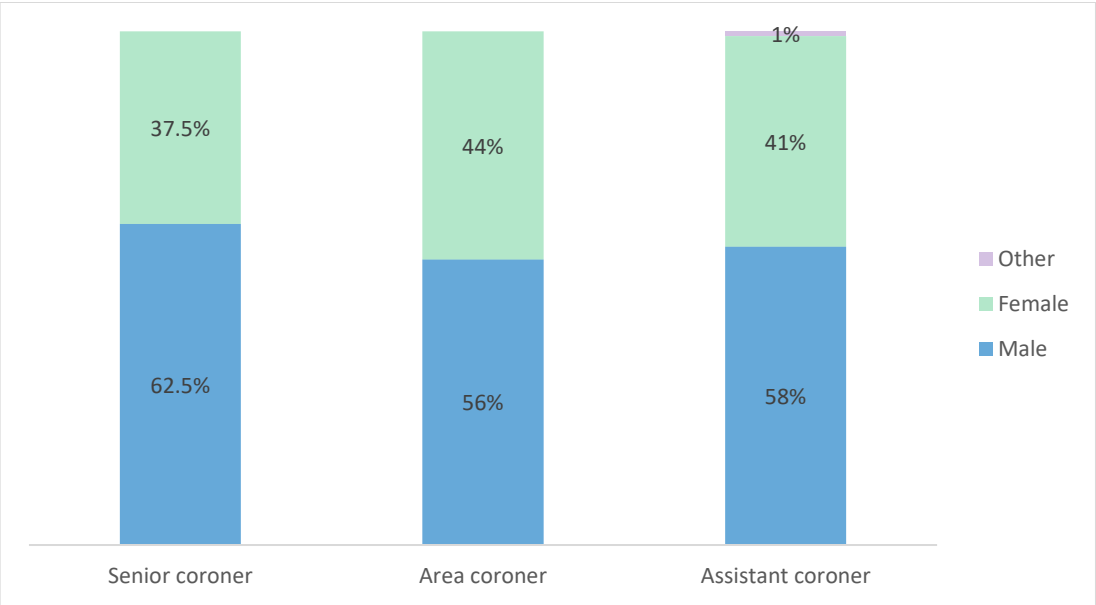
The survey revealed that there are more male than female coroners and that a very small minority of coroners self-identify their gender as "other". Female coroners make up 40.5% of all coroners, which is just over 10% below the female population of England and Wales (50.8%).

**Figure 12 Gender distribution in the coronership (n=326)**




There are some differences in gender by coroner post but, as Figure 13 shows, the differences are not substantial. Female coroners have the lowest representation amongst senior coroners (37.5%), slightly higher representation amongst assistant coroners (41%) and the highest representation amongst area coroners (44%).

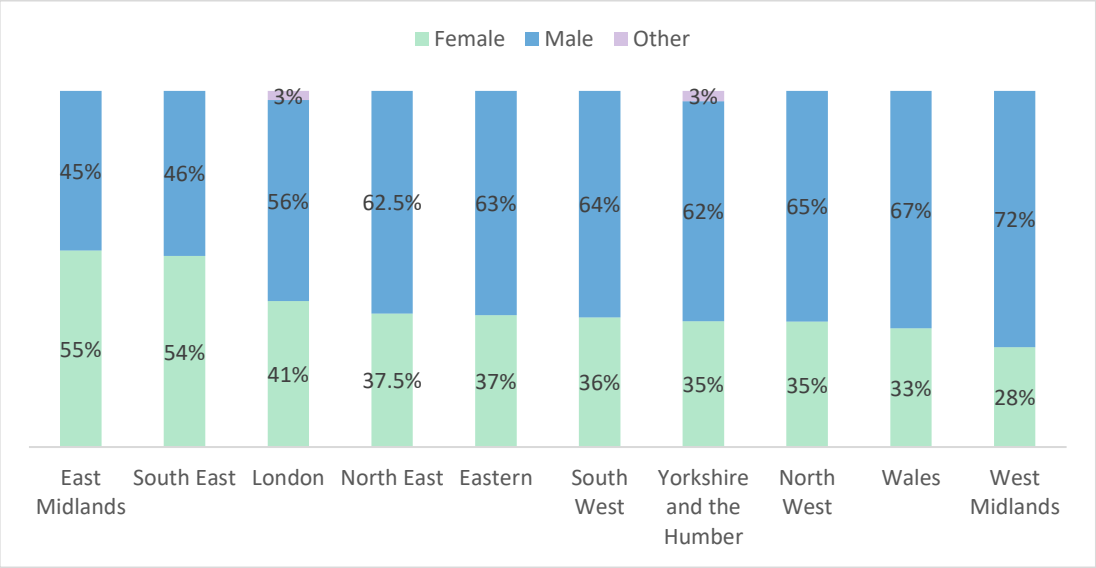
**Figure 13 Coroner posts by gender (n=326)**




The most relevant factor in terms of gender representation appears to be the region in which coroners serve. In the 10 coroner regions of England and Wales, there are only

two, the East Midlands and the South East, where there are more female than male coroners (55% and 54% respectively) (Figure 14). The lowest representation of female coroners is in the West Midlands (28% female), and in most regions, women comprise just over a third of all coroners.

**Figure 14 Coroner gender by region (n=322)**




Despite the continuing under-representation of women in the coroner service, there has been a vast improvement on the situation in 1997 when Tarling found there to be only two female district coroners (out of a total of 118) and only 23 deputy and assistant deputy coroners (out of 182 for whom information was available).[572] As may be seen in Figure 15 and Table 4, since July 2013 more women than men have been appointed coroners.

[572] Tarling (n 13) 7.

**Figure 15 Date of first appointment by gender (n=322)**

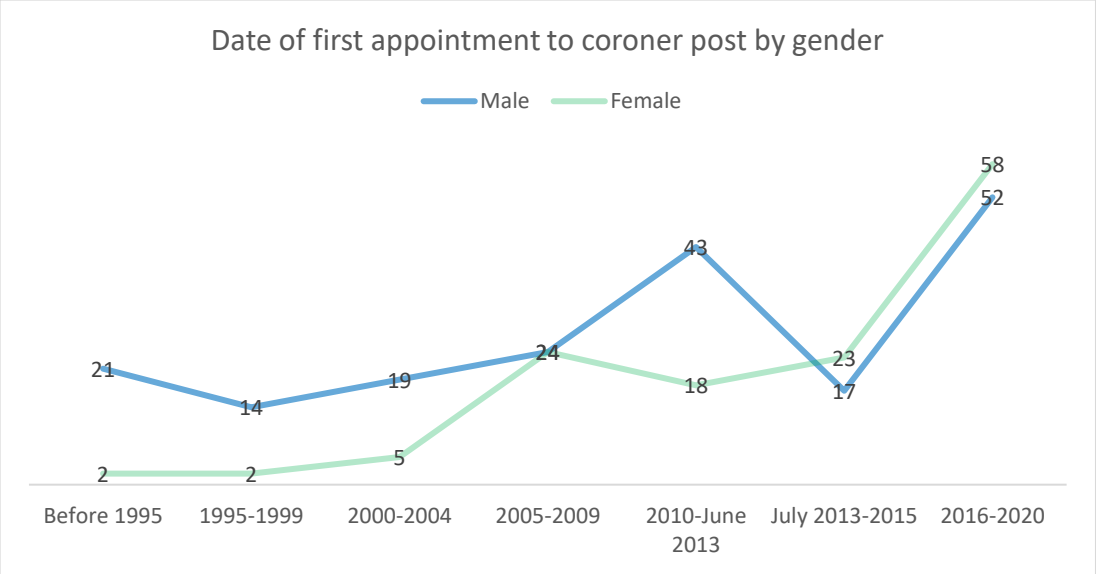


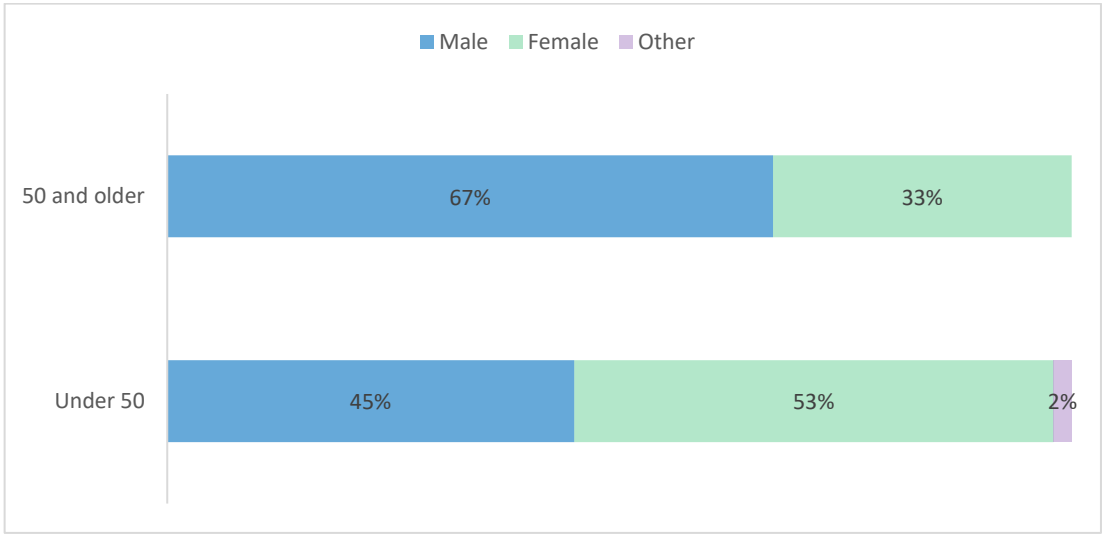

**Table 4 Era of first appointment, by gender (n=322)**

| Date of first appointment | Male | Female |
|---|---|---|
| Before 1995 | 21 | 2 |
| 1995 – 1999 | 14 | 2 |
| 2000 – 2004 | 19 | 5 |
| 2005 – 2009 | 24 | 24 |
| 2010 – June 2013 | 43 | 18 |
| July 2013 – 2015 | 17 | 23 |
| 2016 – 2020 | 52 | 58 |

## 6.6 Age and gender combined

Most coroners over the age of 50 are male. Two thirds (67%) of this cohort are male and one third (33%) is female. As may be seen in Figure 16, the situation is quite different for younger coroners, where women make up just over half (53%) of all coroners under the age of 50.

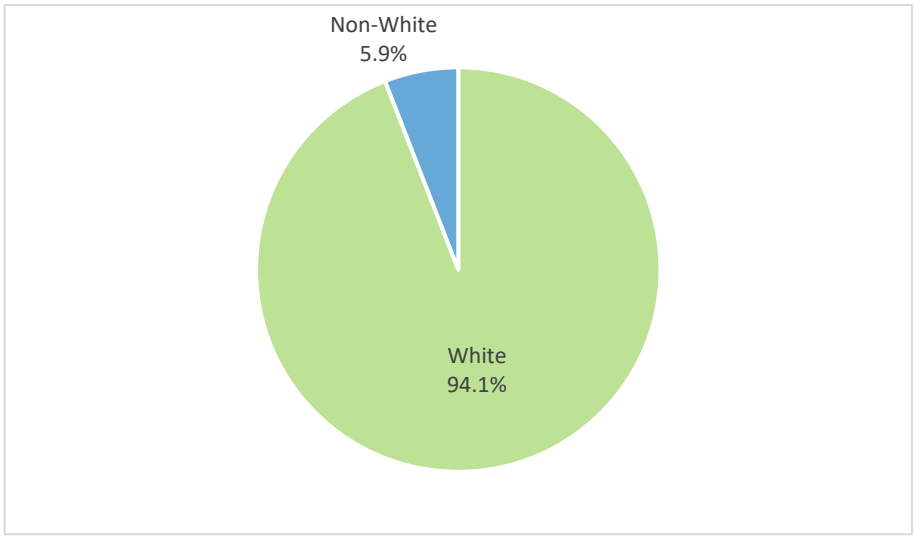
**Figure 16 Coroner age and gender combined (n=322)**




## 6.7 Ethnicity

The coroner service does not reflect the ethnic composition of the population of England and Wales. In the 2011 census, 86% of the population of England and Wales self-identified as White and 14% self-identified as Asian, Black, Mixed and Other Non-White ethnicities. Of the 322 coroners who identified their ethnicity when answering the survey, 94.1% self-identified as White and only 5.9% (19) self-identified as non-White.

**Figure 17 Ethnicity of coroners (n=322)**



The coroner service also does not reflect the diversity of the legal professions from which coroners are recruited. As Table 5 shows, both the Bar (14.7% non-White) and law firms (21% non-White) have greater diversity than the coroner service. The coronership is also less diverse than the courts and tribunals judiciary (7.2% non-White).

**Table 5 Ethnicity of coroners (n=322) compared to that of population ethnicity of England and Wales, of barristers and solicitors and of the courts and tribunals judiciary**

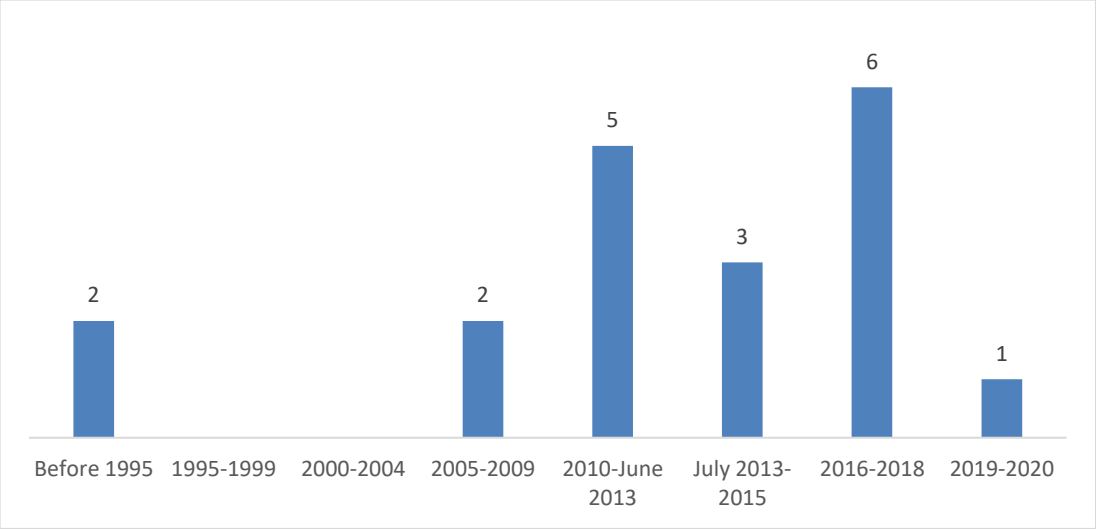
| | White | Asian | Black | Mixed | Other |
|---|---|---|---|---|---|
| England and Wales[573] | 86% | 7.5% | 3.4% | 2.2% | 1% |
| The Bar[574] | 85.3% | 7.2% | 3.2% | 3.2% | 1.2% |
| Law firms[575] | 79% | 15% | 3% | 2% | 1% |
| Courts and tribunals judiciary[576] | 92.8% | 4% | 0.9% | 1.5% | 0.8% |
| **Coroners** | **94.1%** | **2.2%** | **0.9%** | **1.6%** | **1.2%** |

The differences in the make-up of the coroner service and that of the courts and tribunals judiciary will be explored in greater detail in Chapter 8.

Of the 19 non-White coroners, ten were appointed since July 2013 (Figure 18).

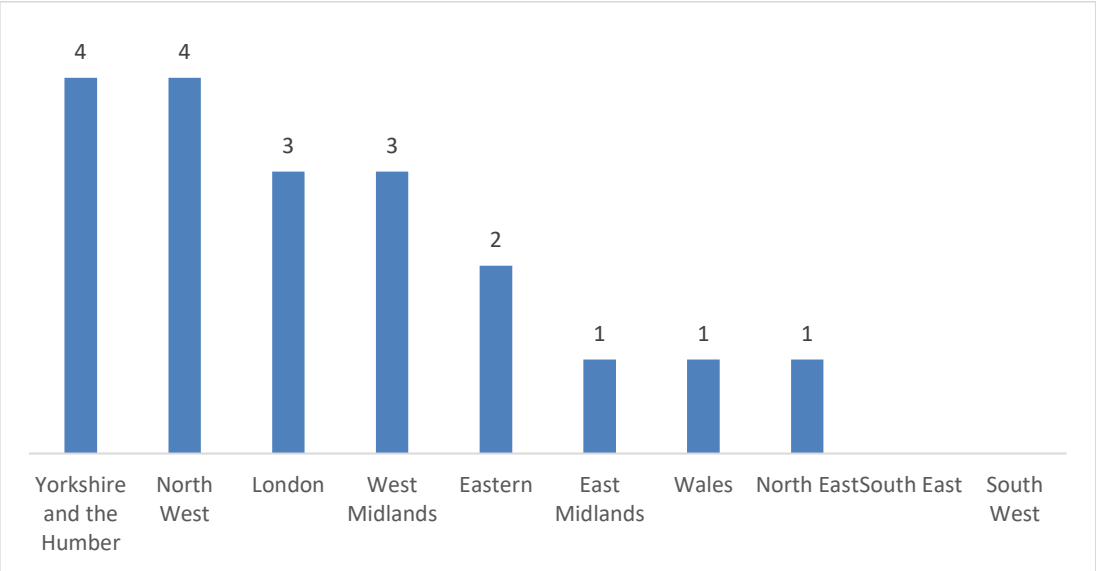
[573] 'Population of England and Wales' (*Ethnicity Facts and Figures*, updated 7 August 2020) <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest#by-ethnicity> accessed 14 September 2022.
[574] 'Diversity at the Bar 2019' (Bar Standards Board 2020) <https://www.barstandardsboard.org.uk/uploads/assets/912f7278-48fc-46df-893503eb729598b8/28f8fbfa-3624-4402-9c8f83af837a1e60/Diversity-at-the-Bar-2019.pdf> accessed 7 December 2020. (The figures in this study add up to just over 100%).
[575] 'How Diverse Is the Legal Profession?' (*Solicitors Regulation Authority*, 20 March 2020) <https://www.sra.org.uk/sra/equality-diversity/key-findings/diverse-legal-profession/> accessed 14 September 2022.
[576] Thomas, '2020 UK Judicial Attitude Survey: England and Wales Courts and UK Tribunals' (n 69) 84.

**Figure 18 Non-White coroners by date of appointment**




Just as with gender, the CAS also revealed there are regional differences in terms of the ethnic diversity of coroners. The North West and Yorkshire and The Humber regions have the largest number of non-White coroners (4 each), but there are no non-White coroners in the South West or South East (which is the region with the highest number of reported deaths in England and Wales).

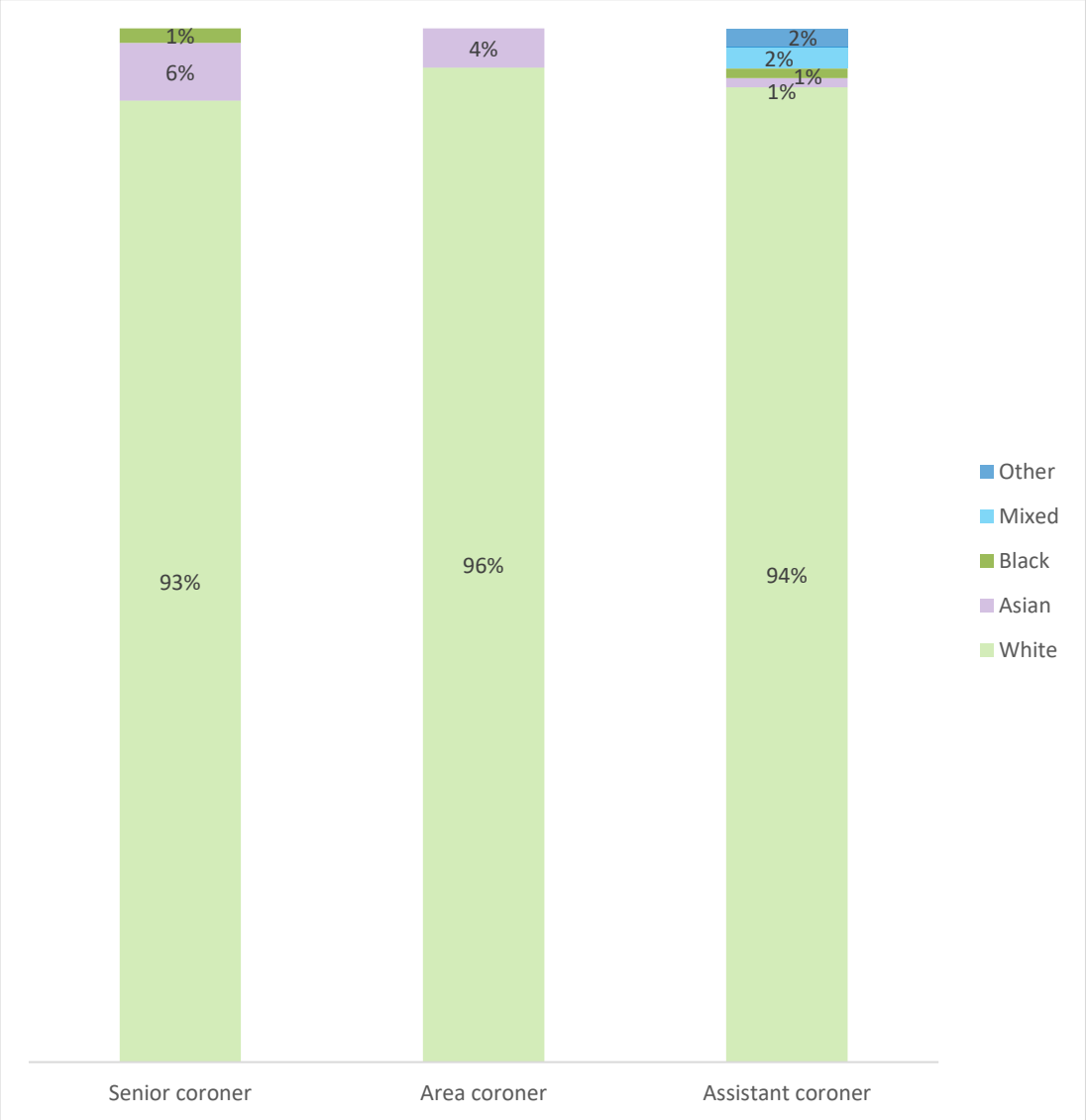
**Figure 19 Numbers of non-White coroners by coroner region**




There are some differences in the proportion of non-White coroners in the three coroner posts. As Figure 20 shows, the office of senior coroner has the largest

proportion of non-white coroners (7%) almost all of whom are Asian; 4% of area coroners are non-White (all of whom are Asian) and 6% of assistant coroners are non-White (with the highest diversity of non-White coroners).

**Figure 20 Coroner post by ethnicity (n=322)**

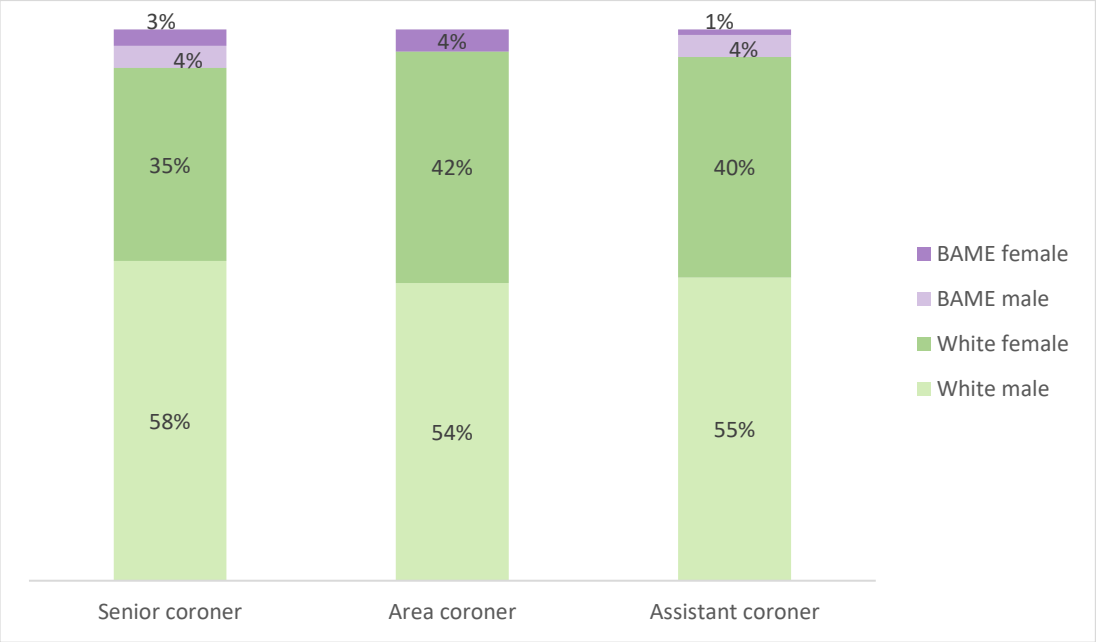



## 6.8 Gender and ethnicity combined

A combined analysis of gender, ethnicity and coroner post shows that non-White males have the lowest representation across all three coroner posts (Figure 21). There are no non-White male area coroners, and non-White males also have the lowest representation amongst assistant coroners (1%) and senior coroners (3%). The largest proportion of White males are found at the highest levels of the coroner service as

senior coroners (58%), while the largest proportion of white women are area coroners (42%).

**Figure 21 Gender and ethnicity combined, by coroner post (n=321)**




## 6.9 Disability

Coroners with a declared disability were asked whether they had a disability and, if so, whether they had requested that reasonable adjustments be made at their courts to enable them to do their jobs to the best of their ability. Of the 347 respondents to the CAS, nine (2.6%) said they had a declared disability and had requested that reasonable adjustments be made.[577] Those adjustments included being permitted to work from home and the purchase of new furniture and IT systems.

## 6.10 Educational background

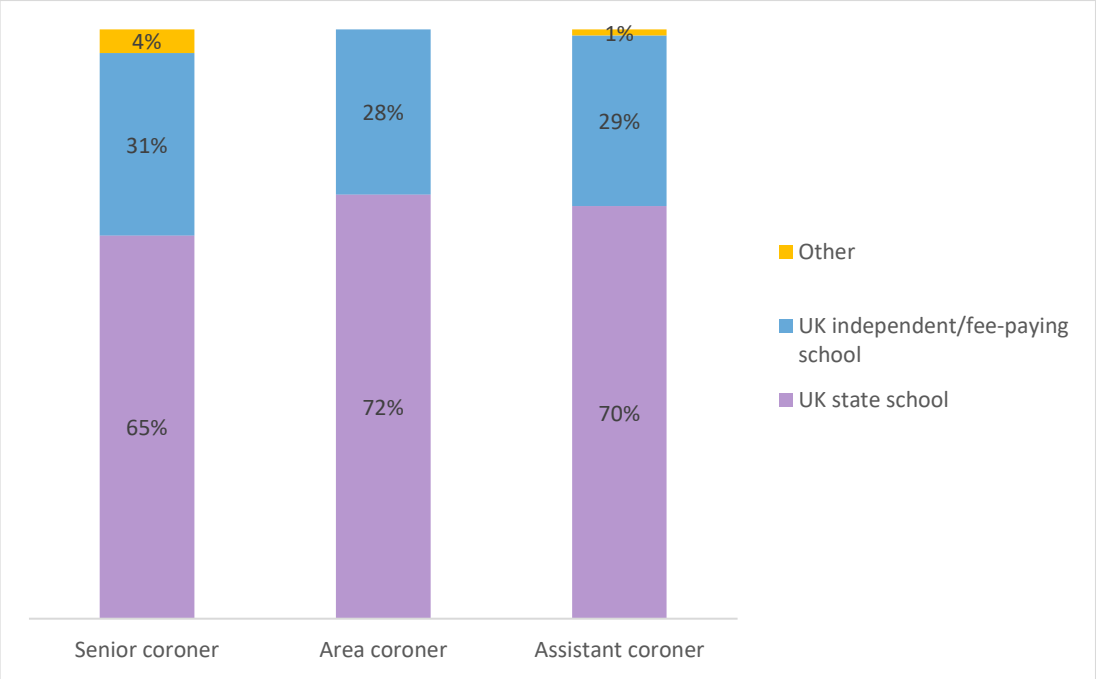
As this research is a study of an "elite group", questions on educational background were included in the CAS. The Sutton Trust's 2014 and 2019 studies of the educational backgrounds of Britain's professional elites "painted a picture of a country whose power structures are dominated by a narrow section of the population: the 7% who

[577] This may underrepresent the percentage of coroners with a disability as the question asked two things at once: *If you have a declared disability, have you requested that reasonable adjustments be made at your court to enable you to do your job to the best of your ability?*

attend independent schools, and the roughly 1% who graduate from just two universities, Oxford and Cambridge."[578] Education is a channel through which elite groups can reproduce their social position and exclusive colleges can act as guardians of stratification patterns.[579] However, as it also offers the potential to address inequitable division in society, the degree of social closure or openness is relevant to the formation of elites.

Looking at all coroners combined, most (70.4%) attended UK state schools, with 30.2% attending UK independent/fee-paying schools and 2% having another secondary education. As Figure 22 shows, there were some differences across the three coroner posts, with senior coroners having the highest proportion of those who were educated in independent or fee-paid secondary schools.

**Figure 22 Secondary education of coroners by post (n=301)**



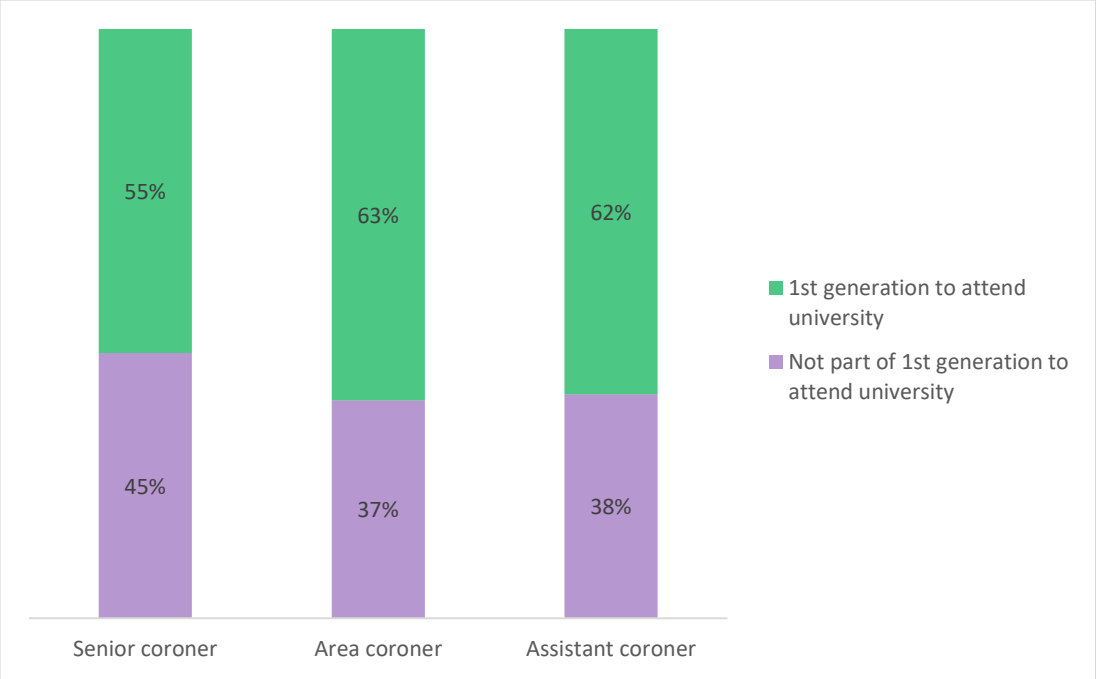

[578] 'Elitist Britain 2019' (The Sutton Trust 2019) 4 <https://www.suttontrust.com/our-research/elitist-britain-2019/> accessed 14 September 2022.
[579] Agnès van Zanten, 'The Sociology of Elite Education' in Michael W Apple, Stephen J Ball and Luis Armando Gandin (eds), *The Routledge International Handbook of the Sociology of Education* (Routledge 2009) 331.

Research shows that only 6% of current students in the UK attend independent or fee-paying schools,[580] and private school attendance has remained relatively stable over time.[581] Therefore it is clear that privately educated individuals are substantially over-represented in the coronership. This is true for other "elites" in Britain: the Sutton Trust found 39% of the elites examined in its report had attended independent schools.[582] The proportion of coroners who attended independent or fee-paying schools (30.2%) is similar to that of CEOs of public bodies (30%[583]), MPs (29%[584]), BBC executives (29%[585]) and FTSE 350 CEOs (27%[586]), though far below that of the senior judiciary (65%[587]).

The CAS also explored coroners' university education and revealed that well over half of coroners (60.2%) were part of the first generation of their family to attend university. But there were also some differences in university experience across the three coroner posts. Figure 23 shows that even though a majority of coroners in all three coroner posts were the first generation of their family to attend university, the lowest proportion (55%) were amongst senior coroners (the same post where the largest proportion of coroners went to independent/ fee-paying secondary schools).

[580] 'ISC Annual Census 2001' (Independent Schools Council 2021) 12 <https://www.isc.co.uk/research/annual-census/isc-annual-census-2021/> accessed 14 September 2022.
[581] 'Elitist Britain 2019' (n 578) 14.
[582] ibid 4.
[583] ibid 45.
[584] ibid 17.
[585] ibid 37.
[586] ibid 27.
[587] ibid 6.

**Figure 23 University education of coroners by post (n=299)**




## 6.11 Professional background

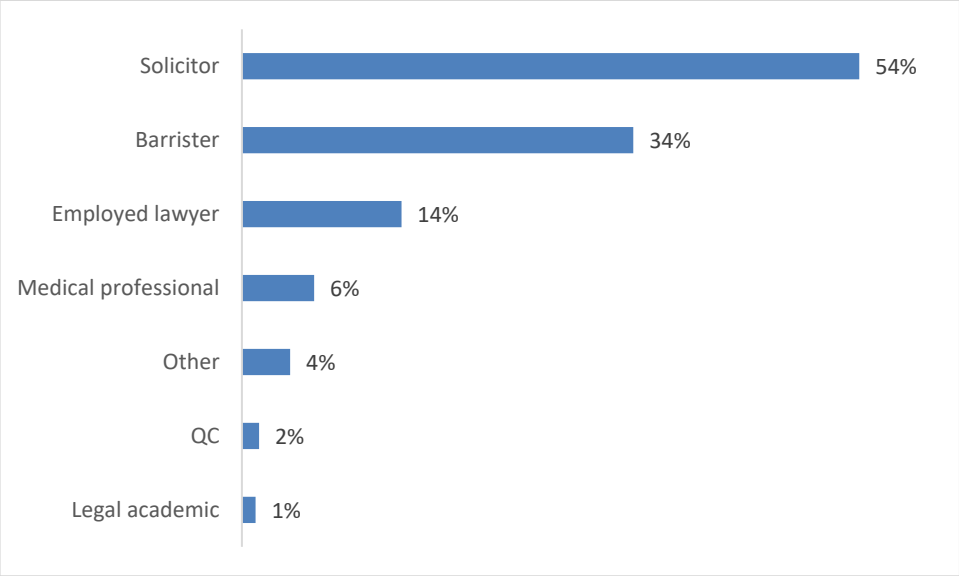
Prior to this research, statistics on the diversity in coroners' professional backgrounds was unknown. As discussed in Chapter 3, the coroner service at the turn of the century was drawn from small pools of applicants; in some areas, pools as small as the partners in a single solicitors' practice.[588] Coroners were able to select their deputy and assistant coroners, whose appointments were rarely challenged by the relevant local authority[589], leading to what Dame Janet Smith described as a "self-perpetuating group".[590] One significant change introduced since Smith's 2003 report is that medical professionals are no longer eligible for appointment as coroners unless they also have five years' post-qualification experience as a lawyer.[591] Prior to the Coroners and Justice Act 2009, the minimum qualification for appointment to coronial office was five years' qualification as a solicitor, barrister or medical practitioner.[592] To learn how many medical practitioners remain in the coroner service, and to see whether there is indeed greater variety in appointees' backgrounds[593] as a result of the first Chief

[588] Smith (n 32) para 7.4.
[589] ibid.
[590] ibid.
[591] Coroners and Justice Act 2009, Sch 3, Part 2, para 3.
[592] Coroners Act 1988, s 2.
[593] Thornton, 'Chief Coroner's Annual Report 2013-14' (n 235) para 52.

Coroner's reforms, the CAS asked coroners to state the type of legal engagement or other work they were in prior to their joining the coroner service.[594]

Just over a majority of all coroners (54%) have a professional background as a solicitor, a third of all coroners are barristers (34%), 18% have some other type of legal professional background, while only 6% (21 coroners) have a professional background as a medical professional.

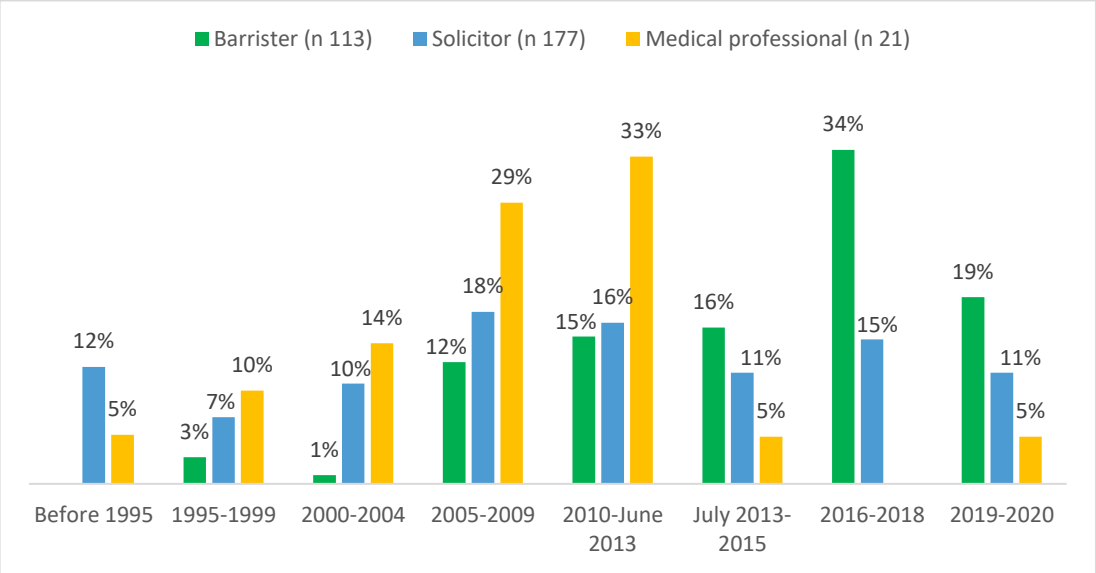
**Figure 24 Professional background: all coroners combined (n=331)**




The CAS also explored when coroners were first appointed. By cross analysing the date of appointment with coroners' professional background it is clear that the first Chief Coroner's changes to the appointment process in July 2013 have had a substantial impact on the types of professionals appointed as coroners (Figure 25). Almost all of the coroners who are medical professionals were appointed before the appointment reforms in July 2013, and since the reforms, the majority of those appointed have been barristers (78 barristers, 66 solicitors and two dual-qualified medical professionals).

[594] Q.52.

**Figure 25 Barrister, solicitor and medical coroners by date of first appointment (n=311)**

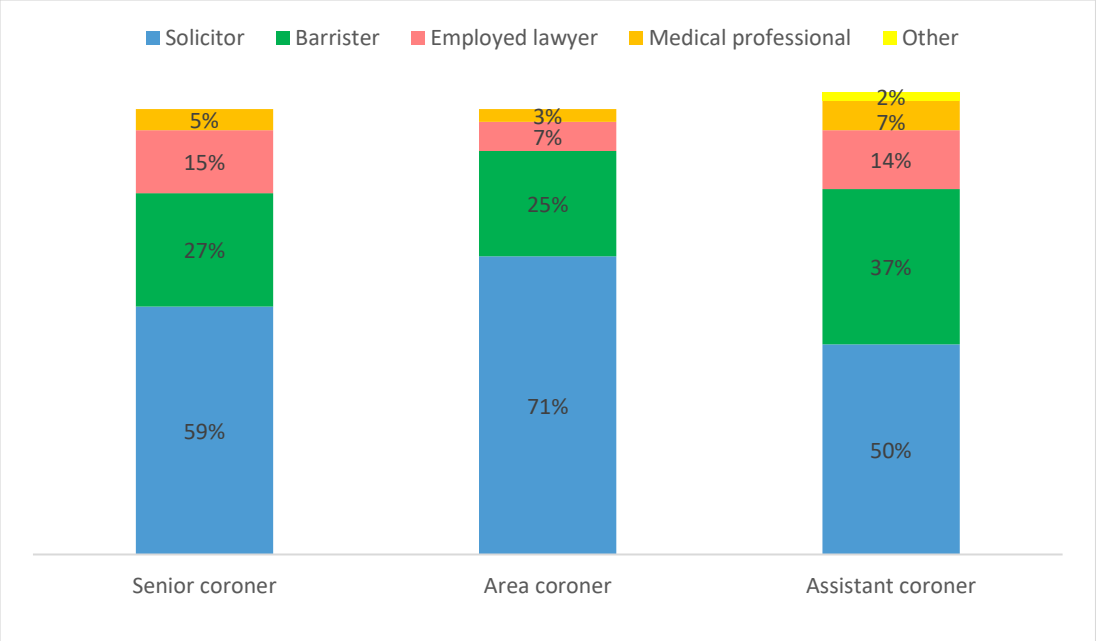



The CAS suggests there has been limited progress in meeting the first Chief Coroner's goal of recruiting more coroners from professions other than solicitor and barrister. Just over half of the 45 coroners who were employed lawyers at the time of their first appointment were recruited post July 2013. There has been only a slight increase in recruitment from backgrounds other than solicitor and barrister. Those who selected the 'other' background included a mediator, "legal trainer" and members of the courts and tribunals judiciary.[595]

There are some substantial differences in professional background for each of the three coroner posts (Figure 26). Area coroners have the highest proportion of solicitors (71%), assistant coroners have the highest proportion of barristers (37%) and senior coroners have the highest proportion of employed lawyers (15%).

[595] Four coroners commented that they are dually qualified in medicine and law.

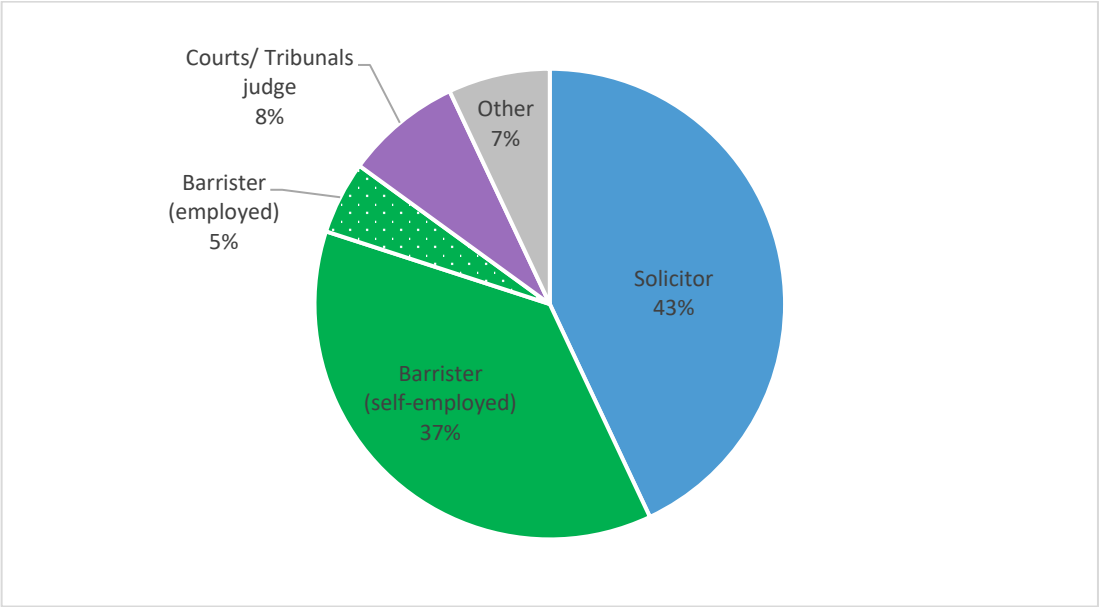
**Figure 26 Professional background by coroner post (n=331)**




The CAS also asked part-time fee paid coroners whether they also currently work in some type of legal engagement and, if so, what was that legal work.[596] As Figure 27 shows, most of these part-time coroners are practising lawyers (43% solicitors and 42% barristers), with a small proportion (8%) also working as members of the courts and tribunals judiciary.

[596] Q.53.

**Figure 27 Main work of part-time fee paid coroners (n=196)**




## 6.12 Summary

This chapter sets out an extensive, up-to-date profile of the composition of the coronership in England and Wales. In doing so it helps to fill the gap in knowledge identified by the House of Commons Justice Committee in its recent report on the coroner service. It confirms that the first Chief Coroner's reforms to the coroner appointment process have had an impact on the composition of the coronership, with more women than men having joined the service and more barristers than solicitors having been appointed since July 2013. However, a gender imbalance remains and the coroner service still does not reflect the diversity of the legal professions from which coroners are recruited.

# Chapter 7 Being a coroner

The Coroner Attitude Survey (the CAS) has not only revealed a detailed picture of the composition of the coroner service in the 21st century but it is the first survey to explore coroners' working lives in detail with all coroners. As explained in Chapter 5, the CAS was the first large-scale quantitative survey of coroners' attitudes and experiences. Most of the previous empirical research about the coroner service used qualitative interviews with a small number of coroners and usually focussed on a discrete issue, such as the investigation of suicide,[597] the role of the family at an inquest[598] or coronial decision-making.[599] The only previous quantitative survey that could be found was conducted 25 years ago.[600] It was not an attitudinal study and was limited to seeking information on coroners' backgrounds and on the organisation of the coroner service in each district.

The CAS sought to learn coroners' views on a wide range of aspects of their working lives. This chapter sets out the survey's findings on coroners' attitudes to their functions[601], to helping the bereaved at inquests, to their relationships with their local authorities, to the impact of the office of Chief Coroner and to proposed further reforms to the coroner service.

## 7.1 Coroners' functions

As discussed in Chapter 2, the coroner's functions have changed over the centuries. The Coroners and Justice Act 2009 states that the purpose of a coroner's investigation into a person's death is to ascertain:

(a) who the deceased was;
(b) how, when and where the deceased came by his or her death; and

[597] Marilyn J Gregory, 'Managing the Homicide-Suicide Inquest the Practices of Coroners in One Region of England and Wales' (2014) 42 International Journal of Law, Crime and Justice 237; Carpenter and others (n 482).
[598] Kirton-Darling (n 57).
[599] Mclean, Roach and Armitage (n 42); Maxwell Mclean, 'The Coroner in England and Wales; Coronial Decision- Making and Local Variation in Case Outcomes' (University of Huddersfield 2015).
[600] Tarling (n 13) 4.
[601] On this topic the CAS built upon McGowan's qualitative research with coroners in 2011. McGowan (n 59).

(c) the particulars (if any) to be registered concerning the death, as required by the Births and Deaths Registration Act 1953.[602]

However the Act does not state *why* it is desirable to discover these facts. In her 2003 report Dame Janet Smith noted that the purpose of the coroner's inquest was unclear.[603] The coroners who submitted evidence to her inquiry emphasised the need for the inquest's purpose to be clearly stated in future legislation. Smith was left with the impression that for coroners, the absence of a clearly defined purpose led to public misunderstanding of their role and unrealistic expectations of inquests.[604] However when McGowan asked coroners in 2011 to state and describe their purpose, there was no consensus.[605]

The survey presented coroners with eight coronial functions and asked them to select what they consider to be their most important[606]:

- To publicly investigate deaths;
- To prevent future fatalities;
- To be an advocate for the dead;
- To facilitate closure for families;
- To identify good practice in medical care or first response;
- To provide accountability for deaths;
- To rule out homicide;
- To provide answers for the family and the public as to how the deceased died.

These functions were highlighted by two of the major policy reviews of the coroner service in the past 50 years[607], they were discussed by previous theses on coroners' work[608] and were each mentioned by one or more of the three coroners who participated in the informal preparatory interviews.

[602] Coroners and Justice Act 2009, s 5(1).
[603] Smith (n 32) para 9.79.
[604] ibid.
[605] McGowan (n 59) iii.
[606] Q.37 in the Coroner Attitude Survey.
[607] Brodrick (n 32) 160; The Luce Review Committee (n 30) 24–25.
[608] Fenwick (n 64) 96; McGowan (n 59).

As Figure 28 shows, there are three functions that almost every single coroner identified as the most important functions of a coroner: "to publicly investigate deaths" (97%); "to prevent future fatalities" (93%); and "to provide answers for the family and the public as to how the deceased died" (91%). Two other functions considered important by a majority of coroners are: "to facilitate closure for families" (70%) and "to provide accountability for deaths" (60%). None of the remaining functions were considered the most important coronial functions by a majority. Less than half of coroners said being "an advocate for the dead" (44%); "to identify good practice in medical care or first response" (40%), and almost no coroners (18%) consider ruling out homicide to be an important function of the coroner.

**Figure 28 Coroner identification of the most important functions of the coroner (n=339)**

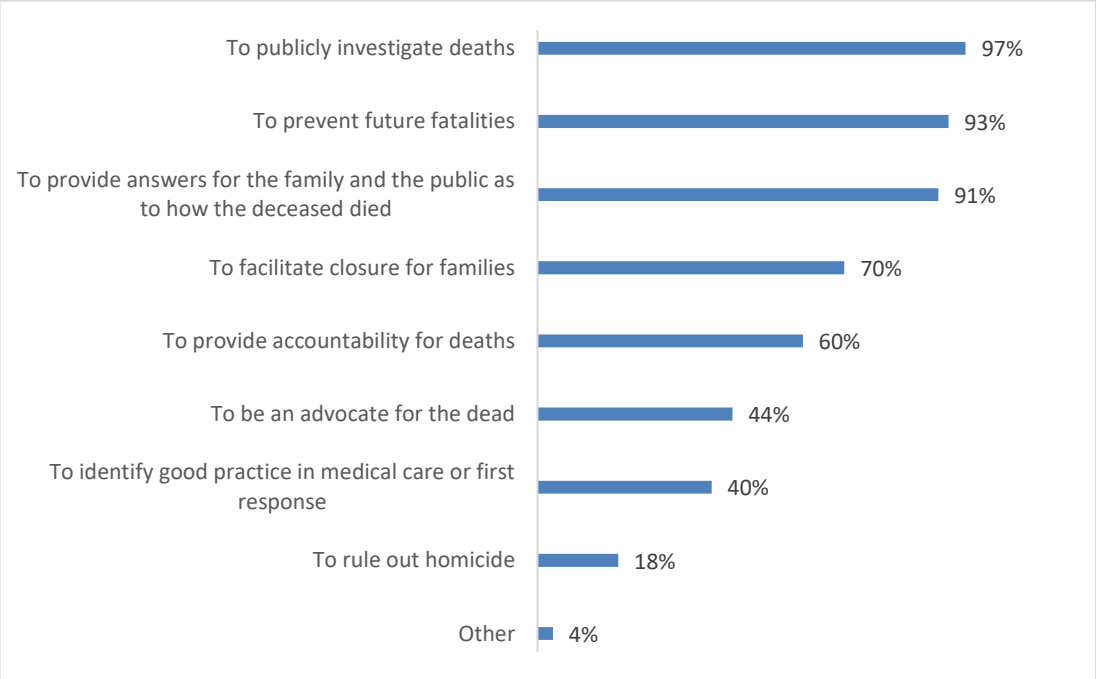
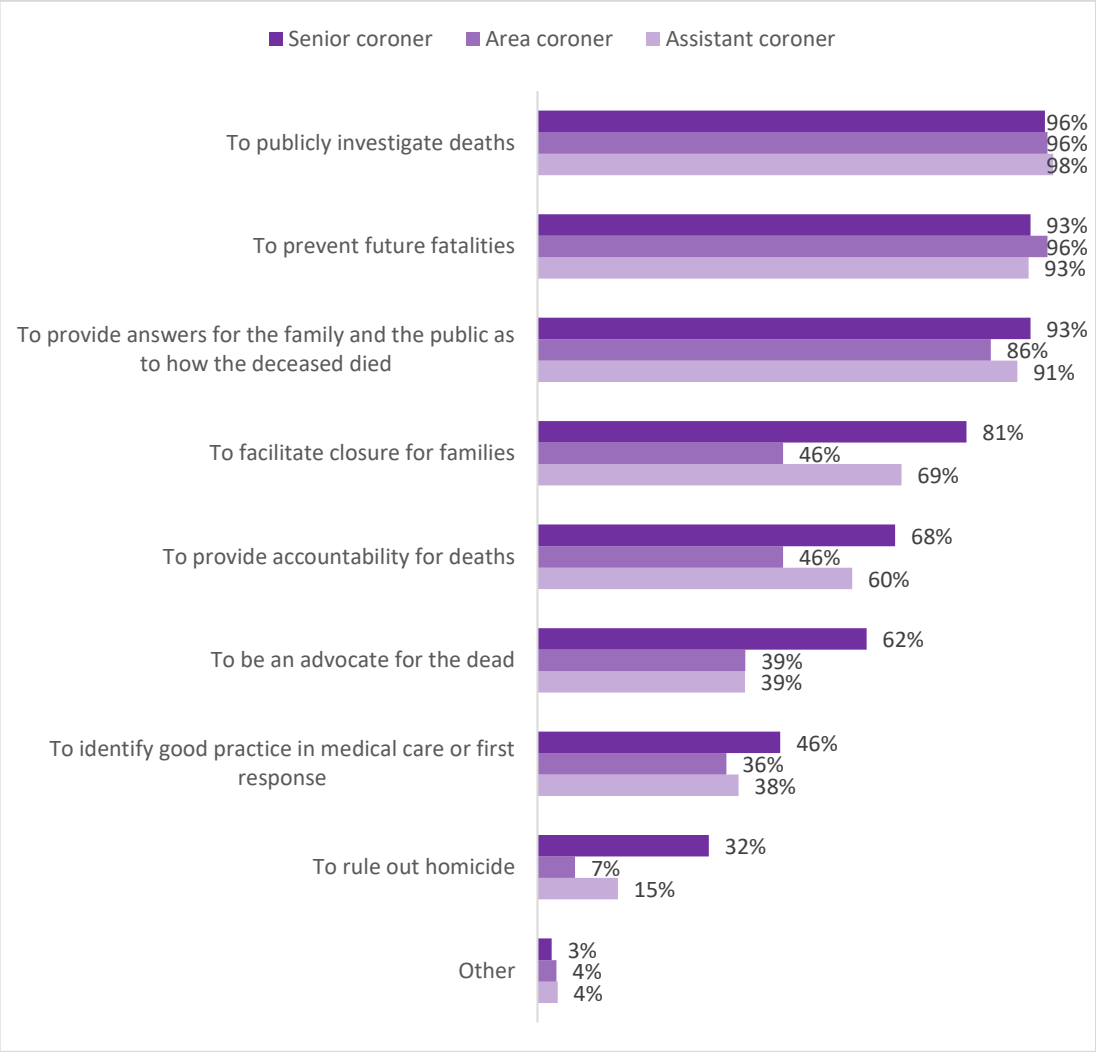



Figure 29 shows that there were differences between the three coroner posts about the importance of several functions of the coroner. While almost all senior coroners said facilitating closure for families was important, less than half of area coroners (46%) identified this function as important. A majority of both senior coroners and assistant coroners said providing accountability for deaths was an important function, but less than half of area coroners (46%) identified this as an important function. And while almost two-thirds of senior coroners saw being "an advocate for the dead" as one of

their most important functions (62%), only 39% of both area coroners and assistant coroners identified this as an important function for them.

Figure 29 also shows how the results suggest that area coroners are much more specific about the most important functions of the coroner: only three functions were identified by a majority of area coroners, whereas five functions were identified by a majority of assistant coroners and six functions by a majority of senior coroners.

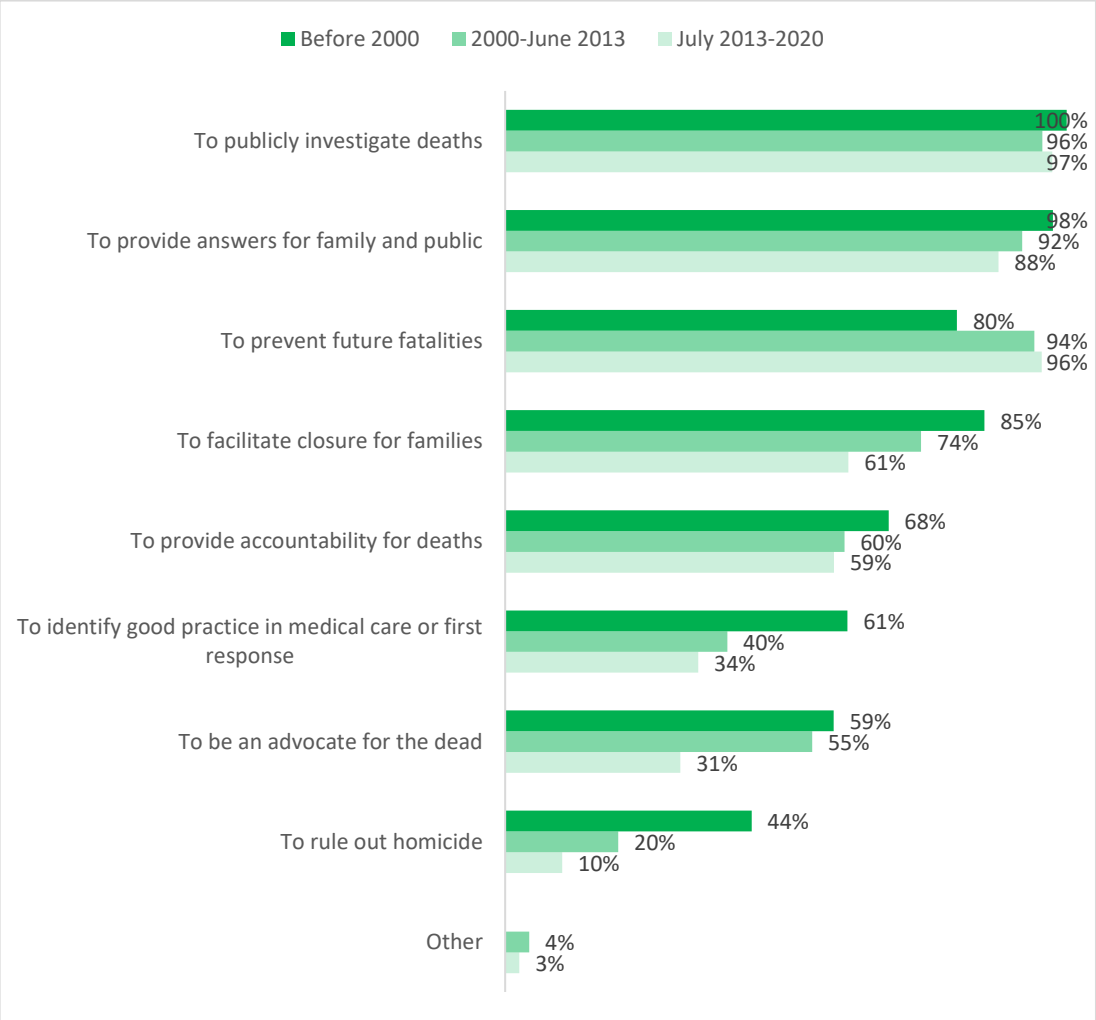
**Figure 29 Coroner identification of the most important functions of the coroner, by post**




The purpose of ruling out homicide is one of the oldest of coronial functions, but it is not seen as important compared with any of the other functions presented to the coroners. As Figure 30 shows, coroners appointed since the 2013 reforms are the least

likely to see ruling out homicide as an important function of the coroner. Almost half of coroners appointed before 2000 (44%) think ruling out homicide is one of their most important functions; 20% of those appointed between 2000 and June 2013 thought it was most important; but only 10% of coroners appointed since July 2013 see ruling out homicide as a most important coronial function.

**Figure 30 Coroner identification of the most important functions of the coroner, by tenure**




The modern coroner service's renewed emphasis on prevention of death is reflected in the "to prevent future fatalities" function being the only one identified by a greater proportion of coroners appointed since 2000 than by those in coronial office before that year. However almost all coroners regardless of tenure consider it a most important function.

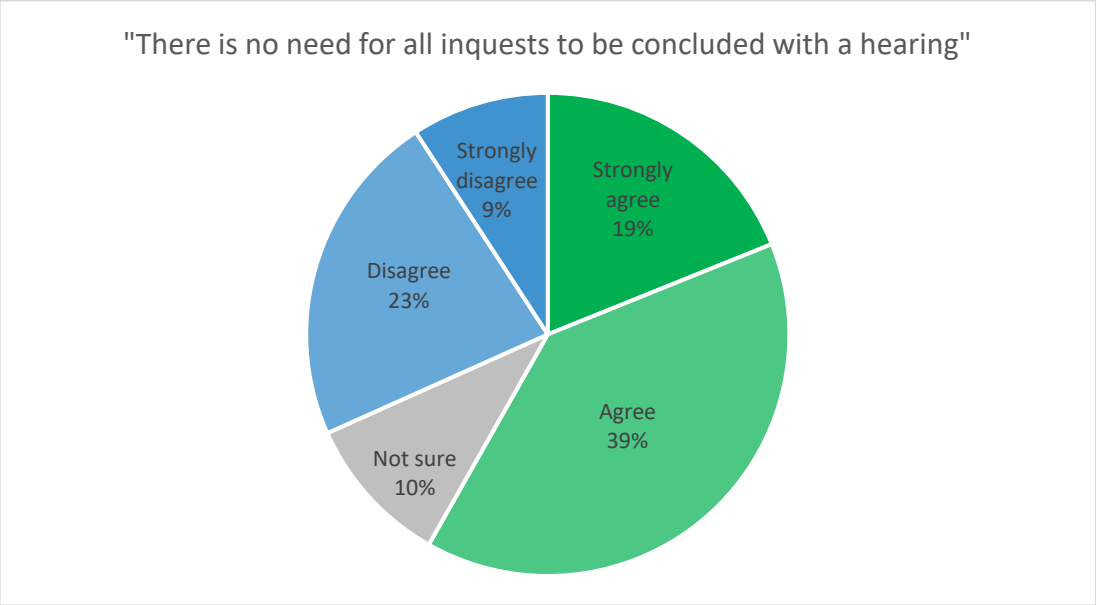
## 7.2 Public aspects of the coroner's role

Two of the three functions that coroners deem most important reflect the public aspect of the coroner's role: public investigation of deaths and providing answers for the public as to how the deceased died. As discussed above, almost all coroners said these two functions were amongst the most important functions of the coroner. However, the second Chief Coroner took the view that in cases where the facts are not contentious, where the outcome is clear, where the family do not want an inquest and there is no other public interest for conducting an inquest in a public hearing, the case could be concluded by a decision "on the papers" with a written ruling by the coroner, and he called for the law to be changed.[609] The government acted upon this recommendation, and the Judicial Review and Courts Act 2022 gave coroners the power to conduct non-contentious inquests in writing.[610]

The CAS explored coroners' views of this change in the law by asking whether they agreed or disagreed with the statement "There is no need for all inquests to be concluded with a hearing".[611] As Figure 31 shows, a majority of coroners (58%) agree with this procedural change; although a third of coroners disagreed (32%). There was no substantial differences on this point based on coroner post or length of time in post.[612]

[609] Lucraft, 'Chief Coroner's Annual Report 2018-19 & 2019-20' (n 308) 33.
[610] Judicial Review and Courts Act 2022, s 40.
[611] Q.40.
[612] Of the coroners first appointed before 2000, the clear majority agreed or strongly agreed (73%), compared with just over half (56%) of those appointed since 2000.

**Figure 31 Coroners' attitudes to whether all inquests must conclude with a hearing (n=338)**

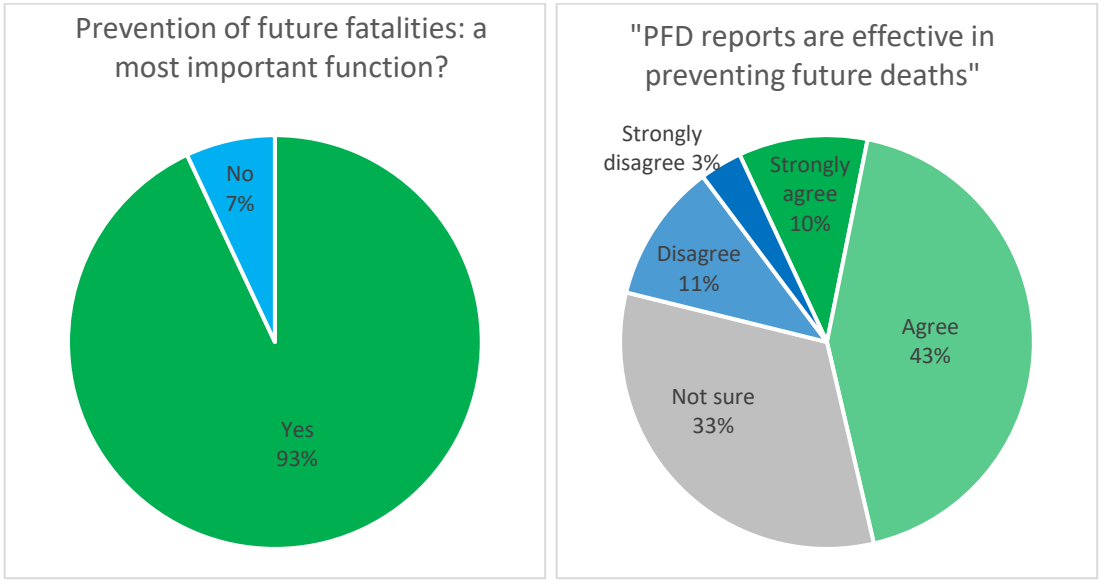



### 7.3 Prevention of future deaths

As discussed in Chapter 4, the modern coroner service has a renewed emphasis on learning lessons from death to prevent further fatalities. As noted above, almost all coroners (93%) said that prevention of future deaths was one of their most important functions. The CAS explored coroners' views on this function further by asking them to say whether they agreed or disagreed with the statement "PFD [prevention of future deaths] reports are effective in preventing future deaths".[613] As Figure 32 shows, only 53% of coroners believe PFD reports are effective in preventing further fatalities; a third (33%) are not sure they are effective, and 14% said they were not effective. This combined finding indicates that many coroners have doubts about the efficacy of the mechanism by which they can fulfil one of their most important functions.

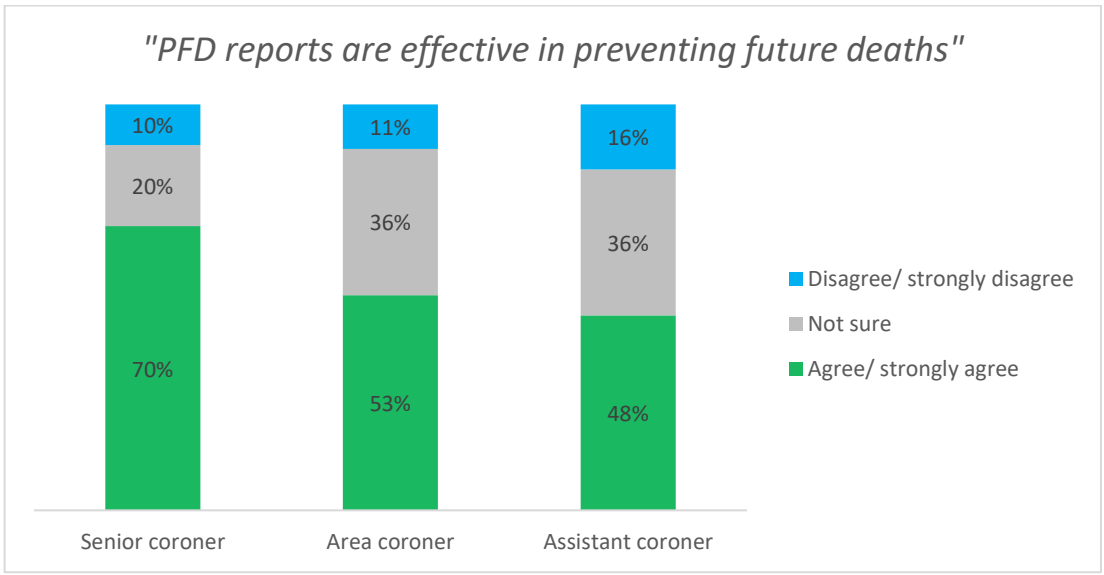
[613] Q.40.

**Figure 32 Coroners' attitudes to the effectiveness of PFD reports (n=338)**




As Figure 33 shows, more senior coroners (70%) agreed that PFD report are effective in preventing future deaths than area coroners (53%) or assistant coroners (48%). Over a third of both area coroners (36%) and assistant coroners (36%) were not sure whether reports are effective.

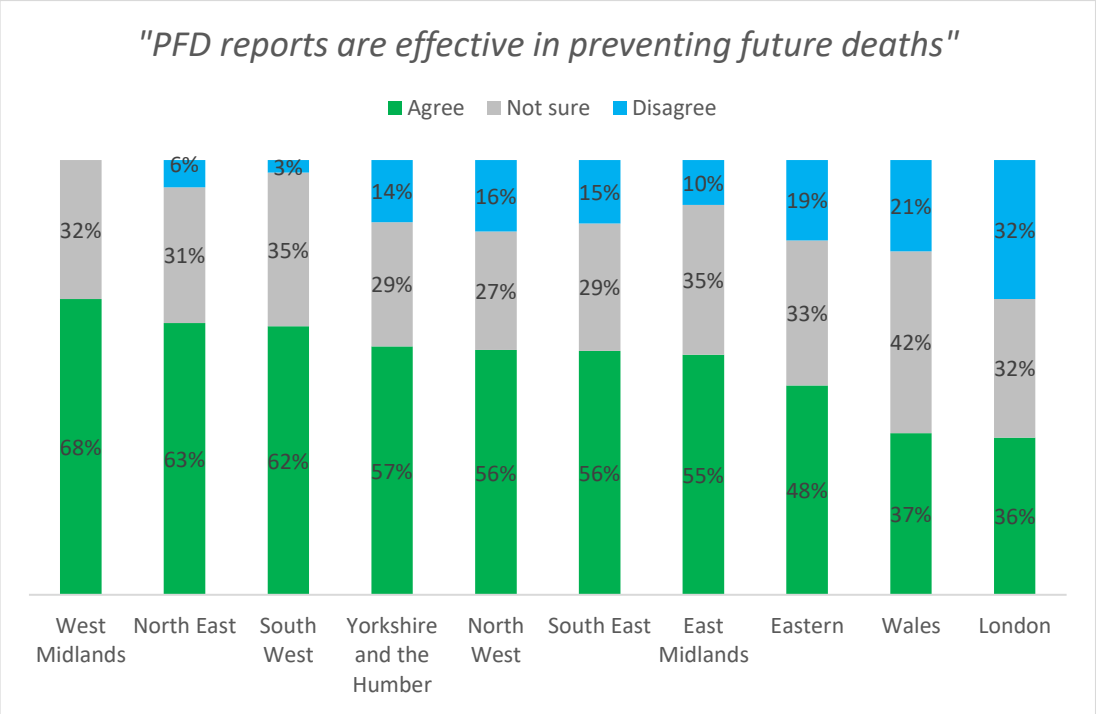
**Figure 33 Coroners' attitudes to the effectiveness of PFD reports, by post (n=338)**




There were also some differences in coroners' attitudes to PFD reports by region (Figure 34). For example, no coroners in the West Midlands said that PFD reports were

not effective in preventing future deaths, but a third of coroners in London (32%) did not feel that PFD reports are effective.

**Figure 34 Coroners' attitudes to effectiveness of PFD reports, by region**




## 7.4 Coroners' commitment to the bereaved

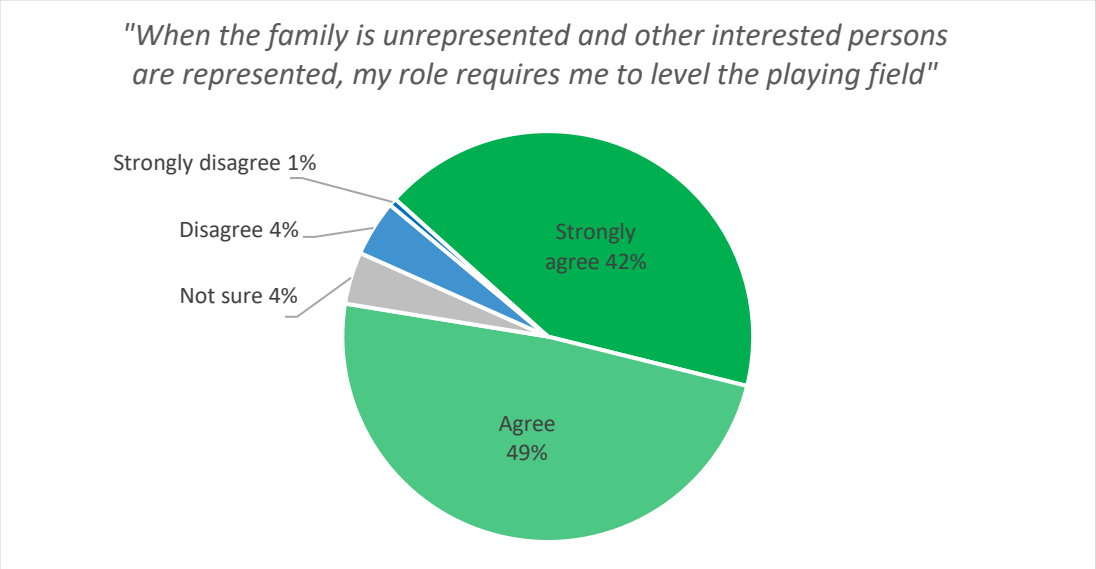
The bereaved have a central role in the contemporary inquest. This is a modern development; both the Luce Review and Dame Janet Smith's reports emphasised that the coroner service at the turn of the century was not meeting the needs of families.[614] Efforts to address this defect, to "put the needs of bereaved families […] at the heart of these services",[615] led Kirton-Darling to take the view that it is "this role of the family which characterises the contemporary inquest".[616] As discussed in Chapter 4, this was also emphasised by the first Chief Coroner Sir Peter Thornton, who argued that answering the needs of the bereaved is the first of the two ways in which the 21st

[614] The Luce Review Committee (n 30) 143, 145; Smith (n 32) para 12.21-12.23, 12.30.
[615] 'Charter for Current Coroner Services: Response to Consultation' (Ministry of Justice 2011) CP(R) 5/2011 3 <https://consult.justice.gov.uk/digital-communications/coroner_service_charter/results/coroner-draft-charter-response.pdf> accessed 14 September 2022.
[616] Kirton-Darling (n 57) 12.

century coroner provides justice to the public.[617] As discussed earlier, in the CAS almost every single coroner said that "providing answers for the family" was one of coroners' most important functions and 70% also said that facilitating closure for families was an important function of the coroner. This suggests that most coroners agree on the centrality of the bereaved in the modern inquest, and coroners' responses to other questions in the CAS support this.

For example, almost all coroners (91%) agreed with the statement that "When the family is unrepresented and other interested persons are represented, my role requires me to level the playing field"[618] (Figure 35).

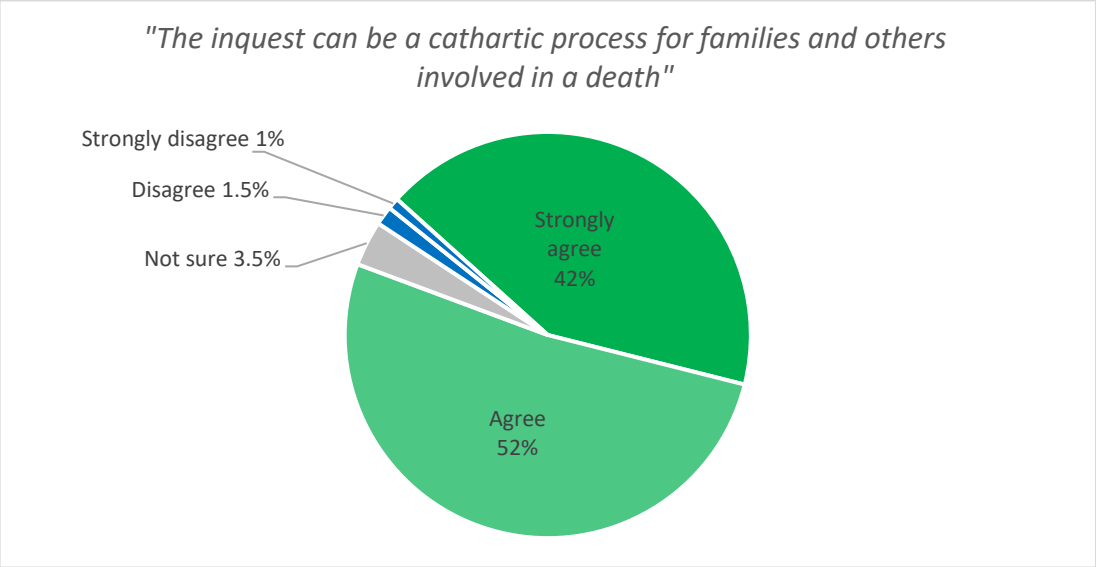
**Figure 35 Coroners' attitudes to role when the family is unrepresented (n=339)**




Coroners were also asked whether they agreed with the statement "The inquest can be a cathartic process for families and others involved in a death".[619] Again, almost every coroner (94%) agreed (Figure 36).

[617] Thornton, 'Howard League Parmoor Lecture 2012: The Coroner System in the 21st Century' (n 232) 7.
[618] Q.40.
[619] Q.40.

**Figure 36 Coroners' attitudes to whether the inquest can be a cathartic process (n=338)**




However, differences between coroners emerged when the CAS explored the appropriateness of certain approaches coroners can adopt to soften the blow felt by bereaved families at inquests. Coroners were asked to say whether they felt four examples of what Freckelton termed "trauma informed practice"[620] are appropriate at inquests[621]:

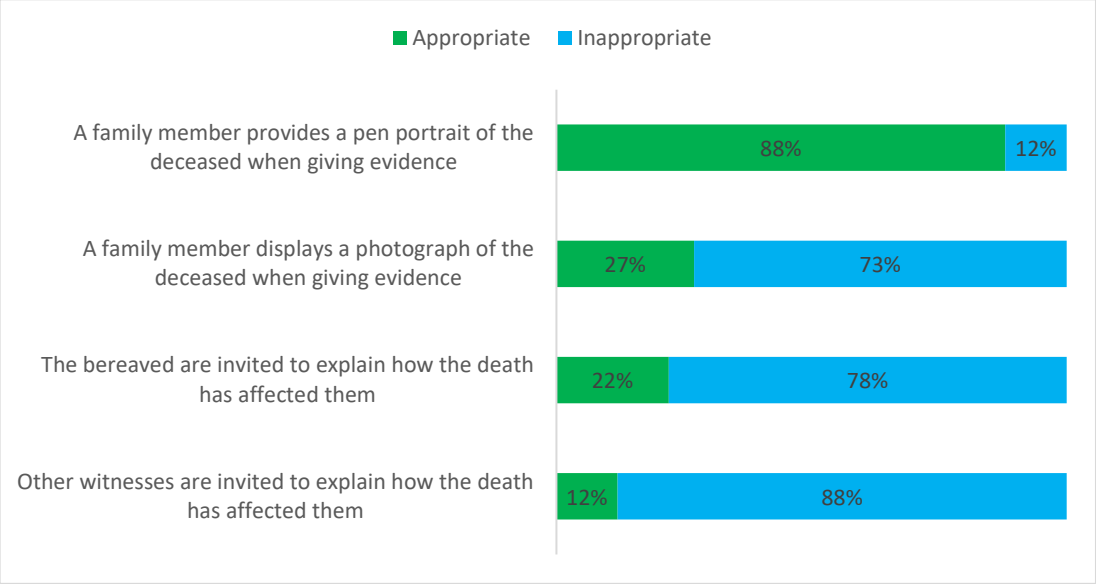
1) permitting a family member giving evidence to the inquest to give a "pen portrait" of the deceased;
2) permitting that family member to display a photograph of the deceased when giving his or her evidence;
3) inviting the bereaved to explain how the death has affected them; and
4) inviting witnesses other than the deceased's family and friends to explain how the death has affected them.

The first three of these techniques (pen portraits, the display of photographs and statements as to the impact of the deaths) were used at the recent public inquiries into the Manchester Arena Bombing and the Grenfell Tower Fire; the fourth was suggested

[620] Freckelton (n 478) 5.
[621] Q.39.

by Freckelton.[622] As Figure 37 shows, the vast majority of coroners (88%) believe it is appropriate for a relative of the deceased to include a "pen portrait" of the deceased when giving evidence to an inquest. But a majority of coroners said they did not feel it was appropriate for any of the other three practices to be used at inquests.

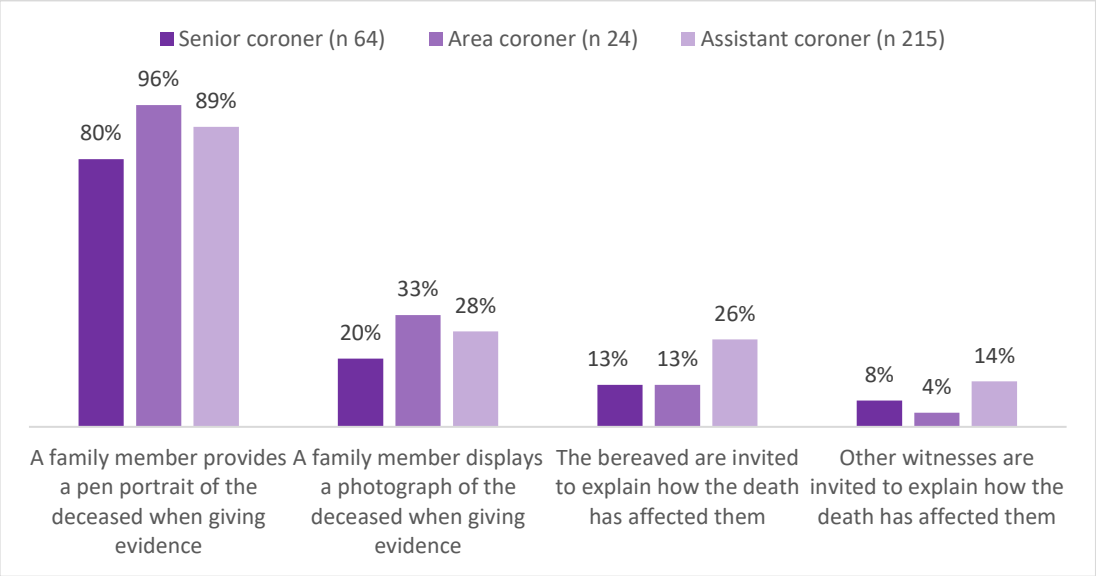
**Figure 37 Coroners' attitudes to four techniques of therapeutic jurisprudence (n=303)**




As figure 38 shows, there are some small differences in views about this across the three coronial posts.

[622] Freckelton (n 478) 27.

**Figure 38 Coroners' attitudes to four techniques of therapeutic jurisprudence, by post**

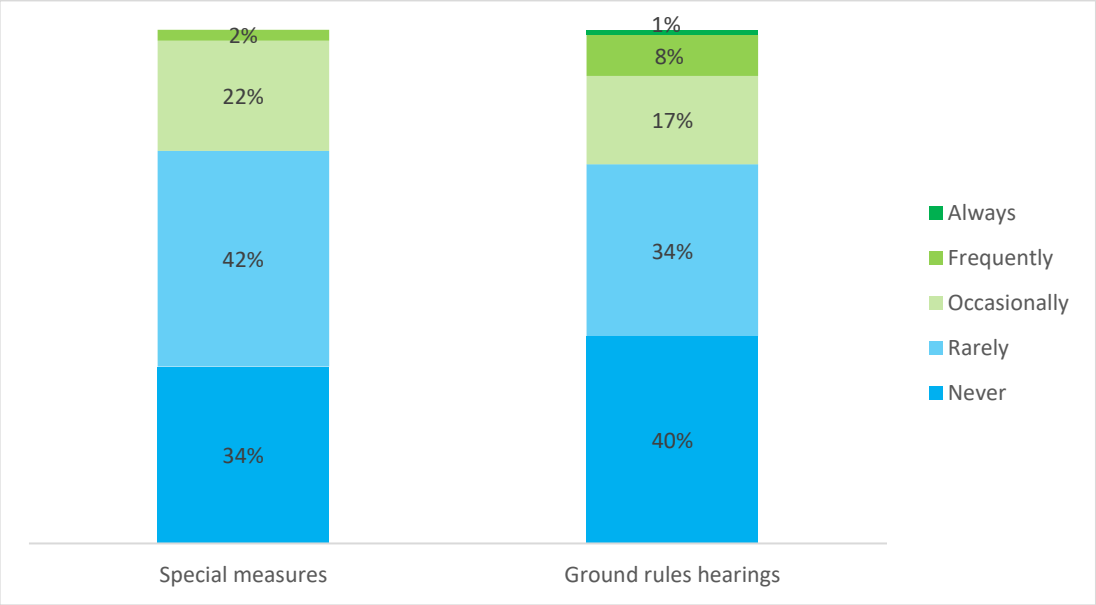



## 7.5 Handling witnesses at inquests

As discussed in Chapter 4, the inquest into the murder of Leeds school teacher Ann Maguire (and the subsequent litigation) led Dolan and Street to warn that coroners' failure to use the witness safeguards routinely deployed in the criminal and family courts risks re-traumatising vulnerable persons giving evidence at inquests.[623] The CAS specifically sought to learn how many coroners make use of the protections now available for vulnerable witnesses at inquests. Coroners were asked how often they used special measures (e.g. allowing witnesses to give evidence via videolink or from behind a screen) at inquests and ground rules hearings (a preliminary hearing in which detailed consideration is given to the particular needs of a vulnerable witness).[624] The survey found that very few coroners use special measures or ground rules hearings at inquests on a regular basis (Figure 39). Three-quarters of all coroners said that they never or rarely used special measures (76%) and never or rarely used ground rules hearings (74%) at inquests they conduct.

[623] Bridget Dolan and Amy Street (n 510).
[624] Q.38.

**Figure 39 Coroner use of special measures (n=326) and ground rules hearings (n=325)**




There was not much difference between coroners in different posts in relation to either special measures or ground rules hearings. Assistant coroners were the least likely to use special measures (70% said they never or rarely used special measures in the inquests they conduct) or ground rules hearing (only 7% said they frequently or always used ground rules hearings), but only a minority of senior coroners and area coroners frequently or always used special measures or ground rules hearings. It is perhaps expected that ground rules hearings were rarely used by assistant coroners, as they are unlikely to be necessary in the short, uncontentious inquests that make up the bulk of most assistant coroners' caseloads. Harder to explain is the little use of such hearings by senior coroners and area coroners as they are more likely to handle the longer and more contentious inquests involving multiple witnesses and interested persons.

**Figure 40 Coroner use of special measures at inquests, by post (n=326)**

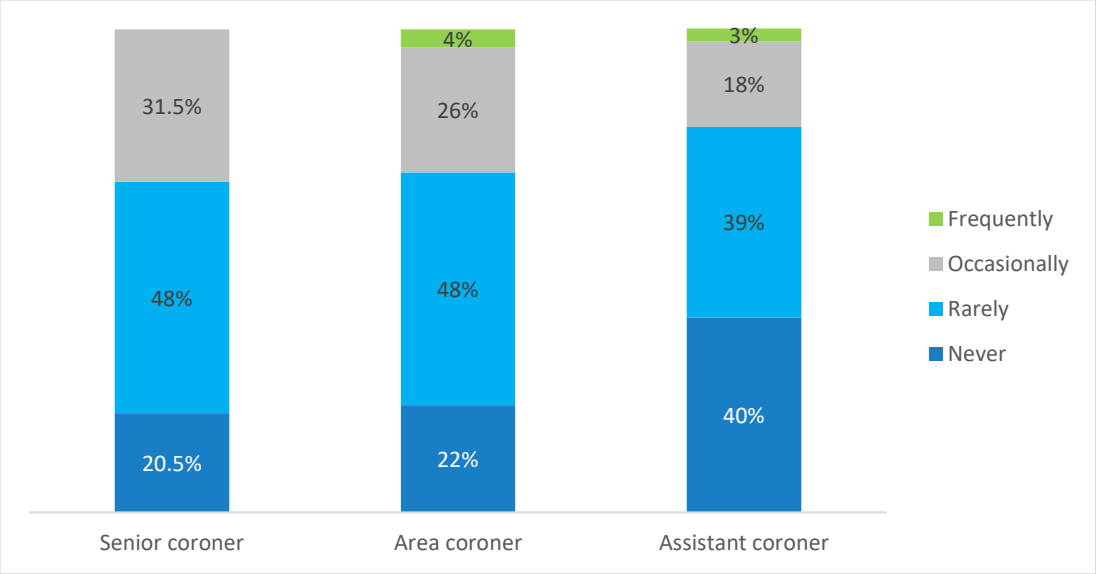
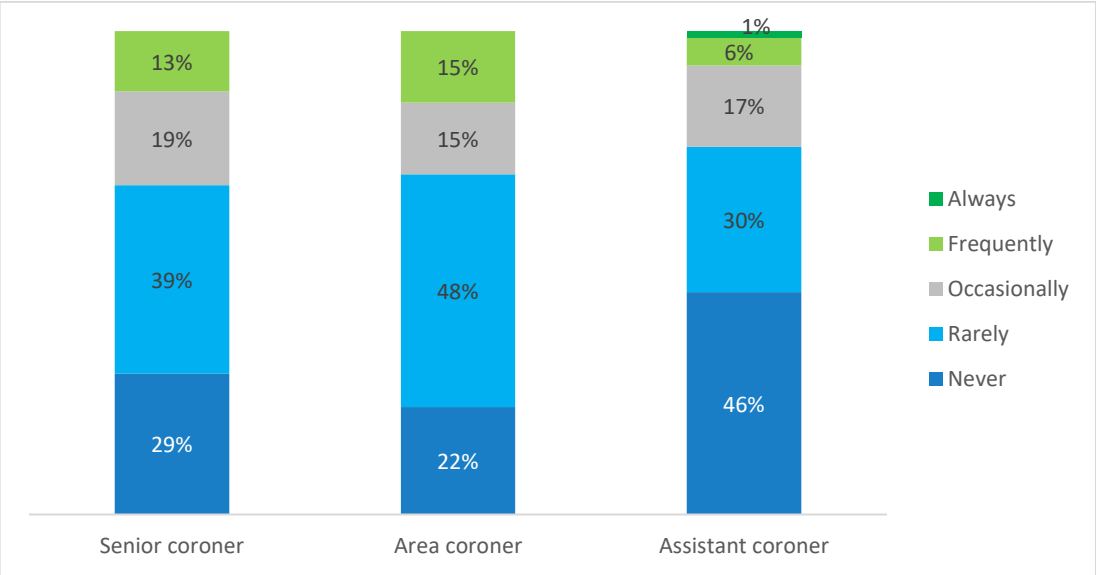
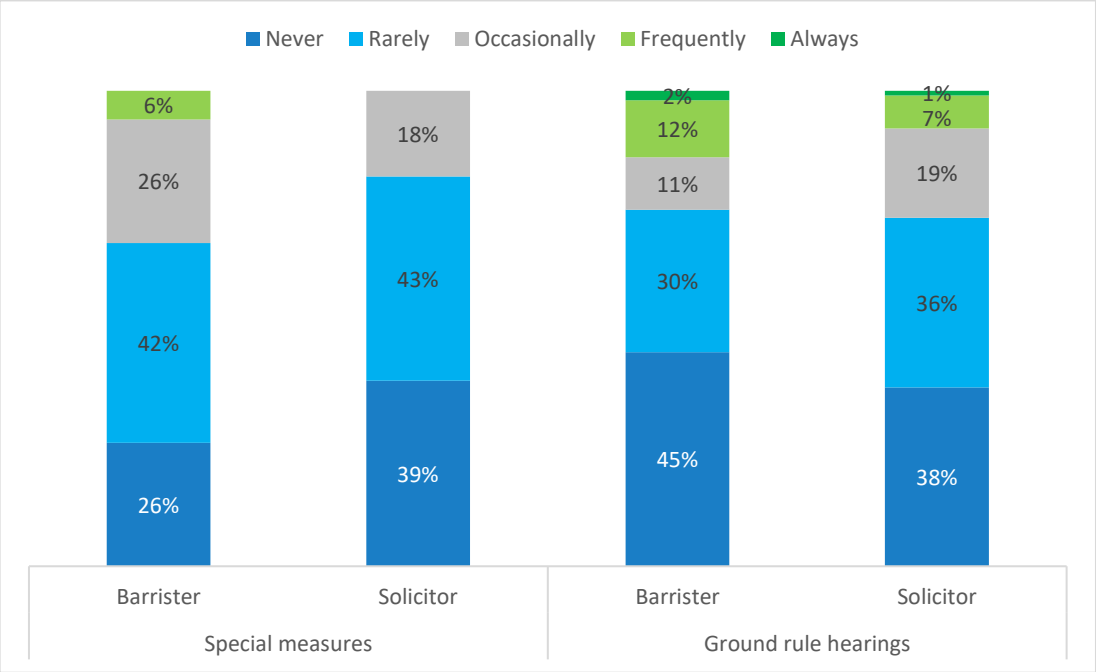



**Figure 41 Coroner use of ground rules hearings, by post (n=325)**




One difference did emerge between coroners who are barristers and those who are solicitors. As Figure 42 shows, a greater proportion of coroners who were barristers at the time of their appointment to the coroner service make use of special measures and ground rules hearings than do solicitor coroners.

**Figure 42 Coroner use of special measures and ground rules hearings, by professional background**




## 7.6 Sitting with juries

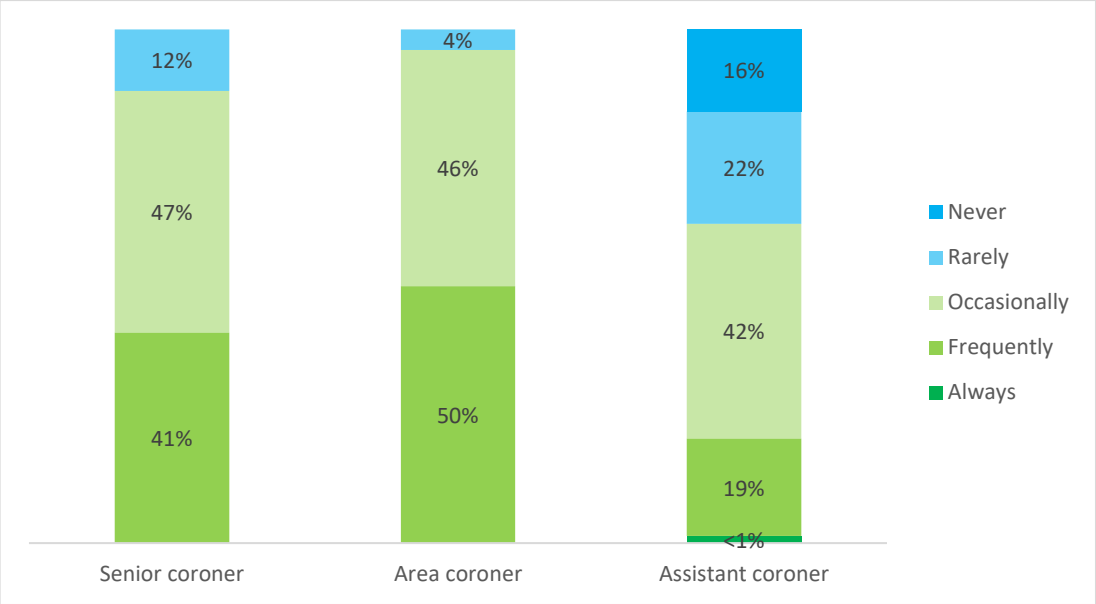
The Coroners and Justice Act 2009 mandates that an inquest must be held *without* a jury[625] unless the coroner has reason to suspect that the deceased died while in custody and that the death was violent or unnatural or the cause of death is unknown; or that the death resulted from an act or omission of a police officer in the purported execution of his or her duty; or that the death was caused by a notifiable accident, poisoning or disease.[626] As noted in Chapter 1, most inquests are held without a jury. The CAS explored coroners' experience of and attitudes to the use of juries in inquests and found that most coroners have had some experience of sitting with a jury: 72% of coroners said they sit with a jury either frequently or occasionally.

When the action or inaction of an agent of the state may have contributed to a death, the subsequent inquest is usually more contentious. As the state's obligations under article 2 of the European Convention on Human Rights may also be scrutinised, inquests into such deaths tend to be heard by more experienced coroners. Senior

[625] Coroners and Justice Act 2009, s 7(1).
[626] ibid, s 7(2). An inquest may also be held with a jury if the coroner thinks there is sufficient reason for doing so (s 7(3)).

coroners and area coroners are therefore more likely to sit with a jury than assistant coroners (Figure 43).

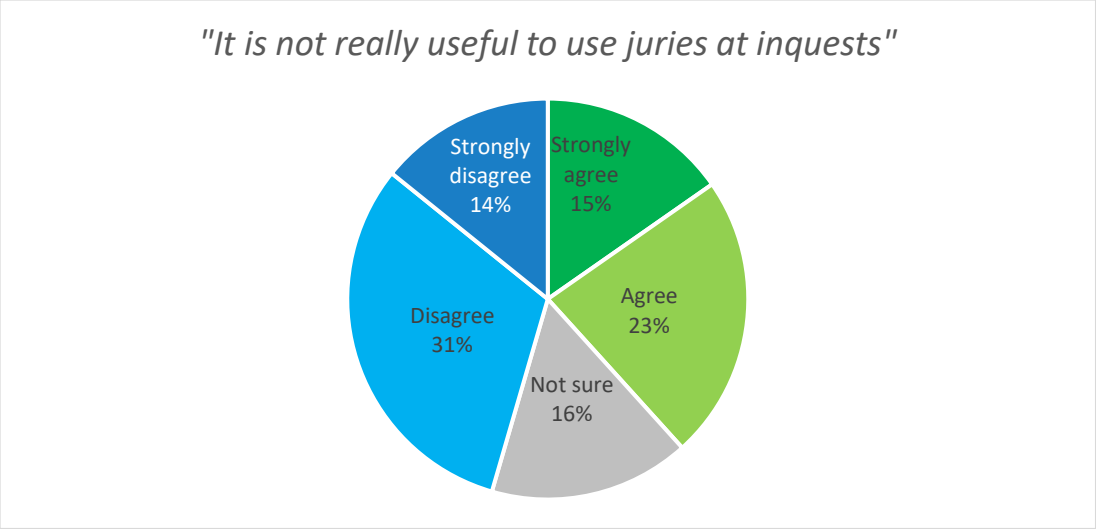
**Figure 43 Coroner frequency of sitting with a jury, by post (n=334)**




The CAS asked coroners about the usefulness of juries at inquests.[627] The results show that coroners are divided as to the utility of juries at inquests, with 38% agreeing that it is not really useful to use juries at inquests, 47% disagreeing and 16% saying they were not sure (Figure 44).

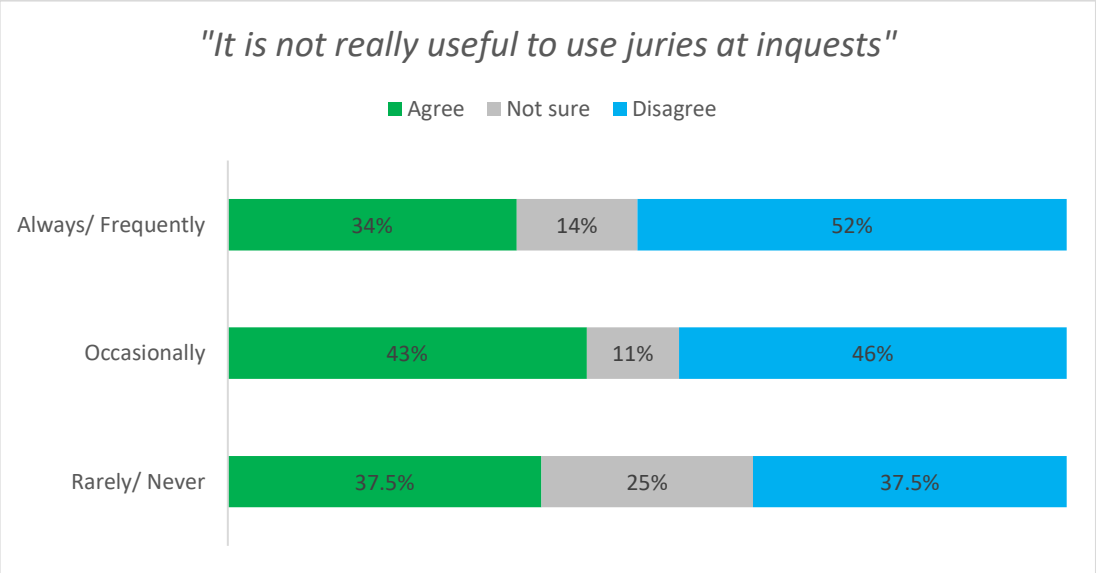
[627] Q.40 of the Coroner Attitude Survey asked coroners whether they agreed or disagreed with the statement "It is not really useful to use juries at inquests".

**Figure 44 Coroners' attitudes to the usefulness of sitting with a jury (n=339)**




But coroners' experience of sitting with a jury appeared to influence their attitudes to the usefulness of juries at inquests. Of coroners who sit with a jury frequently, a majority disagreed that juries were not useful at inquests, with only a third (34%) of the view that it is not really useful to use juries at inquests (Figure 45). In contrast, coroners who rarely or never sit with a jury were equally divided on the utility of juries, with a quarter not sure.

**Figure 45 Coroners' attitudes to the usefulness of sitting with a jury, by the frequency with which they sit with juries (n=334)**



## 7.7 Reform of the coroner service

As discussed in Chapters 2 and 3 above, the damning indictments of the state of the coroner service at the start of the 21st century delivered by the Luce Review and Dame Janet Smith's reports eventually led to significant changes in the service's structure and in the recruitment and training of its coroners. However, in creating the post of Chief Coroner, the government implemented only one of the major reforms recommended by the two reports, disappointing the Coroners' Society, local authorities and other key stakeholders.[628] The CAS explored coroners' views about the significant changes to the coroner service introduced by the Coroners and Justice Act 2009 and by the first Chief Coroner. Instead of the unified, national coroner structure recommended by the Luce Review and Smith, the revised service is marked by the mergers of coroner areas, new appointment processes, new training procedures and coroner appraisals, the creation of nationwide "cadres" of specialist coroners trained in investigating service deaths and mass fatality incidents, and the guidance and leadership of the Chief Coroner.

All coroners were also asked to what extent they felt that their job as a coroner had changed since their first appointment to a coroner post.[629] As Table 6 shows, the vast majority of coroners believe their job has changed significantly since they were first appointed, with over a tenth (13%) taking the view that it has changed completely.

[628] As discussed above in Chapter 2.8.
[629] Q.26.

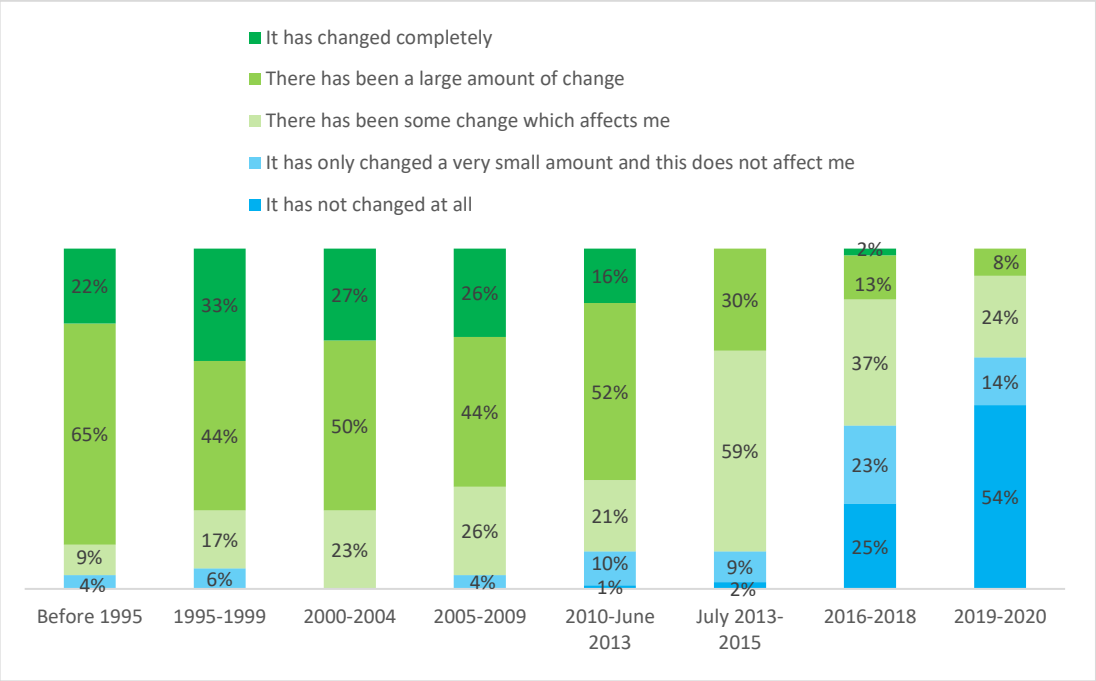
**Table 6 Coroners' views on extent of change since first appointment (n=337)**

| ***To what extent do you feel that your job as a coroner has changed since you were first appointed to a coroner post?*** | **2020 CAS** |
|---|---|
| It has not changed at all | 12% |
| It has only changed a very small amount and this does not affect me | 10% |
| There has been some change which affects me | 29% |
| There has been a large amount of change | 36% |
| It has changed completely | 13% |

Perhaps not surprisingly, those coroners who have been serving the longest time reported experiencing the greatest change to their jobs. André Rebello, HM Senior Coroner for Liverpool and the Wirral since 1994, told the House of Commons Justice Committee that "The coroner service today, generally across the piece, cannot be recognised as the service I joined in 1994."[630] As Figure 46 shows, the proportion of coroners who say the job has changed completely or that there has been a large amount of change falls below 50% only for those appointed from July 2013. However, it appears that even relatively new coroners have had to adjust to significant change. The changes introduced over the past seven years – most notably the issuance of Chief Coroners' guidance and law sheets – are reflected in the fact that amongst those coroners appointed from July 2013 onwards, a majority (57.6%) say that they have been affected by how their job has changed.

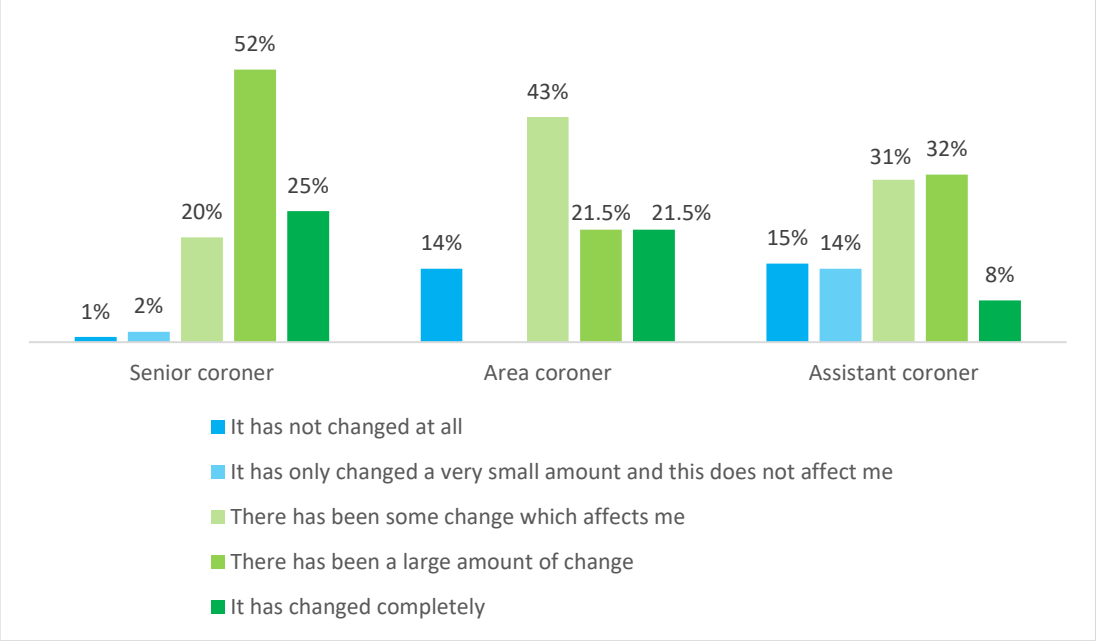
[630] Justice Committee (n 9) para 20.

**Figure 46 Coroners' attitudes on change since appointed, by era of first appointment (n=355)**



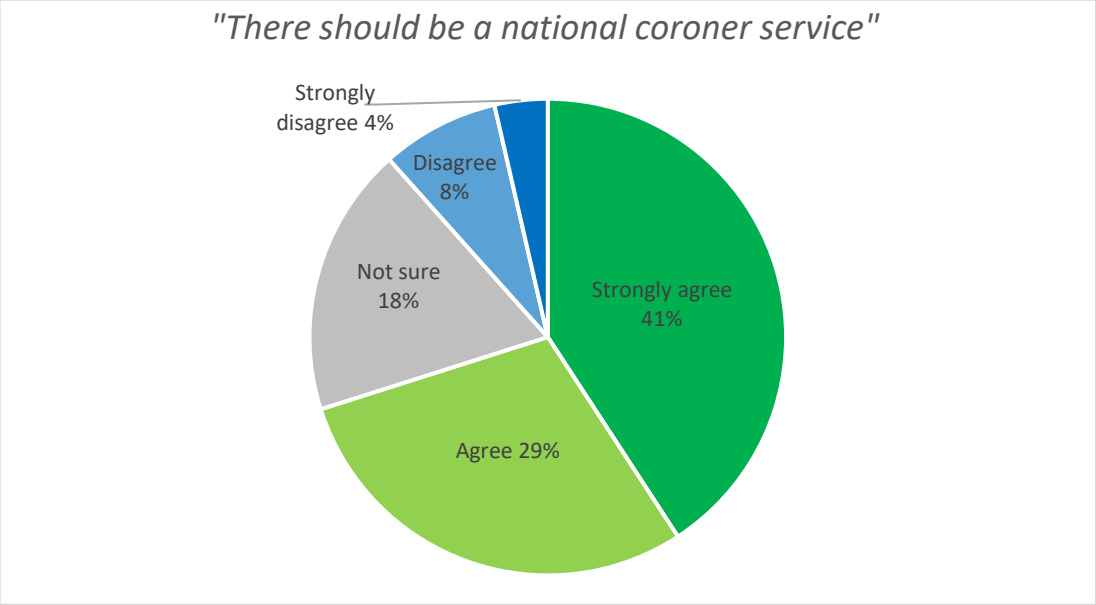

There is a clear difference between coronial posts, with the great majority of senior coroners taking the view that there has been great or complete change. This is likely to be because most senior coroners (86%) first joined the coroner service before the reforms of July 2013.

**Figure 47 Coroners' attitudes on change since appointed, by post (n=337)**



Despite the amount of change coroners seem to have experienced since appointment, the findings of the CAS indicate that coroners feel even further change in the coroner service is necessary. In 2017, Dame Elish Angiolini's report of her Independent Review of Deaths and Serious Incidents in Police Custody had called on the government to "look again at a National Coroner Service".[631] The government response to her report ignored this recommendation. The CAS asked coroners whether they agreed or disagreed with the statement "There should be a national coroner service".[632] The results show a clear majority of coroners (70%) support Angiolini's recommendation for a national coroner service, with only a small minority (12%) opposed to a national coroner service (Figure 48).

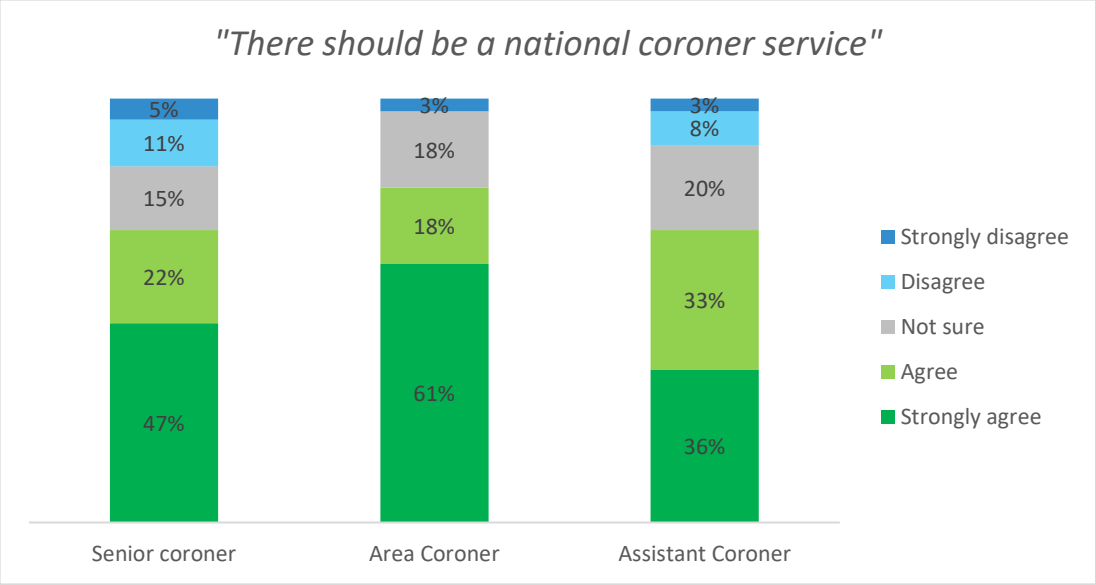
**Figure 48 Coroners' attitudes on a national coroner service (n=338)**




There were no substantial differences in attitude across the three coroner posts, with over two thirds of coroners in each post expressing agreement with the statement (Figure 49). Area coroners expressed the highest level of support.

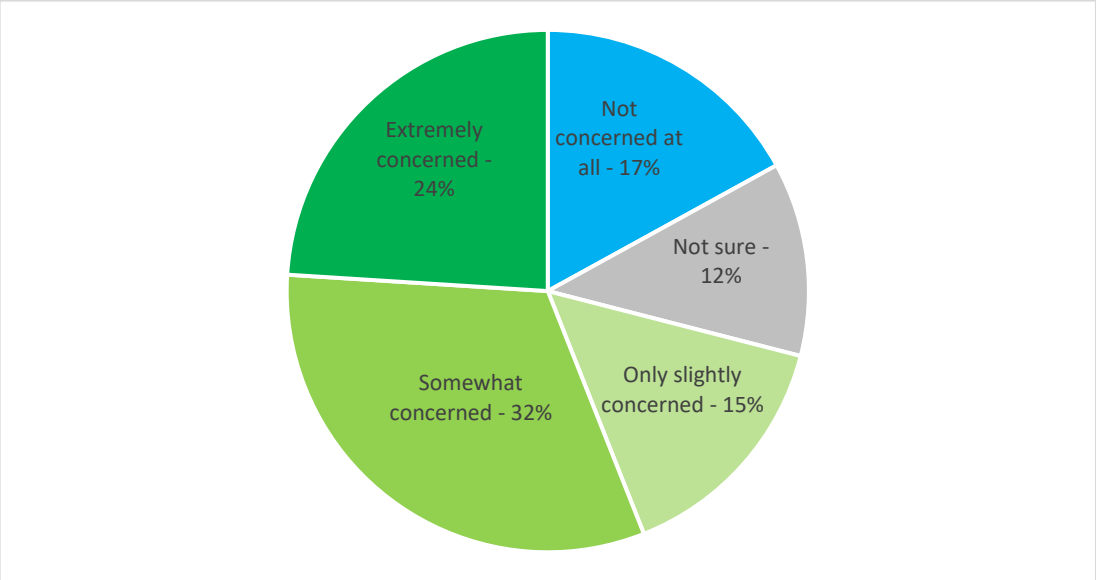
[631] Angiolini (n 38) para 16.78.
[632] Q.40.

**Figure 49 Coroners' attitudes on a national coroner service, by post (n=338)**




The CAS also asked coroners how concerned they were over a lack of a national coroner service.[633] The results reflect the strength of coroners' feelings on the issue (Figure 50), with the overwhelming majority of coroners saying they have concerns (71%) and over half saying they are "extremely" or "somewhat" concerned about the lack of a national coroner service (56%).

**Figure 50 Coroners' concern over lack of a national coroner service (n=343)**




[633] Q.28.

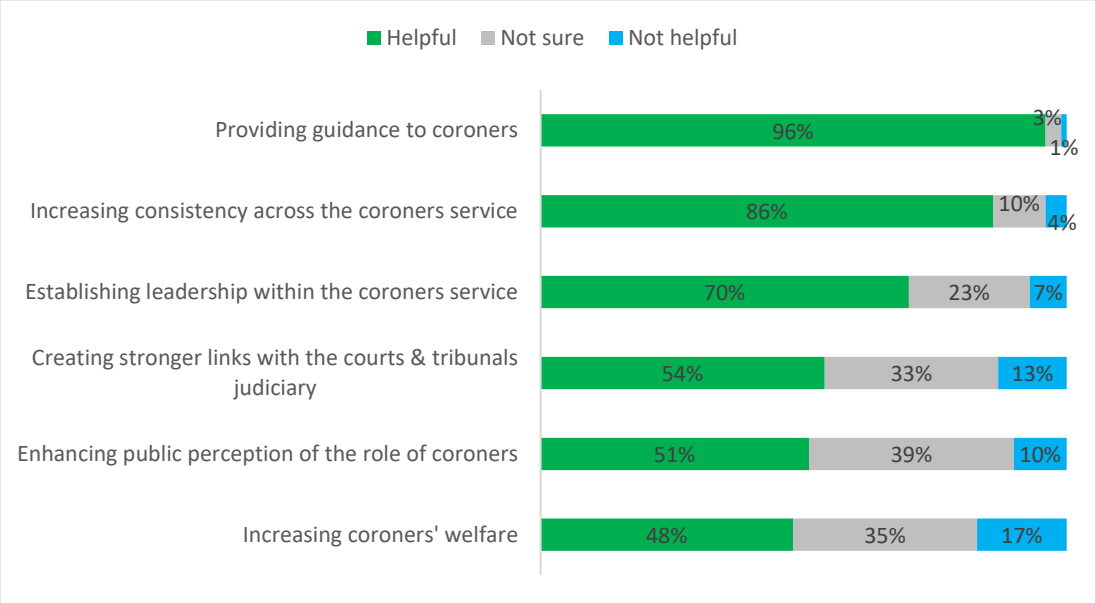
## 7.8 Chief Coroner

Successive governments have resisted calls for a single, unified and centrally funded coroner service by pointing to the national leadership of the Chief Coroner as justification for maintaining a local service.[634] The CAS asked coroners whether the creation of the post of Chief Coroner has been helpful for six important aspects of coroners' work: guidance, consistency, leadership, links with the courts and tribunals judiciary, public perception of coroners and coroners' welfare.[635]

As Figure 51 shows, the vast majority of coroners believe the Chief Coroner has been helpful in establishing leadership in the coroner service, in increasing consistency across the service and in providing them with guidance, and approximately half of all coroners also feel the Chief Coroner has been helpful in creating stronger links with the rest of the judiciary, enhancing public perception of coroners and increasing coroner welfare. However, approximately a third of coroners are uncertain how effective the Chief Coroner has been in strengthening links with the rest of the judiciary, enhancing the public's perception of coroners or increasing coroners' welfare.

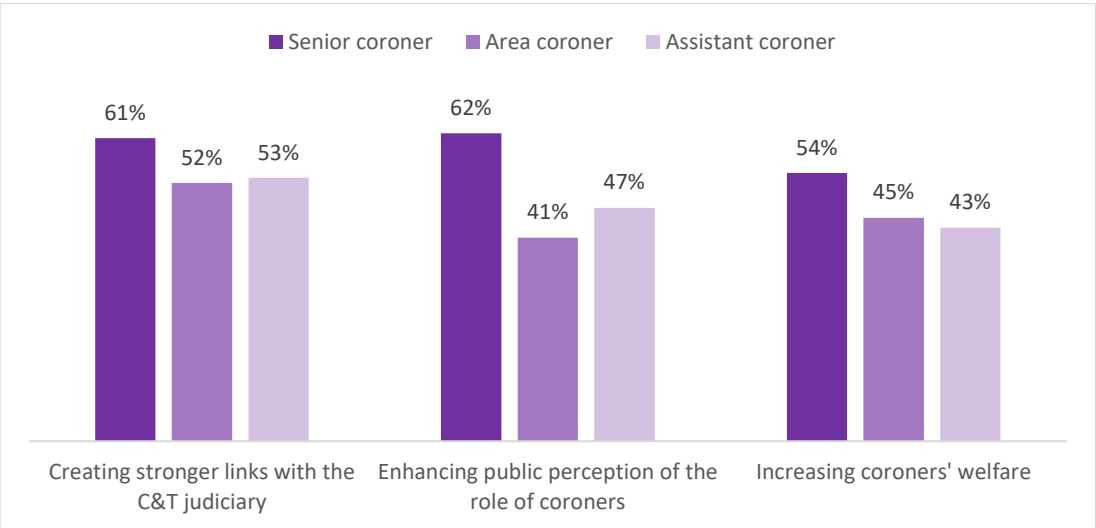
[634] E.g., Harriet Harman MP: "I want people to recognise what the minimum standards should be in the absence of a national system. […] That is something that the chief coroner will be able to help with." HC Deb 8 March 2007, vol 457, col 545WH; Nick Hurd MP: "The recommendation on a national coroner service is one of the recommendations on which the Government are least persuaded at this time. […] the Government's first instinct is to explore what further role the Chief Coroner can play in meeting some of the report's recommendations and requests." HC Deb 30 October 2017, vol 630, col 603.
[635] Q.49.

**Figure 51 Coroners' views on the helpfulness of Chief Coroner (n=331)**




There are some differences in view about the Chief Coroner across the three coroner posts (Figure 52). Senior coroners were more likely than area coroners or assistant coroners to say that the Chief Coroner had been helpful in creating stronger links with the wider judiciary, enhancing public perception of coroners and increasing coroners welfare. One factor that may help to explain this is that senior coroners tend to have more interaction with the Chief Coroner's Office due to their leadership responsibilities for their coroner area.

**Figure 52 Coroners' views on the helpfulness of Chief Coroner, by coroner post (n=331)**

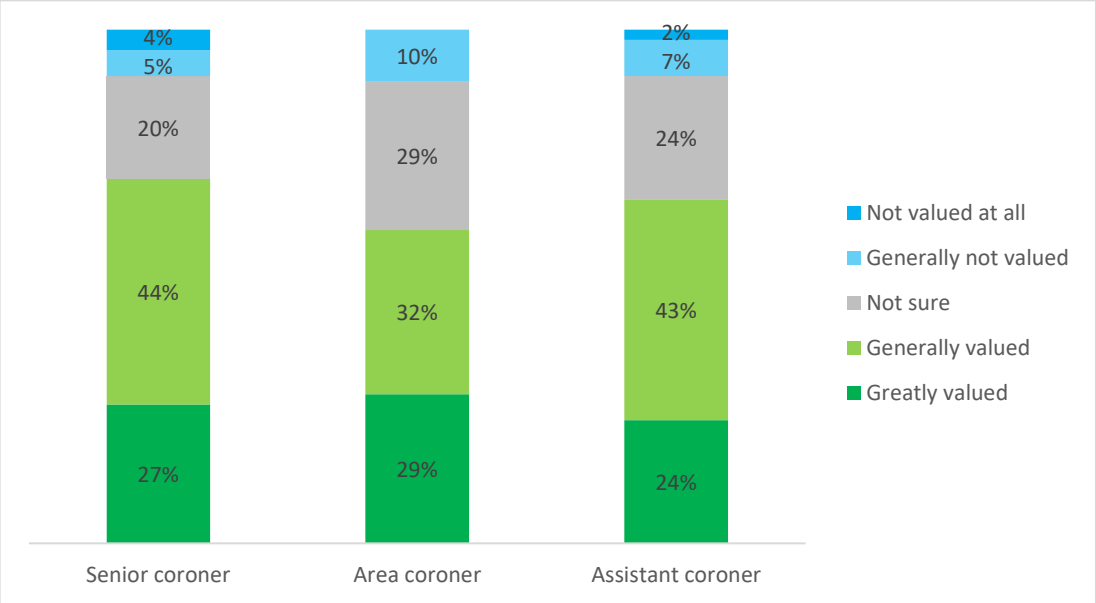


As discussed in Chapter 3, the position of Chief Coroner is not open to serving coroners themselves, a point that was commented on by seven coroners when completing the CAS. For example, one coroner questioned the depth of the Chief Coroners' understanding of the coroner's job:

> "Leadership is better than it was but not ideal. The trouble is the Chief is not a coroner – he is a judge in another judicial area. You do not have the president of the Family Division having been a Construction Court judge! The Chief Coroner needs to have done the day job to truly understand the role and the challenges, not just a couple of high-profile cases where huge legal teams including Counsel to the Inquest are engaged. That is not the reality of the day job."[636]

The CAS also asked coroners how valued they feel by the Chief Coroner.[637] A majority of all coroners (67%) said they feel valued by the Chief Coroner, 23% were not sure and 10% said they did not feel valued. There were only slight differences between the three coroner posts, with area coroners less likely to feel valued by the Chief Coroner (61%) compared with senior coroners (71%) and assistant coroners (67%).

**Figure 53 Extent to which coroners feel valued by the Chief Coroner (n=337)**



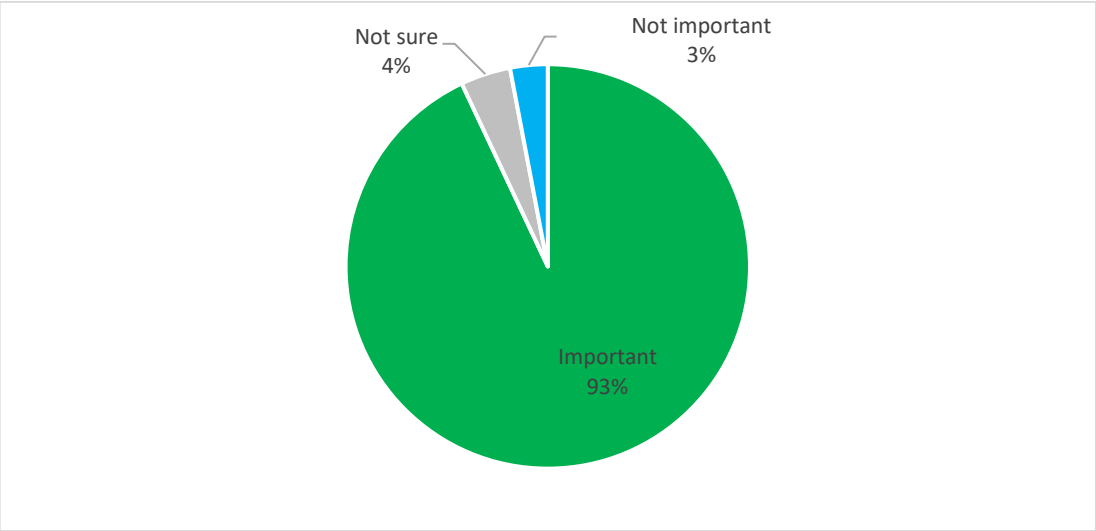

[636] Answer provided by coroner 41 in free text box to Q.49.
[637] Q.34.

## 7.9 Coroners' training

A major change introduced following the creation of the post of Chief Coroner was an overhaul of coronial training[638], and the CAS explored coroners' views of the following: the importance of training, the availability of training, satisfaction with aspects of training, and the areas of training they would most like to undertake in the future.

Almost every coroner (93%) said training opportunities are important to them. [639]

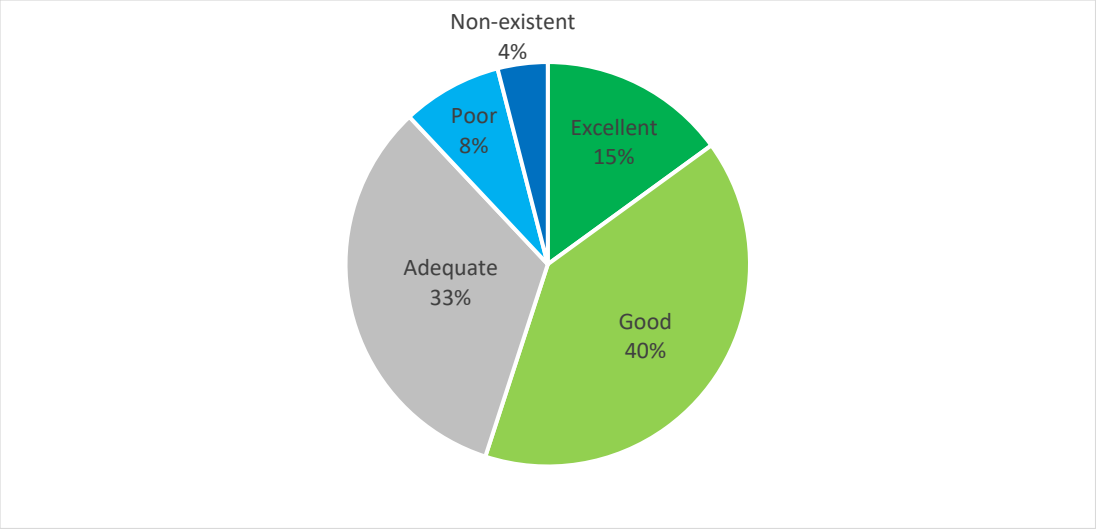
**Figure 54 Importance of training opportunities to coroners (n=352)**




A majority of coroners consider the availability of training opportunities[640] to be 'good' or 'excellent' (55%), with just 12% saying they were 'poor' (8%) or 'non-existent' (4%) (see Figure 55).

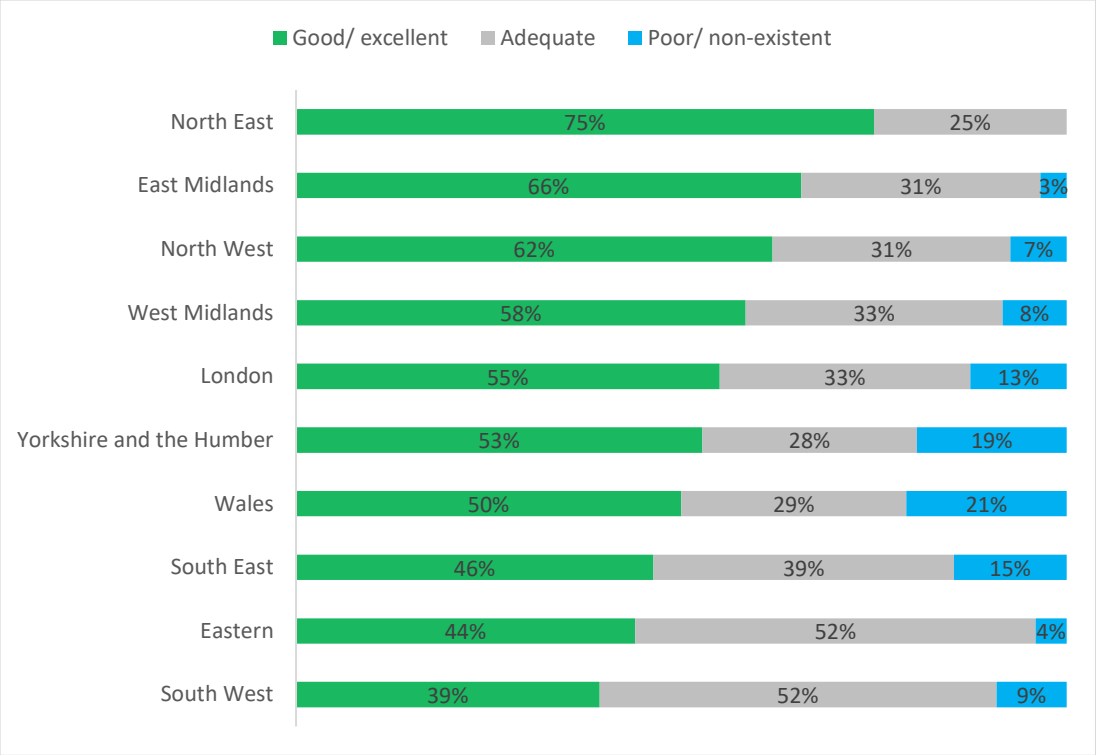
[638] See Chapter 3.4.
[639] Q.10.
[640] Q.11.

**Figure 55 Coroners' assessment of availability of training opportunities (n=349)**




As Figure 56 shows, there are differences according to the local authority where coroners are based. The North East has the largest proportion of coroners who feel the availability of training opportunities to be good or excellent (76%), with none saying they are poor or non-existent. The regions with the greatest proportion of coroners expressing the view that training opportunities are poor or non-existent are Wales (21%) and Yorkshire and the Humber (19%). However, training is no longer provided by local authorities, so it is unclear what may lie behind these differences in view about coroner training.

**Figure 56 Availability of training opportunities, by region (n=349)**




The CAS also asked coroners the extent to which they are satisfied with different aspects of training.[641] Table 7 shows how the vast majority of coroners (83%) are satisfied with the quality of the training they receive, and three quarters (75.5%) also satisfied with the range of training available. Most coroners are satisfied with the time available to undertake training (68.3%), with the time to prepare for courses (65.3%) and with local authority support for training (61.4%), but over one third of coroners said they were either not satisfied at all or it could better.

[641] Q.24.

**Table 7 Satisfaction with training**

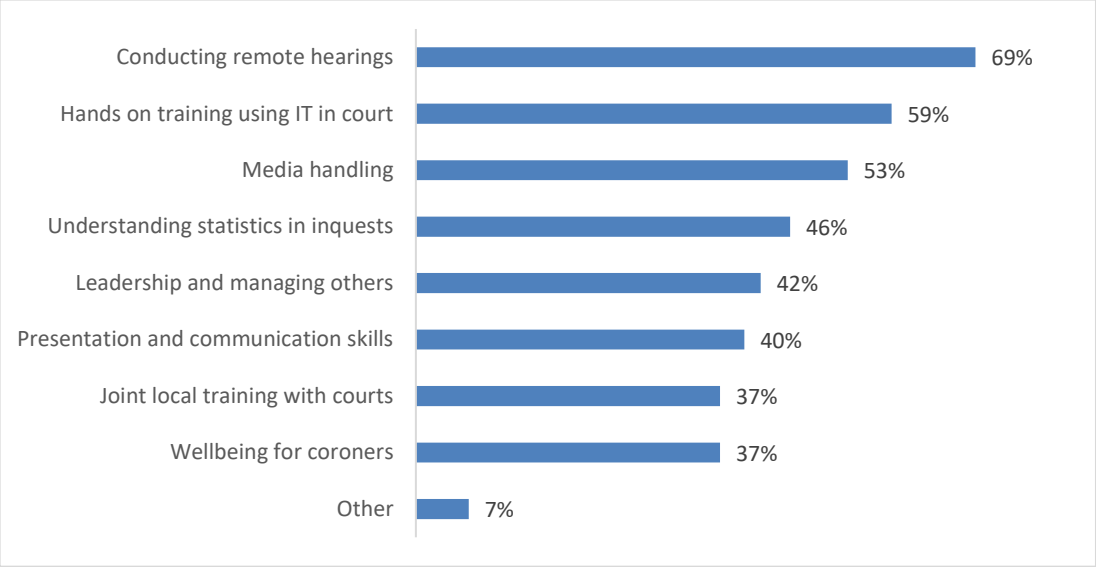
| ***To what extent are you satisfied with the following aspects of training as a coroner?*** | **Completely satisfied** | **Satisfied** | **Could be better** | **Not satisfied at all** |
|---|---|---|---|---|
| Range of training available (n=344) | 17.7% | 57.8% | 21.8% | 2.6% |
| Quality of training available (n=344) | 25.6% | 57.3% | 15.1% | 2% |
| Time available to undertake training (n=344) | 16.6% | 51.7% | 25.6% | 6.1% |
| Time to prepare for training courses (n=343) | 13.4% | 51.9% | 27.1% | 7.6% |
| Local authority support for coroner training (n=342) | 14% | 47.4% | 28.9% | 9.6% |

There is little difference in views across coroner posts, with the exception of local authority support for coroner training. Almost half of assistant coroners expressed dissatisfaction (47%), as opposed to just under one fifth of senior coroners (19%) and one quarter of area coroners (25%). There were four regions where a majority of assistant coroners were dissatisfied with local authority support for training: the South East (62.9%), Eastern (61.1%), the West Midlands (58.3%) and London (54.8%).

The CAS also asked coroners to identify areas in which they would welcome new training courses.[642] Over two thirds of coroners (69%) expressed a desire for training on conducting hearings remotely. However, this is perhaps understandable given that the CAS was conducted in May 2020, at the start of the first lockdown necessitated by the COVID-19 pandemic, when many coroners may have been having to conduct remote inquests for the first time.

[642] Q.25.

**Figure 57 Coroners' interest in new training opportunities (n=337)**




Coroners were also able to write in further suggestions for new training.[643] Of the 47 coroners who added comments, nine said further training on medical matters, five expressed a desire for training on law and procedure, a further five called for training on the coroner's relationship with the relevant local authority, four identified meeting the needs of bereaved families and three highlighted conducting jury inquests.

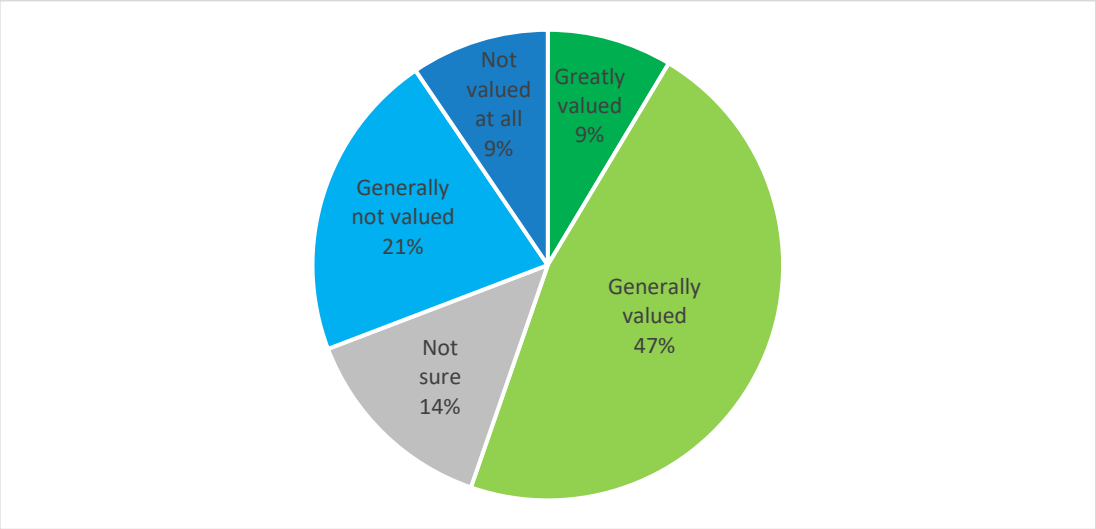
## 7.10 Relationship with local authorities

As discussed in Chapter 2, calls for a national coroner service went unheeded in 2009 and the 21st century coroner service continues to be delivered at a local level, with responsibility for funding and supporting coroners falling to local rather than central government. The CAS addressed various aspects of coroners' relationship with their local authorities in order to better understand coroners' views and how they may affect the prospects of a national coroner service.

Coroners were asked to what extent they felt valued by their relevant local authority.[644] As may be seen in Figure 58, just over half of coroners (56%) feel valued by their local authorities, 30% feel not valued and 14% said they are not sure.

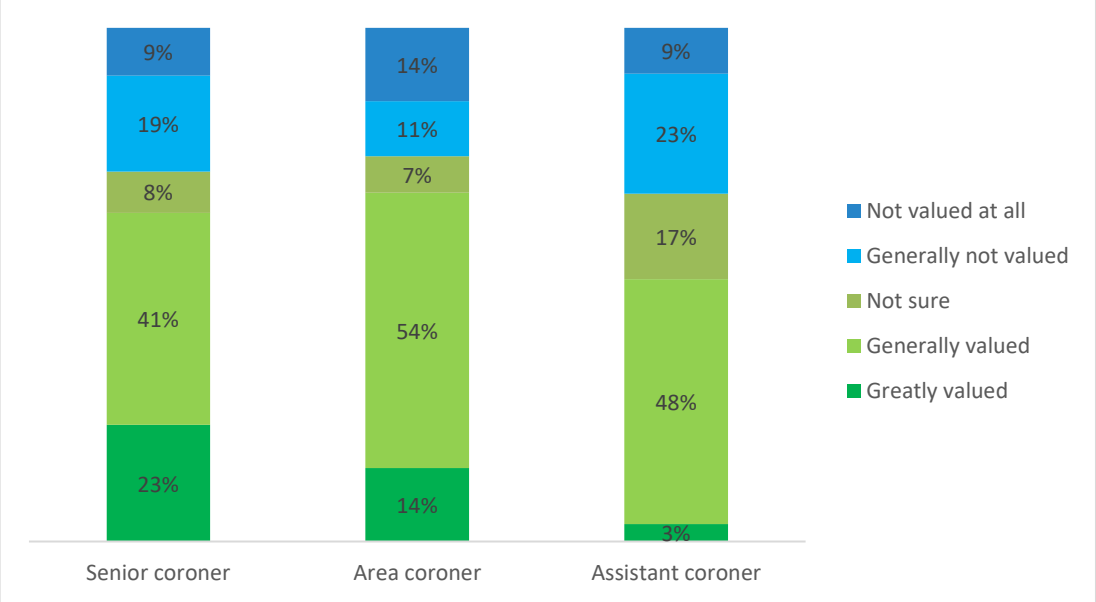
[643] In the free text box for Q.25.
[644] Q.34.

**Figure 58 Extent to which coroners feel valued by their relevant local authority (n=338)**




Both Area Coroners and Senior Coroners are more likely to feel valued by their local authorities than Assistant Coroners (Figure 59).

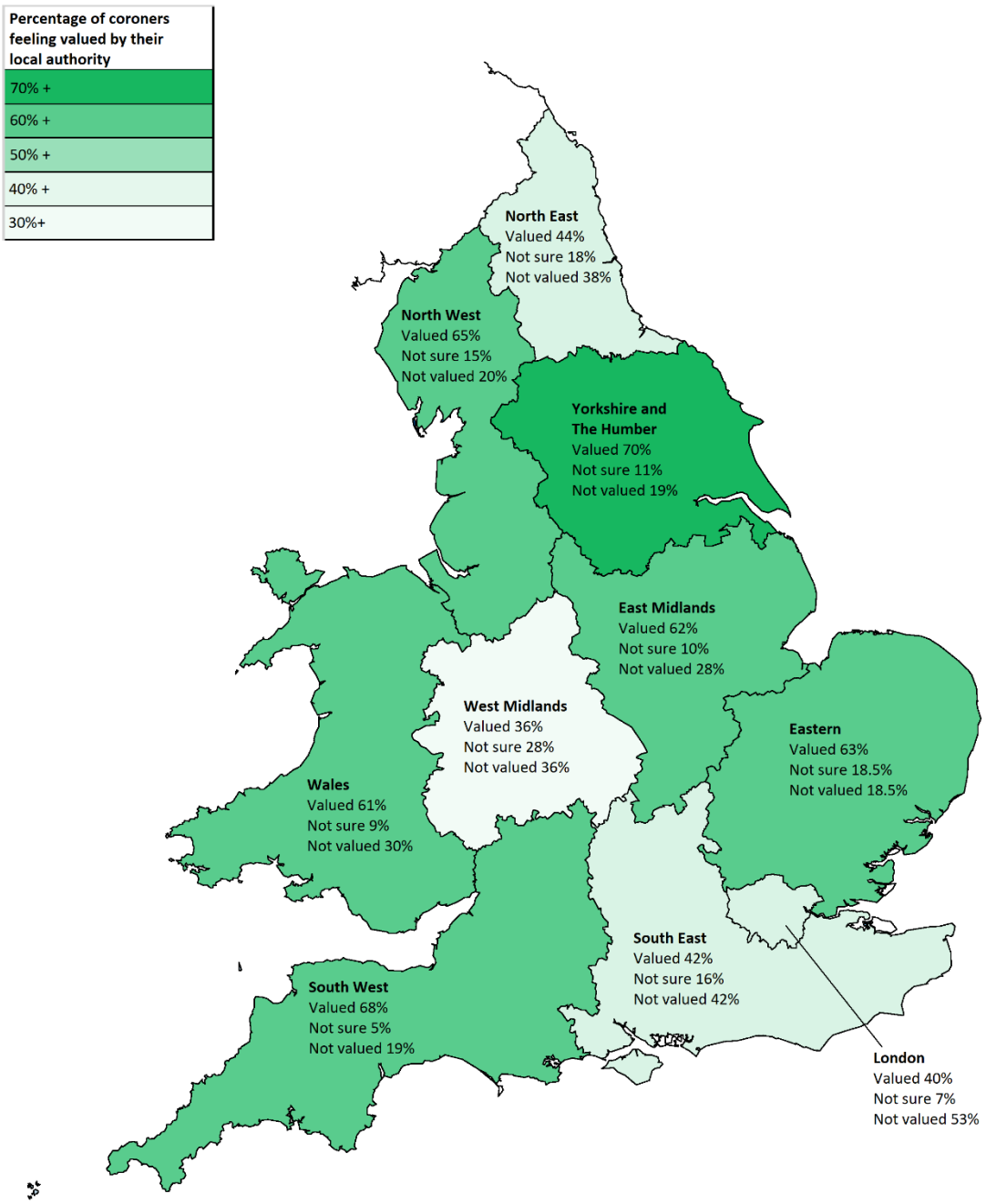
**Figure 59 Extent to which coroners feel valued by their local authority, by post (n=338)**




But there are substantial variations by region in the extent to which coroners feel valued by their local authority (Figure 60). The region with the highest proportion of coroners who feel valued by their local authorities is Yorkshire and the Humber (70%),

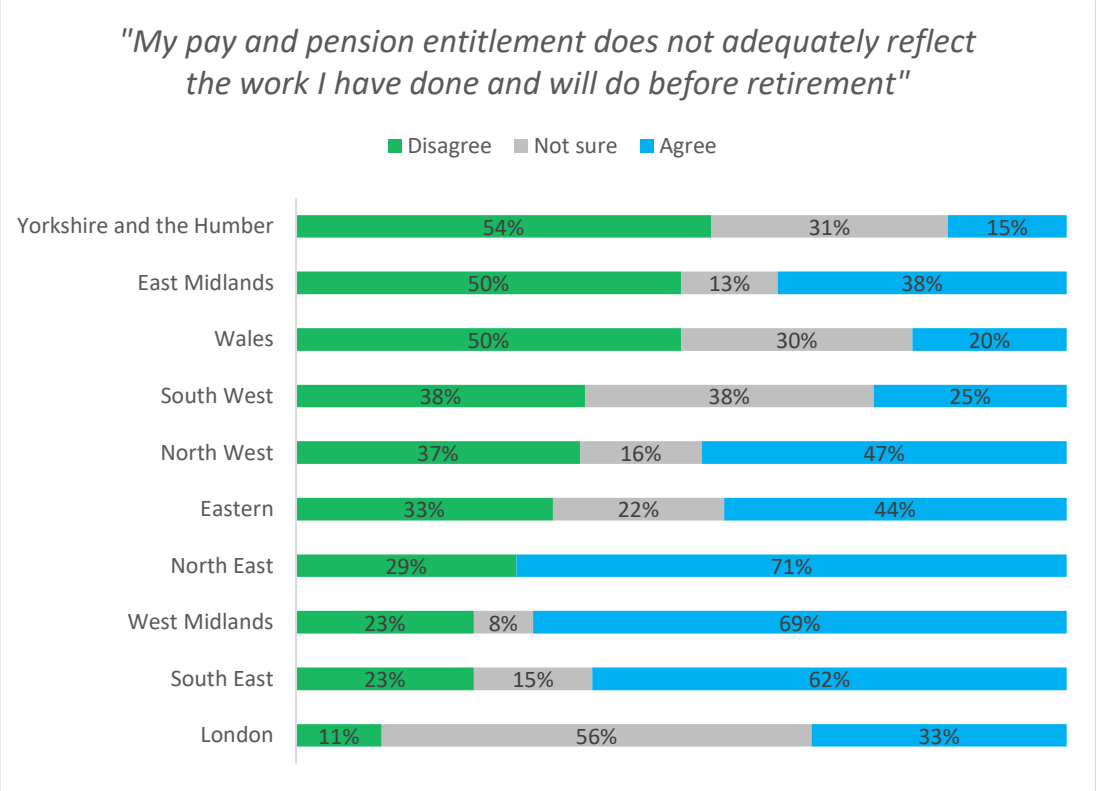
whereas the region with the lowest proportion of coroners that feel valued by their local authority is the West Midlands (36%) and the region with the highest proportion of coroners who said that they do not feel valued by their local authority is London (53% saying they do not feel valued).

**Figure 60 Feeling valued by local authorities, by region (n=326)**



Local authorities remain responsible for coroners' pay and pensions. For senior coroners and area coroners (who are salaried coroners), it appears that the extent to which they feel valued by their local authority is linked to their thoughts on their pay and pension entitlement. All coroners were asked whether they agreed or disagreed with the statement "My pay and pension entitlement does not adequately reflect the work I have done and will do before retirement".[645] As Figure 61 shows, Yorkshire and the Humber, the region with the greatest percentage of coroners reporting that they felt valued by their local authority, was also the region with the greatest proportion of coroners who felt their pay and pension did adequately reflect their work. The West Midlands, the South East and London – the three regions with the lowest percentages of coroners feeling valued by their local authorities – also had the smallest proportions of coroners disagreeing with the statement on pay and pension entitlement.

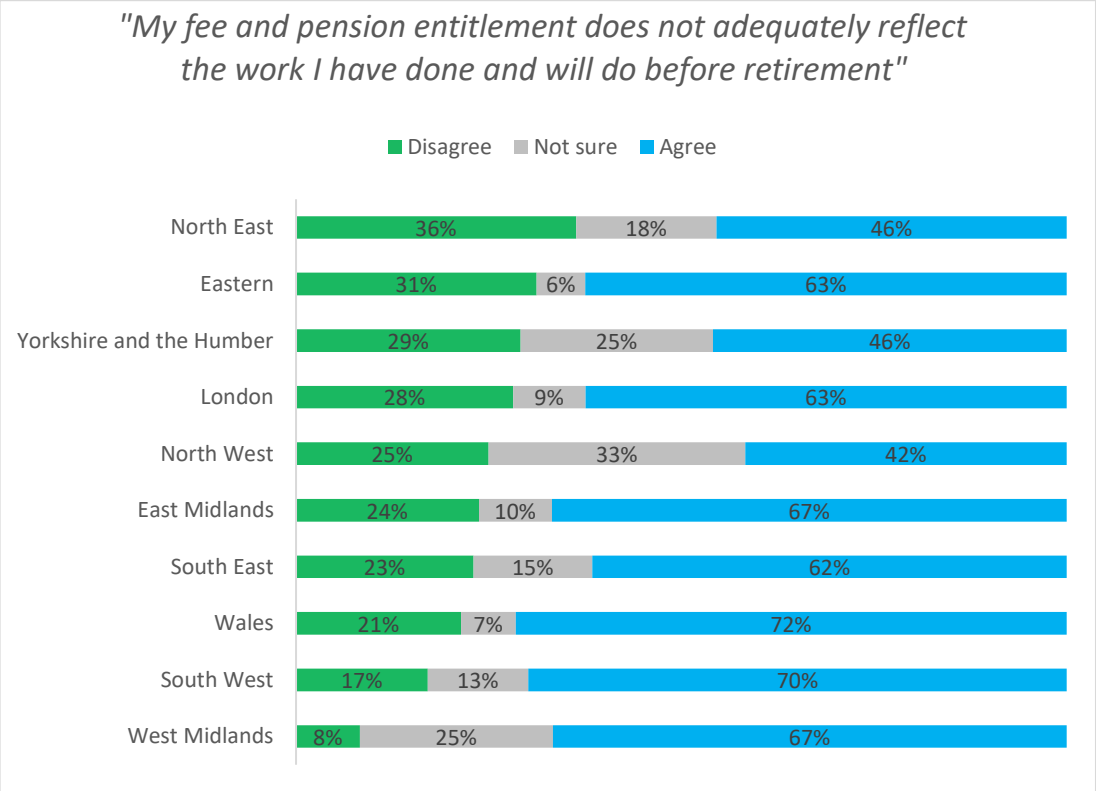
**Figure 61 Senior coroners and area coroners' attitudes on whether their pay and pension entitlement reflect their work, by region (n=102)**




[645] Q.17. The Coroner Attitude Survey also asked coroners a range of questions on their pay and pension entitlement. Only some of these results are reported in this thesis.

The situation was different for assistant coroners, who are fee-paid. They were asked whether they agreed or disagreed with the statement "My fee and pension entitlement does not adequately reflect the work I have done and will do before retirement".[646] As may be seen in Figure 62, in seven out of the ten regions a clear majority of assistant coroners agreed that their fee and pensions entitlement does not reflect their work. In no region did a majority of assistant coroners feel that their fee and pensions entitlement reflected their work. In only one region – the North East – did more than a third (36%) disagree with the statement.

**Figure 62 Assistant coroners' attitudes on whether their fees and pension entitlement reflect their work, by region (n=230)**




## 7.11 Summary

This chapter set out what coroners consider to be their most important functions, and their views on a range of important issues. The CAS confirmed that nearly all coroners agree with Sir Peter Thornton's description of how the modern coroner provides justice: publicly investigating deaths to prevent further fatalities and to provide

[646] Q.19.

answers to the bereaved. However the CAS also revealed that just under half of coroners doubt the efficacy of their reports to prevent further deaths. The chapter makes clear coroners' commitment to assisting the bereaved at inquests but highlights their disagreement with innovations adopted at recent high-profile public inquiries. It also sets out coroners' attitudes to the reforms to their service and on the impact of the Chief Coroners. The view of the vast majority of coroners is that the creation of a national service remains necessary. In the continued absence of a unified coroner structure, the following chapter sets out coroners' views on their place in the wider judiciary of England and Wales and compares their attitudes to aspects of their working lives with those of the courts and tribunals judges.

# Chapter 8 Coroners and judges

Each review of the coroner service in the past 20 years has highlighted the uneven distribution of resources across the coroner areas of England and Wales, with the quality of facilities and levels of clerical support available to coroners varying widely.[647] As discussed in Chapters 2 and 3, as a result of this variation each of these reviews, and every annual report issued thus far by the Chief Coroners, have called for the creation of a unified coroner structure in which the service would no longer be the responsibility of local authorities. It would likely fall to the Ministry of Justice to fund such a national coroner service. HM Courts and Tribunals Service, an executive agency of the MoJ, currently has this responsibility in relation to the unified courts and tribunals. However some coroners are wary of a centrally run service, warning that it may not raise standards across the board but rather lead to a "levelling down".[648]

This chapter sets out coroners' attitudes to a range of aspects of their working lives, including the quality of the buildings they work in and of their administrative support. It compares coroners' views with those of the judges of the courts and tribunals judiciary. As explained in Chapter 5, the Coroner Attitude Survey (the CAS) ran at the same time as the UK Judicial Attitude Survey (the UK JAS) 2020, which covered all salaried judges in England & Wales, Scotland and Northern Ireland. There was a substantial overlap between the two surveys in terms of the questions asked, and this chapter draws on the results of the UK JAS 2020 for England and Wales courts and UK non-devolved tribunals.[649]

However, as the revised procedures for coroners' appointment, training and discipline have undoubtedly brought coroners closer to the rest of the judiciary and increased the extent of the senior judiciary's influence on the service, this chapter first sets out coroners' attitudes to their place in the judiciary and the extent to which they feel valued by their fellow judges and a range of other stakeholders.

[647] E.g., Smith (n 32) para 7.8-7.10; The Luce Review Committee (n 30) 182; Constitutional Affairs Committee (n 9) paras 89–90; Angiolini (n 38) para 16.12.
[648] Justice Committee (n 9) para 148.
[649] Thomas, '2020 UK Judicial Attitude Survey: England and Wales Courts and UK Tribunals' (n 69).

## 8.1 Coroners' place in the judiciary

As discussed in Chapter 2, coroners' pride in their office's long history has been noted on numerous occasions. In his first address to coroners as Chief Coroner, Sir Peter Thornton opened with the words "'Coroner' – that is a good word, with an ancient and fine heritage. I am very proud to have that word in my title".[650] It might have been thought, then, that the office's history and distinct jurisdiction would lead coroners to seek to distinguish themselves as a judicial office, rather than to assert their status as a generic judge. The CAS asked coroners to say whether they agreed or disagreed with the statement "I consider myself to be a judge".[651] Almost all coroners (81%) agreed with the statement (with 42% strongly agreeing), 12% say they did not consider themselves to be a judge and 8% were not sure (Table 8).

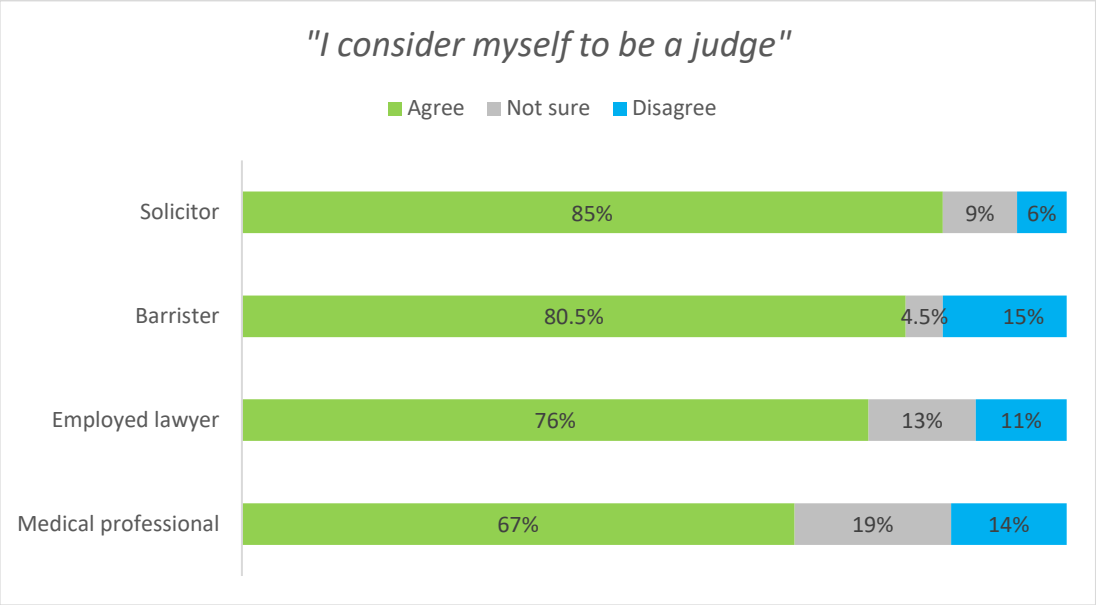
**Table 8 Whether coroners consider themselves to be judges (n=338)**

| ***I consider myself to be a judge*** | **2020 CAS** | |
|---|---|---|
| Strongly agree | 42% | Agree total 81% |
| Agree | 39% | |
| Not sure | 8% | Not sure 8% |
| Disagree | 9% | |
| Strongly disagree | 3% | Disagree total 12% |

This suggests that coroners do not see their post as a wholly separate judicial entity. There is some variation in view about being a judge between coroners with different professional backgrounds (Figure 63). Solicitors, barristers and employed lawyers were more likely to consider themselves to be a judge than medically trained coroners.

[650] Thornton, 'Annual Conference' (n 200) para 2.
[651] Q.36.

**Figure 63 Coroners' attitudes to whether they are judges, by professional background (n=361)[652]**




As discussed in Chapter 2, the Luce Review and Dame Janet Smith found coroners to be cut adrift from mainstream justice administration.[653] The CAS sought to learn whether coroners feel this is still the case, and asked coroners whether they agreed with the statement "I feel part of the judiciary of England and Wales".[654] Just over a third of coroners (35%) agreed. Despite the overwhelming majority of coroners considering themselves to be judges, only a minority of these same coroners (35%) feel part of the wider judiciary of England and Wales (Table 9).

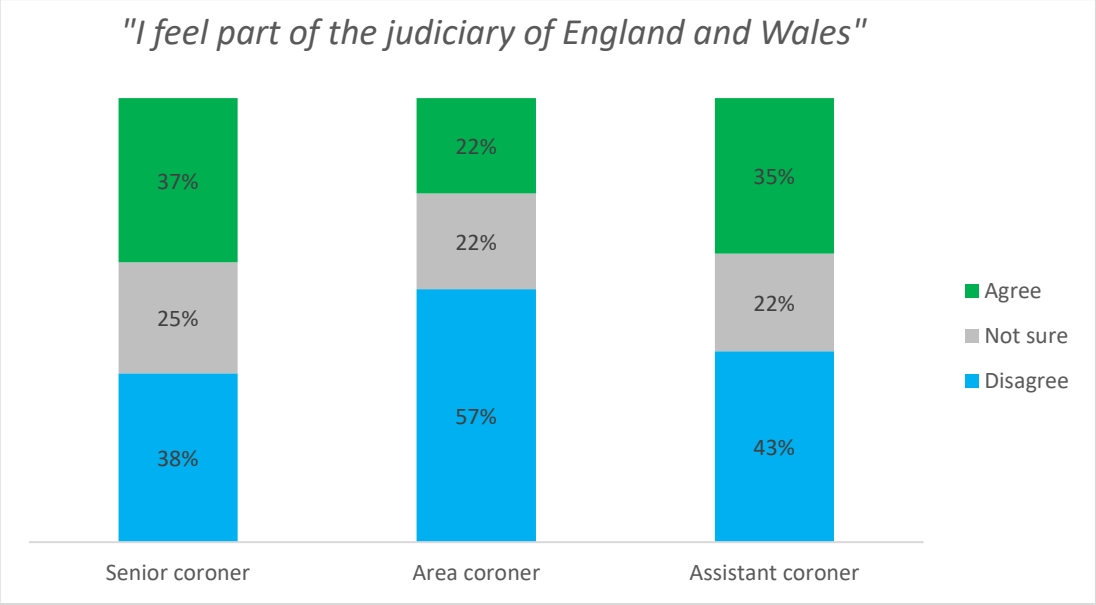
[652] Not included in this figure are the 19 coroners whose various professional backgrounds may be described as 'other'. Medical coroners are included as many coroners used to be drawn from the ranks of the medical profession and the remaining 21 represent the last of those appointed in a previous era.
[653] The Luce Review Committee (n 30) 17; Smith (n 32) para 7.41.
[654] Q.36.

**Table 9 Whether coroners feel part of the judiciary (n=336)**

| *I feel part of the judiciary of England and Wales* | 2020 CAS | |
|---|---|---|
| Strongly agree | 10% | Agree total 35% |
| Agree | 25% | |
| Not sure | 22% | Not sure 22% |
| Disagree | 30% | Disagree total 43% |
| Strongly disagree | 13% | |

However, these views differ by coroner post. As Figure 64 makes clear, the majority of area coroners (57%) do not feel part of the judiciary, while senior coroners and assistant coroners are more divided about this question, with just over a third of both cohorts agreeing with the statement.

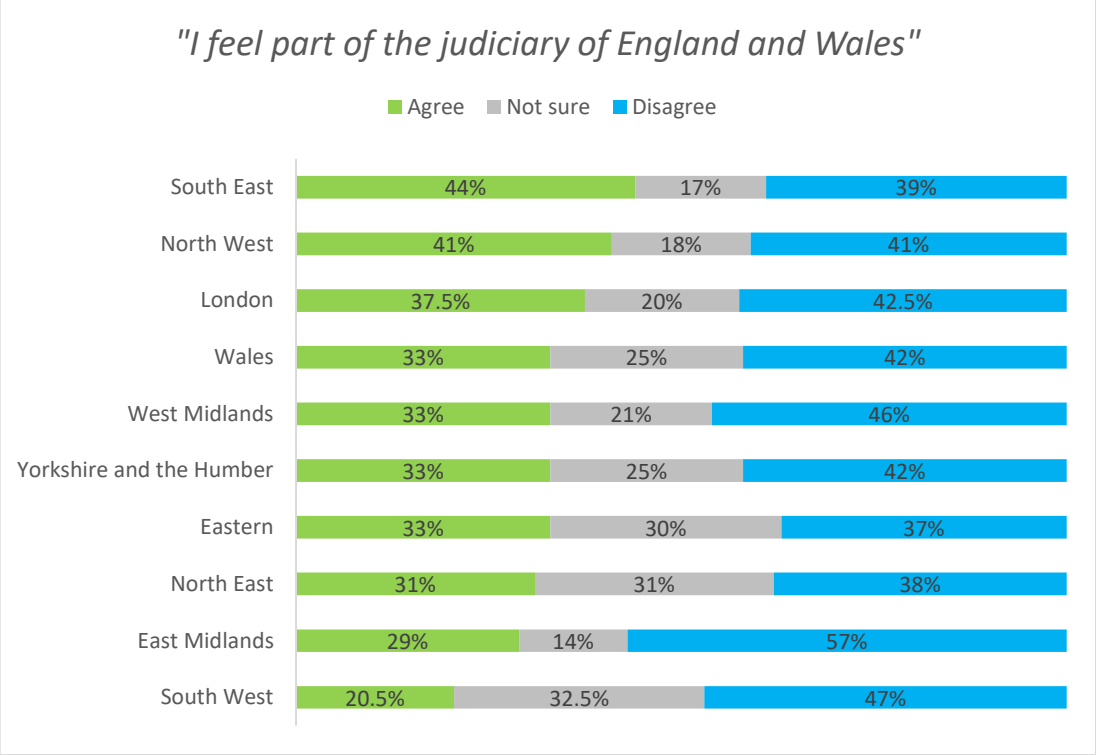
**Figure 64 Feeling part of the judiciary, by coroner post (n=324)**




Coroners' attitudes also vary by region (Figure 65). The South East is the region with the greatest proportion of coroners who feel part of the judiciary of England and Wales, whereas only one fifth of the coroners of the South West feel part of the judiciary. The East Midlands is the only region in which a majority of its coroners expressed a clear

view on the statement, with 57% actively disagreeing with the assertion "I feel part of the judiciary of England and Wales".

**Figure 65 Coroners' attitudes towards their place in the judiciary, by region (n=324)**




Three coroners added comments in the survey about being seen as judges:[655]

> "Coroners are not seen as judges. Why not? A national coronial service would help promote the status of coroners generally. At present patronising phrases are used [such as] "judicial officers" [and] "members of the judicial family". Our work is demanding and should rank as equivalent to circuit judges and any judges in the magistrates or county courts. Esteem is a commodity which would cost little to improve."[656]

> "I strongly believe that there should be a national service and that coroners should be treated as a part of the judiciary like the rest of the courts and tribunals judiciary are."[657]

[655] Of the 345 coroners who answered the survey question on the extent of their concern over the lack of a national coroner service, 37 added comments of which three related to coroners' judicial status.
[656] Answer provided by coroner 36 in free text box to Q.28.
[657] Answer provided by coroner 262 in free text box to Q.28.

> "[We are] referred to as quasi-judicial when in fact exercising powers of a judge."[658]

Another way of exploring in the CAS the extent to which coroners are seen as judges was to ask coroners whether they agreed or disagreed with the statement "Legal representatives at inquests do not consider me to be a judge".[659] Coroners were divided in their views on this: an almost equal proportion of coroners felt that advocates do consider them to be judges (38%) and do not consider them judges (36%), while a quarter (26%) were not sure (Table 10).

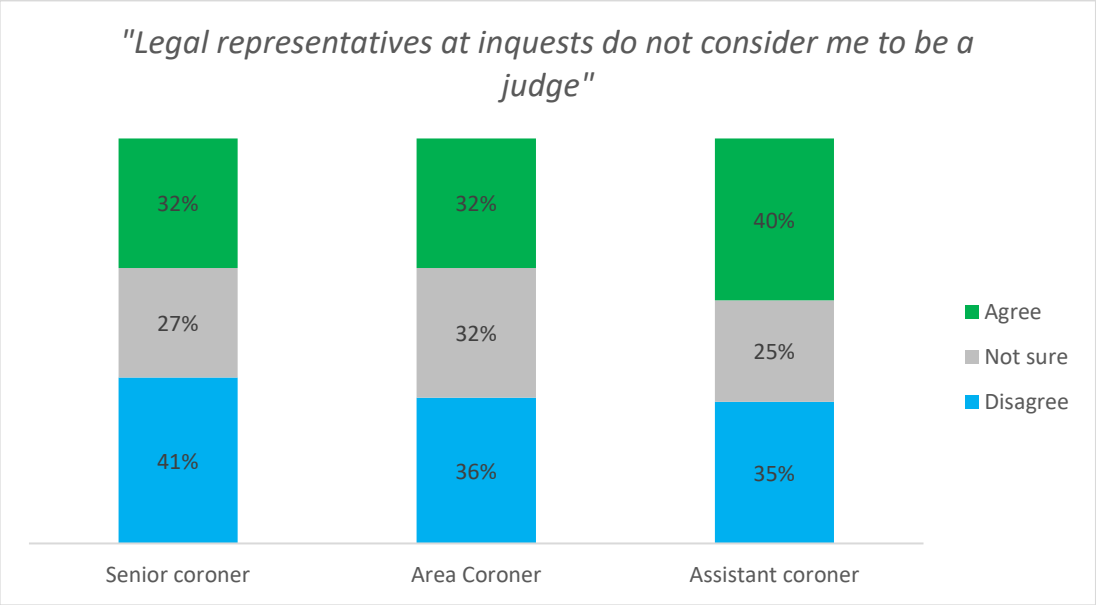
**Table 10 Whether coroners feel advocates consider them to be judges (n=337)**

| ***Legal representatives at inquests do not consider me to be a judge*** | **2020 CAS** | |
|---|---|---|
| Strongly agree | 8% | Agree total 38% |
| Agree | 30% | |
| Not sure | 26% | Not sure 26% |
| Disagree | 30% | |
| Strongly disagree | 6% | Disagree total 36% |

There were not any substantive differences between coroner posts, with slightly more senior coroners saying they felt legal representatives at inquests saw them as judges (41%) compared with area coroners (36%) and assistant coroners (35%) (Figure 66).

[658] Answer provided by coroner 271 in free text box to Q.28.
[659] Q.36.

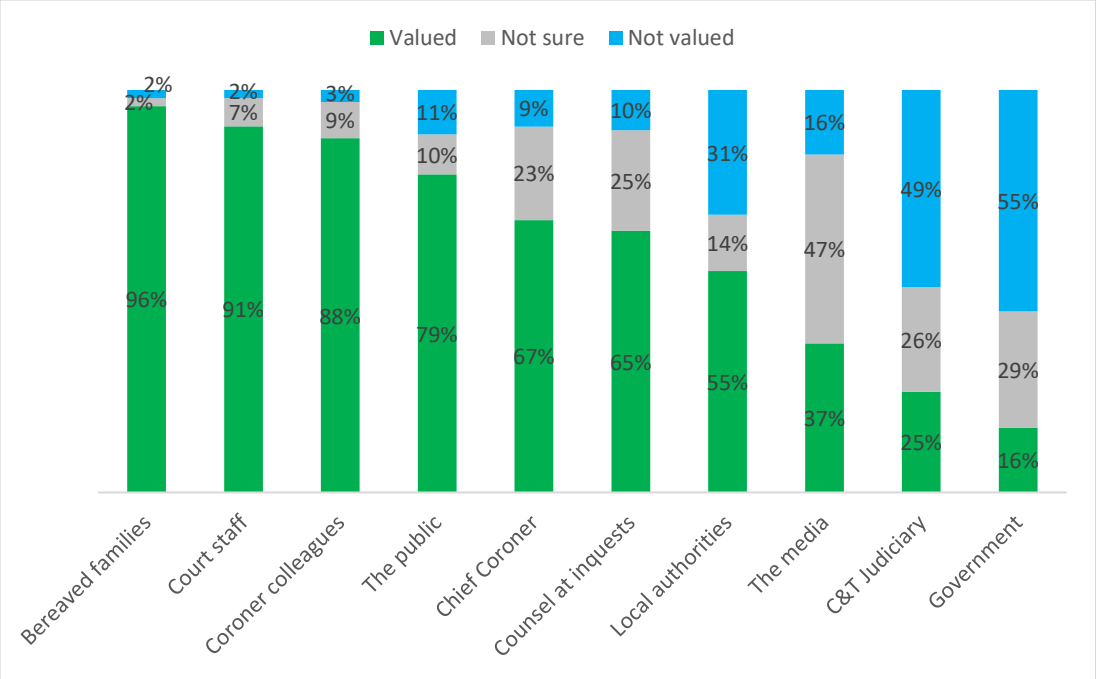
**Figure 66 Whether legal representatives consider coroners to be judges, by coroner post (n=337)**




## 8.2 Feeling valued

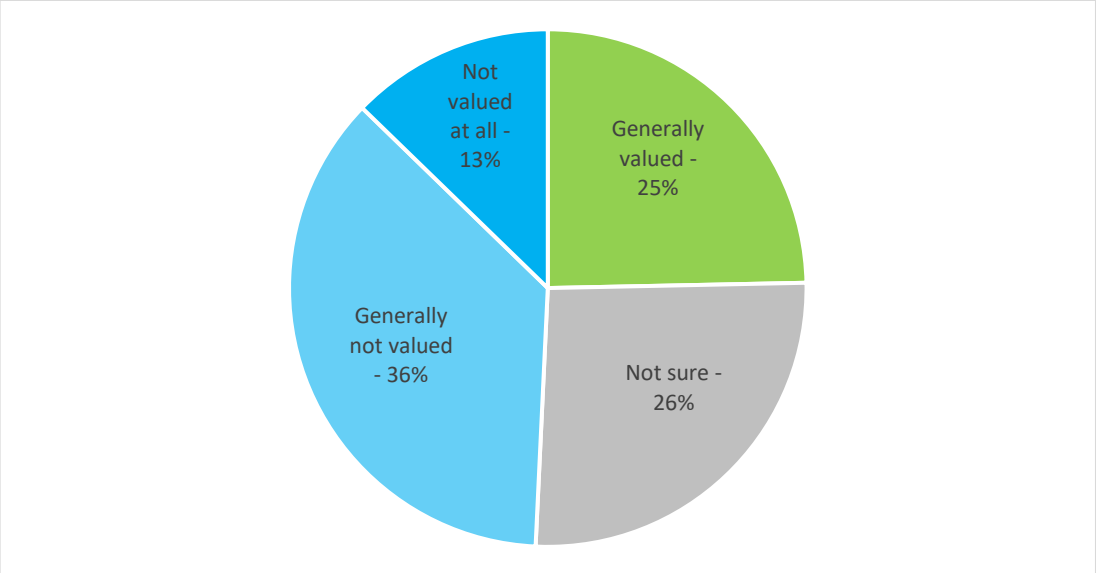
The survey explored the extent to which coroners feel valued by different groups. Coroners feel most valued by the bereaved families in inquests they conduct (96%), and almost all feel valued by court staff (91%), coroner colleagues (88%) and the public (79%) (Figure 67). A majority of coroners also feel valued by the Chief Coroner (67%), counsel at inquests (65%) and, as discussed in Chapter 7, their local authorities (55%). The only groups a majority of coroners do not feel valued by are the media (37%), judges in the courts and tribunals judiciary (25%) and central government (16%).

**Figure 67 Feeling valued by different groups (n=338)**




It is noticeable that only a quarter (25%) of coroners feel valued by other judges, and when coroners' responses were examined in more detail (Figure 68), 13% of coroners said they feel they are not valued at all by the courts and tribunals judiciary.

**Figure 68 Extent to which coroners feel valued by the courts and tribunals judiciary (n=338)**

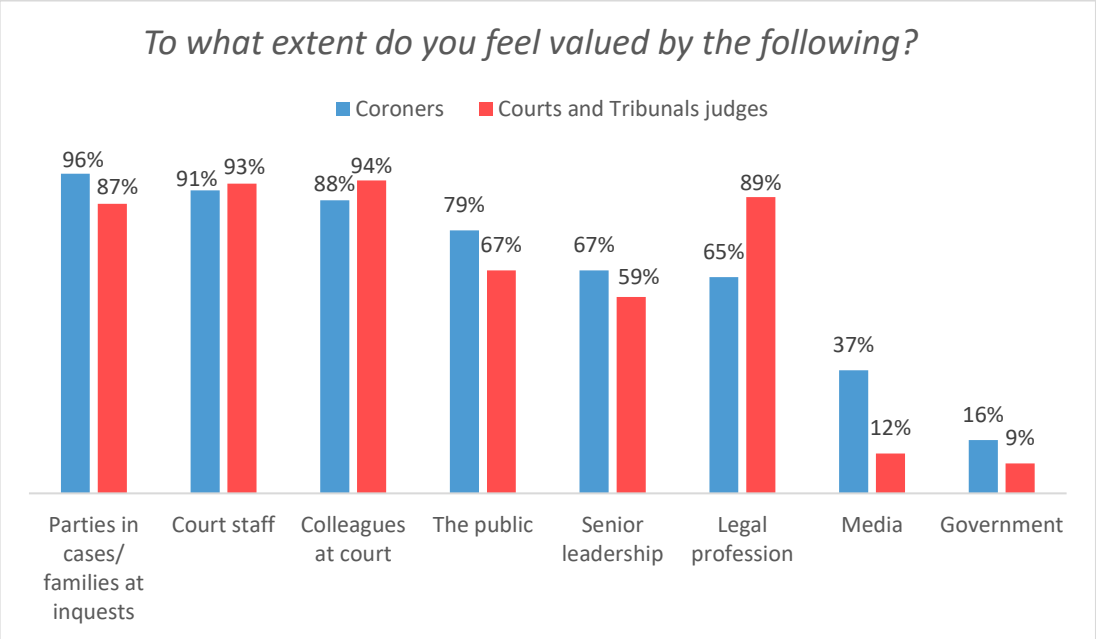



There were no large differences in view on this issue across coroner posts.

### 8.3 Feeling valued: coroners and courts and tribunals judges compared

The CAS and the UK JAS 2020 asked very similar questions about the extent to which coroners and judges felt valued by different groups. Overall there are similar results in relation to feeling valued by court staff, by colleagues at court, and by parties in cases/ families at inquests, but there are marked differences in the extent to which coroners and courts and tribunals judges feel valued by the legal profession and the media (Figure 69). The vast majority of the judges (89%) felt valued by the legal profession, and while a majority of coroners also felt valued by legal professionals, it was a much lower proportion (65%). However, a larger proportion of coroners (79%) than judges (67%) felt valued by the public. While neither a majority of coroners or courts and tribunal judges felt valued by the media, a larger proportion of coroners felt valued by the media (37%) compared with only 12% of courts and tribunal judges. And marginally more coroners felt valued by the government (16%) compared with courts and tribunal judges (9%).

**Figure 69 Extent to which coroners and courts and tribunals judges feel valued by different groups (coroners n=337; judges n=1795)[660]**




[660] It is important to note in relationship to "senior leadership" that the UK Judicial Attitude Survey 2020 asked courts and tribunals judges to state the extent to which they felt valued by "senior leadership in the judiciary", whereas the Coroner Attitude Survey asked coroners about the Chief Coroner.

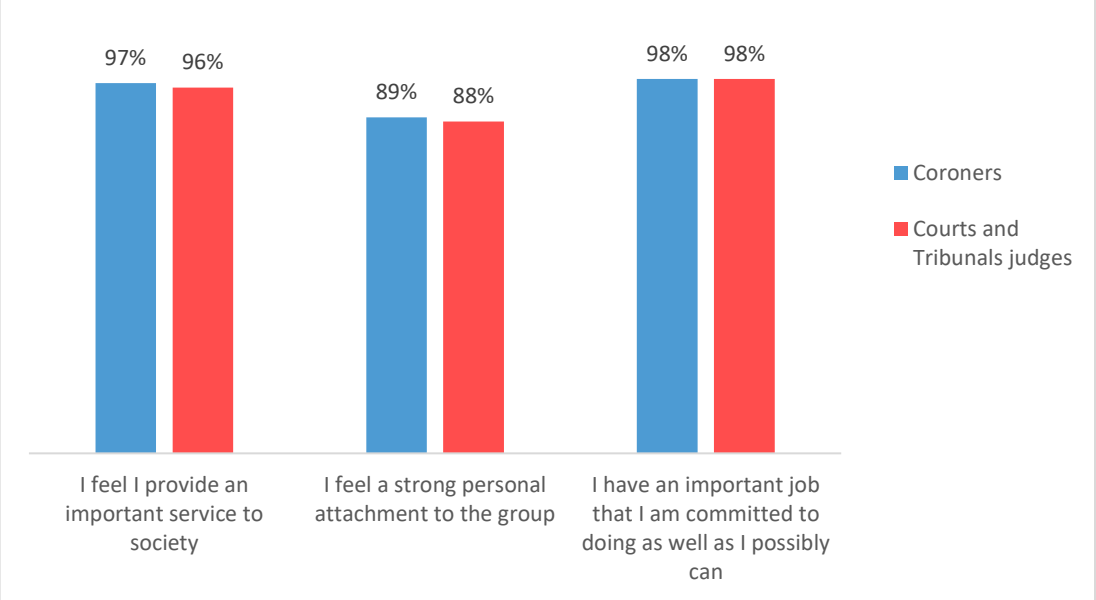
## 8.4 Service to society, belonging and satisfaction with their judicial work

The CAS and the UK JAS included three similar questions in which respondents were asked to agree or disagree with three statements about their service to society and belonging to their judicial groups:[661]

- "I feel I provide an important service to society"
- "I feel a strong personal attachment to being a member of the coroner service [CAS]/ judiciary [UK JAS]"
- "I feel I have an important job that I am committed to doing as well as I possibly can".

The results for coroners and courts and tribunal judges are remarkably similar (Figure 70), with almost all coroners and other judges agreeing with all three statements.

**Figure 70 Coroners' and courts and tribunals judges' attitudes to service (coroners n=338; judges n=1786)**




[661] Q.36 in the Coroner Attitude Survey.

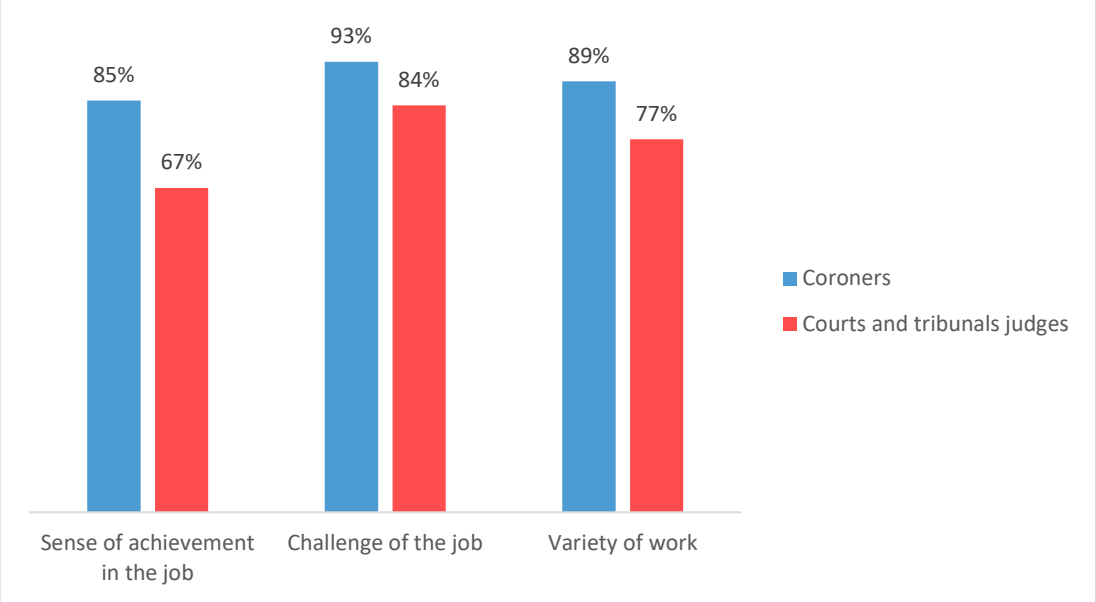
Coroners and courts and tribunal judges were also asked three identical questions about how satisfied they are with aspects of their job:[662]

- The sense of achievement in the job;
- The challenge of the job; and
- The variety of the work.

The vast majority of coroners are satisfied with all three aspects.

There was little variation in levels of satisfaction between coronial posts. But there were some differences in levels of job satisfaction between coroners and courts and tribunals judges (Figure 71). In all three areas of job satisfaction, more coroners were satisfied than courts and tribunal judges.

**Figure 71 Coroners and courts and tribunals judiciary job satisfaction (coroners n=345; judges n=1822)**




## 8.5 Applying and encouraging others to apply

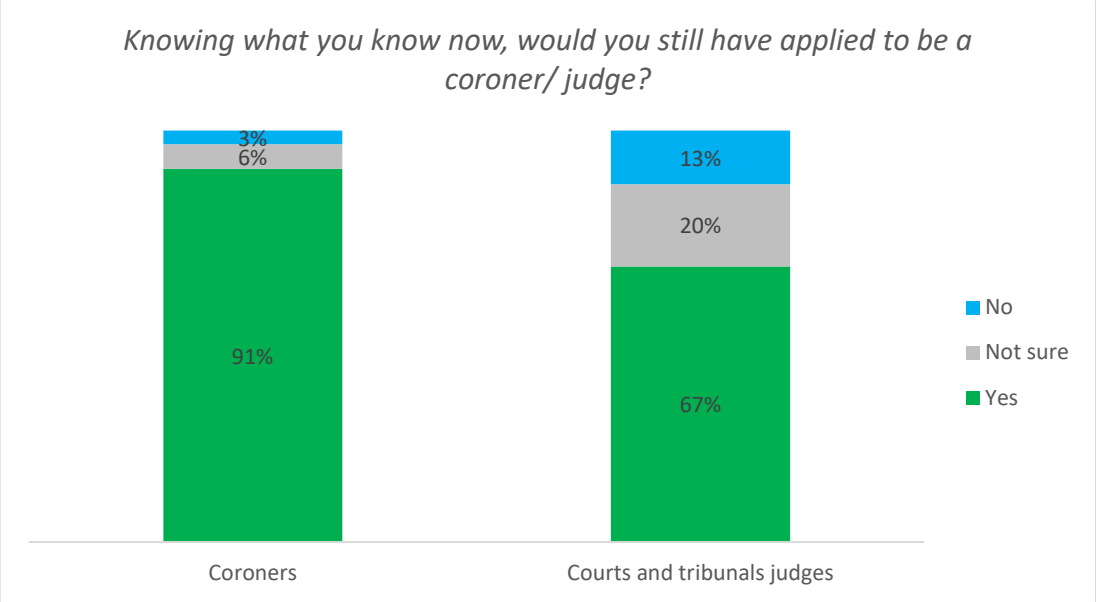
The CAS and the UK JAS asked coroners and courts and tribunals judges two questions about applying to be a coroner/ courts and tribunals judge:

[662] Q.23 in the Coroner Attitude Survey.

- "Knowing what you know now about your job as a coroner/ judge would you still have applied?"[663]
- "Would you encourage suitable people to apply to be a coroner/salaried judge?"[664]

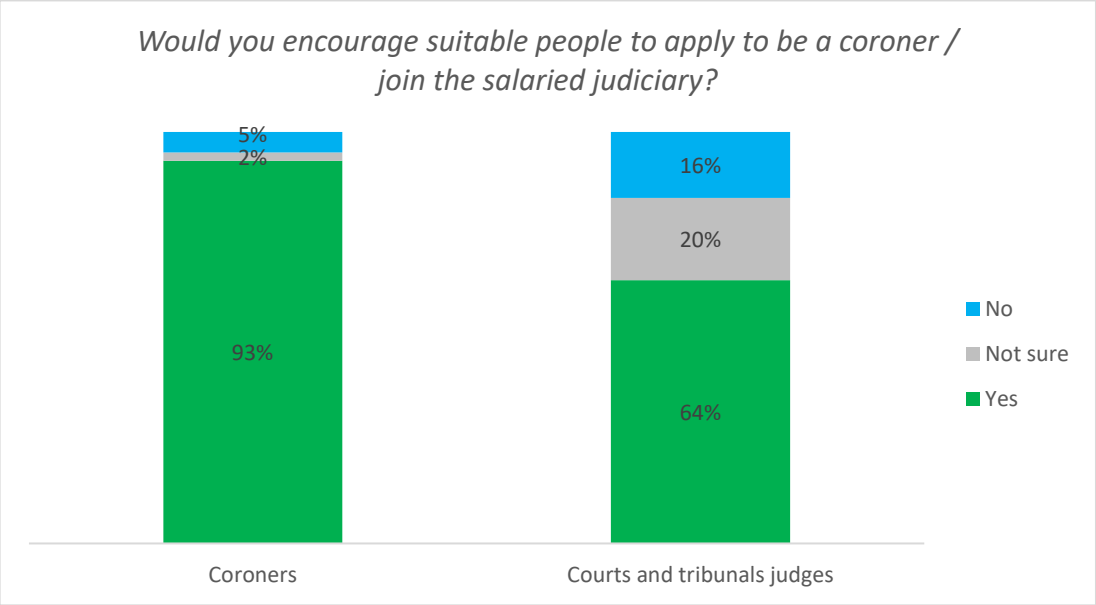
As Figures 72 and 73 show, there was a substantial difference between coroners and courts and tribunal judges on both questions. While almost all coroners said they would still apply to be a coroner (81%) and encourage others to apply to be a coroner (93%), only 67% of the courts and tribunals judges said they would still apply and only 64% of courts and tribunals judges said they would encourage others to apply to the salaried judiciary.

**Figure 72 Comparative retrospective views on applying (coroners n=336; judges n=1782)**




[663] Q.41 in the Coroner Attitude Survey.
[664] Q.42 in the Coroner Attitude Survey.

**Figure 73 Comparative willingness to encourage applications (coroners n=333; judges n=1781)**




Both the CAS and UK JAS also asked coroners and courts and tribunals judges for the reasons they would encourage and discourage suitable people to apply to join their ranks.[665]

As shown in Table 11, a majority of coroners gave four reasons for why they would encourage applications: the challenge of the work (88%), public service (82%), intellectual satisfaction (78%) and the chance to contribute to justice being done (71%). These reasons were also selected by a majority of the courts and tribunals judges. While a majority of the judges also identified job security (64%) and half identified a sense of collegiality (50%) as reasons for encouraging applications, only small minorities of coroners selected these as reasons (16% and 21% respectively).

[665] Q.43 and Q.44 in the Coroner Attitude Survey.

**Table 11 Reasons coroners and courts and tribunals judges would encourage people to apply to join the coroner service/ courts and tribunals judiciary (coroners n=331; judges n=1781)**

| ***The reasons I would encourage suitable people to apply to join the Coroner's Service/ salaried judiciary are:*** | **Coroners** | **Courts and tribunals judges** |
|---|---|---|
| Challenge of the work | 88% | 74% |
| Public service | 82% | 72% |
| Intellectual satisfaction | 78% | 68% |
| Chance to contribute to justice being done | 71% | 74% |
| Sense of collegiality | 21% | 50% |
| Job security | 16% | 64% |

There were only two reasons why a majority of coroners would discourage people from applying to become a coroner: the isolation of the job (59%) and the feeling of being second best compared with judges (53%). In contrast, there was only one reason why a majority of courts and tribunals judges would discourage people from applying to the salaried judiciary – the experience of changes to pension entitlements (58%). Half of the judges also identified reduction in income as a reason why they would discourage applicants.

**Table 12 Reasons why coroners and courts and tribunals judges would discourage people from applying to join the coroner service/ courts and tribunals judiciary (coroners n=327; judges n=1779)**

| ***The reasons I would discourage suitable people from applying to join the Coroner's Service/ salaried judiciary are:*** | **Coroners** | **Courts and tribunals judges** |
|---|---|---|
| Isolation of job | 59% | 44% |
| Feeling of being second best compared with judges | 53% | N/A |
| Lack of support from local authorities | 37% | N/A |
| Poor quality of physical work environment | 37% | 41% |
| Reduction in income | 34% | 50% |
| Lack of respect for coroners/ judges | 30% | 40% |
| Lack of administrative support | 26% | 44% |
| Constant policy changes | 14% | 44% |
| Experience of changes to pension entitlements | 11% | 58% |

## 8.6 Societal respect

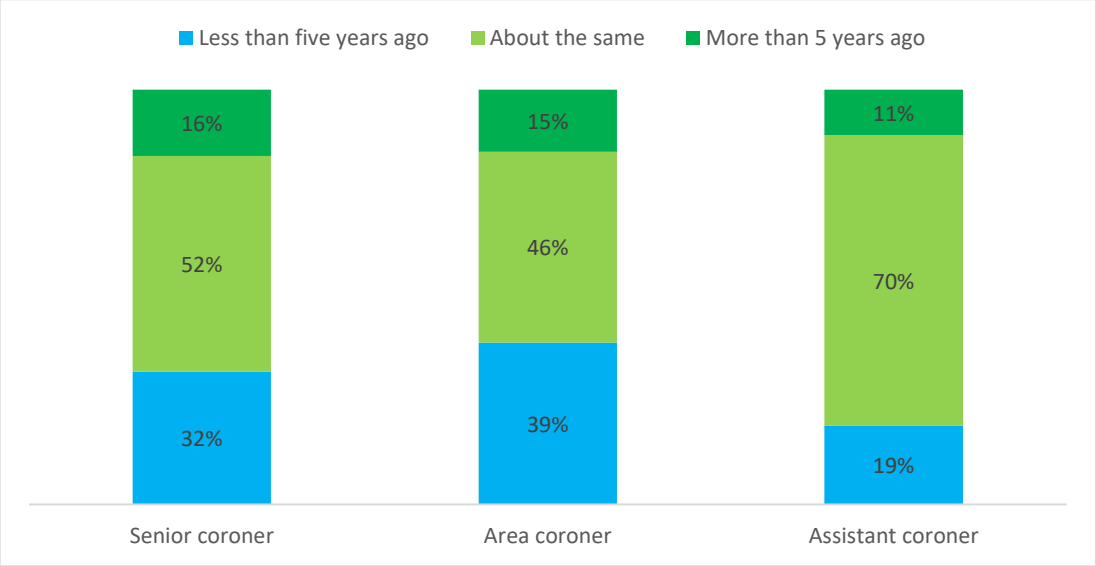
The CAS and the UK JAS asked coroners and judges to what extent they felt they were respected by society at large. Most coroners (63%) feel that there has been little change in the extent to which coroners are respected by society at large today compared with five years earlier.

**Table 13 Societal respect (n=323)**

| ***Coroners are respected by society at large*** | |
|---|---|
| Less than they were 5 years ago | 24% |
| About the same as they were 5 years ago | 63% |
| More than they were 5 years ago | 13% |

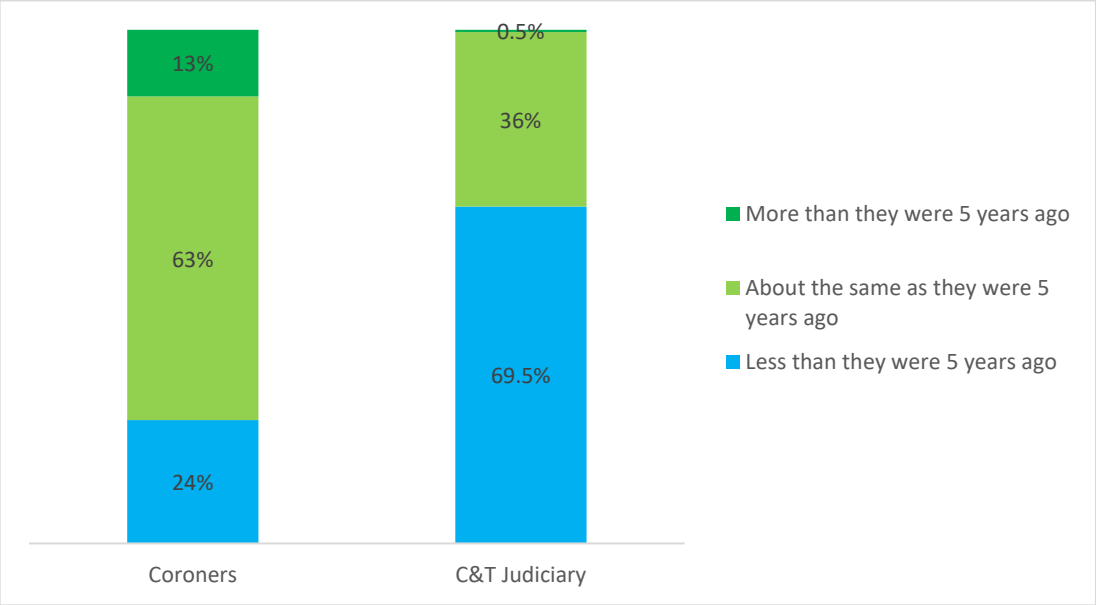
There were some differences by coroner post (Figure 74). Area coroners were more divided in their views and had the largest proportion of coroners (39%) who felt that coroners are respected by society less than they were five years earlier.

**Figure 74 Societal respect, by coroner post (n=323)**




There were substantial differences between coroners and courts and tribunals judges on this issue (Figure 75). Two thirds of coroners (65%) felt society's respect for them was about the same as it had been five years earlier, but 69% of courts and tribunals judges felt they were less respected by society at large now compared with five years ago.

**Figure 75 Comparative feelings of respect by society at large (coroners n=323; judges n=1786)**




## 8.7 Workload

The CAS and UK JAS asked identical questions of coroners and courts and tribunals judges about workload over the previous 12 months.

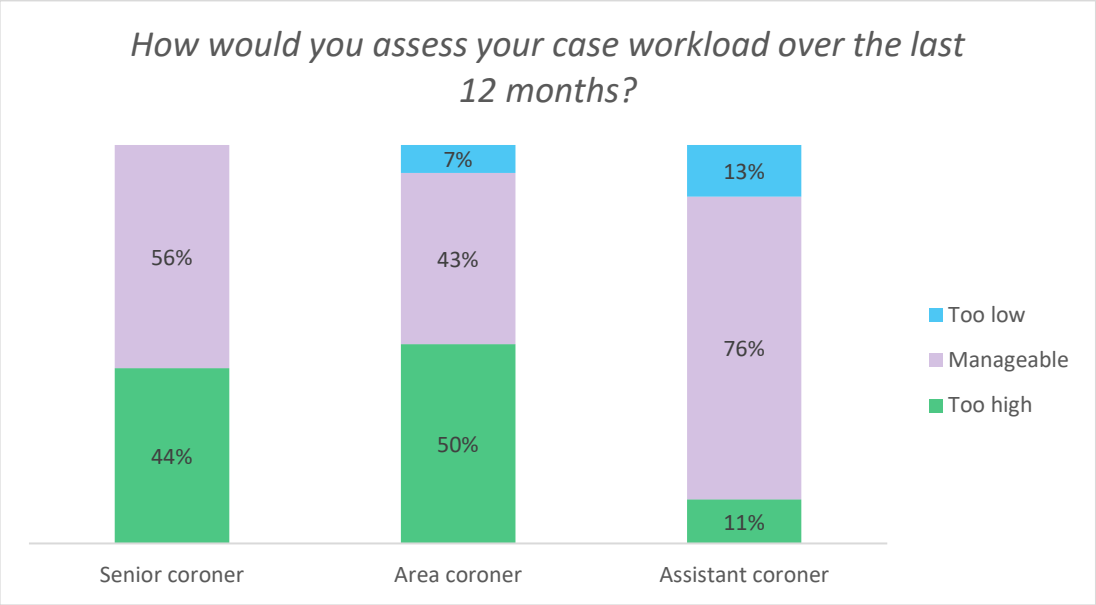
Most coroners (70%) said their case workload was manageable.

**Table 14 Coroners' assessment of case workload over the last 12 months (coroners n=353; judges n=1869)**

| ***How would you assess your case workload over the last 12 months?*** | **Coroners** | **Courts and tribunals judges** |
|---|---|---|
| Too high | 22% | 34% |
| Manageable | 70% | 64% |
| Too low | 8% | 2% |

However, as Figure 76 shows, the case workload of senior coroners and area coroners was very different to that of their assistant colleagues. Half of area coroners (50%) and 44% of senior coroners said their case workloads were too high, while 76% of assistant coroners said it was manageable.

**Figure 76 Coroners' assessment of case workload over the last 12 months, by coroner post (n=353)**




The CAS and UK JAS also asked coroners and courts and tribunals judges to assess their non-casework workloads in the previous 12 months.[666] There were similar results. A majority of coroners who have such work said it was manageable (61%).

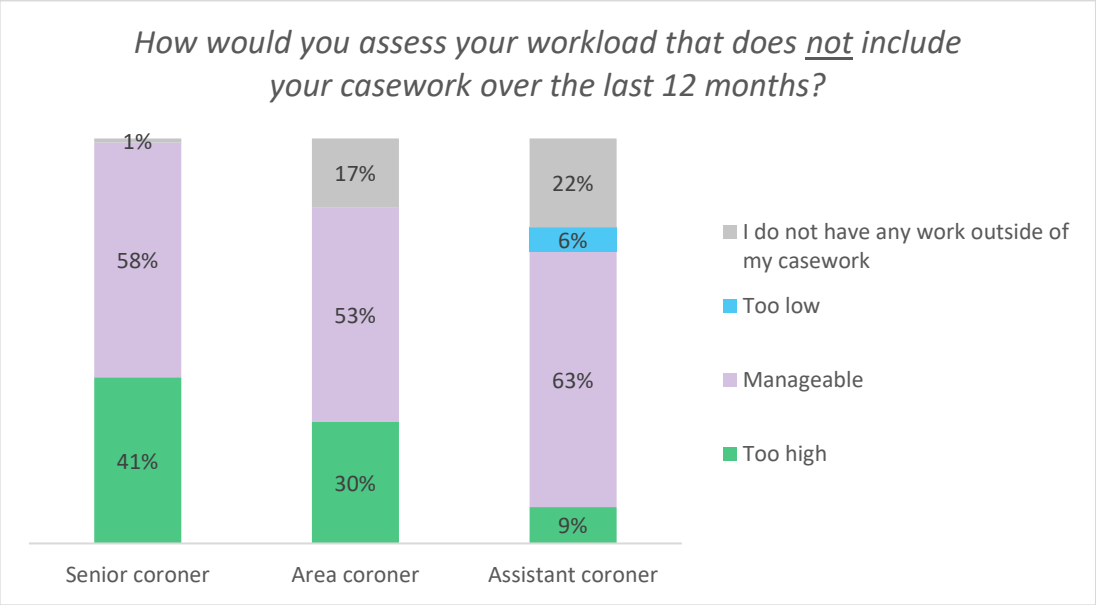
**Table 15 Non-case workload over the last 12 months (May 2019-2020) (coroners n=353; judges n=1869)**

| ***How would you assess your workload that does not include your casework over the last 12 months?*** | **Coroners** | **Courts and tribunals judges** |
|---|---|---|
| Too high | 19% | 24% |
| Manageable | 61% | 63% |
| Too low | 3% | 0% |
| I do not have any work outside of my casework | 17% | 13% |

However 41% of senior coroners and 30% of area coroners said their non-case workload was too high.

[666] Q.9 in the Coroner Attitude Survey.

**Figure 77 Coroners' assessment of non-case workload over the last 12 months (May 2019-2020), by coroner post (n=353)**




## 8.8 Other working conditions

The CAS and the UK JAS also asked coroners and courts and tribunals judges several identical questions about other working conditions at their courts. They were asked to assess the:

- amount of administrative support
- quality of administrative support
- morale of court staff
- physical quality of court building
- maintenance of the court building
- physical quality of personal work space
- security at court

There were some differences between coroners' assessments and those of the courts and tribunals judges (see Figures 78 and 79). Coroners rated all the following more highly than courts/tribunal judges: the amount and quality of their administrative support, the morale of court staff, the physical quality of their court buildings and the maintenance of their court buildings  In contrast, courts/tribunal judges rated security

at their courts and the physical quality of their personal work space more highly than coroners.

**Figure 78 Coroners' and courts and tribunals judges' assessment of administrative support and staff morale (coroners n=353; judges n=1572)**

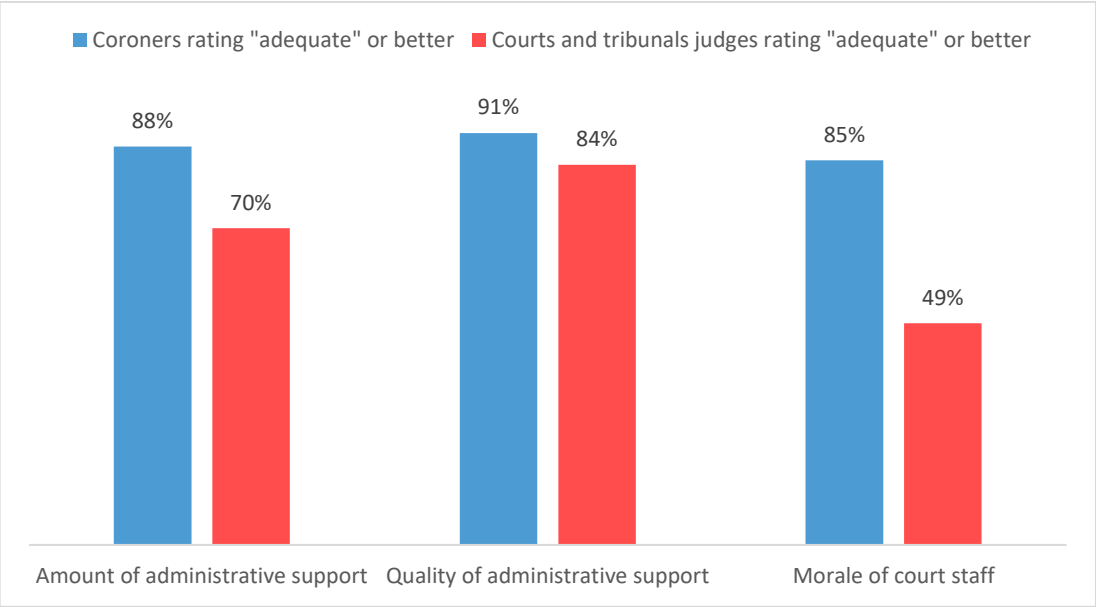
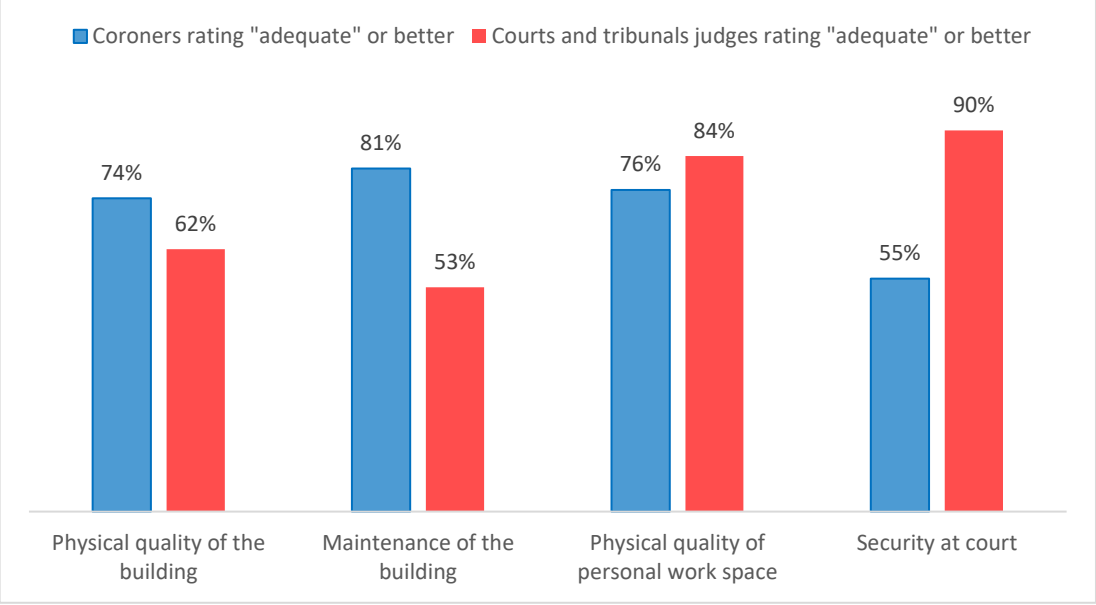



**Figure 79 Coroners' and courts and tribunals judges' assessment of adequacy of working conditions (coroners n=353; judges n=1572)**



### 8.9 Concerns about personal security

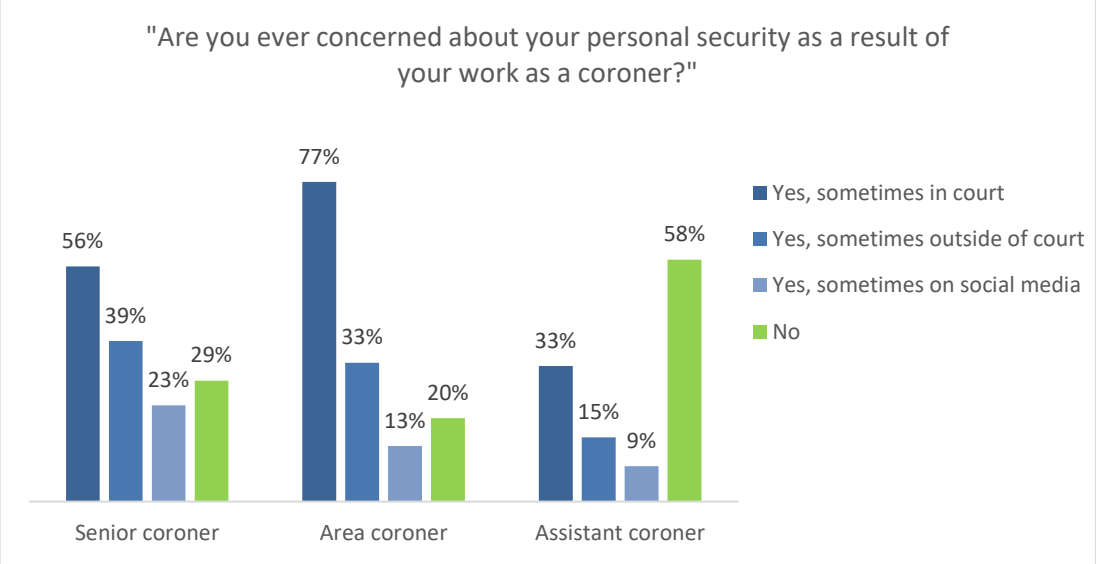
The CAS and UK JAS also asked coroners and courts and tribunal judges identical questions about whether they are ever concerned about their personal security as a result of their work (Table 16).

**Table 16 Coroners' and courts and tribunal judges' concerns for their personal security (coroners n=354; judges n=1826)**

| ***Are you ever concerned about your personal security as a result of your work as a coroner/ judicial role?*** | **Coroners** | **Courts and tribunals judges** |
|---|---|---|
| Yes, sometimes in court | 44% | 42% |
| Yes, sometimes outside of court | 22% | 37% |
| Yes, sometimes on social media | 13% | 9% |
| No | 47% | 40% |

Amongst coroners there were some differences between coroner posts (Figure 80). Most noticeably, 77% of Area Coroners and 56% of senior coroners said they are sometimes concerned about their personal security in court, while only 33% of assistant coroners had these concerns.

**Figure 80 Coroners' concerns for their personal security, by coroner post (n=354)**



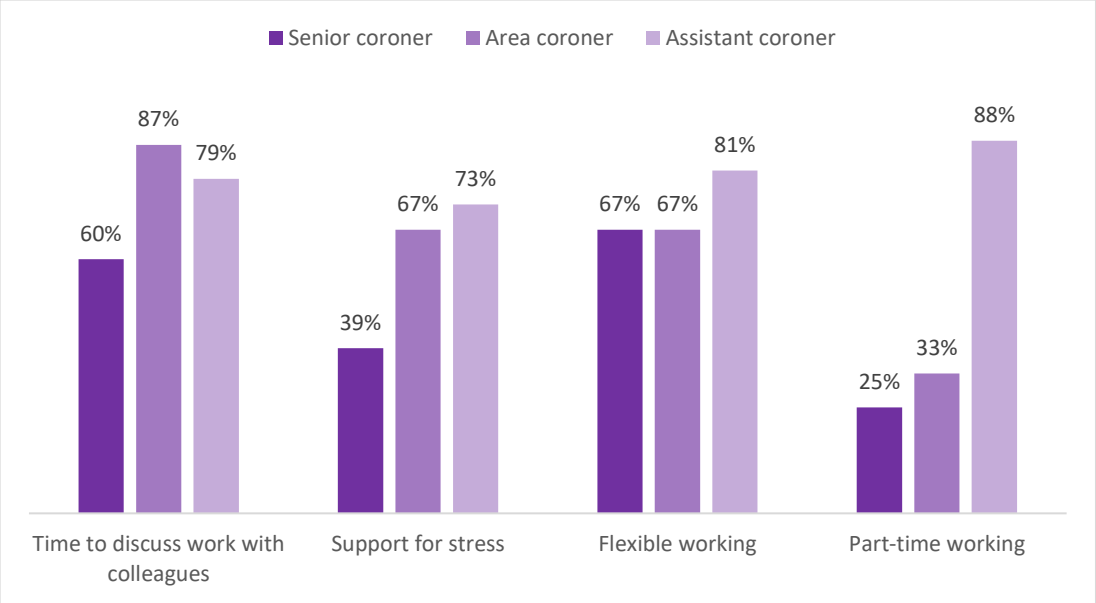
## 8.10 Support and flexible working

Coroners and courts and tribunals judges were asked to rate the importance and availability of support and flexible working patterns. Almost all coroners (92%) saw having time to discuss work with coroner colleagues as important. Over three quarters (77%) identified support for dealing with work-related stress as important. Two thirds of coroners (67%) said having the ability to work flexible hours is important, and 60% were of this view in relation to the option of working on a part-time basis. However, as Figures 81 and 82 show, the availability of opportunities for support does not meet coroners' demand.

**Figure 81 Coroners' view of the importance and availability of opportunities (n=354)**

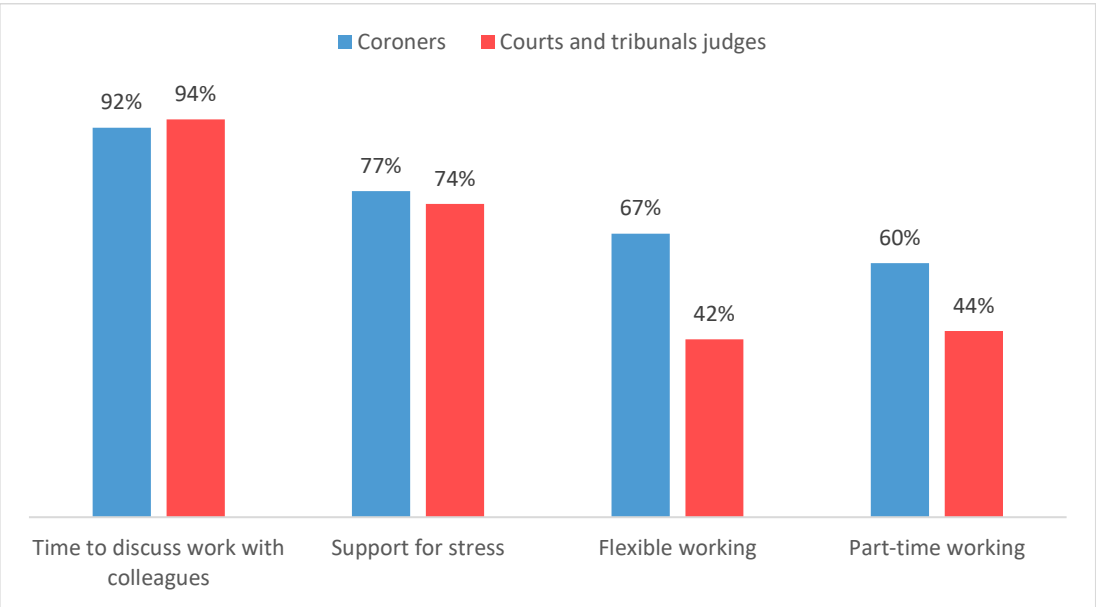

The availability of these opportunities differs across coronial posts. Only 60% of senior coroners said they had time to discuss work with colleagues, and a minority (39%) said they had access to support for work-related stress. While two thirds (67%) of senior coroners and area coroners can take advantage of flexible working, only a quarter of senior coroners (25%) and a third of area coroners (33%) can work on a part-time basis.

**Figure 82 Coroners' view of the availability of opportunities by post (n=354)**



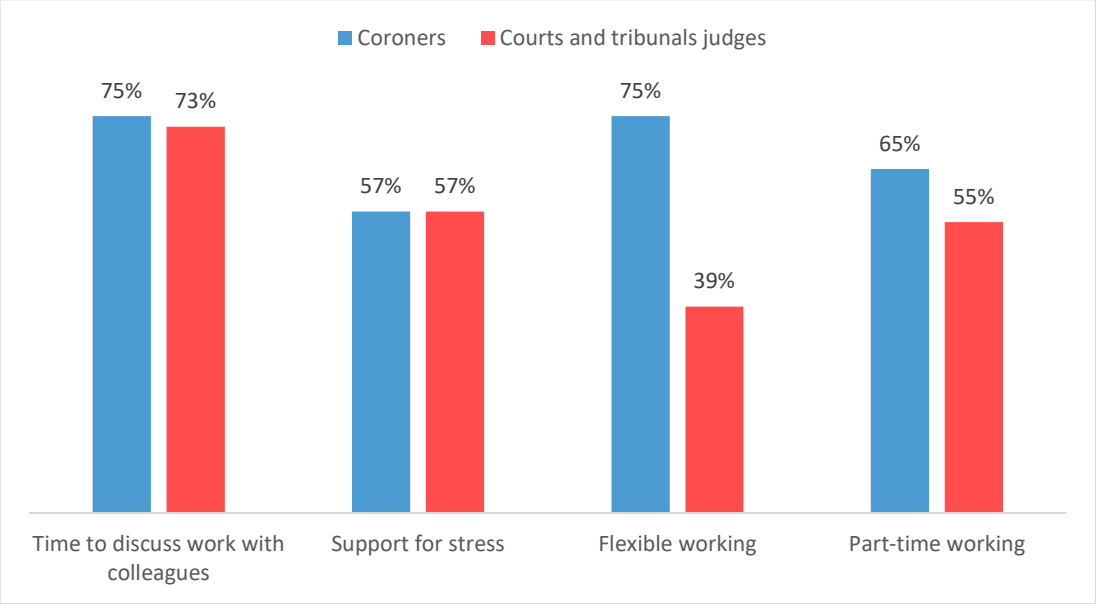

Having time to discuss work with colleagues and support for stress are important to both coroners and courts and tribunals judges, and their results are very similar (Figure 83). In contrast, while flexible working and part-time working are important to a majority of coroners, they are important to a minority of the judges.

**Figure 83 Coroners' and courts and tribunals judges' assessment of importance of specific opportunities (coroners n=352; judges n=1887)**



In terms of the comparative availability of these opportunities, the results are remarkably similar in relation to time to discuss work with colleagues and support for stress (Figure 84). In contrast, there is a stark difference in the availability of flexible working and a smaller difference in relation to opportunities to work part-time.

**Figure 84 Availability of specific opportunities for coroners and courts and tribunals judges (coroners n=352; judges n=1887)**




## 8.11 Sources of stress for coroners

There was one area that the CAS explored in more detail for coroners than the UK JAS did for courts and tribunal judges: significant sources of stress. Only one aspect – the isolation of the job – was identified by a majority of coroners (57%) as a significant source of stress in their job as a coroner. Just under half of respondents also identified the pressure of making rulings (44%) and concern about letting down bereaved families (43%).

**Table 17 Significant sources of stress for coroners (n=327)**

| ***Which of the following do you consider significant source of stress in your job as a coroner?*** | |
|---|---|
| Isolation of job | 57% |
| Pressure of making rulings | 44% |
| Concern about letting families down | 43% |
| Likelihood of decisions being challenged | 39% |
| Lack of a professional support network | 34% |
| 24/7 nature of the work | 29% |
| Sole focus on death | 26% |
| Dealing with media coverage of inquests | 19% |
| Criticism for delay in releasing the body | 14% |
| Having to watch graphic visual evidence | 9% |

There were some significant differences in attitudes across coroner posts on this issue (Table 18). Senior coroners view the isolation of the job (79%) and the "24/7" nature of coroners' work (51%) to be the most significant sources of stress. For area coroners it is the pressure of making rulings (60%). Assistant coroners highlighted concern about letting down bereaved families (43%), the isolation of the job (42%) and the pressure of making rulings (42%).

**Table 18 Significant sources of stress for coroners, by coroner post (n=327)**

| ***Which of the following do you consider significant sources of stress in your job as a coroner?*** | **Senior coroners** | **Area coroners** | **Assistant coroners** |
|---|---|---|---|
| Isolation of the job | 79% | 47% | 42% |
| Pressure of making rulings | 40% | 60% | 42% |
| Concern about letting families down | 42% | 40% | 43% |
| Likelihood of decisions being challenged | 32% | 37% | 35% |
| Lack of professional support network | 42% | 17% | 28% |
| 24/7 nature of the work | 51% | 43% | 14% |
| Sole focus on death | 29% | 30% | 21% |
| Dealing with media coverage of inquests | 22% | 23% | 15% |
| Criticism for delay in releasing the body | 20% | 20% | 9% |
| Having to watch graphic visual evidence | 8% | 10% | 7% |

### 8.12 Summary

The results set out in this chapter reveal the disconnect felt by coroners. While they consider themselves to be judges, only a quarter of coroners feel valued by their peers in the courts and tribunals and just over a third feel part of the wider judiciary. Coroners do feel valued by the public and to a greater extent than that of the courts and tribunals judges. Unlike the majority of the judges, only a small minority of coroners believe that societal respect for their office diminished over the previous five years. It would appear that that Dame Janet Smith was right to conclude that the public retains an affection for the coroner's inquest.[667]

The rest of the chapter ought to give advocates of a national coroner service pause for thought. With the exception of the physical quality of personal workspace and the level of security at court, the results set out above do not paint a gloomy picture of the

[667] Smith (n 32) para 19.11.

coroner service in 2020, particularly when considered alongside the findings of the UK JAS. The CAS results lend support to arguments that the level of consistency that a centrally resourced, unified service may achieve would not necessarily match the high standards in coroner areas that are currently well-resourced. These results are considered in the following chapter's discussion of whether the creation of a national coroner service remains necessary.

# Chapter 9 The representativeness of coroners and public confidence

At the outset of the Grenfell Tower Inquiry, Leslie Thomas KC, representing 17 core participants including bereaved families and survivors of the fire, urged the chair, Sir Martin Moore-Bick, to consider the importance of diversity amongst those investigating the fire that led to the deaths of 72 people:

> "… sir, the submissions that were made to you about the panel, the representation on the panel -- this isn't just lip service, this isn't saying, "I want somebody who looks like me for the sake of somebody who looks like me" -- no, it's much more than that. […] I've asked you to take a long hard look at your panel, your assessors, your team, and ask yourself: does it pass the smell test? Because that relates to perception, public perception. Do they understand us? Do they speak our language? Do they know anything about social housing? How many of them have lived in a tower block or on a council estate or in social housing? That affects confidence. Confidence or lack of it affects participation. And a lack of participation from the very people who matter will affect justice. And a lack of justice is injustice."[668]

Diversity in the judiciary has long been recognised as a significant influence on the public perception of the fairness of the judicial process.[669] Any discussion about this in relation to coroners has been hampered by the absence of information on the composition of the coroner service. Before this research there was no reliable information about coroner demographics or on coroners' backgrounds and experiences prior to judicial appointment. The only previous attempt at collecting such information was conducted a quarter of a century earlier and was limited to learning the age and sex of each coroner and whether their professional qualification was in law or medicine.[670] The research undertaken in this thesis has provided new, crucial and highly reliable information about who coroners are and how representative they are of the population in England and Wales. This chapter discusses the importance of this

[668] Grenfell Tower Inquiry, Procedural Hearing, 11 December 2017, pp. 137-38.
[669] Kate Malleson, 'Creating a Judicial Appointments Commission: Which Model Works Best?' [2004] Public law 102; Cheryl Thomas, 'Judicial Diversity in the United Kingdom and Other Jurisdictions: A Review of Research, Policies and Practices' (The Commission for Judicial Appointments 2005).
[670] Tarling (n 13).

extensive, up-to-date profile of the composition of the coronership set out in Chapter 6 and its implications for the level of public confidence in coroners.

## 9.1 The diversity of the coronership and its implications for public confidence

The comments of Leslie Thomas KC to the Grenfell Inquiry built on a large body of scholarship going back many years that has established a connection between the diversity of the judiciary and the public perception of the fairness of courts. Most of this research was undertaken in the United States, but a significant amount has also been produced in England and Wales.[671] The senior judiciary of England and Wales today recognises diversity as "fundamental to the rule of law"[672] and acknowledges that "public confidence in and the legitimacy of the judiciary are sustained by a judiciary that reflects the broad composition of the society it serves."[673] At first glance the results of the Coroner Attitude Survey suggest the coroner service faces the same challenge as that of the courts and tribunals judiciary in achieving greater diversity in the pool of applicants for judicial roles.

One hypothesis of this research was that since 2013 there would have been an increase in female and BAME representation among newly appointed coroners. This supposition took into consideration the professionalised and better publicised recruitment procedures since the first iteration of the Chief Coroner's guidance on appointments in July 2013. In its written submission to the House of Commons Justice Committee's inquiry into the Coroner Service, the Coroners' Society of England and Wales noted with approval the efforts at improving diversity in the coronership:

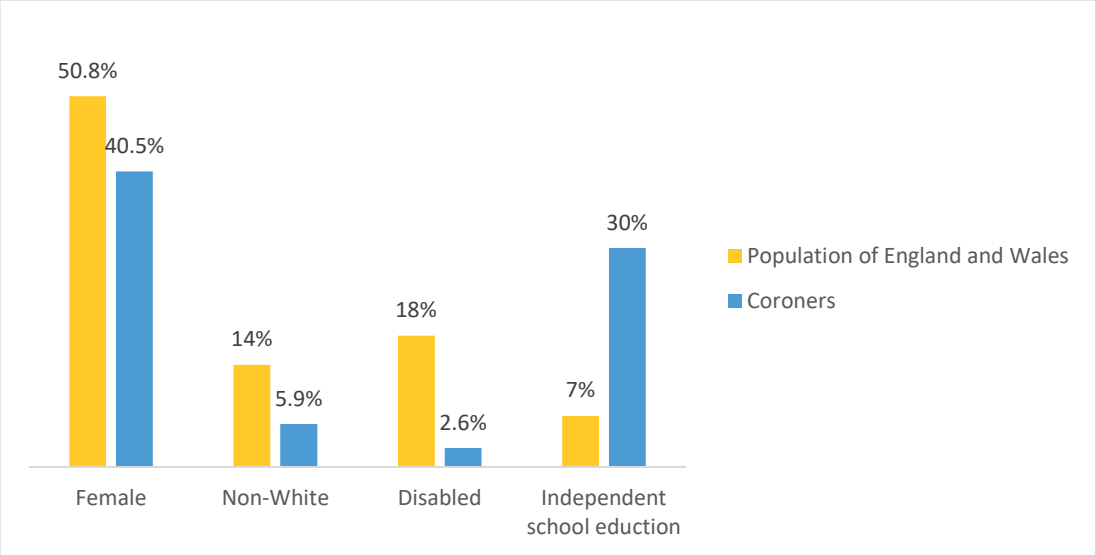
> "The Chief Coroner has recognised that it is important that the judiciary reflects the public we serve. To increase opportunity and to ensure diversity periodic courses are offered by the Chief Coroner to encourage

[671] See, for example, Erika Rackley, 'What a Difference Difference Makes: Gendered Harms and Judicial Diversity' (2008) 15 International Journal of the Legal Profession 37; Kate Malleson, 'Diversity in the Judiciary: The Case For Positive Action' (2009) 36 Journal of law and society 376; Hilary Sommerlad, 'The "Social Magic" of Merit: Diversity, Equity, and Inclusion in the English and Welsh Legal Profession' (2015) 83 Fordham law review 2325; Lady Hale, 'Making a Difference? Why We Need a More Diverse Judiciary' (2020) 56 Northern Ireland legal quarterly 281.
[672] 'Judicial Diversity and Inclusion Strategy 2020 – 2025' (Courts and Tribunals Judiciary 2020) 10 <https://www.judiciary.uk/guidance-and-resources/judicial-diversity-and-inclusion-strategy-2020-2025-launched/> accessed 14 September 2022.
[673] ibid.

> applications for Coroner appointments. These courses are very popular and have increased the open competition for vacancies."[674]

The hypothesis and the Coroners' Society were only partially correct. There has been a significant increase in female representation in the coronership since July 2013. With just under two thirds (61.3%) of female coroners having been appointed since that date, the survey results suggest the Chief Coroners' reforms of the recruitment process have had a very positive impact on gender diversity. We should be mindful of Thomas' observation that "improving the role of women in judiciaries can be closely connected to an overall increase in diversity in general."[675] But despite an increase in the number of women appointed to the coronership, the coroner service does not reflect the population of England and Wales in terms of either gender or ethnicity. As Figure 85 shows, women, those of minority ethnic backgrounds, those with comprehensive school education and the disabled all remain underrepresented in the coronership.

**Figure 85 The representativeness of coroners[676]**




The coroner service is no more representative of the population of England and Wales than is the courts and tribunals judiciary. The proportion of women in the coronership (40.5%) is very slightly greater than the proportion of women in the courts and

[674] 'Written Evidence from The Coroners' Society of England & Wales' (n 266).
[675] Thomas, 'Judicial Diversity in the United Kingdom and Other Jurisdictions: A Review of Research, Policies and Practices' (n 669) 19.
[676] Data from 2011 Census and 'Elitist Britain 2019' (n 578) 4.

tribunals judiciary (39.3%), but the proportion of non-White coroners (5.9%) is smaller than the proportion of non-White judges (7.2%) and disabled people are underrepresented to a greater extent in the coronership (only 2.6% of coroners have a disability) than in the courts and tribunals judiciary (6.3% of judges have a disability). In relation to other diversity factors, the survey results show coroners' secondary education mirrors that of most courts and tribunals judges, with just over 70% of coroners having attended a UK state schools and 30% having attended an independent or fee-paying school.[677] Similarly, like all other judicial posts apart from the High Court and Court of Appeal, a majority of coroners (60.2%) were in the first generation of their family to attend university.

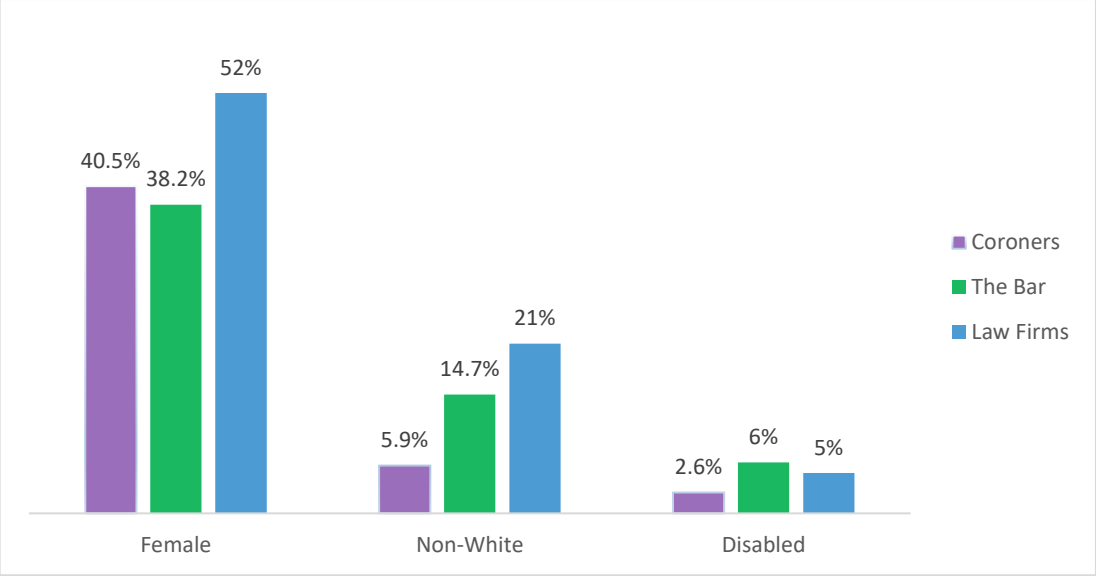
There is a "prestige effect"[678] evident in the courts and tribunals judiciary, with the higher, more prestigious posts (which are also those with accompanying higher financial remuneration) appearing to be heavily stratified by socio-economic background.[679] However the prestige effect is not so obvious in the coroner service. While the office of senior coroner is the coroner post with the highest proportion of coroners who were not in the first generation of their family to attend university (45%) and highest proportion of coroners educated in independent or fee-paid secondary schools (65%), the differences across coroner posts are not as great as those in the courts and tribunals judiciary.[680]

In terms of professional background, the first Chief Coroners' reports for 2014-2015 and 2015-2016 highlighted the variety of legal roles from which new coroners are drawn.[681] The Coroner Attitude Survey results confirm the coroner service is no longer the "self-perpetuating group"[682] that Dame Janet Smith described in 2003. Whereas

[677] 74% of District Judges (Mags), 70% of First Tier Tribunal Judges and of Upper Tribunal Judges, 69% of Employment Tribunal Judges and 67% of District Judges (Civil) attended UK state schools. At the circuit bench, 56% of judges attended UK state schools. A majority of the judges of the High Court and Court of Appeal attended independent schools. Thomas, '2020 UK Judicial Attitude Survey: England and Wales Courts and UK Tribunals' (n 69) 86.
[678] 'Elitist Britain 2019' (n 578) 13.
[679] While only 35% of Court of Appeal judges were in the first generation in their family to attend university, this figure rises to 42% of the High Court bench. Amongst circuit judges it rises again to 60%. The post of District Judge (Mags) has the greatest proportion of those who were the first generation of their family to attend university (70%).
[680] See Figures 22 and 23 on pages 155 and 157.
[681] Sir Peter Thornton, 'Chief Coroner's Annual Report 2014-15' (2015) para 74; Thornton, 'Chief Coroner's Annual Report 2015-16' (n 303) para 52.
[682] Smith (n 32) para 7.4.

once the coroner service was a relatively closed shop drawn largely from the solicitors' profession, the results of the Coroner Attitude Survey shows it has become increasingly attractive to barristers seeking judicial office, who now make up a third of the service.[683] However the coroner service does not reflect the diversity of the legal profession from which it recruits its new members. As seen in Figure 86 the proportion of women in the coronership is slightly greater than that at the Bar (38.2%) but far behind the proportion of female lawyers in the solicitors' profession (52%) from which the majority of coroners are recruited. The proportion of non-White coroners is far less than the proportion at the Bar (14.7%) or in law firms (21%).[684] Disabled people are underrepresented in the legal profession (6% of the Bar and 5% of law firms) but not to the same degree as in the coronership.

**Figure 86 The coroner service and the legal profession**




The bi-annual reports produced by the Bar Standards Board[685] and the Solicitors Regulation Authority[686] on the diversity of their respective professions measure social mobility in different ways. As the response rates of barristers and solicitors also differ, a comparison with the data produced by the Coroner Attitude Survey is not possible. However both surveys provide data on lawyers' school attendance which, when compared with the results of the Coroner Attitude Survey, provide further evidence

[683] See Figure 25 on page 159.
[684] See Table 5 on page 151.
[685] 'Diversity at the Bar 2019' (n 574).
[686] 'How Diverse Is the Legal Profession?' (n 575).

that the coronership is not representative of the legal profession. The SRA results published in 2020 revealed that 22% of solicitors had attended independent schools compared to 30.2% of the coroner service. A majority of barristers did not provide information on their schooling.[687]

Ultimately, however, the results of this detailed research into coroners' backgrounds show that the coroner service in 2020 cannot be described as representative of the population of England and Wales in terms of gender, ethnicity, disability and education. Coroners may feel valued by the public and believe they retain a high level of societal respect, but unless they become more representative of the society they serve they may struggle to respond should the public perception of coroners change. The Coroner Attitude Survey results suggest they would not pass the "smell test" posed by Leslie Thomas KC.

### 9.2 Increasing diversity in the Coroner Service

One way in which diversity may be increased would be to remove responsibility for coroner recruitment from local authorities. While local authorities are free to appoint qualified applicants from outside their jurisdiction and vacancies are now advertised much more widely, recruitment at a local level may still make it harder for some areas to attract applicants from non-traditional backgrounds. The Coroners' Society's written evidence highlighted the significant variation between individual coroner areas in terms of demographics, with some areas having a large population of older, retired people and little ethnic diversity, whereas others have a much younger and ethnically diverse demographic. As coroners are recruited by the local authorities with responsibility for these coroner areas rather than by a single, central body, they are tied to their coroner areas once appointed and do not have a simple route to working elsewhere in England and Wales.

[687] 52.5% of barristers declined to provide information on their secondary education. Nevertheless the figure of 17% of counsel who reported having attended an independent school led the BSB to conclude that the Bar has a disproportionately high percentage of graduates of independent schools. The BSB survey also provided information on the percentage of barristers who are part of the first generation of their family to attend university. However the response rate was 49.2%. Of those barristers who did provide information, 46.8% were of the first generation to attend university.

A contrast may be made with the recruitment of judges for the circuit and district benches. Applicants for those posts are asked to indicate the areas of England and Wales in which they would like to sit if appointed as a judge. While the Senior Presiding Judge strives to deploy successful candidates to their preferred circuit, business needs may dictate appointment to a different part of the country. However, after five years' service a courts and tribunals judge can request a transfer to a different circuit or court centre. Coroners, on the other hand, are unable to make a transfer request to work in another coroner area. (They can of course apply for an advertised post elsewhere in England and Wales, but this involves an open competition). The Coroner Attitude Survey results suggest this inflexibility may deter candidates unwilling to commit to working at a court far from home: 26% of assistant coroners and 16% of senior coroners said a requirement to sit in a location too far from home is a factor making it more likely that they will leave the coroner service before reaching compulsory retirement age.[688] Given the stark differences in demographics between many coroner areas, this may impact upon diversity in the coroner service. Of course, it must be acknowledged that the courts and tribunals judiciary also lags far behind both the Bar and law firms in terms of ethnic diversity, so any gains in coroner diversity from the introduction of centralised recruitment may be modest.[689] However, the introduction of such a reform, whether as a consequence of a unified, national coroner service or as an aspect of a revised system still delivered at a local level, would remove one possible disincentive by offering those considering a career as a coroner a means of entering the service without committing themselves to one geographic area for the rest of their career.

### 9.3 Retaining public trust despite a lack of diversity

Two factors may work to help coroners retain public trust despite the homogeneity of their ranks. The first, highlighted in Chapter 1, is that many people have, at best, only a vague understanding of the coroner's role. For those without direct experience of attending a coroner's court, their knowledge of the jurisdiction will come largely from high profile cases reported in the media, such as the inquests into military deaths in

[688] Q.32.
[689] In the Judicial Attitude Survey 2020, non-White judges comprised 7.2% of the salaried judiciary that self-identified their ethnicity. Thomas, '2020 UK Judicial Attitude Survey: England and Wales Courts and UK Tribunals' (n 69) 84.

war zones, or that of Natasha Ednan-Laperouse. Press reports of such cases have cast the coroner in a good light, doggedly pursuing the truth from powerful institutions. Quotes from grateful relatives of the deceased thanking the coroner for his or her conduct of the inquest are typically included.[690] The inquests into the deaths at Hillsborough Stadium that ran between 2014 and 2016 were not typical of coroners' work but have also shaped how many people think of the coroner's inquest.[691] The bereaved families' long campaign for fresh inquests and the widespread coverage of their joy, relief and sense of justice at the conclusions provided a powerful recent example of a theme that emerges from the review of coronial history in Chapter 2, namely sections of the public relying on the coroner's inquest to hold the powerful to account. The Hillsborough coverage likely lay behind the demands from some of the Grenfell Tower bereaved for inquests rather than a public inquiry after the June 2017 tragedy.[692]

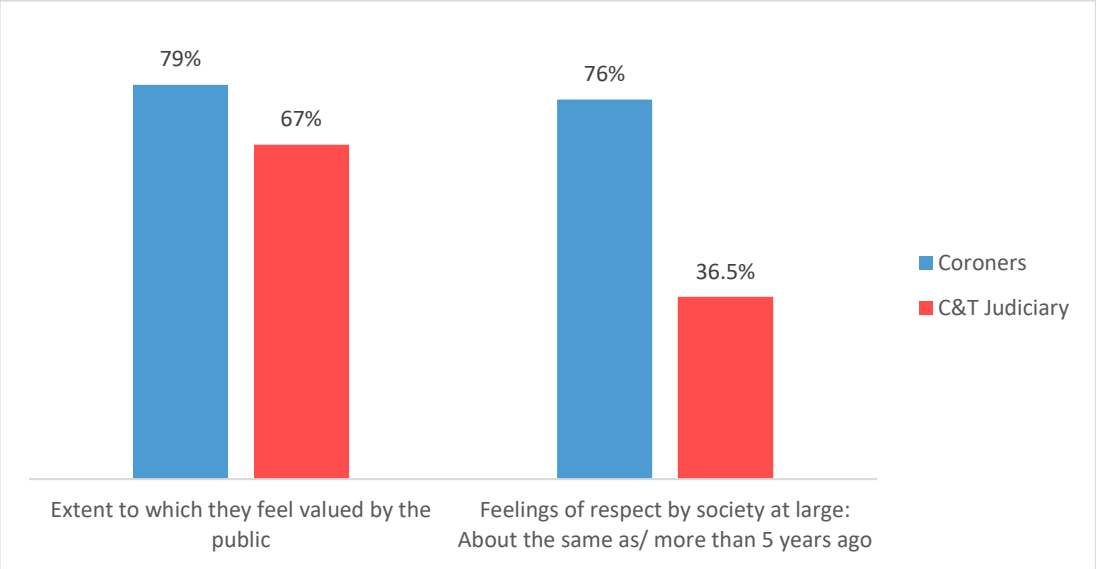
The second factor that may cause the public to look past the coroner service's lack of diversity relates to those with direct experience of the inquest process. It must be remembered that those who come before the coroners' courts are in a different position to those who use the civil courts or who appear in the criminal courts as defendants or witnesses. Even in the much more typical inquests that do not attract public attention, the stress of the legal process is regularly compounded by grief or by other strains such as the trauma of having discovered the body. A coroner who can deftly navigate such emotions to help a bereaved family achieve closure or assist witnesses in giving their best evidence, whilst at the same time fulfilling their own statutory role, will very likely enjoy the confidence of such court users. The Coroners' Society concluded its submission to the Justice Committee with many examples of messages from bereaved families thanking coroners for their assistance and conduct of inquests. In his oral evidence, the Society's secretary, André Rebello, told the Committee that the "vast

[690] 'Pret A Manger allergens labelling inadequate, coroner rules' (*ITV News*, 28 September 2018) <https://www.itv.com/news/london/2018-09-28/pret-a-manger-allergens-labelling-inadequate-coroner-rules> accessed 14 September 2022.
[691] Despite the fact that it was actually a senior judge, Sir John Goldring, who conducted the investigation. 'Written Evidence from The Coroners' Society of England & Wales' (n 266).
[692] See letter of Sadiq Khan to Theresa May, discussed at page 81 above.

majority of people who engage with coroners send us an awful lot of compliments and thanks".[693] He urged its members to read the examples in the written submission.

Rebello's statement is supported by findings of the Coroner Attitude Survey. Almost all coroners (96%) reported that they felt valued by bereaved families at inquests. Furthermore, while the survey was not designed to measure the degree of public confidence in the coroner service, it did ask coroners whether they felt valued by the public. The overwhelming majority of coroners (79%) said they felt valued by the public (in contrast to only 67% of the courts and tribunals judiciary saying they felt valued by the public). The survey also revealed that most coroners feel respected by society at large. The majority (63%) felt societal respect for coroners was about the same as it was five years previously and 13% felt it had increased. This contrasts starkly with the vast majority of courts and tribunals judges (69.5%) who felt less respected by society at large.[694]

**Figure 87 Feeling valued by the public and societal respect**




## 9.4 Further benefits of diversity

Research conducted in the United States also suggests there may in some circumstances be a second benefit of promoting diversity in the judiciary: different

[693] 'Oral Evidence to the Justice Committee: The Coroner Service, HC 282' (n 449) Q5.
[694] Thomas, '2020 UK Judicial Attitude Survey: England and Wales Courts and UK Tribunals' (n 69) 4. See Figure 75 on page 214 above.

perspectives contribute to better judicial decision-making.[695] Some studies of the decisions of collegiate appellate courts indicate that diverse panels of judges consider a wider range of matters before forming their judgment, with the presence of even a single judge from a minority background correlating to different court outcomes.[696] Other studies suggest such diversity leads to decision-making that is more likely to be in line with the requirements of the law.[697] The empirical research on the relationship between judicial diversity and case outcomes has overlooked the office of coroner. Nevertheless, even in the relatively small body of academic work conducted on coronial death investigation there is some troubling evidence about coroner decision-making and diversity.

The 2013 analysis by Mclean et al of Ministry of Justice data on inquest conclusions in the 10-year period 2001-2010, noted in Chapter 1 of this thesis, revealed that investigations of female deaths are less likely to proceed to inquest than male deaths and, where there is an inquest, coroners are less likely to find female deaths to be unnatural deaths than male deaths.[698] It indicated that some coroners are "especially gendered"[699] in their decision-making, constantly more likely to favour a particular inquest conclusion according to the sex of the deceased. An earlier study by Neeleman et al of 329 cases of likely suicides in inner London between 1991 and 1993 found coroners' classification of self-inflicted deaths to be biased with respect to the ethnicity

[695] Brenda Hale, the first female Law Lord and President of the UK Supreme Court, has argued that the feminist judgment projects – in which significant judgments handed down by the higher courts are rewritten by female jurists imagining that they had been part of the relevant tribunal – provide objective evidence that different perspectives may result in different judicial decisions. Lady Hale, 'Kuttan Menon Memorial Lecture: Equality in the Judiciary' (London, 13 February 2013) 20, <https://www.supremecourt.uk/docs/speech-130221.pdf> accessed 14 September 2022. See, for example, Rosemary C Hunter, Clare McGlynn and Erika Rackley, *Feminist Judgments : From Theory to Practice* (Hart 2010); Máiréad Enright, Julie McCandless and Aoife O'Donoghue, *Northern/Irish Feminist Judgments: Judges' Troubles and the Gendered Politics of Identity* (1st edn, Hart Publishing Ltd 2017).
[696] Charles M Cameron and Craig P Cummings, 'Diversity and Judicial Decision-Making: Evidence from Affirmative Action Cases in the Federal Courts of Appeal 1971-1999' Columbia Law Review; as quoted by Thomas, 'Judicial Diversity in the United Kingdom and Other Jurisdictions: A Review of Research, Policies and Practices' (n 669) 59; Jonathan P Kastellec, 'Racial Diversity and Judicial Influence on Appellate Courts' (2013) 57 American Journal of Political Science 167.
[697] Cass R Sunstein, *Why Societies Need Dissent* (Harvard University Press 2003); as quoted by Thomas, 'Judicial Diversity in the United Kingdom and Other Jurisdictions: A Review of Research, Policies and Practices' (n 669) 59.
[698] Mclean, Roach and Armitage (n 42) 936.
[699] ibid.

and national origin of the deceased.[700] Another study of the classification of suicide found that coroners varied in their interpretation of what constitutes evidence of intent[701] and did so according to their professional background.[702] The authors suggested that coroners recruited from the medical profession "adhere, paradoxically, more strictly to the 'letter of the law' than those without medical degrees."[703]

These studies are few in number and were conducted in different eras of coronial law. Nevertheless, their findings should still be of concern to leaders in the coroner service today. They show how the make-up of the coronership is not simply a matter of appearances – important though that is to public perception – but something that may directly impact upon coroners' core function: the delivery of justice by publicly establishing the true facts of a death. The findings of the studies cited above indicate that this end was not achieved.

A diverse society like that in England and Wales requires a diverse judiciary; when judicial decisions are reached from only one perspective the chances of all cases ending in just outcomes are low. Thomas has argued that for this fundamental reason, "diversity needs to be considered an integral part of what is meant by merit (ie, the qualities needed to deliver justice) for appointment."[704] The Coroner Attitude Survey results show that the coroner service has become much more diverse since the studies discussed above were undertaken. However, they also show there is a long way to go to truly increase the number of perspectives contributing to judicial decisions in death investigations. This is necessary for people to have confidence in coroners. As Leslie Thomas KC reminded Sir Martin Moore-Bick, such confidence affects participation. His salutary warning that the participation of those affected by a death is essential to justice chimes with the statements of the Chief Coroners that "bereaved families must

[700] Neeleman, Mak and Wessely (n 52) 463 Compared with Whites, Afro-Caribbean true likely suicide rates were lower, and those of Indian and Asian women higher. Compared with Whites born in England and Wales, those born in other parts of Britain or in Ireland had very high rates.
[701] O'Donnell and Farmer (n 49).
[702] Neeleman and Wessely (n 52).
[703] ibid 471.
[704] Thomas, 'Judicial Diversity in the United Kingdom and Other Jurisdictions: A Review of Research, Policies and Practices' (n 669) 30.

at all times be at the heart of the coroner process."[705] The importance of diversity therefore matters not only in the highest profile inquiries but in all inquests.

## 9.5 Conclusion

The Coroner Attitude Survey has produced the first in-depth profile of the make-up of the coroner service in the 21st century. It has revealed that diversity in the coroner service has increased, particularly since July 2013, but is no more representative of the population of England and Wales than is the courts and tribunals judiciary. This lack of diversity may affect the level of public confidence in the coroner service, though the unique circumstances of death investigation may mitigate against a loss of confidence based solely on the service's homogeneity. The lack of diversity may also impact coroners' decision-making, which research suggests has, at times, wrongly taken into account the sex and ethnicity of the deceased. This too can affect public confidence. The survey results suggest the service is moving in the right direction but has a long way yet to go.

[705] Thornton, 'Chief Coroner's Annual Report 2013-14' (n 235) para 10; Lucraft, 'Chief Coroner's Annual Report 2017-18' (n 234) para 11.

# Chapter 10 Therapeutic jurisprudence and inquests

The Coroner Attitude Survey captured coroners' views as to the distinct form of justice they administer. The functions identified by coroners as being their most important – "to publicly investigate deaths" and "to prevent future fatalities" – show that coroners largely agree with Thornton's formulation of the 21st century coroner's purpose (discussed in Chapter 4). Over 90% of coroners identified both of these ends. However, the survey results also confirm McGowan's finding that there is no consensus amongst coroners as to their purpose.[706] The purpose most frequently cited by the coroners interviewed by McGowan was aiding families of the deceased. Some of those coroners described this as finding answers for the family; others as helping families through the grieving process.[707] The Coroner Attitude Survey saw these as separate ends and the results suggest coroners do too: over 90% of respondents selected "to provide answers for the family and the public as to how the deceased died", whereas only 70% identified "to facilitate closure for families".

To date, the question of how coroners in England and Wales should aid the family of the deceased and others affected by a death has been the subject of very little academic research. The few studies that have addressed this have relied on qualitative interviews with a small number of coroners. This research is the first to reveal the attitudes of the coronership as a whole. This chapter considers whether the coronial inquest can be a cathartic process for those affected by a death and explores coroners' attitudes to four methods used in recent, high profile death investigations to facilitate closure. It considers whether this is an appropriate role for the coroner.

## 10.1 Cathartic inquests?

The Coroner Attitude Survey asked coroners whether they agreed with the statement "The inquest can be a cathartic process for families and others involved in a death".[708] Almost all coroners agreed (94%), with almost half strongly of that view (42%). There is certainly a disconnect between coroners' views on the therapeutic potential of the

[706] McGowan (n 59) iii.
[707] ibid 133.
[708] Q.40.

inquest and those of some families. The JUSTICE working party on reform of institutional responses to deaths warned in 2020 that while inquests can serve a cathartic function, "the claim that they actually do so should be treated with caution."[709] Dr Sara Ryan, a working party member whose son Conor died while under the care of an NHS trust[710], argued that many "well-meaning assumptions" are made, typically by senior professionals, about the experiences of families within inquiry processes with no underpinning evidence:

> "A key assumption is catharsis and I find it bewildering and disconcerting that the experience of giving evidence in an enquiry process, being forced to re-live and revisit unspeakably traumatic events and be questioned (or even interrogated) about them is seen as somehow positive."[711]

This view echoes those highlighted by a 2003 report produced by the charity INQUEST. It said: "...families have frequently described the experience as one that adds to, rather than diminishes, distress and that it marginalises them leaving them with more questions than answers".[712] Both the Luce Review and Dame Janet Smith accepted that a public hearing in the coroner's court has the potential to compound the distress experienced by the bereaved.[713]

Why, then, do so many coroners think the inquest can be a cathartic process? In its submission to the Justice Committee's 2021 inquiry into the Coroner Service, the Coroners' Society of England and Wales pointed to the "countless" thank you cards received by coroners each year. The submission provided numerous examples of grateful families' messages, stressing that such compliments are "not […] routinely collated as they are the norm, not the exception".[714] Perhaps the apparent discrepancy can be understood when we remember that most inquests are not protracted, contentious hearings in which bereaved families must face examination by counsel but relatively straightforward matters, conducted by the coroner alone and concluded in a

[709] 'When Things Go Wrong: The Response of the Justice System' (JUSTICE 2020) para 6.34.
[710] 'Jury found neglect contributed to the death of 18 year old Conor Sparrowhawk', *INQUEST* (16 October 2015) <https://www.inquest.org.uk/connor-sparrowhawk-inquest-conclusions> accessed 14 September 2022.
[711] 'When Things Go Wrong: The Response of the Justice System' (n 709) para 6.34.
[712] 'How the Inquest System Fails Bereaved People: INQUEST's Response to the Fundamental Review of Coroner Services' (INQUEST 2002) 3.
[713] The Luce Review Committee (n 30) 79; Smith (n 32) para 113.
[714] 'Written Evidence from The Coroners' Society of England & Wales' (n 266).

day or even a matter of hours. The Coroners' Society has likened the coroner's work to an iceberg, with the vast majority of their efforts for bereaved families hidden from view.[715] In considering coroners' answer to the Coroner Attitude Survey question on the cathartic potential of the inquest, it can safely be assumed that they considered the entirety of their work rather than thinking only of inquests marked by adversarialism.

But should facilitating closure for families be a function of the coroner (let alone one of the most important functions)? McGowan has pointed out how other professionals are surely better suited to helping the bereaved process and deal with their grief.[716] If this is a role for the coroner then qualifications other than law surely ought to be required for appointment. McGowan also questioned the legality of coroners acting on behalf of the family, highlighting the practice of some coroners to reach an "open" conclusion in cases of self-inflicted death when a suicide conclusion, opposed by the deceased's family, might be more accurately rendered:[717]

> "…if one of the few means whereby they provide families with a service that gives them 'closure', 'finality' or 'peace' is to adapt the verdict in order to minimise their distress, this purpose is to the detriment of the greater good as it may undermine the goal of better public health by failing to record properly causes of death which represent identifiable health related social trends and currents."[718]

There are two aspects to the therapeutic jurisprudence embraced by coroners in Australia's coronial jurisdictions. As described by Freckelton:

> "Therapeutic jurisprudence […] is in part a practical orientation towards minimizing adverse outcomes. And it is in part about working with the realities of the broad repercussions of the law to fashion them as constructively as possible."[719]

There can be no objection to coroners being mindful that most of those who come before their courts are grieving and perhaps in shock at the loss of a loved one and taking steps to acknowledge this pain and lessen the chances of the legal process

[715] ibid.
[716] McGowan (n 59) 154.
[717] ibid 151.
[718] ibid 150.
[719] Ian Freckelton, 'Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence' (2008) 30 Thomas Jefferson Law Review 575, 577.

causing further distress. More problematic is the suggestion that coroners ought to positively pursue beneficial outcomes. There is no statutory or common law basis for such a role.

### 10.2 Four therapeutic approaches

The Coroner Attitude Survey explored the appropriateness of certain approaches coroners can adopt to soften the blow felt by bereaved families at inquests. The methods covered by the survey are those most commonly discussed as a means of humanising public investigations of death. Coroners were asked to say whether they felt the following four practises are appropriate at inquests[720]:

1) permitting a family member giving evidence to the inquest to give a "pen portrait" of the deceased;
2) permitting that family member to display a photograph of the deceased when giving his or her evidence;
3) inviting the bereaved to explain how the death has affected them; and
4) inviting witnesses other than the deceased's family and friends to explain how the death has affected them.

The first three of these practices (pen portraits, the display of photographs and statements as to the impact of the deaths) were used at the recent public inquiries into the Manchester Arena Bombing and the Grenfell Tower Fire; the fourth was proposed by Freckelton.[721]

#### 10.2.1 Pen portraits

The fresh inquests into the deaths of those who died in the Hillsborough Stadium disaster opened with the bereaved families providing 96 "pen portraits" of their loved ones. These statements, given in evidence, provided information about the deceased in life: his or her job or schooling, their interests and plans for the future. In his government-commissioned report on the experiences of the victims' families, Bishop

[720] Q.39.
[721] Freckelton (n 478) 27.

James Jones wrote that "the use of pen portraits at the fresh Hillsborough inquests helped to put the families at the heart of proceedings".[722] He described the process as "vital in humanising the inquests" and also recognised the "therapeutic" impact upon the bereaved.[723] Matthew Hill, a barrister who acted as First Junior Counsel to the Hillsborough inquests, has also described how pen portraits of the deceased also served a practical purpose in helping the jury to understand who each person was: "at various points throughout the hearings the evidence given about a nickname or particular hobby could be used to help remind the jury of which individual was being discussed."[724] As Hill pointed out, the criticisms of the original Hillsborough inquests stemmed not only from the outcome but also from the process the coroner followed, "and in particular from a perceived failure to devote sufficient time and attention to the unique events experienced by each of those who died."[725] The JUSTICE working party, impressed by how the fresh inquests successfully avoided a repetition of this failing, recommended that the Chief Coroner "clarify that pen portraits are an important way of placing the bereaved and their loved one at the heart of the process."[726]

The Coroner Attitude Survey found the vast majority of coroners (88%) believe the use of pen portraits at inquests to be appropriate. There were only small differences across coroner posts: 80% of senior coroners said it is appropriate for a relative of the deceased to provide a pen portrait in evidence to the inquest, whereas almost all area coroners (96%) and 89% of assistant coroners see it as appropriate.[727]

### 10.2.2 Displaying a photo of the deceased

The Hillsborough coroner, Sir John Goldring, permitted each family to display a photograph of their deceased relative while delivering their pen portrait. After the inquests concluded, Bishop Jones called on the Chief Coroner to ensure the practice is

[722] Jones (n 39) 100.
[723] ibid 100.
[724] Matthew Hill, 'Major Inquiries and Inquests - Lessons and Warnings from Bloody Sunday and Hillsborough' (1 Crown Office Row 2017) para 90 <https://files.justice.org.uk/wp-content/uploads/2017/10/06170622/Inquests-and-Inquiries-Matthew-Hill.pdf> accessed 14 September 2022.
[725] ibid 89.
[726] 'When Things Go Wrong: The Response of the Justice System' (n 709) para 5.5.
[727] See Figure 38 on page 174.

widely adopted. He saw "no proper reason why a coroner should seek to prevent it".[728] Three years later, at the public inquiry investigating the deaths of the victims of the 2017 Manchester Arena attack, the inquiry chairman Sir John Saunders took the view that he and all those attending would be assisted by being able to view a photograph of the deceased while the pen portrait evidence concerning each deceased was given.[729] He allowed the photographs to be viewed on the hearing room screens and included them in his Inquiry report, alongside the pen portrait summaries provided by families for the start of the evidence hearings.[730] At the Grenfell Tower Inquiry Sir Martin Moore-Bick went further, permitting survivors to use a range of media to tell the stories of the dead.[731] Rather than label this evidence as pen portraits, the inquiry described this stage of its process as "commemoration hearings" – unprecedented in death investigation in England and Wales – for the bereaved to pay tribute to the deceased.

However, the Coroner Attitude Survey results revealed that most coroners are opposed to such an approach. Only 27% of coroners think it appropriate for a relative of the deceased to display a photograph while giving evidence to an inquest. Of the sixty coroners who added comments to explain their answers to these survey questions, most expressed concern as to the impact of a photograph on other interested persons at the inquest. One coroner remembered his experiences as an advocate:

> "I spent many years as an inquest advocate for (mainly) NHS Trusts. Their witnesses often find inquests deeply distressing and their upset can be enhanced by hearing about the effect of death or by seeing the deceased. It is unfair to witnesses to expect them to cope with those things when they fall outside our scope and remit. (I recall one case in which midwives had to attend a hearing in which family members wore tee-shirts bearing a photograph of the dead baby - truly awful for them)."[732]

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[728] Jones (n 39) 62.
[729] Manchester Arena Inquiry, 'Protocol on pen portrait evidence', para 18 <https://manchesterarenainquiry.org.uk/2019/wp-content/uploads/2020/02/Protocol-on-pen-portrait-evidence.pdf> accessed 14 September 2022.
[730] Manchester Arena Inquiry, 'Manchester Arena Inquiry Volume 2: Emergency Response', vol 2-I, November 2022 <https://files.manchesterarenainquiry.org.uk/live/uploads/2022/11/03141804/MAI-Volume-2-Part-i.pdf> accessed 24 November 2022.
[731] Owen Bowcott, 'All inquiries should use Grenfell's tributes model, charity says', *The Guardian* (London, 30 May 2018) <https://www.theguardian.com/uk-news/2018/may/30/all-inquiries-should-use-grenfell-tributes-model-charity-says> accessed 14 September 2022.
[732] Answer provided by coroner 24 in free text box to Q.39.

There was some difference between coroner posts. While there is only a small minority of coroners in each post that believe the display of photographs of the deceased is appropriate, senior coroners (20%) are less likely than their area coroner (33%) and assistant coroner (28%) colleagues to find photographs appropriate.

### 10.2.3 Permitting interested persons to explain how the death has affected them personally

If coroners are conscious of the potential adverse impact on other inquest participants, highlighted in the Australian research quoted by Freckelton[733], they stop short of adopting Freckelton's recommendation that they allow both families and interested persons the opportunity to explain how the death has affected them personally. Only 22% of coroners thought this appropriate for the bereaved and only 11% in relation to other interested persons. Many of the sixty coroners who added comments were of the view that such statements were not relevant to the four statutory questions the inquest must answer[734] and could prejudice the proceedings. One such comment criticised the approach adopted by Goldring, Saunders and Moore-Bick:

> "None of the above are part of ss 5 and 10 CJA 2009 - which is what is relevant as to who, when, where and how. In non- controversial cases there is no harm to give a bereaved person closure, but such matters should not be part of a jury's decision making as they should only consider relevant evidence. These matters have crept into practice as inexperienced judges sitting as coroners have sought to meet political and public expectations even though not supported by the law..."[735]

Other coroners warned that allowing interested persons to give evidence as to how the death had affected them personally opened the door to eulogising. They argued that coronial proceedings should not be allowed to become a memorial service.

A potential compromise may be the "special procedure inquest" proposed by the JUSTICE working party for dealing with both mass fatalities and series of single deaths causatively linked through systemic failure. The working party recommended the incorporation of a non-evidential forum to facilitate the therapeutic giving of

[733] Discussed above in Chapter 4.
[734] Namely, who the deceased was and how, when and where the deceased came by his or her death.
[735] Answer provided by coroner 44 in free text box to Q.39.

testimony by the bereaved and others.[736] However given coroners' workloads and limited resources, this is unlikely to be a workable solution unless each such special procedure inquest is led by a coroner without a caseload to manage and with the assistance of his or her own counsel.

### 10.3 Chief Coroner's guidance on pen portraits and photographs

The Coroner Attitude Survey results also indicate a disconnect between coroners' views and those of the Chief Coroner. The Chief Coroner's guidance on the use of pen portraits and the display of photographs, issued in July 2021 and taking on board the recommendations of the JUSTICE and Bishop Jones reports, is permissive. It suggests it is common at an inquest for a coroner to ask a bereaved family for information on what the deceased was like in life. However, the guidance goes further, welcoming and endorsing an approach that includes inviting the bereaved family to share a family photograph of the deceased. It tells coroners that the cases in which such an approach would not be appropriate are rare exceptions. For the Chief Coroner, coroners should not merely allow families to speak about the deceased and to show a photograph, they should actively inform families in advance of the inquest that presenting such material is permitted. The survey results indicate the majority of coroners (73%) believe such an approach to be inappropriate at an inquest.

In support of his stance, the Chief Coroner pointed to the "recent inquests of national importance" that used pen portraits to "humanise the process and give dignity to the bereaved".[737] But here too the survey suggests coroners' disagreement. In addition to the coroner quoted above, two coroners who added comments to their answers to these survey questions also blamed high profile, judge-led inquests for introducing matters with little or no evidential value:

> "In high profile inquests, eg Hillsborough, the proceedings became a memorial service for a while. The same at the London Bridge Inquests. This 'emotional dimension' dilutes the role of the inquest as an objective seeker of the truth rather than a public appeasement for angry families."[738]

[736] 'When Things Go Wrong: The Response of the Justice System' (n 709) para 6.37.
[737] 'Guidance No. 41 Use of "Pen Portrait" Material' (Chief Coroner 2021) para 3.
[738] Answer provided by coroner 36 in free text box to Q.39.

> "[…] the vast majority of Inquests are not complex or large and are not the high profile cases where all the above have happened. We could not cope doing all of these things in all inquests and unrealistic expectations are being set by some of the more high profile inquests. Whilst we are hugely skilled in managing and caring for bereaved relatives we have to maintain equilibrium in our Courts. Inquests are very difficult for all participants."[739]

These comments support the observation made by the Coroners' Society in its submission to the Justice Committee that it may be better for certain high-profile inquests to be turned into public inquiries in order not to confuse the public and to keep expectations about coroners' courts in check.

However, perhaps more usefully for bereaved families who wish to speak about the character and life of their loved ones, the Chief Coroner's guidance also ties such therapeutic approaches to one of the four statutory questions that an inquest must answer: namely "who" the deceased was. Construing the word "who" in a broader sense – including the personality of the deceased as opposed to merely his or her name – might address concerns expressed by the coroners who added comments to their survey responses saying that the inquest should not stray from answering the four statutory questions.

The Chief Coroner's guidance distinguished between different types of inquest and how the obligations on the coroner are different. Where a coroner sits without a jury but where other interested persons are present, the guidance notes that pen portraits and photographs are "acceptable and easy to manage by the coroner".[740] The guidance then departs from the views of coroners as revealed by the survey, as the Chief Coroner acknowledged that "occasionally it may be appropriate to talk about the impact of the death on the bereaved".[741] Even at inquests heard by a coroner sitting with a jury, the Chief Coroner's guidance remains permissive of pen portraits and family photographs. Rather than making exception for the extra challenges of managing a jury inquest, the guidance simply states that "The type of material to be permitted, the amount of it and the timing of its admission will be a matter of judgment for the coroner." This

[739] Answer provided by coroner 219 in free text box to Q.39.
[740] 'Guidance No. 41 Use of "Pen Portrait" Material' (n 737) para 4 (iii).
[741] ibid.

restatement of the coroner's wide discretion is premised on a presumption in favour of admitting a family's statement or photograph. Coroners may bristle at how little of the guidance addresses their concern about the potential for proceedings to stray from their statutory purpose. It concludes: "Depending on what is said, the coroner may have to warn the jury that what was said is not evidence. Experience shows that many families accept there have to be boundaries […]"[742]

The survey results suggest that more work is likely necessary to persuade coroners of this approach. It is unlikely that a Chief Coroner appointed from the ranks of senior coroners would have issued quite such permissive guidance. It is perhaps a reminder that the Chief Coroner, recruited from the criminal courts that are familiar with victim impact statements and increasingly attentive of the needs of witnesses, is an outsider in the coroner service.

### 10.4 Use of ground rules hearings and special measures

Bishop Jones recommended that coroners be trained to intervene to protect family members from unfair and hostile questioning.[743] He also called on the Chief Coroner and Ministry of Justice introduce the use at inquests of position statements that would require each interested person to set out the stance they intended to take during proceedings[744] so that a witness would not be taken by surprise by the tone of a lawyer's questioning.[745] Perhaps a more conventional answer may be the greater use of the ground rules hearings and special measures now routine in the criminal and family courts. The Coroner Attitude Survey results provided robust empirical evidence confirming Dolan and Street's assertion that these safeguards for witnesses are under-utilised at inquests: three-quarters of all coroners said that they never or rarely used special measures (76%) and never or rarely used ground rules hearings (74%) at inquests they conduct.[746] Of course such safeguards are unnecessary in the vast majority of inquests, but their limited use by senior coroners and area coroners[747] –

[742] ibid 4 (iv).
[743] Jones (n 39) 101.
[744] ibid 100.
[745] The use of position statements was proposed by lawyers acting on behalf of the families at the fresh Hillsborough inquests. The proposal was not accepted by the coroner.
[746] See Figure 39 on page 175.
[747] Just under a third of both senior coroners and area coroners made at least occasional use of special measures and ground rules hearings at inquests. See Figures 40 and 41 on page 176.

more likely to handle the longer, more contentious inquests than assistant coroners – is surprising given coroners' belief in the inquest's cathartic potential and the importance of facilitating closure. As discussed in Chapter 4, such witness safeguards are a useful tool regularly deployed in criminal and family proceedings to prevent the re-traumatising of vulnerable people who are required to give evidence in court.

## 10.5 Conclusion

The Coroner Attitude Survey revealed, for the first time, the attitudes of the whole coronership to the methods adopted in recent high-profile inquests and inquiries in order to aid the bereaved. It is the first research to reveal coroners' attitudes to the Chief Coroner's guidance on the display by families of a photograph of the deceased and on his suggestion that coroners may, in some inquests, permit a family member to describe how the death has affected them personally. With the exception of the use of pen portraits, the vast majority of coroners are opposed to these methods. They see them as unrelated to their statutory duties and a threat to the fairness of proceedings where there are other interested persons present in court.

The Coroners' Society is right to argue that the pressure on coroners' time and resources means that certain practices adopted by public inquiries cannot easily be applied in most inquests. Coroners are also entitled to be concerned at how tributes to the deceased need to be carefully managed so as not to challenge the integrity of the court process; responses to unique tragedies such as the Grenfell Tower fire are not easily replicated at inquests conducted into single deaths, each with their own particular challenges and contested facts. Coroners certainly can and should take steps to limit anti-therapeutic outcomes, but that should be the extent of the obligation. Therapeutic jurisprudence's suggestion that they also proactively seek to achieve positive outcomes for those affected by death would draw coroners away from their statutory role.

# Chapter 11 A national or local coroners service?

The question of whether coroner services in England and Wales should continue to be delivered at a local level or become the responsibility of central government has been debated for at least 50 years. The unification of the separate coroners' courts has been endorsed in every annual report issued thus far by the Chief Coroners; by the House of Commons Justice Committee in 2020; by Dame Elish Angiolini in her 2017 government-commissioned review of deaths in custody; by both of the wide-ranging reviews of death investigation published in 2003 by Dame Janet Smith and the Luce Committee; and, to a lesser extent, by the Brodrick Inquiry in 1971. However, successive governments have failed to act on these recommendations, asserting the importance of the coroner's local ties and placing faith in the new office of Chief Coroner. Missing from the debate are the opinions of rank-and-file coroners. The findings of the Coroner Attitude Survey provide the first insight into the views of this crucial constituency. This chapter discusses how this important new knowledge advances the debate over the necessity of a unified national coroner service.

## 11.1 The benefits and drawbacks of a locally delivered coroner service

The current localised service is not without its advantages. It is obvious from reading the submission of the Coroners' Society of England and Wales to the 2021 Commons Justice Committee inquiry that the society is proud of coroners' local ties and service to their respective communities.[748] The Society reiterated how coroners are traditionally from their area, know their area well and adapt their service to meet local demands. It quoted suggestions that "a bereaved family is arguably better served when they know that the coroner and his or her coroner's officer are very familiar with the location of the fatal road traffic collision or with the NHS trust or care home where their loved one died."[749] The Society also warned that in a centrally run service, coroners may lose their independence and distinct identity. It foresaw a system run by Whitehall civil servants with little knowledge of coronial functions, with coroners being told to sit in spare courtrooms in magistrates' courts and bereaved families having to mix with criminal defendants. Finally, the high standards of service currently

[748] 'Written Evidence from The Coroners' Society of England & Wales' (n 266).
[749] ibid.

found in some coroner areas may no longer be the benchmark in a national coroner system: it is very possible that a government seeking to cut costs may decide to achieve uniformity of services by levelling down rather than levelling up.

Against this, critics argue that the extent of unevenness of resourcing creates a post code lottery that affects bereaved families.[750] His Honour Judge Lucraft KC, the second Chief Coroner, saw a properly funded national service as the way to address some of these inequalities.[751] In the absence of a national service, coroners strive to make do with what they have, dependent on a "grace and favour" relationship with other agencies.[752] Standards and practices also vary greatly, with "patchiness" of services across England and Wales making it difficult for professionals such as Victim Support's National Homicide Service to provide support and advice as to the coronial process.[753] Such inconsistency also confuses the medical professionals on which the coroner service relies. The president of the Royal College of Pathologists told the Justice Committee of the very different levels of professionalism found in the two coronial jurisdictions that cover one of the hospitals in which he works.[754] In one he gets an almost instantaneous response to his phone calls; in the other he does not know how to make contact with a coroner or coroner's officer, other than to send an email with little hope of a swift reply.[755] Advocates of a national coroner service argue that "the quality of each local coroner service should not have to depend on the local authority and the Senior Coroner having a shared understanding and priorities".[756]

What has been missing in this debate has been a clear picture of what all coroners themselves actually think about the level at which their service is delivered. The numerous reviews referred to in the introduction engaged with some coroners, or with the Coroners' Society, but the views of all coroners were unknown until the Coroner Attitude Survey. This research is the first study of the coroner service to present the views of the coronership as a whole on the question of a national coroner service. The survey results revealed that 70% of coroners agree there should be a national coroner

[750] Justice Committee (n 9) paras 150 and 152.
[751] ibid 156.
[752] Angiolini (n 38) 12.
[753] Justice Committee (n 9) para 153.
[754] ibid 152.
[755] ibid.
[756] ibid 158.

service, with only a small minority (12%) opposed. The failure of the government to legislate for a centrally-run, unified structure is a concern to coroners: 56% described themselves as somewhat or extremely concerned by the lack of a national coroner service, with only 17% expressing no concerns at all.

### 11.2 Coroners' isolation

Other results from the Coroner Attitude Survey may explain why so many coroners are in favour of a new national coroner service. To date, the arguments over whether the coroner service ought to be delivered on a national or local basis have, understandably, focussed on the needs of those who come before the coroners' courts. Recent academic literature on the coroner service has highlighted the variation in coroners' practices and inquest conclusions between coroner areas[757], overlooking the impact of the service's atomised structure upon those who serve the public as coroners. The isolation of some coroners was a major theme that emerged from the results of the survey. "I love my job but it can be the loneliest place in the world being a Senior Coroner."[758] This comment, added by a coroner in response to the survey question asking coroners what they considered to be significant sources of stress in their job[759], suggests at least some coroners continue to toil on their own, unable to draw upon the professional support or camaraderie of colleagues.

The survey revealed that over half of coroners (57%) cited "isolation" as a significant source of stress in their job. Isolation was also the reason cited most by coroners (59%) for why they would discourage suitable people from applying to join the coroner service (although it should be remembered that the overwhelming majority of coroners (92%) would in fact encourage applications). As might be expected for those in leadership positions, the effects of solitary working were felt most keenly by senior coroners. Just under four fifths of senior coroners (79%) identified "isolation" as a significant source of stress and 71% cited it as a reason why they would discourage suitable people from applying to join the coroner service. Similarly, the lack of a professional support network – identified by almost a third of coroners (31%) – is a

[757] See, for example, Mclean, Roach and Armitage (n 42); Mclean (n 599).
[758] Answer provided by coroner 316 in free text box to Q.15.
[759] Q.15.

greater problem for those at the top of each coroner area, with 42% of senior coroners finding it significantly stressful.[760] While most coroners (75%) said the amount of time they had to discuss work with colleagues was adequate or better, 40% of senior coroners described it as being poor or non-existent.

It should, perhaps, not be a surprise that the post of senior coroner is a lonely position. The Brodrick Committee described the coroner as an "isolated" figure in 1971[761] and just over 30 years later both the Luce Review and Dame Janet Smith drew attention to coroners' continued isolation from both medical administration and the rest of the justice system.[762] The efforts and innovations of the Chief Coroners and the revised training procedures probably means that the extent to which "coroners are left to their own devices"[763] is not as great as it was in 2003. However, almost two decades later, the results of the Coroner Attitude Survey suggest that even now too many coroners still "have little contact with what their colleagues are doing"[764] and lack "the kind of peer support available to those holding other types of judicial office."[765]

The survey results suggest coroners are not just isolated from one another and from the wider judiciary but also from the local governments that appoint and fund them. While a majority of coroners (55%) reported feeling valued by their local authority, a significant minority (31%) said they did not feel valued by their local authority, with 10% feeling not valued at all. Only 12% of coroners cited a supportive local authority as a reason for encouraging applications, while over a third (34%) identified a lack of support from their local authority as a reason why they might discourage applications

[760] It is interesting that while there is no real difference between the percentages of male senior coroners and female senior coroners who find the isolation of the job and the lack of a professional support network to be significant sources of stress, the survey results show significant differences between female and male coroners at area coroner and assistant coroner level. While 47% of male area coroners and 37% of male assistant coroners said the isolation of the job was a significant source of stress, it was identified by 58% of female area coroners and 48% of female assistant coroners. Similarly, the lack of a professional support network was cited by only 13% of male area coroners and 19% of male assistant coroners in contrast to 25% of female area coroners and 37% of female assistant coroners.
[761] Brodrick (n 32) para 11.39.
[762] The Luce Review Committee (n 30) 17; Smith (n 32) para 7.41, 7.44.
[763] Smith (n 32) para 7.41.
[764] ibid 7.44.
[765] ibid.

(40.6% amongst senior coroners). A significant minority (38.5%) also took issue with the level of support offered by their local authority for coroners undertaking training.

The results of the Coroner Attitude Survey confirm that coroners' own experiences of their job vary greatly across England and Wales.[766] The number of coroners that identified the isolation of the job as a significant source of stress was not the same in each region, ranging from 39.1% of Welsh coroners to 68% of coroners in the West Midlands.[767] There was also significant regional variation in the results of the survey question on whether coroners feel valued by their local authority.[768] In four regions – the North East, the South East, London and the West Midlands – a minority of coroners reported feeling valued by their local authority, with the majority of the capital's coroners (53%) stating that they did not feel valued. While a clear majority (61.8%) of coroners in the North West deemed the time available to them to discuss work with colleagues as "excellent" or "good", as much as 50% of their peers in the North East said the availability of such opportunity in their coroner areas is poor. All of this indicates a wide variability in the coroner service dictated by geographic location and local authorities' approaches to the service.

### 11.3 Is a national coroner service the answer?

In the recent past these variations between coroner areas in England and Wales prompted the Luce Review, Smith and Angiolini to recommend the creation of a single, unified service. However, in its written submission to the Justice Committee, the Coroners' Society asserted that the right question to ask is how coroners can retain "all the benefits of being a local service while being resourced to a national standard."[769]

The Society's commitment to maintaining local ties may be seen in how it chose to highlight some coroners' concern over the merger of coroner areas, noting that some

[766] The following results revealing variation across England and Wales are not presented in the results chapters of this thesis.
[767] This remained true for those at the top of coroner areas in these two regions: "isolation of the job" was identified as a significant source of stress by only two of the six Welsh senior coroners who answered that survey question (33.3%), compared to seven of the nine senior coroners in the West Midlands who provided an answer (77.8%).
[768] Q.34.
[769] 'Written Evidence from The Coroners' Society of England & Wales' (n 266).

see "even this relatively mild expansion of areas […] to be detrimental to the service".[770] The submission argued that "problems may be significantly compounded by a move towards a national service". It claimed there is a "real apprehension" amongst coroners that a single, unified service would be of the "lowest common denominator". Listing various pros and cons of the creation of a national service, the Coroners' Society's submission argued that the main advantages are already (or could be) enjoyed without the need for a unified, single structure.

However, the Coroner Attitude Survey revealed that the majority of rank-and-file coroners feel rather differently about the prospect of a national coroner service. The results cast doubt on how accurately the Coroners' Society's submission reflects the views of all coroners: the survey results are at odds with the Society's claims of apprehension and concern over the merger of coroner areas and calls for a national service.

The Coroners' Society is right that some of the benefits they list could be achieved without a national unified service and, with the Chief Coroner's creation of specialist cadres of coroners, some coroners are already working in coroner areas other than their own. However, it is difficult to see how greater consistency in resources could be achieved without a national service. The extent of the unevenness of resourcing and its impact on the service that coroners can provide was noted by the Luce Review, by Smith, by Angiolini and in every annual report issued thus far by the Chief Coroners. Witnesses to the Justice Committee inquiry repeatedly spoke of a service that is fragmented and under-resourced. They included the coroners who gave evidence. The Birmingham and Solihull coroners admitted:

> "Inevitably the mechanism to fund coronial services through their local authorities does create a post code lottery. Those councils with financial challenges will be less able to support their coronial services and the families involved in those cases."[771]

This discrepancy is unacceptable in a modern judicial system, from which all citizens are entitled to expect a comparable level of service and adherence to modern judicial

[770] ibid.
[771] Justice Committee (n 9) para 150.

standards of fairness and predictability. However it is likely that such variation will forever be a feature of a service run at a local level. With so many local authorities there will always be variation in their understandings of the coroner's judicial role and, as a result, variation in the support they provide to (and in the demands they make of) their coroners. Some coroners will keep enjoying the benefit of purpose-built courtrooms with adequate additional space for bereaved families, other interested persons and witnesses, while others must continue to borrow magistrates' courts or make do with renting large rooms in public buildings. Differing budget pressures also mean the impact of national problems, such as the shortage of pathologists available to carry out coronial autopsies, will be felt in different ways in different coroner areas. As one coroner commented in her survey response, it is difficult to imagine such differences would be tolerated elsewhere in the judiciary:

> "I greatly support [calls for] a national coroner service which would bring consistency to the […] way coroners are treated. We should be treated no differently to other members of the judiciary. Being part of a national service would make us truly independent and not constrained by restrictions imposed by different local authorities. Becoming more integrated into the judiciary is important."[772]

Such variation presents a particular challenge to those who argue that local delivery remains best. As Kevin McLoughlin, the senior coroner for West Yorkshire (East), wrote to the Justice Committee:

> "If the Coronial Service is to be lifted to the next stage of professionalism, it is essential to develop comparable standards in each aspect of the service provided: accommodation, resources, operating practices and most importantly, equivalence of outcome for bereaved families."[773]

### 11.4 What could be lost in a national coroner service

The Justice Committee heard evidence that the creation of a Coroner Service Inspectorate would be a good way of ensuring local authorities properly funded their coroner services. The creation of an inspectorate had been recommended by the Luce

[772] Answer provided by coroner 75 in free text box to Q.28.
[773] Kevin McLoughlin, 'Written evidence from Kevin McLoughlin, Senior Coroner for West Yorkshire (East)' (Justice Committee, House of Commons 2020) 25 August 2020 <https://committees.parliament.uk/writtenevidence/10122/pdf/>, accessed 14 September 2022.

Review in 2003, which envisaged a body whose "concern would be with timeliness of process, standards and suitability of the physical environment and the provision of prompt and clear information to families"[774] and which could examine complaints made by members of the public. It was also a recommendation of the working party established by the reform and human rights organisation JUSTICE in 2020, under the chairmanship of retired High Court judge Sir Robert Owen, to investigate how the justice system responds to mass fatality incidents and patterns of individual deaths resulting from systemic failure.[775] The Coroners and Justice Act 2009 had provided for such oversight,[776] but before the Act was brought into force the Coalition Government of 2010-2015 abolished the Inspectorate of Courts Administration as part of its "Bonfire of the Quangos". The relevant provision was then repealed. André Rebello, HM Senior Coroner for Liverpool and the Wirral who questioned the need for nationalising coroner services,[777] told the Justice Committee that the failure to create an inspectorate was a "missed opportunity":

> "We need a courts inspectorate under the Ministry of Justice. That courts inspectorate could then judge coroner areas by inspection, pretty much like Ofsted, and check that the model coroner area appended to the Chief Coroner's annual report is being met; that resources have been provided to the coroner service; that the accommodation is suitable; that private space is given to bereaved families so they can have time with their loved ones; that coroners are working efficiently; and that the budgets are monitored."[778]

This recommendation was endorsed by other witnesses to the inquiry, including the then Chief Coroner,[779] and was adopted by the Justice Committee in its final report.[780] The Government's response was limited to a promise to consider the recommendation, "alongside other ministerial priorities".[781] The Committee's members would probably be wise not to hold their breath. While the creation of a small Coroner Service Inspectorate would serve to highlight those coroner areas underfunded by their local authorities and would bolster the Chief Coroner's efforts to drive up standards, it

[774] The Luce Review Committee (n 30) 176.
[775] 'When Things Go Wrong: The Response of the Justice System' (n 709) para 2.36.
[776] Coroners and Justice Act 2009, s 39.
[777] 'Oral Evidence to the Justice Committee: The Coroner Service, HC 282' (n 449) Q5.
[778] Justice Committee (n 9) para 161.
[779] ibid 163.
[780] ibid 166–167.
[781] 'The Coroner Service: Government Response to the Committee's First Report' (n 37) 13.

would not on its own be a panacea to criticisms of a post-code lottery in the quality of coroner services.

It must be acknowledged that it is by no means certain that a unified, national coroner service would address coroners' concerns. Of the handful of senior coroners who made individual submissions to the Justice Committee inquiry, most warned that an underfunded national service would not make significant improvements and would likely reverse the good work that has been achieved in the coroner areas that are currently well-resourced. The Coroners' Society's submission warned that any national coroner service "must be modelled on the best resourced current services", rather than achieving standardisation by lowering the quality of coroner services across the board.

The Coroner Attitude Survey results on coroners' assessment of their working conditions should give advocates of a national coroner service pause for thought. These results suggest most coroners are generally satisfied with their administrative support and with the quality and maintenance of their court buildings (see Figure 79). A comparison with the results for the corresponding questions in the Judicial Attitude Survey 2020 may surprise coroners: their colleagues in the rest of the judiciary did not rate as highly their administrative support and court buildings provided by HM Courts and Tribunals Service. Only in their assessment of court security (90% said it was adequate, good or excellent) did the courts and tribunals judges provide a significantly higher rating than coroners (55% of whom rated security as at least adequate). These results lend credence to the Coroners' Society's warning that standards may drop rather than rise if the coroner service's funding and support are made the responsibility of HMCTS (or some other agency of central government).

As Professor Nicola Padfield pointed out to the Justice Committee inquiry, the disadvantages of replacing the current local service are also clear. She echoed the Coroner Society's warning of "Big Brother", highlighting how "central 'control' could lead to the importation of unhelpful 'managerialism'"[782] by civil servants with little

[782] Nicola Padfield, 'Written Evidence from Nicola Padfield QC (Hon)' (Justice Commitee, House of Commons 2020) <https://committees.parliament.uk/writtenevidence/9951/html/> accessed 14 September 2022.

knowledge of the coronial jurisdiction. Padfield also argued that "the authority and legitimacy of the coroner may well be strengthened by a strong local connection."[783] As discussed in Chapters 2 and 9, coroners have at times enjoyed a level of trust and popularity that is perhaps unusual amongst the ranks of the judiciary. This may be a result of their local ties. Wakley's view of the coroner as "the people's judge" was certainly to do with the fact that the coroner was the only judge that the people elected to office. Despite the fact that since 1888 it has been for local authorities to appoint coroners, Dame Janet Smith, writing in 2003, found the tradition of the coroner's inquest to be popular with the general public.[784] The Hillsborough and Marchionness families' long campaigns for inquests are examples of the public's faith in the coronial process to achieve justice. A further example is the initial anxiety felt by the families of those who died in the Grenfell Tower fire following the announcement that the coroner's inquests would be suspended for a public inquiry. As discussed in Chapter 9, the Coroner Attitude Survey results indicate that coroners feel they remain popular and trusted: nearly all coroners said they feel valued by bereaved families and 80% of coroners felt valued by the public, compared with 66% of Courts and Tribunal judges.[785]

But as was discussed in Chapter 3, the traditional link between coroners and their areas is disappearing. Local authorities now encourage applications for coronial posts from those who live and work in other parts of England and Wales. The second Chief Coroner expressed an interest in regional recruitment of pools of assistant coroners from which different coroner areas could draw,[786] which if implemented would break the centuries-old tradition of a coroner area choosing its own coroners. Given that high profile inquests such as those into the deaths of the London Bridge and Borough Market terror attack are often led not by a coroner but by a senior judge drafted in from the courts and tribunals judiciary, it is difficult to see how public trust in the inquest process is still reliant on coroners knowing their area.

[783] ibid.
[784] Smith (n 32) para 19.11.
[785] See Figure 69 on page 206.
[786] Lucraft, 'Chief Coroner's Annual Report 2016-17' (n 236) para 50.

## 11.5 The contribution of the jury

One local link that would remain in a national coroner service would be the coroner's jury. Just as juries in the Crown Court are drawn from each court's local catchment area, even though the Crown Court and its judges are part of the centrally run HM Courts and Tribunals Service, coroners' juries in a national system would continue to maintain the symbolic and historical tradition of the "ordinary peers of the deceased […] anxiously inquiring into the facts of his or her death."[787] Of course, jury involvement would be the case in only a small percentage of inquests, so an investigation into a death from, e.g., a road traffic accident at a locally notorious junction may, in a national coroner service, proceed without any local knowledge of the roads in question. However, the need for coronial proceedings to deliver to the general public the form of public accountability described by Dawn Oliver and Mark Elliot (discussed in Chapter 4) is arguably highest in the inquests where juries are required. The Coroner Attitude Survey results suggest coroners would support maintaining juries in a unified, national coroner system.

The survey found that of coroners who frequently sit with a jury, the majority (52%) found it useful to use juries at inquests (Figure 45). The coroners of the 1970s who greeted the Brodrick Committee's recommendation that juries no longer be mandatory at inquests would probably be surprised to learn that the jury survived into the 21st century. Gavin Thurston, the former coroner for Westminster and the Queen's Household who thought it "indisputable that juries make no contribution to most inquests",[788] would likely be similarly taken aback that so many coroners in 2020 took a contrary view on the question of the inquest jury's usefulness.

The survey was conducted at the start of the Covid-19 pandemic (May 2020) when jury inquests were suspended. At this time it was already clear that there would be a backlog of jury inquests which would be exacerbated by the need to find spaces large enough to cater for socially distanced jurors.[789] In his evidence to the House of

[787] Thomas and others (n 12) para 16.1.
[788] Thurston (n 145) 30.
[789] LexisPSL, 'Coronavirus (COVID-19)—Impact on Coroners' Inquests and the Investigation of Deaths' (*LexisNexis*, 27 May 2020) <https://www.lexisnexis.co.uk/legal/news/coronavirus-covid-19-impact-on-coroners-inquests-the-investigation-of-deaths> accessed 14 September 2022.

Commons Justice Committee in September 2020, André Rebello asked the government to consider a legislative amendment that would suspend for a couple of years the requirement to sit with a jury. Without such a change, he predicted that many investigations put on hold by COVID-19 "may go on for another four or five years while [coroners] catch up, because death does not stop."[790] The additional pressure caused by the pandemic may have influenced the response of some senior coroners to the survey question of the usefulness of using a jury at an inquest. It is perhaps significant that even when faced with growing backlogs of jury inquests, such a sizeable minority (35.2%) of senior coroners still maintained that juries are useful. (In contrast, a much greater percentage of assistant coroners (49.4%), who do not face leadership responsibilities in their respective coroner areas, disagreed with the statement that "it is not really useful to use juries at inquests"). If a subsequent Coroner Attitude Survey is run in the future, it would be useful to retain this question as to the utility of juries in order to see whether coroners' views are different post-pandemic.

In arguing for the retention of juries despite the backlog in holding inquests that had built up by September 2020, Deborah Coles, director of INQUEST, emphasised to the Justice Committee the important role played by juries at inquests where the conduct of the state is being scrutinised.[791] While she bolstered her argument by referring to 21st century human rights jurisprudence, her stance is no different to that of the Victorians who welcomed the "popular flavour"[792] that coroners' juries lent to 19th century inquests into deaths in prisons or factories. The hope that juries gave bereaved families during the industrial revolution – that the coroner's inquest would offer them a chance to hold powerful institutions to account – remains live today. The JUSTICE working party found the coroner's jury to be "an element of the inquest process viewed favourably by all the bereaved people we consulted."[793] The role of the jury is also appreciated by the Chief Coroner. In his sixth and seventh annual reports, HHJ Lucraft QC acknowledged the jury's contribution to ensuring public accountability by

[790] 'Oral Evidence to the Justice Committee: The Coroner Service, HC 282' (n 449).
[791] Justice Committee (n 9) para 219.
[792] Sim and Ward (n 104) 246.
[793] 'When Things Go Wrong: The Response of the Justice System' (n 709) para 2.2.

describing jury inquests as "a vital part of the armoury of the coroner and public involvement in the examination of the circumstances surrounding some deaths".[794]

With the creation of a national coroner service very unlikely to be imminent given the current government's stance, it is worth noting two significant reasons for retaining the jury in the existing, locally delivered coroner service. A jury can serve to put useful distance between a coroner and his or her local authority when the latter is itself an interested person at an inquest – any conclusion critical of local government is that of the jury and not the coroner who must continue to work closely with the authority once the inquest is over. Furthermore, as coroners with a prison in their area may find themselves having to conduct numerous inquests into deaths in that prison, the presence of a jury is a guarantee of objectivity and a safeguard against the danger of coroners becoming too ready to accept the evidence of familiar witnesses.

### 11.6 A national approach elsewhere in the justice system

It is ironic that while the government maintains that local is best in the coroner service, its Judicial Review and Courts Act 2022 will abolish the 75 local justice areas in England and Wales.[795] The long-standing principle that those accused of crime should be tried by people from and with knowledge of their own locality is, the government has decided, no longer the dominant concern. Instead, it is legislating to "provide the courts with the freedom and flexibility to manage their caseloads more effectively and ensure that cases are dealt with sooner and in more convenient places."[796] Senior coroners and area coroners would surely welcome such freedom and flexibility, particularly those who assessed their caseload and non-case workload in the 12 months to May 2020 as "too high".[797] An example of where it would have assisted a senior coroner to have been able to draw on the support provided by a national service may be found in the case of *R (Rotsztein) v HM Senior Coroner for Inner North London*.[798] In *Rotsztein* the children of the deceased successfully challenged the coroner's

[794] Lucraft, 'Chief Coroner's Annual Report 2018-19 & 2019-20' (n 308) para 31.
[795] Judicial Review and Courts Act 2022, section 46.
[796] Judicial Review and Courts Bill Explanatory Notes, page 13. Available at <https://publications.parliament.uk/pa/bills/cbill/58-02/0152/en/210152en.pdf> accessed 14 September 2022.
[797] See Figures 76 and 77.
[798] *R (Rotsztein) v HM Senior Coroner for Inner London North* [2015] EWHC 2764 (Admin).

decision to direct an invasive post-mortem examination to determine the cause of death of their mother. The deceased was an Orthodox Jew who, her children felt sure, would have been horrified by the performance of an invasive post-mortem examination on her corpse. After the coroner considered and rejected the religious objections raised, the family successfully applied for an injunction restraining the performance of an invasive procedure. Mr Justice Mitting accepted the coroner's evidence of the "considerable pressure of time"[799] under which she works. While he acknowledged that "it is unreasonable to expect perfection in decision-making by a coroner in those circumstances", he added "What can reasonably be expected is a fundamentally correct legal approach."[800] For Joshua Rozenberg, the matter was further evidence of the deficiencies of a coroner service delivered on a local, rather than national, basis.[801] He noted that the Inner North London Coroner Area includes the largest number of Jews in England and Wales, as well as many Muslims. He too acknowledged coroners' heavy workloads but pointed out that the out-of-hours injunction won by the Rotsztein family was possible because "there is always a High Court judge on duty to hear urgent applications. And that, in turn, is possible because the High Court operates nationally rather than locally."[802] Rozenberg submitted that only a national coroner service could avoid further anguish for newly bereaved families (and save local taxpayers from footing the bill for their coroner's costs in the High Court).

Other parts of the justice system are benefiting from adopting a national approach. The President of the Employment Tribunals of England and Wales has brought together a group of judges drawn from the 10 Employment Tribunal regions in an enterprise termed the "virtual region".[803] It is not an Employment Tribunal region in the usual sense: the members of this group take advantage of video technology to hear cases while sitting on a fully remote basis. This has rebalanced judicial resources across England and Wales.[804] The virtual region seeks to reduce waiting times in London and

[799] ibid, at [25].
[800] ibid.
[801] Joshua Rozenberg, 'A welcome review of coroners', *Law Society Gazette*, 2 November 2015.
[802] Ibid.
[803] Barry Clarke and Shona Simon, 'A Road Map for 2021-22' <https://www.judiciary.uk/wp-content/uploads/2021/03/ET-road-map-31-March-2021.pdf> accessed 14 September 2022.
[804] At the start of 2021, the four Employment Tribunal regions covering London and the South East of England generated half of the national caseload and held 60% of the backlog of single claims but had to make do with only a third of judicial resources. 'A guide to the virtual region of the Employment Tribunals (England and Wales)', 23 July 2021, unpublished.

the South East by taking advantage of judges' sitting capacity in other parts of the country. Just as NHS trusts in need of emergency medical or nursing cover can turn to a staff bank, so Employment Tribunal regions in need of judicial cover can turn to the virtual region.[805] A unified coroner service would allow the busiest coroner areas to avail of such innovations. Advertisements for assistant coroner posts currently all recognise that some areas are busier than others:

"The Chief Coroner and the Lord Chancellor would expect an assistant coroner to offer a minimum of 20 sitting days each financial year. However, it is recognised that there is a variance of workload in each area."[806]

Problems of "unmanageable" [807] workloads in coroner areas struggling with inadequate resources – such as Nottinghamshire in 2021, where coroners were dealing with caseloads three times the size of that recommended by the Chief Coroner[808] – could be alleviated if senior coroners could seek additional administrative support from a central pool of coroners' officers or if they could allocate inquests that may be held partially remotely or in writing to underutilised assistant coroners in other regions of the country.

In reaching its conclusion that "the Ministry of Justice should unite coroner services into a single service for England and Wales"[809], the Justice Committee noted how "The majority of witnesses to our inquiry, two Chief Coroners, and almost everyone who has been commissioned to review aspects of the Coroner Service sees the need for a unified service for England and Wales."[810] As Joshua Rozenberg observed in relation to the government's refusal to publish its own 2015 Review of Coroner Services, "we

[805] A judicial working group headed by the Deputy Head of Civil Justice is exploring whether a similar scheme may work in the county court to alleviate pressure on the district bench. A separate study is examining whether judicial "boxwork" – the large volume of paper applications and case management correspondence – could, in digital form, be referred to a central pool of Deputy District Judges working remotely. (Personal knowledge of the researcher from his position as legal advisor to the Master of the Rolls).
[806] See advertisements posted on the Coroners' Society website: <https://www.coronersociety.org.uk/vacancies/> accessed 30 June 2022.
[807] Matt Jarram, 'Family's Distress as Coroners Left with "unmanageable" Workload in Nottingham' *Nottingham Post* (4 June 2021) <https://www.nottinghampost.com/news/nottingham-news/familys-distress-coroners-left-unmangeable-5487292> accessed 14 September 2022.
[808] ibid.
[809] Justice Committee (n 9) para 157.
[810] ibid.

can be confident that there is a similar message in the review the government wants to bury."[811] Like every previous such recommendation, it was rejected by the government. The Ministry of Justice response to the Justice Committee reiterated previous arguments that the expense of creating a national coroner service would be disproportionate to the benefits it might bring (choosing to ignore the argument that much of the cost would be offset by the concomitant reduction in local authorities' funding). It also cited the likely scale of the project, noting how it "took a large team and significant resources over three years" to bring 42 magistrates' courts committees inside HM Courts Service.[812] The government went further, hinting that it might spend less on a unified service than local authorities presently spend on coronial services. With the Coroner Attitude Survey revealing almost three quarters of coroners believe there should be a national coroner service, the government's latest dismissal of the recommendation will clearly not have been well received by the vast majority of coroners.

### 11.7 A national approach in other jurisdictions

What can we learn from the structure of coroner services elsewhere? The service that has received the greatest approbation is that of the state of Victoria in Australia.[813] As a federal system, Australia does not have a national coroner service, although some Australian coroner services do operate at a national level.[814] Each Australian state or territory has its own coroner service, the most advanced of which is the Coroners Court of Victoria, recognised globally as the leader in coronial reform.[815] All of the state's coroners work for the same service. The Coroners Court of Victoria is itself linked to

[811] Joshua Rozenberg, '"Dead and Buried"' *The Critic* (July 2021) <https://thecritic.co.uk/issues/july-2021/dead-and-buried/> accessed 14 September 2022.
[812] 'Reform of the Coroners' System and Death Certification: Government Response to the Constitutional Affairs Select Committee's Report' (n 204) 12.
[813] Ontario, Canada is also regarded as a leader in setting high coronial standards. However its service is significantly different to that in England and Wales and Australia as it has a public health focus and most of its coroners are medical professionals. Ian R Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press 2006) 79.
[814] Such as the National Coronial Information Service, an online database of mortality data and records from Australian inquests that is the first of its kind anywhere in the world and unparalleled in its ease of access and transparency. <https://www.ncis.org.au> accessed 14 September 2022.
[815] Rebecca Scott Bray, 'New Victorian Coroners Act' (2009) 34 Alt LJ 207; as cited in Moore (n 452) 30. HM Senior Coroner David Heming described the Victoria service as 'the gold standard' in personal correspondence with this researcher.

the rest of the Victorian judiciary as it sits within the governance structure of Court Services Victoria.

Perhaps more can be gleaned from studying two other, unitary, states that inherited the coronial tradition from England and which have taken different paths in dealing with their decentralised coroner services. The Irish coroner service, like that of England and Wales, remains delivered at a local level across 38 coroner districts. Like its counterpart across the Irish Sea, calls for root-and-branch reform from coroners and other stakeholders and a critical government-commissioned review have largely been ignored. A recent editorial in the *Irish Times* noted that while some useful legislative changes have been made in the 22 years since the Department of Justice's Working Group recommended structural reform (falling short of a national, unified system), "successive governments have skirted the fundamental issues around the structure and funding of the service".[816] The problems highlighted in the paper's series of articles on the work of the Irish coroner are the same issues described in reviews of the coroners' courts of England and Wales: wide variations in practices between coroner districts; delays; underfunding and evenness of resources; and confusion as to the purpose of the inquest. The editorial concluded:

> "The State urgently needs a national Coroner Service agency that would standardise procedures, centralise information and ensure consistency. A Chief Coroner should lead this professionalised service, and all coroners should be appointed transparently."[817]

A happier situation may be found in New Zealand. In 2006 New Zealand "reversed the old pattern of following England"[818] and established a unified coroner service. Prior to the Coroners Act 2006 (NZ), there were 74 coroners located throughout the country. Today New Zealand has 17 full-time coroners working in nine court centres in a centralised system headed by a Chief Coroner.[819] Much of New Zealand's reforms were modelled on the coroner service in Victoria. Early successes of the new

[816] 'The Irish Times view on Ireland's coroner service: failing the living and the dead', *Irish Times* (Dublin, 5 June 2022) <https://www.irishtimes.com/opinion/editorials/2022/06/05/the-irish-times-view-on-irelands-coroner-service-failing-the-living-and-the-dead/> accessed 14 September 2022.
[817] ibid.
[818] Neil MacLean, 'The Vision and the Reality: Reflections on the Evolving Role of the New Zealand Coroner in 2015' (2015) 23 Waikato law review : Taumauri 1, 21.
[819] Coronial Services of New Zealand <https://coronialservices.justice.govt.nz/about/chief-coroner-and-coroners/> accessed 14 September 2022.

centralised system included the establishment of a National Initial Information Office, providing an around-the-clock, single point of contact for doctors to discuss and refer cases and co-ordinating all aspects of coronial cases, up to and including the release of the body. Such an initiative in England and Wales would no doubt be warmly welcomed by the president of the Royal College of Pathologists, who would no longer have to wonder how to make contact with the coroner's office or whether he would get a reply.[820] A further achievement in New Zealand's new national system was the establishment of a duty coroner roster, which improved the turnaround time for releasing to families the bodies of deceased people whose deaths had been reported to the coroner. Had such an initiative existed in England and Wales, the senior coroner for Inner North London would probably have seen no need to implement her "cab rank" policy for the release of bodies, which the High Court declared unlawful.[821] In a 2015 lecture given following his retirement as New Zealand's first Chief Coroner, Neil MacLean reviewed the success of the 2006 reforms and admitted he had enjoyed how his country's service had surpassed that in England and Wales (whilst acknowledging the progress being made under Sir Peter Thornton KC's leadership): "Each time I go, I realise I have less and less to impart to them, but for a while it was a good feeling of a reversal of the apron strings."[822]

### 11.8 Has the creation of the office of Chief Coroner been a success?

In rejecting the Justice Committee's recommendation, the Ministry of Justice reasserted its faith in the modest reforms enacted in 2009 and partly implemented since July 2013. Since the first draft of the Coroners and Justice Bill was published in June 2006, successive administrations have invoked the role of the Chief Coroner when dismissing calls for a unified, national system. The then Labour government set the bar very high for those who have been appointed Chief Coroner when, in its response to the Constitutional Affairs Committee's criticism, it asserted the new office's

[820] Justice Committee (n 9) para 152.
[821] *Adath Yisroel Burial Society v HM Senior Coroner for Inner North London* [2018] EWHC 969 (Admin), discussed at page 75 (n 309) above.
[822] MacLean (n 818) 21.

leadership could ensure delivery of "the best features of a national structure"[823] in a service still provided at a local level.

The post of Chief Coroner was introduced in 2013 to provide judicial leadership, guidance and support to coroners and to promote consistency of standards and practice across England and Wales. The survey results[824] indicate that the creation of the office has been a success in meeting these aims. The overwhelming majority of coroners were of the view that the post of Chief Coroner has been beneficial for increasing consistency across the coroner service (86%) and establishing leadership within the coroner service (70%). Nearly all coroners (96%) believe that the guidance provided by the Chief Coroners has been helpful. Both independent reviews and government statements have recognised the creation of the office of Chief Coroner as a "significant advance for the system"[825] and "a key reform"[826]; the Coroner Attitude Survey results provide empirical backing for these observations.

The Coroners' Society submission to the Justice Committee inquiry also lauded the positive impact of the role of Chief Coroner, saying the post has also "raised the profile of coroners, helping them integrate better with the wider judiciary and access services such as welfare."[827] This claim is less robustly supported by the results of the survey. In terms of raising the profile of coroners, the Coroners' Society may have had in mind the Chief Coroner's efforts to cultivate relationships with the diverse range of stakeholder groups who have direct interaction with the coroner service and to broaden public awareness of coroners' work through talks, meetings and interviews.[828] The survey found that a majority of coroners (51%) agreed that the creation of the office of Chief Coroner has been helpful in enhancing the public perception of the role of coroners, although 39% said they were not sure. Coroners' uncertainty as to the impact of the Chief Coroner may be explained by the observation elsewhere in the Coroners' Society's written evidence that high profile inquests conducted by a senior courts and tribunals judge sitting as a coroner are exceptional cases, far removed from the norm,

[823] 'Reform of the Coroners' System and Death Certification: Government Response to the Constitutional Affairs Select Committee's Report' (n 204) 8.
[824] See Figure 51 on page 186.
[825] Angiolini (n 38) para 16.68.
[826] 'The Coroner Service: Government Response to the Committee's First Report' (n 37) 3.
[827] 'Written Evidence from The Coroners' Society of England & Wales' (n 266).
[828] Lucraft, 'Chief Coroner's Annual Report 2018-19 & 2019-20' (n 308) paras 130–132.

that are likely to give the public unrealistic expectations of the inquest process. The Coroners' Society told the Justice Committee that "it would be helpful to have public inquiries in these cases instead of inquests to avoid comparison, confusion and upset."[829]

While the survey found a majority of coroners (54%) feel the Chief Coroner has been helpful in creating stronger links between coroners and the courts and tribunals judiciary, it does not follow that the forging of such links depends on the Chief Coroner being recruited from the High Court or Circuit benches. Anecdotal evidence suggests that of the judges eligible to apply, few have expressed an interest in the post with many being reluctant to interrupt their own career paths or to forgo a mixed caseload. The second Chief Coroner, HHJ Lucraft KC, continued to sit at the Old Bailey throughout his time as the head of the coroner service. As the post of Chief Coroner ought not to be a part-time position held by a senior judge with responsibilities elsewhere,[830] a change in the law allowing for the appointment of a senior coroner of sufficient experience and skill would be welcome. This reform would have the further benefit of addressing coroners' fears that judges' reluctance to accept appointment may result in the Chief Coroner position becoming "a sinecure"[831] at the end of a Circuit judge's career.

In terms of increasing coroners' welfare, the survey found a minority of coroners (48%) were of the view that the creation of the post of Chief Coroner has been helpful. This result may be explained by another survey finding: that a significant number of coroners (41%) sometimes have concerns about their personal safety in court as a result of their work. Over a fifth of coroners (22%) reported having such concerns outside of the courtroom too. Almost half of coroners (45%) said they would like more guidance on ensuring their safety in court. While the UK Judicial Attitudes Survey 2020 revealed that an almost identical proportion of the courts and tribunals judiciary (42%) sometimes had concerns about personal safety in court, the additional

[829] 'Written Evidence from The Coroners' Society of England & Wales' (n 266).
[830] 'When Things Go Wrong: The Response of the Justice System' (n 709) para 2.35.
[831] 'Written Evidence from The Coroners' Society of England & Wales' (n 266).

comments left by some coroners suggest that some feel the misperception as to their judicial status impacts upon their welfare:

> "Coroners are often not perceived as judges and, if correcting that view would assist [and judges may be best able to comment as I appreciate that a lack of respect can be shown to them too] then taking steps to change public perception may assist."[832]

> "We do not have the respect [enjoyed by the] mainstream judiciary and consideration of our personal safety is non-existent."[833]

Other comments left in response to the questions on welfare are relevant to the question of whether the post of Chief Coroner makes up for the failure to introduce a unified, national coroner service. Coroners highlighted how some local authorities' lack of understanding of the coroner's role impacts upon their welfare:

> "There has never been any importance or cognizance of the issue of security by the Local Authority who have a failure to understand the judicial aspect of our work and the stress and strain that this can create - especially when making decisions that are unpalatable or unpopular to some members of the family, who often are unrepresented and do not understand the nuances of coronial law, decisions and limitations."[834]

> "I previously sat in another jurisdiction as a full time salaried judge and it is striking at how casual security is regarded for Coroners by the local authority compared with the MOJ."[835]

The survey results suggest there is more for the Chief Coroner to do in increasing coroners' welfare. However this is no small task. While he can emphasise the judicial nature of the coroner's work and do more to promote coroners' acceptance as judges, coroners' working conditions and the security measures in place in their courts remain matters wholly within the preserve of local authorities across England and Wales. So long as the coroner service remains run on a local basis, coroners' welfare is one matter where the Chief Coroner is unable to deliver "the best features of a national structure".

[832] Answer provided by coroner 49 in free text box to Q.13.
[833] Answer provided by coroner 354 in free text box to Q.13.
[834] Answer provided by coroner 173 in free text box to Q.13.
[835] Answer provided by coroner 270 in free text box to Q.13.

## 11.9 Coroners' training

For Professor Padfield, the arguments in favour of a national coroner service are not yet persuasive. She sees the major problem in the coroner service as not the "unevenness" in services between different coroner areas but the quality of individual coroners and their staff in responding to the wide variety of deaths they must investigate. She told the Commons Justice Committee inquiry:

> "Coroners need extraordinary skills: energy and curiosity, determination, integrity, neutrality, empathetic communication skills, excellent understanding of law and medicine, team leadership and case management skills."[836]

The Coroner Attitude Survey reveals training is very important to coroners themselves, with almost all (93%) describing training opportunities as important. While training existed for coroners before the appointment of the first Chief Coroner, the new regime for coroner training was seen by the first Chief Coroner Sir Peter Thornton as an essential part of his reforms and is one of most noticeable ways in which the contemporary coroner service differs from that which existed pre-2009.

The survey results indicate that Professor Padfield's concern about coroner quality is not unrelated to the debate over whether the coroner service should remain delivered at a local level or be structured on a national basis. While only a small minority of coroners (12%) described the availability of training opportunities as poor or non-existent, coroners' views varied between regions. In the North East 75% of coroners described opportunities for training as good or excellent, whereas in the South West this number fell to only 39%.[837] While over a fifth (21%) of coroners in Wales said opportunities for training were poor or non-existent, only 3% in the East Midlands were of this view and there were no coroners in the North East who thought this. Local authorities would surely protest that this is not their fault as they do not have responsibility for coroner training, and the results suggest there is more work for the Chief Coroner to do. Local authorities cannot be let of the hook entirely though. The survey results support the complaint by the Chief Coroners that some local authorities

[836] Nicola Padfield (n 782).
[837] See Figure 56 on page 190.

are leaving their coroners "out of pocket" when attending compulsory training,[838] with a sizeable minority (38.5%) of coroners not satisfied with their local authority's support for training.

Those who are wary of a national coroner service would highlight the corresponding results in the UK Judicial Attitudes Survey 2020. While around a third of coroners were not satisfied with the time available to undertake training (31.7%) or with the time available to prepare for training courses (34.7%), a much higher proportion of the courts and tribunals judiciary were dissatisfied with these aspects of their training. Almost half of the judges (48%) were not satisfied with the time available to undertake training and the vast majority (73%) were not satisfied with the time they had to prepare in advance.[839] Given how important training is to coroners, its future in any unified, centrally run system must be considered by those advocating for a national coroner service.

## 11.10 Conclusion

The Coroner Attitude Survey has revealed for the first time the views of all coroners on the question of whether coroner services across England and Wales should be unified and centrally run. The great majority are in favour of a national coroner service and harbour concerns over the government's failure to legislate. The significance of these findings, and of those that reveal coroners' attitudes to the office of Chief Coroner, is increased following the government's decision not to publish its post-implementation review of the reforms introduced by the Coroners and Justice Act 2009. While the Coroner Attitude Survey produced further evidence of troubling variation across coroner areas in England and Wales, when compared with the results of the UK Judicial Attitude Survey this research should give those who advocate for a national coroner service pause for thought. Coroners' satisfaction with their administrative support and working conditions is generally higher than that of courts and tribunals judges. The two surveys together indicate that there is indeed much that could be lost in a new centrally run service.

[838] E.g. Lucraft, 'Chief Coroner's Annual Report 2016-17' (n 236) para 157.
[839] Thomas, '2020 UK Judicial Attitude Survey: England and Wales Courts and UK Tribunals' (n 69) 60.

# Chapter 12 Ensuring the coroner service is not forgotten

This chapter draws on the results of the first ever survey of the attitudes and experiences of all coroners in England and Wales to set out proposals for reform of the coroner service so that it is fit for the 21st century. It addresses key policy areas such as coroners' reports to prevent future deaths, transparency in the coroners' courts, and coroners' relationship with the rest of the judiciary. It also recommends areas for further research in this under-developed area of legal scholarship.

## 12.1 Prevention of future deaths

The Coroner Attitude Survey results revealed that a third of coroners are not sure whether PFD reports are effective in preventing future deaths. A further 14% of coroners are of the opinion that such reports are not effective. Given that PFD reports are the primary means by which coroners fulfil their role in highlighting how further fatalities may be prevented, it is significant and troubling that so many coroners harbour doubts as to the efficacy of their reports. Both the Chief Coroner and the government recognise that coroners' reports are vitally important[840] but the Justice Committee received evidence of wide variations in the numbers of reports issued by different coroners.[841] The survey results suggest a reason for coroners' differences in approach: almost half of coroners did not agree with the assertion that reports are effective. In a future Coroner Attitude Survey, it would be good to ask coroners to state the frequency with which they issue PFD reports. This would allow enable a break down of the results on the question relating to reports' efficacy and to see whether those who harbour doubts nevertheless issue reports.

The evidence of one senior coroner to the Justice Committee's recent inquiry suggests that even coroners who do routinely issue PFD reports share the feeling that the reports are a missed opportunity, undermined by inaction and analysis by others outside of the coroner service:

[840] 'Guidance No.5 Reports to Prevent Future Deaths' (n 369) para 2; 'The Coroner Service: Government Response to the Committee's First Report' (n 37) para 22.
[841] Justice Committee (n 9) para 193.

> "I have written many Prevention of Future Death reports over the years. Some have led to noticeable changes to policy, practice and services. A number have not though, and very similar situations leading to deaths in similar circumstance have been all too common. There is a lack of a proper central hub to properly monitor such reports and to follow them up and to try and secure change. It is not the function of the coroner to suggest what improvements to a situation should be, just to highlight shortcomings, and so someone else needs empowering to take matters forward."[842]

Interestingly, in relation to PFD reports' lack of teeth, André Rebello has suggested that the local structure of the coroner service is an advantage. Where a coroner's report is not acted upon, the staff of the public body or institution in question will likely have to face the discomfort of explaining themselves before the very same coroner in the event of another death. An example of this would be the prison officers of HMP Woodhill having to appear multiple times before the Senior Coroner for Milton Keynes. Rebello told the Committee: "The public embarrassment of not having addressed the issue in the first place is one way in which things can change."[843] However, as discussed in Chapter 4, things did *not* change at HMP Woodhill despite the prison's acceptance of the points raised in the coroner's reports.[844]

The shortcomings of PFD reports and the deficiencies of the systems in place for considering their contents are long established and recognised even outside the world of coronial justice. The fact that almost half of coroners themselves do not believe reports will necessarily result in beneficial change should add an extra impetus to calls for reform. The law should be changed to create some sanction for a failure to respond to a coroner's report: coroners could be given the power to issue a summons, to impose a fine or to treat a failure to respond as contempt of court. The creation of a national oversight body that could collate, analyse and disseminate learning, such as the independent "Office for Article 2 Compliance" proposed by Dame Elish Angiolini[845], would represent a sea change in how reports are treated and ensure far fewer "disappear into the ether". At the very least the Chief Coroner should be given the funding and resources to overhaul the current means by which reports and responses

[842] ibid 195.
[843] 'Oral Evidence to the Justice Committee: The Coroner Service, HC 282' (n 449) Q 19.
[844] See pages 101-102 (n 431) above.
[845] Angiolini (n 38) 233.

are published, so that the important data produced by coroners' investigations is better organised and easier to search.

There is a danger that coroners' reports will soon become a very obvious sign of the jurisdiction's neglect. Elsewhere in the justice system, a robust strategy for data collection, analysis and sharing underpins the HMCTS reform programme announced in September 2016.[846] The ambitious goal of a digital civil justice system championed by Sir Geoffrey Vos MR since January 2021 has at its heart the cohesion of courts, tribunals and disparate dispute resolution providers, including the seamless sharing of information through the utilisation of new technology.[847] The provisions for coroners' reports look distinctly analogue in comparison. The basic failure to provide for an accessible, user-friendly website for coroners' reports that would introduce at least a degree of organisation to coroners' preventative efforts allows the lessons that may be learned from inquests to be wasted. Simply posting reports and responses on the Judiciary.uk website does not make it easy for government, lawyers, healthcare providers, the public or coroners themselves to draw parallels between deaths and to see what action has and has not been taken as a result of a coroner's report. Reforms such as those suggested above would likely give coroners greater confidence that PFD reports are effective in preventing future deaths. It is easy to see why coroners may doubt their reports will make a difference, but they could draw inspiration from their proactive 19th century forebears and play their part too by making greater use of reports and doing so in a consistent way.

### 12.2 Transparency in the coroners' courts

It is very unlikely that the current government will belatedly act to create the "Office of Article 2 compliance" proposed by Angiolini and endorsed by the Commons Justice

[846] Lord Chancellor, Lord Chief Justice, and Senior President of Tribunals, 'Transforming Our Justice System' <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/553261/joint-vision-statement.pdf> accessed 14 September 2022; Natalie Byrom, 'Digital Justice: HMCTS Data Strategy and Delivering Access to Justice' (The Legal Education Foundation 2019) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835778/DigitalJusticeFINAL.PDF> accessed 14 September 2022.

[847] See, for example, the Master of the Rolls' keynote speech at London International Disputes Week 2021 on 10 May 2021, available at <https://www.judiciary.uk/wp-content/uploads/2021/05/MR-to-LIDW-10-May-2021.pdf> accessed 14 September 2022.

Committee. While such a body remains necessary if the full preventative potential of coroners' investigations is to be realised, there are more limited, quicker and less expensive steps that the government could still take now to improve matters, and which would likely increase coroners' confidence in the effectiveness of their PFD reports.

In a recent judicial review hearing in the High Court[848], Mr Justice Fordham expressed surprise that neither the Record of Inquest nor the coroner's "Findings and Conclusion" document (a very detailed 35-page, 200-paragraph statement written to explain her decisions at the end of a very complex inquest) were readily available online in a publicly accessible form. The judge felt that "it would be a real and substantial advantage for anyone who wished to do so, to see the document to which the Court was referring in its own judgment, in its entirety".[849] At present, in England and Wales, very few coronial documents are made readily available to the public online. They are effectively lost to scrutiny. This is in contrast to Northern Ireland, where the findings of judge-led inquests are published online on the Judiciary NI website.[850] The gold standard for coronial transparency is Australia, where all coroners' findings and any recommendations made are published on the websites of each states' coroner service[851] and deposited in the national database of mortality data on deaths reported to a coroner.[852]

Brigid Dolan KC has argued that publishing the more important coronial findings would help improve public understanding of the coroner's court process and with it public confidence in the coronial system.[853] It may also serve to reassure the many coroners who, when completing the Coroner Attitude Survey, reported doubts as to the efficacy of their reports in preventing further deaths and encourage them to make greater use of their reporting power. This will, of course, cost money. But if the government still takes the view that it can achieve the "best features of a national

[848] *R (Ture) v Senior Coroner for Manchester North* [2022] EWHC 1027 (Admin).
[849] ibid [5].
[850] <https://www.judiciaryni.uk/judicial-decisions?search_api_views_fulltext=inquest&action=search> accessed 14 September 2022.
[851] E.g., <https://www.coronerscourt.vic.gov.au/inquests-findings/findings> accessed 14 September 2022.
[852] The National Coronial Information System <https://www.ncis.org.au> accessed 14 September 2022.
[853] Brigid Dolan, 'Do Buttered Parsnips Taste Better? Publishing Coronial Conclusions' (*UK Inquest Law Blog*, 10 May 2022) <https://www.ukinquestlawblog.co.uk/butteredparsnips/> accessed 14 September 2022.

structure"[854] in a locally delivered system headed by a Chief Coroner, then it must back the Chief Coroner with sufficient funds and resources to create and maintain a user-friendly online database of inquest documents. In terms of the coronial purpose of prevention of further deaths, the "best features of a national structure" are undoubtedly those of Australian states.

### 12.3 Coroners' judicial status

One of this research's hypotheses was that a majority of coroners would distinguish between the judicial offices of coroner and judge. This theory was based on coroners' pride in their office's long and unique history and on the first Chief Coroner's emphasis on the coroner's distinct role and particular skills.[855] It was therefore a surprise that so many coroners (81%) agreed with the statement "I consider myself to be a judge", and that so many (42%) were strongly of that view.[856] This result was reflected in the submission of the Coroners' Society to the Justice Committee inquiry later in the year, which made clear the Society's position that "coroners are judges, judges who investigate deaths". It also referred to the "coronial judiciary".

However, the survey results also reveal that despite most coroners seeing themselves as judges, many coroners (43%) do not feel part of the judiciary of England and Wales and over a fifth (22%) expressed uncertainty.[857] At first, this may appear to be contradictory. It may be explained by the further result that only a quarter of coroners felt valued by the judges of the courts and tribunals judiciary. Here too the Coroners' Society's evidence to the Justice Committee sheds some light. While the Society was at pains to put on record how Lord Burnett LCJ and HHJ Mark Lucraft QC "could not have been more enabling and welcoming to coroners as part of the judicial family of judges"[858], it could not say the same about the rank and file of the judiciary. The Society's submission complained that when coroners and courts and tribunal judges

[854] 'Reform of the Coroners' System and Death Certification: Government Response to the Constitutional Affairs Select Committee's Report' (n 204) 8.
[855] Thornton, 'Annual Conference' (n 200) paras 2, 19.
[856] See Table 8 on page 199.
[857] See Table 9 on page 201.
[858] 'Written Evidence from The Coroners' Society of England & Wales' (n 266).

meet at cross-jurisdictional training, or when fatalities being investigated by coroners give rise to other court proceedings,

> "It is not understood by other judges that Coroners are judges and should be referred to and treated as such, rather than judicial office holders carrying out a quasi-judicial function. Work is needed in this area."[859]

Interestingly, coroners may not be the only part of the judiciary to feel misunderstood. In 2021, Sir Keith Lindblom, the Senior President of Tribunals, noted the "persistence of a culture within the judiciary in which tribunal judges and courts judges tend to view themselves as separate and disunited."[860] He stated his belief that it is not helpful or correct to think of a divided judiciary and asserted "simply, a judge is a judge".[861] The survey results indicate that coroners may observe this discussion with some envy: while tribunal judges may feel divorced from their brethren in the Crown Court and county court, 43% of coroners do not feel part of the judiciary at all. For a majority (53%) of coroners, the feeling of being second best to judges would cause them to discourage those considering applying to join their ranks. The Senior President of Tribunals said that he and the Lord Chief Justice were committed to overcoming divisions between courts judges and tribunals judges to achieve "greater cohesion and harmony".[862] He saw cross-deployment as key: "Encouraging tribunal judges to sit in the courts, and courts judges in the tribunals, will engender a greater understanding of each other's roles and jurisdictions."[863] Unfortunately the "One Judiciary" strategic objective does not extend to coroners. This is despite a number of coroners having experience of sitting in other jurisdictions – the survey found at least 34 coroners hold an additional post in the courts and tribunals judiciary.[864]

The Coroners' Society argued that it is easy for the senior judiciary to state that coroners are fully part of the "judicial family" of judges but that this assertion is not

[859] ibid.
[860] Sir Keith Lindblom, 'Senior President of Tribunals' Annual Report 2021' (2021) 5 <https://www.judiciary.uk/announcements/senior-president-of-tribunals-annual-report-2021-is-published/> accessed 14 September 2022.
[861] ibid.
[862] ibid.
[863] ibid 6.
[864] Just under a quarter of coroners (22.3%) answered 'Yes' to holding an additional judicial post, but many of those who added an additional comment indicated a coroner post in another coroner area.

borne out by the evidence.[865] It highlighted how coroners' access to e-Judiciary – a platform which provides Courts and Tribunal judges with information and which enables communication – is partial, with most services not available to coroners. In contrast, over 99% of courts and tribunals judges have full access.[866] Access to legal information resources is turned off for coroners.[867] The Society also pointed out how assistance from Judicial Office human resources is not as readily available for coroners as it is for judges.[868] It suggested that "the most telling evidence" of all of the wider judiciary's refusal to embrace coroners as judges is that the Coroners' Society – "the oldest of all judicial associations" – is the only professional group not represented on the Judge's Council.[869]

Further evidence of why coroners do not feel valued by the rest of the judiciary may be found in the brief description of coroners provided on the website of the courts and tribunals judiciary:

> "Although the post they hold is judicial, and legal qualifications and experience are often required, coroners are not considered to be members of the courts judiciary. However, for especially high-profile inquests a judge may be appointed to oversee the proceedings as a deputy coroner."[870]

Not only is this incorrect – all coroners must be legally qualified and satisfy the judicial eligibility criteria – but to those unfamiliar with coronial history it gives the impression that coroners' position outside of the judicial fold relates to their status or ability to handle significant cases.[871] This gives rise to a problem more serious than slighting nomenclature. Coroners have also highlighted the huge discrepancy in their resources

[865] 'Written Evidence from The Coroners' Society of England & Wales' (n 266).
[866] Thomas, '2020 UK Judicial Attitude Survey: England and Wales Courts and UK Tribunals' (n 69) 21.
[867] The author of the CSEW submission presumed this is because the Ministry of Justice is unwilling to provide the Judicial Office with funds for extending the provision of these resources to coroners.
[868] This is a particular problem for coroners, who may be reluctant to use the HR resources of the local authority that provides their funding as that relevant authority may often be an interested person in the coroners' investigations.
[869] The Judiciary website explains "The primary function of the present Judges' Council is to be a body broadly representative of the judiciary as a whole which will inform and advise the Lord Chief Justice on matters as requested from time to time."
[870] <https://www.judiciary.uk/about-the-judiciary/the-justice-system/coroners/> accessed 14 September 2022.
[871] There are further inaccuracies: nine years on from the coming into force of the Coroners and Justice Act 2009, the Judiciary website still refers to "deputy and assistant deputy coroners" and incorrectly asserts that there are 92 separate coroners' jurisdictions in England and Wales.

and those given to judge-led high-profile inquests, "which the coroner can only look upon with envy". With ample funds to instruct solicitors and counsel, inquests conducted by judges from the courts and tribunals judiciary "raise the bar and expectations of the public from the coroner service".[872]

However the Coroners' Society's own website still describes the coroner as "an independent judicial office holder, appointed by the local authority."[873] The Ministry of Justice's Guide to Coroner Services uses the same formulation.[874] The definition of the modern coroner provided by Christopher Dorries, former senior coroner for Yorkshire South West area, in his guide to coronial law and practice invokes the office's history: "the coroner remains an independent judicial officer, responsible to the Crown".[875] The results of the survey suggest this unfamiliar and arcane language is not favoured by today's coroners, who overwhelmingly see themselves as judges. The Coroners Society argued in its submission to the Justice Committee that coroners should be called "Judge [name], HM Coroner". This would be a simple change and ought to be uncontroversial. Coroners have long been recognised as judges. In 1827 Lord Tenterden CJ asserted "The Court of the coroner is a Court of Record of which the coroner is the Judge"[876] and more recently Lord Justice Laws described the coroner's status as a judge as being "beyond contention".[877] Nor should the change lead to any confusion. The adoption of the simple formulation used by the Coroners Society – "Coroners are judges […] who investigate deaths which are unexplained, violent or unnatural or in custody or otherwise in state detention" ought to avoid misunderstanding on the part of the public.

Perhaps if coroners were recognised unequivocally as judges it would not be necessary for Chief Coroners to have to remind local authorities that the coroner is not an employee or a department of the council and that the authority may not interfere in the coroner's judicial work. It is not hard to imagine coroners' morale being sapped by

[872] The Coroners Society told the Justice Committee that "The cost of the judge-led inquests would fund many a coroner area for all reported deaths for a considerable time. It would be helpful to have public inquiries in these cases instead of inquests to avoid comparison, confusion and upset."
[873] <https://www.coronersociety.org.uk/faqs/> accessed 14 September 2022.
[874] <https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide> accessed 14 September 2022.
[875] Dorries (n 10) para 1.55.
[876] Garnett v Farrand (1827) 6 B. & C. 611 at 625; 108 E.R. 576 at 581.
[877] Forrest v Lord Chancellor [2011] EWHC 142 (Admin) [27].

pressure from their cash-strapped local authorities as officials step over constitutional boundaries to question the coroner's instruction of an expert witness or of counsel to an inquest. This problem brings us back to the question of whether there ought to be a single, national coroner service. It is unlikely that coroners operating within a unified system funded by central government would have reason to insist upon their independence as judges. Coroners' may also feel differently about their place in the wider judiciary if they too worked as part of one greater whole.

There is a limit to the extent to which the Chief Coroner can create stronger links between coroners and the courts and tribunals judiciary. While a majority of coroners (54.4%) feel the Chief Coroner has been helpful in this regard, the post is itself perhaps a constant reminder to coroners of their status in relation to the other judges. The Coroners' Society has spoken of the "glass ceiling" that prevents senior coroners from becoming Chief Coroner, but this metaphor is not apt as the barrier is quite visible. A statutory provision[878] permits only a judge of the High Court or a Circuit judge to be appointed to head the coroner service. An amendment to the Coroners and Justice Act 2009 that would allow senior coroners to aspire to become Chief Coroner may positively alter coroners' relationship with the courts and tribunals judiciary.

There are a number of steps that could be taken immediately by the Lord Chief Justice and Chief Coroner in order to improve coroners' relationship with other judges. At the very least, references on the Judiciary.uk website to coroners' status and qualifications ought to be accurate. The senior judiciary (and the Coroners' Society) should also stop using the accurate but clunky description of "judicial office holder" in favour of the much more readily understood "judge". Merely adopting the simple definition provided in the Ministry of Justice's updated guidance – "A coroner is a special type of judge appointed by a local authority to investigate certain deaths"[879] – would no doubt be welcomed by coroners. Welcoming the Chief Coroner or a representative of the Coroners' Society onto the Judges' Council and inviting coroners to participate in relevant, cross-jurisdictional judicial training seem easy ways of reassuring coroners that they are not the poor relations of the courts and tribunals judiciary. The current

[878] Coroners and Justice Act 2009, sch 1 para 8.
[879] 'A Guide to Coroner Services for Bereaved People' <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859076/guide-to-coroner-services-bereaved-people-jan-2020.pdf> accessed 14 September 2022.

efforts by the judiciary and Ministry of Justice to realise their shared ambition of creating "One Judiciary"[880] represents a good opportunity to bring coroners into the fold. A failure to reassert coroners' place in the "single judicial family" at the same time as ties between other judges are strengthened would likely send the opposite message.

A further reform currently under consideration by the senior judiciary is a change in how District Judges are addressed in court.[881] It is proposed that advocates and litigants in person use "judge", a more modern and gender-neutral form of address, rather than "sir" or "madam". If implemented, there is no reason why this change ought not to be extended to coroners' courts as well. It would answer the Coroners' Society's call for its members to be referred to and treated as judges without requiring a change in their statutory title of coroner. This may be a satisfactory compromise between a cohort demanding greater recognition as judges (yet proud of their unique office) and a new Chief Coroner for whom terminology matters and who feels the maintenance of the inquisitorial jurisdiction requires coroners to resist the importation of the "alien vocabulary of other jurisdictions".[882]

The Coroner Attitude Survey revealed coroners' deep attachment to the coroner service, their strong belief in the societal importance of their work and their commitment to doing as good a job as they possibly can. In light of these findings (and the finding that 55% of coroners feel not valued by the government), the government could consider reviewing its position that senior coroners, as a category, are not among those able to see sensitive material related to issues of national security. Permitting coroners to apply to undergo the security clearance process necessary for hearing the most sensitive inquests would likely serve to boost coronial morale, demonstrate that

[880] 'Pursuing "One Judiciary" by the Lord Chancellor, the Lord Chief Justice of England and Wales and the Senior President of Tribunals' (*Courts and Tribunals Judiciary*, 8 July 2022) <https://www.judiciary.uk/announcements/pursuing-one-judiciary-by-the-lord-chancellor-the-lord-chief-justice-of-england-and-wales-and-the-senior-president-of-tribunals/> accessed 14 September 2022.
[881] Personal knowledge of the researcher from his position as legal advisor to the Master of the Rolls.
[882] Thomas Teague, '"The Coroner's Inquest" - Annual Leeming Lecture at the University of Bolton' (*Courts and Tribunals Judiciary*, 22 July 2022) paras 30–32 <https://www.judiciary.uk/publications/chief-coroner-leeming-lecture-2022/> accessed 14 September 2022.

their work and skills are valued by government and recognise their place in the judiciary.

### 12.4 Suggestions for future research

Firstly, it would be desirable to run the Coroner Attitude Survey again. Hoffmann-Lange has argued that single studies of elites may be of significant descriptive value, but that they remain "small mosaic pieces to the puzzle of elite structures and their impact on social and political change."[883] While this one-off Coroner Attitude Survey provided valuable background information and insights into matters of interest and concern to coroners, much greater benefits could be gained from repeating the survey at regular intervals. The UK Judicial Attitude Survey, conducted in 2014, 2016, 2020 and again in 2022, has been able to identify the direction as well as the extent of change in judges' attitudes over time. It would be good if further surveys of coroners could be run in conjunction with future iterations of the UK Judicial Attitude Survey. It should also be remembered that this research was conducted at the height of the first wave of the Covid-19 pandemic. Repeating the survey at some point in the future would shed light on how the unusual circumstances of May 2020 may have affected coroners' answers to the survey questions.

If the Coroner Attitude Survey is repeated in the future, it would offer a chance to explore the reasons why coroners favour the creation of a national coroner service. It would also be beneficial to include questions seeking coroners' views on whether their independence as judges is respected by the diverse stakeholders of the coroner service. Chapter 2 of this thesis explored how, in previous eras, pressure from the senior judiciary and local and central government impacted upon coroners' status and freedom; the extent to which today's coroners feel influenced by these and other actors is unknown. Chapter 3 examined modern institutional guarantees of independence but noted Angiolini's finding that coroners' dependence on other agencies "tests the viability of the coroner's role as an inquisitorial judge"; it is unknown how many coroners agree with this assessment. Chapter 4 highlighted factors that limit the preventative potential of PFD reports and the Coroner Attitude Survey found many

[883] Hoffmann-Lange (n 515) 925.

coroners have doubts as to their efficacy. A future survey could explore with coroners what they think may improve the impact of their reports. It would also be useful to expand the section of the survey that sought information on coroners' backgrounds to include a question on coroners' religious faith and observance. Appreciation of the needs of different faith communities was an issue in the Inner North London coroner area that led to the judicial review brought by the Adath Yisroel Burial Society.[884] One of the coroners interviewed as part of the background research that informed the content of the Coroner Attitude Survey raised the importance of their own religious faith to their work as a coroner.

This thesis provides an insight into how coroners understand their role. It found just over half of coroners (56%) feel valued by their local authority. An important next step in coronial research in this jurisdiction would be to explore how well local authorities in England and Wales understand the role of their coroners and their responsibility to support coronial work. In the long-running debate over whether the coroner service ought to be delivered on a local or national basis, the local government perspective is unknown. By shifting the focus from coroners to local authorities, a future researcher could greatly develop our understanding of how coroners are perceived by this important constituency and of the circumstances in which coroners work.

## 12.5 Conclusion

The main purpose of this research was to fill a sizeable knowledge gap about the coroners of England and Wales, and it has done so in three main ways. First, the Coroner Attitude Survey produced the first extensive profile of the composition of the 21st century coroner service, where there was little reliable data previously, and enabled a comparative analysis of the diversity of coroners compared with that of the courts and tribunals judiciary in England and Wales. Second, it addressed another lacuna in previous research on coroners by revealing the attitudes of today's coroners to their unique judicial role, their experiences of serving as coroners and their views on a range of key policy issues facing the coroner service. Finally, it discovered

[884] See page 75 (n 309) above.

coroners' attitudes to their membership of the judiciary and compared their views on aspects of their working lives with those of the courts and tribunals judges.

The coroner service in 2022 cannot be described as a forgotten service. It has made huge strides under the leadership of the Chief Coroners and today is a much more professional service, working to common, national standards that are reflected in robust recruitment procedures, appraisals of assistant coroners and a carefully designed and compulsory training programme. The Chief Coroner's annual report provides a regular assessment of the health of the service that was missing before 2013 and which can be cited by coroners, parliamentarians or other stakeholders. Today the work of coroners commands greater parliamentary attention and is discussed regularly by prominent legal bloggers.[885] It must be acknowledged that central government has listened to the Chief Coroner, acting upon some if not all of His Honour Judge Lucraft KC's recommended law changes.

However, it certainly could be accurately described as a neglected service. Even putting to one side for a moment the failure to create the unified national coroner service recommended by almost all reviewers of the coroner system, there is still much evidence to suggest that coroners and their work remain an afterthought for government. Too many PFD reports are permitted to disappear into the ether, with no sanction for those recipients who fail to reply to the coroner. There is still no central body in place with the means to collate reports and analyse their content so that coroners' preventative work is not in vain. Nor has the government acted upon the numerous warnings that coronial pathology services in England and Wales are under severe strain and in need of urgent corrective action. There remains unacceptable variation in coroners' working conditions and resources across the country, but the government has not created even the small Coroner Service Inspectorate that could force local authorities to meet the standards of the Chief Coroner's "model coroner area".[886] The government's recent response[887] to the Justice Committee's report on the coroner service suggests the neglect will continue.

[885] E.g., the UK Human Rights Blog (https://ukhumanrightsblog.com) and the UK Inquest Law Blog (http://ukinquestlawblog.co.uk).
[886] Lucraft, 'Chief Coroner's Annual Report 2018-19 & 2019-20' (n 308) 39.
[887] 'The Coroner Service: Government Response to the Committee's First Report' (n 37).

This thesis has sought to show that the 21st century coroner is not some fossil of legal history to be found in a quiet backwater of the English legal system. Contemporary coroners do an important and difficult job that is underappreciated. They are deserving of greater respect from both central government and their judicial peers and sustained attention from legal researchers. Coroners have always adapted to changes in law and society to continue serving their communities. Those changes now regularly present coroners with legal questions and fact-finding challenges of great complexity. As dedicated coroners strive to provide answers for the public, their status as specialist judges in the judiciary of England and Wales should no longer be left in doubt.

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# Appendices

## List of appendices

**Appendix 1:** The Coroner Attitude Survey

**Appendix 2:** Email from the Chief Coroner to all coroners, 21 May 2020

**Appendix 3:** Email from the Chief Coroner to all coroners, 27 May 2020

**Appendix 1**

# Coroner Attitude Survey 2020

### 2020 Coroner Attitude Survey

The Judicial Institute of University College London (UCL) has been asked by the Chief Coroner to conduct the first ever **Coroner Attitude Survey (CAS)** in England and Wales. This **survey** has been developed through a Working Group with representatives from the Coroners Service.

### Why it is important for you to take part in this survey

By completing this survey you will be ensuring that coroners' views are taken into account in important decisions about the future of the service. Although there have been surveys of this type conducted with other branches of the judiciary in the past, this is the first time the survey has been extended to coroners. The 2020 CAS is running alongside the **2020 Judicial Attitude Survey (JAS)** for salaried judges in the Courts and Tribunals across the UK. Both the Chief Coroner and the Lord Chief Justice agree it is important that this survey and one for the courts and tribunals judiciary run at the same time.

### The Survey and COVID-19

The 2020 Coroner Attitude Survey was scheduled to run this spring, and despite the challenges we all face as a result of Covid-19, it was felt that it was important to carry on with the survey. Our work as coroners has carried on through the emergency, and it remains as important as ever to understand how coroners feel about their role, their working lives and their plans for the future. Most of the survey questions include "free text" boxes where you can leave additional comments, and you may wish to use these boxes to say whether your answers to specific questions have been affected by Covid-19 and would have been different before the pandemic.

### Confidentiality

The survey is **completely voluntary and anonymous**. Your survey responses **cannot be traced back** to you personally. In order to ensure full anonymity in the survey, it is not possible for you to start the survey, save some responses and return to complete the survey later. This would require the survey system to be

able to identify you by your email or IP address. So you need to complete the survey in one go.

**Thank you for taking the time to do the survey, which should take 5-10 minutes.**

**Use of the Survey**

UCL has undertaken in writing not to use any information collected in its research, save with the express consent of the Chief Coroner. The anonymised, collated data will be held by the Chief Coroner's Office.

Publication or disclosure, either in whole or in part, of any survey findings may be included in materials submitted to public bodies. Disclosure of submitted information may also be requested in accordance with, for instance, the Freedom of Information Act 2000 or the Freedom of Information (Scotland) Act 2001. Where such disclosure is sought UCL and/or the Chief Coroner's Office undertake to take such steps as appropriate and as they believe applicable to seek exemptions from such disclosure.

**Your participation in this survey and your answers to the following questions will be extremely helpful.**

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Start

# Coroner Attitude Survey 2020

## Your Judicial Post

1. **Please indicate which is the main post you currently hold.**

   **(*If you have multiple posts please select what you consider is your main post and you can provide any further details in the box below*)**

   - ○ Assistant Coroner
   - ○ Area Coroner
   - ○ Senior Coroner
   - ○ Other (please specify in box below)

2. **Are you:**

   - ○ Salaried full-time coroner
   - ○ Salaried part-time coroner
   - ○ Fee paid coroner
   - ○ Other (please specify in the box below)

3. **When were you first appointed to a coroner's post?**

   - ○ Before 1995
   - ○ 1995 - 1999

- ○ 2000 - 2004
- ○ 2005 - 2009
- ○ 2010 - June 2013
- ○ July 2013 - 2015
- ○ 2016 - 2018
- ○ 2019 - 2020

4. **How long have you been in your current coroner post (ie, the post you indicated in Question 1)?**

- ○ Less than 1 year
- ○ 1-5 years
- ○ 6-10 years
- ○ 11-15 years
- ○ 16-20 years
- ○ 21-25 years
- ○ 26-30 years
- ○ Over 30 years

5. **Do you currently hold any judicial post in addition to the coroner post you have indicated in Question 1 above?**

- ○ No
- ○ Yes (please feel free to provide details in the box below - but it is not required)

Back Next

# Coroner Attitude Survey 2020

## Working Conditions

6. **How would you rate working conditions as a coroner compared with 5 years ago?**

- ○ Significantly better
- ○ Better
- ○ About the same
- ○ Worse
- ○ Significantly worse
- ○ Not applicable to me (I was not a coroner 5 years ago)

7. **Please provide an assessment of the following working conditions at the main court or coroner's office where you work (and NOT in relation to remote working from home).**

| | Excellent | Good | Adequate | Poor |
|---|---|---|---|---|
| Amount of administrative support | ○ | ○ | ○ | ○ |
| Quality of administrative support | ○ | ○ | ○ | ○ |
| Morale of court staff | ○ | ○ | ○ | ○ |
| Physical quality of the building | ○ | ○ | ○ | ○ |
| Maintenance of the building | ○ | ○ | ○ | ○ |
| Physical quality of your personal work space | ○ | ○ | ○ | ○ |
| Space to meet and interact with other coroners | ○ | ○ | ○ | ○ |
| Security at your court | ○ | ○ | ○ | ○ |

8. **How would you assess your case workload over the last 12 months?**

- ○ Too high
- ○ Manageable
- ○ Too low

9. **How would you assess your workload that does not include your casework over the last 12 months?**

- ○ Too high
- ○ Manageable
- ○ Too low
- ○ I do not have any work outside of my casework

10. **To what extent do you feel the following are important to you?**

| | Important | Not sure | Not important |
|---|---|---|---|
| Opportunities for flexible working hours | ○ | ○ | ○ |
| Opportunities to work part-time | ○ | ○ | ○ |
| Time to discuss work with colleagues | ○ | ○ | ○ |
| Opportunities to sit in other jurisdictions | ○ | ○ | ○ |
| Opportunities for career progression | ○ | ○ | ○ |
| Support for dealing with stressful conditions at work | ○ | ○ | ○ |
| Training opportunities | ○ | ○ | ○ |

11. **Please assess the availability of each of the following in your current coroner post:**

| | Excellent | Good | Adequate | Poor | Non-existent |
|---|---|---|---|---|---|
| Opportunities for flexible working hours | ○ | ○ | ○ | ○ | ○ |
| Opportunities to work part-time | ○ | ○ | ○ | ○ | ○ |

| | | | | | |
|---|---|---|---|---|---|
| Time to discuss work with colleagues | ○ | ○ | ○ | ○ | ○ |
| Opportunities to sit in other jurisdictions | ○ | ○ | ○ | ○ | ○ |
| Opportunities for career progression | ○ | ○ | ○ | ○ | ○ |
| Support for dealing with stressful conditions at work | ○ | ○ | ○ | ○ | ○ |
| Training opportunities | ○ | ○ | ○ | ○ | ○ |

Please feel free to provide any further comments on these issues

12. **During the Covid-19 emergency how often are you coming into work at your court or coroner's office?**

- ○ All of the time
- ○ Most of the time
- ○ Occasionally
- ○ Not at all

Please feel free to provide any further comments

Back Next

# Coroner Attitude Survey 2020

## Welfare

13. **Are you ever concerned about your personal security as a result of your work as a coroner?**

**(*Please select as many options as apply to you*)**

- [ ] Yes, sometimes when I am in court
- [ ] Yes, sometimes outside of court
- [ ] Yes, sometimes on social media
- [ ] No

Please feel free to comment about your personal security as a coroner

14. **Do you feel you would benefit from more guidance or assistance on any of the following?**

| | Yes I would like more guidance on this | Not sure | No I don't need more guidance on this |
|---|---|---|---|
| How to ensure my safety in court | ○ | ○ | ○ |
| How to ensure my safety out of court | ○ | ○ | ○ |
| How to deal with internet and social media coverage about my work as a coroner | ○ | ○ | ○ |
| How to safely use the internet and social media as a coroner | ○ | ○ | ○ |

Please feel free to comment about assistance on these or any other welfare issue

15. **Which of the following do you consider significant sources of stress in your job as a coroner?**

***Please select as many options as reflect your view.***

- [ ] Isolation of the job
- [ ] Lack of a professional support network
- [ ] Pressure of making rulings
- [ ] Dealing with media coverage of inquests
- [ ] Concern about letting families down
- [ ] Likelihood of decisions being challenged
- [ ] Having to watch graphic visual evidence
- [ ] 24/7 nature of the work
- [ ] Sole focus on death
- [ ] Criticism for delay in releasing the body
- [ ] Other (please specify in the box below)

16. **If you have a declared disability, have you requested that reasonable adjustments be made at your court to enable you to do your job to the best of your ability?**

- ( ) Yes
- ( ) No
- ( ) Not applicable to me

If you answered YES, please indicate in the box below if the adjustments

requested have been made to your satisfaction:

Back Next

# Coroner Attitude Survey 2020

Questions 16 and 17 are for Senior Coroners and Area Coroners only

Question 18 is for fee-paid Assistant Coroners only

## Salary and Pensions

17. **This question is for Senior and Area Coroners only**

**Senior and Area Coroners: Please indicate how much you agree or disagree with the following statements**

| | Strongly agree | Agree | Not sure | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| I am paid a reasonable salary for the work I do. | ○ | ○ | ○ | ○ | ○ |
| I have had a loss of net earnings over the last 2 years. | ○ | ○ | ○ | ○ | ○ |
| The salary issue is affecting my morale. | ○ | ○ | ○ | ○ | ○ |
| The salary issue is affecting the morale of coroners I work with. | ○ | ○ | ○ | ○ | ○ |
| My pay and pension entitlement does not adequately reflect the work I have done and will do before retirement. | ○ | ○ | ○ | ○ | ○ |
| The amount of out of hours work required to do the job is affecting me. | ○ | ○ | ○ | ○ | ○ |
| If I could earn additional income through out of court work I would pursue this option. | ○ | ○ | ○ | ○ | ○ |
| I follow closely the developments about judicial pensions. | ○ | ○ | ○ | ○ | ○ |

| | | | | | |
|---|---|---|---|---|---|
| I follow closely the developments about the tax implications on pension contributions for coroners | ○ | ○ | ○ | ○ | ○ |
| I would like to know more about developments in judicial pensions. | ○ | ○ | ○ | ○ | ○ |

18. **This question is for Senior and Area Coroners only.**

**Prior to my appointment as a salaried coroner, I was earning:**

- ○ Substantially less than my coroner salary on appointment
- ○ Less than my coroner salary on appointment
- ○ About the same as my coroner salary on appointment
- ○ More than my coroner salary on appointment
- ○ Substantially more than my coroner salary on appointment
- ○ I am not a salaried coroner

19. **This question is for fee-paid Assistant Coroners only**

**Assistant Coroners: Please indicate how much you agree or disagree with the following statements.**

| | Strongly agree | Agree | Not sure | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| I am paid a reasonable fee for the work I do | ○ | ○ | ○ | ○ | ○ |
| The fee issue is affecting my morale | ○ | ○ | ○ | ○ | ○ |
| The fee issue is affecting the morale of coroners I work with | ○ | ○ | ○ | ○ | ○ |
| My fee and pension entitlement does not adequately reflect the work I have done and will do before retirement | ○ | ○ | ○ | ○ | ○ |
| (If you are part of the local authority pension scheme) The pension is | ○ | ○ | ○ | ○ | ○ |

| | | | | | |
|---|---|---|---|---|---|
| reasonable for the work done | | | | | |

Back Next

# Coroner Attitude Survey 2020

## Resources & Digital Working

20. **Please provide an assessment of the following IT resources available to you at the main Coroner's Court where you work:**

| | Excellent | Good | Adequate | Poor | Non-existent |
|---|---|---|---|---|---|
| Standard of IT equipment provided for you personally to use (ie, laptop, desktop computer) when working at court | ○ | ○ | ○ | ○ | ○ |
| Standard of IT equipment available to you for working remotely | ○ | ○ | ○ | ○ | ○ |
| Standard of IT equipment used in your court (eg, video playback and live link equipment) | ○ | ○ | ○ | ○ | ○ |
| Internet access in your court building | ○ | ○ | ○ | ○ | ○ |
| Internet access when working remotely | ○ | ○ | ○ | ○ | ○ |
| IT support when working in your court building | ○ | ○ | ○ | ○ | ○ |
| IT support when working remotely | ○ | ○ | ○ | ○ | ○ |

Please feel free to provide any further details

21. **This question asks about your access to different digital resources:**

| | Yes | No |
|---|---|---|
| Are you regularly required to use an electronic case system? | ○ | ○ |

| | | |
|---|---|---|
| Are you on e-Judiciary? | ◯ | ◯ |
| Does your court have Wi-Fi available in court? | ◯ | ◯ |
| Does your court have Wi-Fi in all other parts of the court building? | ◯ | ◯ |

Please feel free to provide any further details

22. **Please rate the following:**

| | Excellent | Good | Adequate | Poor | Non-existent |
|---|---|---|---|---|---|
| Usability of the electronic case system | ◯ | ◯ | ◯ | ◯ | ◯ |
| Availability of training on electronic case systems | ◯ | ◯ | ◯ | ◯ | ◯ |
| Quality of training on electronic case system | ◯ | ◯ | ◯ | ◯ | ◯ |
| Functionality of e-Judiciary | ◯ | ◯ | ◯ | ◯ | ◯ |
| Quality of Wi-Fi in your court | ◯ | ◯ | ◯ | ◯ | ◯ |

Please feel free to provide any further details

Back Next

# Coroner Attitude Survey 2020

## Training and Personal Development

23. **To what extent are you satisfied with the following aspects of your coroner role:**

| | Completely satisfied | Satisfied | Could be better | Not satisfied at all |
|---|---|---|---|---|
| Sense of achievement in the job | ○ | ○ | ○ | ○ |
| Challenge of the job | ○ | ○ | ○ | ○ |
| Variety of work | ○ | ○ | ○ | ○ |
| Opportunities for career progression | ○ | ○ | ○ | ○ |
| Cross deployment opportunities | ○ | ○ | ○ | ○ |
| Opportunities for regular personal review of my coroner role with someone in a leadership position | ○ | ○ | ○ | ○ |

Please feel free to provide any further comments on these specific issues

24. **To what extent are you satisfied with the following aspects of training as a coroner:**

| | Completely satisfied | Satisfied | Could be better | Not satisfied at all |
|---|---|---|---|---|
| Range of training available | ○ | ○ | ○ | ○ |
| Quality of training available | ○ | ○ | ○ | ○ |
| Time available to undertake training | ○ | ○ | ○ | ○ |

| | | | | |
|---|---|---|---|---|
| Time to prepare for training courses | ○ | ○ | ○ | ○ |
| Local authority support for coroner training | ○ | ○ | ○ | ○ |

Please feel free to provide any further comments on these specific issues

25. **In which, if any, of the following areas would you welcome coroner training opportunities?**

***(Please select as many options as apply to you)***

- ☐ Wellbeing for coroners
- ☐ Media handling
- ☐ Presentation and communication skills
- ☐ Leadership and managing others
- ☐ Joint local training with courts
- ☐ Understanding statistics in inquests
- ☐ Hands on training using IT in court
- ☐ Conducting remote hearings
- ☐ Other (please specify in the box below)

Back Next

# Coroner Attitude Survey 2020

## Change in the Coroners Service

26. **To what extent do you feel that your job as a coroner has changed since you were first appointed to a coroner post? *(This question should be answered without taking into account any recent changes that may have occured in your job as a result of Covid-19)***

- ○ It has not changed at all
- ○ It has only changed a very small amount and this does not affect me
- ○ There has been some change which affects me
- ○ There has been a large amount of change
- ○ It has changed completely

27. **The following explore your view of changes in your job as a coroner.**

**(*If possible please provide a response to each statement*)**

| | Strongly Disagree | Disagree | Not sure | Agree | Strongly Agree |
|---|---|---|---|---|---|
| The judiciary was managing change well before Covid-19. | ○ | ○ | ○ | ○ | ○ |
| The judiciary is managing change well during Covid-19. | ○ | ○ | ○ | ○ | ○ |
| Too much change has been imposed on the judiciary in recent years. | ○ | ○ | ○ | ○ | ○ |
| More change is still needed in the judiciary. | ○ | ○ | ○ | ○ | ○ |
| The amount of change in recent years has brought judges to | ○ | ○ | ○ | ○ | ○ |

| | | | | | |
|---|---|---|---|---|---|
| breaking point. | | | | | |
| The judiciary needs to have control over policy changes that affect judges. | ○ | ○ | ○ | ○ | ○ |
| Despite any reservations I may have about changes in the judiciary I still enjoy my job as a judge. | ○ | ○ | ○ | ○ | ○ |

28. **How concerned are you by each of these issues affecting the role of the coroner?**

| | Not concerned at all | Only slightly concerned | Not sure | Somewhat concerned | Extremely concerned |
|---|---|---|---|---|---|
| Lack of a national coroner service | ○ | ○ | ○ | ○ | ○ |
| Personal security for coroners | ○ | ○ | ○ | ○ | ○ |
| Personal security for coroner's officers and staff | ○ | ○ | ○ | ○ | ○ |
| Lack of a common so"ware programme for cases | ○ | ○ | ○ | ○ | ○ |
| Low morale amongst coroners | ○ | ○ | ○ | ○ | ○ |
| Stressful working conditions | ○ | ○ | ○ | ○ | ○ |

Please feel free to provide any further comment:

Back Next

# Coroner Attitude Survey 2020

## Future Planning

29. **Might you consider leaving the coroners service in the next 5 years?**

- ○ Yes
- ○ No
- ○ I am currently undecided about this
- ○ I will reach compulsory retirement age in the next 5 years but plan to leave before that date.
- ○ I will reach compulsory retirement age in the next 5 years and plan to stay until that date.

30. **On 1 April 2020, what was your age in YEARS and MONTHS?**

**On 1 April 2020, my age was** _____ **years and** _____ **months**

31. **The following explore your views on retirement from the coroners service:**

| | Strongly Disagree | Disagree | Not sure | Agree | Strongly Agree |
|---|---|---|---|---|---|
| Coroners should not be required to retire at 70. | ○ | ○ | ○ | ○ | ○ |
| The main reason I would leave the coroners service before the compulsory retirement age is to do other things while I am able. | ○ | ○ | ○ | ○ | ○ |
| The main reason I would leave the coroners service before compulsory retirement age is dissatisfaction with my job as a coroner. | ○ | ○ | ○ | ○ | ○ |

Please feel free to provide any further comments

32. **Which of the following factors would make you more likely to leave the coroners service before reaching compulsory retirement age?**

**(*Please select as many options as apply to you*).**

- [ ] Increase in workload
- [ ] Limited opportunities for promotion
- [ ] Limits on pay awards
- [ ] Reduction in pension benefits
- [ ] Lack of respect for coroners by government
- [ ] Reduction in administrative support
- [ ] Further demands for out of hours working
- [ ] Introduction of online courts
- [ ] Lack of stimulating work
- [ ] Increase in unrepresented interested persons
- [ ] Lack of effective leadership of the judiciary
- [ ] Stressful working conditions
- [ ] Inability to move to salaried part-time working
- [ ] Requirement to sit in a location too far from home
- [ ] Attacks on coroners by the media
- [ ] Court closures
- [ ] Personal health issues
- [ ] Inability to work more flexible hours
- [ ] Personal security concerns

- [ ] 24/7 nature of the work
- [ ] Sole focus on death
- [ ] Nature of the evidence heard
- [ ] Attitudes of judges in related proceedings in criminal or family courts
- [ ] Uncertainty over the future of my part of the judiciary
- [ ] Other (please specify in the box below)

Please feel free to provide a further comment:

33. **Which of the following factors would make you more likely to remain in the coroners service until compulsory retirement age?**

**(*Please select as many options as apply to you*).**

- [ ] Appointment to a higher post
- [ ] Change of work location
- [ ] Higher remuneration
- [ ] Better administrative support
- [ ] Reduction in workload
- [ ] Increased flexibility in working hours
- [ ] Greater variation in work
- [ ] Having more leadership responsibilities
- [ ] Greater certainty over the future of my part of the judiciary
- [ ] Support for dealing with stressful working conditions
- [ ] Opportunity for sabbatical
- [ ] Opportunity to work part-time
- [ ] Increase in families being represented at inquests

- [ ] Better security for coroners
- [ ] Greater respect for the work coroners do
- [ ] Incorporation of Coroners Service into Courts & Tribunals Service
- [ ] Other (please specify in the box below)

Please feel free to provide a further comment:

Back Next

# Coroner Attitude Survey 2020

## Being a Member of the Coroners Service

34. **As a coroner, to what extent do you feel valued by the following groups?**

| | Greatly valued | Generally valued | Not sure | Generally not valued | Not valued at all |
|---|---|---|---|---|---|
| Public | ○ | ○ | ○ | ○ | ○ |
| Government | ○ | ○ | ○ | ○ | ○ |
| Courts & Tribunal judiciary | ○ | ○ | ○ | ○ | ○ |
| Local authority in my area | ○ | ○ | ○ | ○ | ○ |
| Families in inquests I conduct | ○ | ○ | ○ | ○ | ○ |
| Counsel in inquests I conduct | ○ | ○ | ○ | ○ | ○ |
| Court staff | ○ | ○ | ○ | ○ | ○ |
| Media | ○ | ○ | ○ | ○ | ○ |
| Coroner colleagues at my court | ○ | ○ | ○ | ○ | ○ |
| Chief Coroner | ○ | ○ | ○ | ○ | ○ |

Please feel free to provide any further comments

35. **Coroners are respected by society at large**

- ○ Less than they were 5 years ago
- ○ About the same as they were 5 years ago

- ◯ More than they were 5 years ago

Please feel free to provide any further comments

36. **The following explore your views of your work as a coroner.**

| | Strongly disagree | Disagree | Not sure | Agree | Strongly agree |
|---|---|---|---|---|---|
| As a coroner I feel I provide an important service to society | ◯ | ◯ | ◯ | ◯ | ◯ |
| I feel a strong personal attachment to being a member of the coroners service | ◯ | ◯ | ◯ | ◯ | ◯ |
| I feel I have an important job that I am committed to doing as well as I possibly can | ◯ | ◯ | ◯ | ◯ | ◯ |
| I consider myself to be a judge | ◯ | ◯ | ◯ | ◯ | ◯ |
| I feel part of the judiciary of England and Wales | ◯ | ◯ | ◯ | ◯ | ◯ |
| Legal representatives at inquests do not consider me to be a judge | ◯ | ◯ | ◯ | ◯ | ◯ |

Back Next

# Coroner Attitude Survey 2020

## Inquests and the Coroner's Role

37. **Which of the following do you feel are the most important functions of the coroner?**

***Please select as many options as reflect your view***

- [ ] To publicly investigate deaths
- [ ] To prevent future fatalities
- [ ] To be an advocate for the dead
- [ ] To facilitate closure for families
- [ ] To identify good practice in medical care or first response
- [ ] To provide accountability for deaths
- [ ] To rule out homicide
- [ ] To provide answers for the family and the public as to how the deceased died
- [ ] Other (please specify in the box below)

38. **How often are the following used in inquests you conduct?**

| | Always | Frequently | Occasionally | Rarely | Never |
|---|---|---|---|---|---|
| Special measures | ○ | ○ | ○ | ○ | ○ |
| Ground rules hearings | ○ | ○ | ○ | ○ | ○ |
| Juries | ○ | ○ | ○ | ○ | ○ |

39. **Which of the following do you feel are appropriate at inquests?**

***Plesae select as many options as reflect your view***

- [ ] A family member provides a pen portrait of the deceased when giving evidence
- [ ] A family member displays a photograph of the deceased when giving evidence
- [ ] The bereaved are invited to explain how the death has affected them
- [ ] Other witnesses are invited to explain how the death has affected them

Please feel free to provide any further comments here

40. **The following statements explore your views on inquests and the role of the coroner?**

| | Strongly agree | Agree | Not sure | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| When the family is unrepresented and other interested persons are represented, my role requires me to level the playing field. | ○ | ○ | ○ | ○ | ○ |
| The inquest can be a cathartic process for families and others involved in a death. | ○ | ○ | ○ | ○ | ○ |
| There is no need for all inquests to be concluded with a hearing. | ○ | ○ | ○ | ○ | ○ |
| PFD reports are effective in preventing future deaths. | ○ | ○ | ○ | ○ | ○ |
| It is not really useful to use juries at inquests. | ○ | ○ | ○ | ○ | ○ |
| There should be a national coroner service. | ○ | ○ | ○ | ○ | ○ |

# Coroner Attitude Survey 2020

## Joining the Coroner's Service

41. **Knowing what you know now about your job as a coroner would you still have applied for a coroner's post?**

- ○ Yes
- ○ No
- ○ Not sure

42. **Would you encourage suitable people to apply to be a coroner?**

- ○ Yes
- ○ No
- ○ Not sure

Please feel free to provide any further comments

43. **The reasons I would encourage suitable people to apply to join the Coroner's Service are:**

**(*Please select as many options as reflect your view*)**

- ☐ Challenge of the work
- ☐ Sense of collegiality
- ☐ Job security
- ☐ Intellectual satisfaction
- ☐ Salary

- [ ] Public service
- [ ] Respect in the community
- [ ] Pension
- [ ] Administrative support
- [ ] Less pressurised environment than practice
- [ ] Prestige of the job
- [ ] Chance to contribute to justice being done
- [ ] Supportive local authority
- [ ] Supportive police force
- [ ] Other (please specify in the box below)

Please feel free to provide a further comment:

44. **The reasons I would <u>discourage</u> suitable people from applying to join the Coroner's Service are:**

**(*Please select as many options as reflect your view*)**

- [ ] Isolation of the job
- [ ] Constant policy changes
- [ ] Lack of variety in the work
- [ ] Lack of respect for coroners
- [ ] Experience of changes to pension entitlements
- [ ] Lack of personal control over working time
- [ ] Reduction in income
- [ ] Lack of administrative support
- [ ] Poor quality of physical work environment

- [ ] Feeling of being an employee or civil servant
- [ ] Appointments process
- [ ] Too much out of hours work required to do the job
- [ ] Lack of support from local authorities
- [ ] Lack of support from police
- [ ] Rigid hierarchical work environment
- [ ] Too few opportunities for promotion
- [ ] Feeling of being second best compared to judges
- [ ] Constant dealing with death and grief
- [ ] Other (please specify in the box below)

Please feel free to provide a further comment:

Back Next

# Coroner Attitude Survey 2020

## Leadership

45. **Please indicate if you currently:**

***(Please tick as many answers as apply to you)***

- [ ] hold a formal leadership position in the judiciary (e.g., as a Senior Coroner, an officer in the CSEW, chairing a regional group of coroners, part of one of the specialist cadre of coroners on DVI, Military Deaths, etc)?
- [ ] undertake any additional responsibilities as a judge that are not formal leadership roles (e.g., Judicial College duties as a Course Director, Syndicate leader, part of a local resilience forum or local trainer, etc.)?

46. **Would you be interested in taking on more leadership responsibilities in your judicial role?**

- [ ] Yes
- [ ] Yes but there are none available in my jurisdiction
- [ ] I would be interested if leadership roles were properly rewarded
- [ ] No a leadership role is not for me
- [ ] No I have (or have had) enough leadership responsibilities already
- [ ] Not at the present time but possibly in future
- [ ] Not sure

47. **Do you feel that judicial leadership roles are allocated fairly?**

- ○ Yes
- ○ No
- ○ I do not know enough about how it is done to say

If you answered No please feel free to provide reasons why

48. **The following explore your views of your immediate leadership judge(s):**

| | Strongly Agree | Agree | Not sure | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| I would like my immediate leadership judge to help me evaluate how I am performing as a judge | ○ | ○ | ○ | ○ | ○ |
| I would like to be able to discuss my career development with my immediate leadership judge | ○ | ○ | ○ | ○ | ○ |
| I would like to be able to speak with someone other than my immediate leadership judge about my career development. | ○ | ○ | ○ | ○ | ○ |
| Case allocation is done fairly by my local leadership judge | ○ | ○ | ○ | ○ | ○ |
| I receive good support from my immediate leadership judge | ○ | ○ | ○ | ○ | ○ |

Please feel free to provide any further comments

49. **How helpful has the creation of the position of Chief Coroner been for any of the following?**

| | Helpful | Not sure | Not helpful |
|---|---|---|---|
| Increasing coroners' welfare | ○ | ○ | ○ |
| Increasing consistency across the coroners service | ○ | ○ | ○ |
| Providing guidance to coroners | ○ | ○ | ○ |

| | | | |
|---|---|---|---|
| Enhancing public perception of the role of coroners | ○ | ○ | ○ |
| Creating stronger links with the courts & tribunals judiciary | ○ | ○ | ○ |
| Establishing leadership within the coroners service | ○ | ○ | ○ |

Please feel free to provide any further comments on this issue here

Back Next

## Covid-19 and this Survey

50. **The 2020 Coroner Attitude Survey is being run during the Covid-19 emergency, and you are welcome to provide any further comments in the box below about how, if at all, your answers to this survey may have been affected by Covid-19.**

Back Next

## General Information

51. **What is the main geographic region where you sit as a coroner?**

- ○ London
- ○ Eastern
- ○ East Midlands
- ○ West Midlands
- ○ North East
- ○ North West
- ○ South East
- ○ South West
- ○ Yorkshire and the Humber
- ○ Wales

Please feel free to provide a further comment:

52. **Before joining the Coroner's Service what type of legal engagement or other work were you in?**
**(*Please tick as many answers as apply to you*)**

- ☐ Barrister
- ☐ Employed lawyer
- ☐ Legal academic
- ☐ Legal executive

- [ ] QC
- [ ] Solicitor
- [ ] Medical professional (please indicate your medical specialism in the box below)
- [ ] Other (please specify in the box below if you would like to)

53. **This Question is for PART-TIME FEE PAID Coroners ONLY**

**As well as being a part of the Coroner's Service, what type of legal engagement or other work do you continue to engage in?**

***Please tick as many answers as apply to you***

- [ ] Barrister (self employed)
- [ ] Barrister (employed)
- [ ] Solicitor
- [ ] Legal Executive
- [ ] Legal Academic
- [ ] Other (please specify in the box below)

54. **Are you:**

- ( ) Male
- ( ) Female

- ○ Other

55. **What is your age group?**

- ○ Under 35
- ○ 35-39
- ○ 40-44
- ○ 45-49
- ○ 50-54
- ○ 55-59
- ○ 60-62
- ○ 63-65
- ○ 66-67
- ○ 68-69
- ○ 70 or over

56. **Do you have any of the following?**

- ☐ Children you support financially
- ☐ Caring responsibilities for a family member(s)?

57. **This question asks about your education experience**

***(Please tick as many boxes as apply to you)***

- ☐ Secondary education - I attended a UK state school
- ☐ Secondary education - I attended a UK independent/fee-paying school
- ☐ Secondary education - I attended a school outside the UK
- ☐ Secondary education - other
- ☐ University - I was part of the first generation of my family to attend university

- [ ] University - I was not part of the first generation of my family to attend university
- [ ] Other (please specify in the box below)

58. **What is your ethnic group?**

- ○ White - English
- ○ White - Welsh
- ○ White - Scottish
- ○ White - Irish
- ○ White - Other
- ○ Mixed - White and Black Caribbean
- ○ Mixed - White and Black African
- ○ Mixed - White and Asian
- ○ Mixed - any other mixed background
- ○ Asian - Indian
- ○ Asian - Pakistani
- ○ Asian - Bangladeshi
- ○ Asian - Chinese
- ○ Asian - any other Asian background
- ○ Black - Caribbean
- ○ Black - African
- ○ Black - any other Black background
- ○ Arab
- ○ Any other ethnic group

Back Next

## The Survey

59. **This survey was:**

- ○ Too long
- ○ About the right length
- ○ Not long enough

60. **How long did it take you to complete this survey?**

- ○ No more than 5 minutes
- ○ Less than 10 minutes
- ○ Less than 15 minutes
- ○ Less than 20 minutes
- ○ Less than 30 minutes
- ○ 30 minutes or longer

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Back Finish

Thank you for taking part in the 2020 Coroner Attitude Survey. Your answers have now been received.

Your participation has been extremely valuable and very much appreciated.

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# Appendix 2

**From:** chiefcoronersoffice
**Date:** Thursday, 21 May 2020 at 15:16
**To:** chiefcoronersoffice
**Subject:** Coroner Attitude Survey 2020 - Launch 27 May 2020

Dear Coroner,

I am pleased to announce that next week, **Wednesday 27 May 2020**, will be the launch of the Coroner Attitude Survey. This first ever Coroner Attitude Survey (CAS) was scheduled to run this spring, and despite the challenges we are all currently facing as a result of Covid-19, it was felt that it was important to carry on with the survey. Our work as coroners has carried on through the emergency, and it remains as important as ever to understand how coroners feel about their role, their working lives and their plans for the future.

The survey is being run by the Judicial Institute of University College London (UCL JI). This independent academic Institute runs the UK Judicial Attitude Survey for England and Wales, Scotland and Northern Ireland, and the survey will be open to **ALL** coroners in England and Wales. The Judicial Attitude Survey has not previously been extended to coroners and therefore, this is an exciting opportunity for coroners to provide their thoughts, views and attitudes by taking part.

The Coroner Attitude Survey will be running alongside the Judicial Attitudes Survey, but the contents of the survey have been carefully adapted for coroners through a working group involving coroners and members of my office. This was to ensure that it was specific and relevant for coroners and the data captured will be useful in providing an overall picture of your attitudes towards your working lives as coroners.

The survey should take no longer than 10-15 minutes to complete and covers the following topics:

- Working attitudes
- Welfare
- Salary and Pensions
- Resources and digital working
- Training and personal development
- Change in the coroner's service
- Future planning
- Being a member of the Coroner's service
- Inquests and the coroner's role
- Joining the coroner's service
- Leadership

It also will collect general information about gender, ethnicity and age which will provide an insightful view of the diversity of the coroner world. However, as with any survey you can only extract what is put in, so please do take the time to complete the survey which will be running until the 22 June 2020. I also encourage all senior and area coroners to make sure that all their assistant coroners also take part.

I want to reassure you that the survey is completely anonymous. It will not ask for any information that directly identifies you. The anonymised data are collected and analysed by the UCL JI to produce a report which will be held by my office. UCL have signed an undertaking which states that they cannot use this information in its research without my express permission. Where disclosure of any raw data is sought or disclosure of the report prior to publication, UCL and myself will take any necessary and appropriate steps believed applicable to seek exemptions from such disclosure.

The reports from the JAS 2016 and 2014 were published on the judicial websites and can be viewed at the following links:

**England and Wales and UK Tribunals:**
2016: https://www.judiciary.uk/wp-content/uploads/2017/02/jas-2016-england-wales-court-uk-tribunals-7-february-2017.pdf
2014: https://www.judiciary.uk/wp-content/uploads/2015/02/jac-2014-results.pdf

**Scotland**
2016: http://www.scotland-judiciary.org.uk/Upload/Documents/JudicialAttitudeSurvey2016Scotland23October2016.pdf
2014: http://www.scotland-judiciary.org.uk/Upload/Documents/JudicialAttitudeSurvey2014Scotland.pdf

**Northern Ireland**
2016: https://judiciaryni.uk/sites/judiciary/files/media-files/Judicial%20Attitude%20Survey%202016%20Northern%20Ireland%20Report%20%28Final%29%209.11.16.pdf
2014: https://judiciaryni.uk/sites/judiciary/files/media-files/Judicial%20Attitude%20Survey%202014%20Northern%20Ireland%20Report%2018.11.14.pdf

It is my intention to publish the report of the results from the Coroners Attitude Survey in line with the other branches of the judiciary. This report will follow the format of those above and will be completely anonymous.

I shall be sending the link to the survey next week which I hope you will look out for.

Your assistance in completing the survey will be greatly appreciated.

Yours sincerely

HH JUDGE MARK LUCRAFT QC
THE RECORDER OF LONDON AND
CHIEF CORONER

Royal Courts of Justice,
Strand, London WC2A 2LL

# Appendix 3

**From:** chiefcoronersoffice
**Date:** Wednesday, 27 May 2020 at 11:17
**To:** chiefcoronersoffice
**Subject:** Launch of the 2020 Coroner Attitude Survey today

**The 2020 Coroner Attitude Survey (CAS) launches today.**
**You can fill in the survey by clicking this link: https://opinio.ucl.ac.uk/s?s=66052**
**I am asking that all coroners in England and Wales take the time to fill it in, even though I understand how busy you all are.**

Although there have been surveys of this type conducted with other branches of the judiciary in the past, this is the first time the survey has been extended to coroners. The 2020 CAS is running alongside the **2020 Judicial Attitude Survey (JAS)** for salaried judges in the Courts and Tribunals across the UK. Both the Chief Coroner and the Lord Chief Justice agree it is important that this survey and one for the courts and tribunals judiciary are run at the same time.

The survey has been developed by the Judicial Institute of University College London (UCL) on behalf of the Chief Coroner through a Working Group with representatives from the Coroners Service.

**Why it is important for you to take part in this survey**

By completing this survey you will be ensuring that coroners' views are taken into account in important decisions about the future of the service. You may wonder why we are running the survey in the midst of the Covid-19 pandemic. The Coroner Attitude Survey had been scheduled to be run this spring, and despite the challenges we all face as a result of Covid-19, it was felt that it was important to carry on with it. Our work as coroners has carried on through the emergency, and it remains as important as ever to understand how coroners feel about their role, their working lives and their plans for the future.

The survey is **completely voluntary and anonymous**, and **should take only 5-10 minutes to complete.**

**Your participation in this survey and your answers to the survey questions will be extremely helpful.**

Many thanks,

His Honour Judge Mark Lucraft QC
The Recorder of London and
Chief Coroner of England and Wales