



CHIEF CORONER

**HIS HONOUR JUDGE PETER THORNTON QC, CHIEF CORONER**

**ANNUAL CONFERENCE**

**THE CORONERS' SOCIETY OF ENGLAND AND WALES**

**21 SEPTEMBER 2012**

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1. Mr President. Ladies and Gentlemen. Coroners.
2. 'Coroner' - that is a good word, with an ancient and fine heritage. I am very proud to have that word in my title and I am delighted to have the opportunity to give my first major speech as the Chief Coroner of England and Wales to coroners at the Annual Conference of the Coroners' Society of England and Wales.
3. The Society is a splendid and valuable organization. For more than 165 years it has represented the interests of coroners, supporting them, informing them, discussing with them, suggesting to them, arguing with them - in a way which is unique and clearly wholly admirable. The indefatigable work on a daily basis of its Secretary, its Officers and its Committee Members on behalf of coroners is truly inspirational. I congratulate the Society for all it does and I know will continue to do in your interests. As Chief Coroner I applaud the work of the Society.
4. Of course, as you know, there very nearly was no Chief Coroner at all. The Coroners and Justice Act 2009 was created with broad all-party support. It is not the most radical of documents in terms of change, but at the heart of it was something new, two things new: the creation of a new post, the Chief Coroner, a High Court or Circuit judge; and a new system of appeals to the Chief Coroner against decisions of coroners.
5. After an open competition I was appointed Chief Coroner by the Lord Chief Justice who had consulted with the Lord Chancellor (as the Act requires). I received my letter of appointment on 6 May 2010. Unfortunately that was not an auspicious day for appointments. It was the day of the last general election. The new Government was not keen on having a Chief Coroner; in difficult times it was considered to be too expensive.
6. The civil servants came to see me with gloomy faces and I was very politely told to keep up the day job at the Old Bailey. It is not often that you get an

apology in person from the Lord Chief Justice and the Lord Chancellor two days running. They were really very nice about it.

7. The formal announcement that there would be no Chief Coroner was made by the then Minister, Jonathan Djanogly MP, in October 2010. So the Chief Coroner (and all his powers) was placed into Schedule 1 of the Public Bodies Bill - commonly known as 'the bonfire of the quangos' - for abolition. The House of Lords, in their amending and revising role, led by the impressive Baroness Finlay, a doctor (Dr Finlay) and professor of palliative medicine, voted in December 2010 by a very large majority to keep the Chief Coroner off the funeral pyre. But the Government remained unimpressed. In December 2011 the Public Bodies Bill was due to become law.
8. Meanwhile I had been appointed to conduct the inquest into the death of Ian Tomlinson who died during the G20 protests in the City of London in 2009. It was my first experience of the loneliness of the long-distance coroner.
9. However, the final twists in the Chief Coroner's tale came last year. In June the Government announced that the Chief Coroner would be moved from Schedule 1 to Schedule 5 of the Public Bodies Bill so that some of the Chief Coroner's powers could be retained and distributed to the Lord Chief Justice and the Lord Chancellor. And finally in November of last year the post was re-created. Kenneth Clarke MP, then Lord Chancellor and Secretary of State for Justice, stated: 'The new post will be focused on working to deliver the reform to coroner's services that we all want to see and which I previously argued should be delivered by the Lord Chief Justice and myself.' I have not been told why that decision was made. There was certainly a lot of lobbying before it was made by the Royal British Legion and other groups. I do not propose to speculate.
10. There was, however, one major casualty. The Chief Coroner's appellate powers would not be implemented; they were specifically repealed in the Public Bodies Act. There has been some discussion about appeals since. However, Parliament has made its decision and I shall, of course, work within those parameters.
11. However, you do now have a Chief Coroner, for England and Wales. I took up my appointment on 17 September. I hope you will, at least at first, be more generous about me than Alun Michael MP (former Minister) was in the passage of the Coroners and Justice Bill when he said, considering the administrative side of the Chief Coroner's role: 'The Chief Coroner is a judge, so he is not necessarily competent to run anything.' I make no comment about that. I am a judge, a Senior Circuit Judge, and perhaps in my defence I could say that the Brodrick Committee which reported in 1971 into *Death Certification and Coroners* was chaired by Norman Brodrick, also a judge of the Central Criminal Court.
12. It is my purpose as Chief Coroner to provide leadership for the coroner system, to implement and develop reform, to create a more coordinated and accountable system, all with a national consistency and quality of standards and approach.
13. Under the 2009 Act I am accountable to the Lord Chief Justice, who can hire and fire the Chief Coroner, and I must report annually to the Lord Chancellor. I have statutory functions and duties, but I, like you, am an independent

judicial office holder and I am therefore independent of Government, central and local. That does not mean that I will not co-operate with Government. I will. Under the Act the Lord Chancellor must consult me about certain things. I must consult him about certain things.

14. Indeed my approach to all I do will be collaborative - not just with the new Lord Chancellor, Chris Grayling MP, and Minister Helen Grant MP, but with all of you and all those closely involved in the coroner process.
15. Therefore since my re-appointment on 22 May 2012 I have been out and about. I have visited coroners' courts. I have talked to coroners, well listened mostly. I have listened to coroners officers and other staff, and local authority officers and managers (singly and in batches) and senior police and community representatives. I have listened to officers and volunteers from the Coroners' Courts Support Service. I have spoken with the Chair of the Independent Advisory Panel on Deaths in Custody and HM Chief Inspector of Prisons and the Director of Public Prosecutions.
16. I have been to the Royal British Legion, and spoken to INQUEST and other voluntary organisations. I have talked to the Defence Inquests Unit and been on the Ministry of Defence course at Warminster. I am now fully equipped to fire an AK 47, but hope that will not become a regular necessity in my new job.
17. I have discussed the implementation of the 2009 Act with the Ministry of Justice Coroner Reform Team, training with the Judicial College, and complaints with the Office of Judicial Complaints. I have talked to Tom Luce and Dame Janet Smith. And many more. And there are many more to come.
18. So far, at least, I have enjoyed my time enormously. I have not, of course, met all of you. But I would like to. Please do not hesitate to come up to me over the next couple of days and tell me what you have to say from your perspective. I need to know. I want to know.
19. And I would like to say right from the start, coroners, that I have been incredibly impressed by the dedication which you bring to your work. I have been truly moved by your devotion to duty, your conscientiousness, your sensitivity, your independence, your deep involvement in the whole coroner process. As my daughter would say, 'awesome'. 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.
20. But I suspect you would be the first to admit that the coroner system is not perfect. And many of you, talking to me, have acknowledged that there is a lack of consistency, a lack of leadership and a lack of guidance. I intend to address these problems.
21. My ten point plan for the next twelve months looks like this. –

### **(1) The Coroners and Justice Act 2009**

22. I shall oversee the implementation of the relevant parts of the Coroners and Justice Act 2009. It is a pity that coroners could not have had an Act of their own (as they have had in many statutes, including those in 1843, 1844, 1860, 1887, 1926, 1955, 1980 and 1988.). But never mind.

23. The coroner provisions of the 2009 Act (most of them at least) are expected to come into force in June 2013. Much of the Act consolidates earlier legislation. But there are a number of changes which are significant.

#### Coroner areas

24. Coroner districts will become coroner areas and the Lord Chancellor, after consultation, will be able to create larger or combined areas where appropriate. This will reduce the overall number of coroner areas, as was recommended in the Luce Review in 2003. In the short term 111 coroner areas will become 97 areas. In the meantime local authorities have been asked by the Ministry of Justice to give their views on further mergers; their responses are coming in.

#### Coroner nomenclature

25. There will be three types of coroner under the Act: senior coroner, area coroner and assistant coroner. Each coroner area will have a coroner in charge, named in the Act as 'the senior coroner' for the area. Each area may also have one or more 'area coroners', full or part time, with both senior and area coroners being salaried through the local authority. I can see no particular reason for using the term 'area coroner' widely. It is a little confusing and unnecessary. I envisage that each senior coroner, as before, will have one or more deputies (full or part time). Each deputy will be an area coroner under the Act but need not normally be referred to as an area coroner.
26. As at present the salaried coroners will be assisted by 'assistant coroners' who will be fee paid. All coroners - senior, area or assistant coroners (using the Act's nomenclature) - will broadly have the same powers and duties. So where the Act refers to the powers of the senior coroner it is referring to the powers held by all coroners.
27. Therefore, each coroner area will have a senior coroner, one or more deputy coroners (technically – area coroners) and also assistant coroners.

#### Appointments, terms and conditions

28. From commencement of the Act new appointments of coroners, of whichever rank, will be from lawyers only (under the strict five year judicial appointment condition) and all coroners will retire at 70. These provisions do not apply to existing coroners, although it does mean, for example, that an existing doctor assistant coroner could not in future step up to be a senior or deputy coroner without the necessary legal qualification.
29. All fresh appointments will be made by the local authority, with the consent of the Chief Coroner and the Lord Chancellor. The Lord Chancellor can also decide how many coroners are required in any one area. In other words senior coroners will no longer be making their own appointments (of deputies and assistants). There is not even a provision for the senior coroner to be consulted although I am sure he or she will be. And, although it is not in the Act, it is unlikely that spouses or partners will be permitted to be appointed in the same area.

30. The appointments change emphasises the fundamental significance of the local authority in the new regime. Most, if not all, local authorities now expect, and rightly in my view, a wholly collaborative approach from coroners. That is further underlined since the new Act (in Section 24) requires local authorities to secure the provision of such staffing and accommodation as 'are needed by the coroners for that area to carry out their functions'. This means that where there is reduced police authority funding, or none at all, the local authority will have a statutory duty to provide the appropriate level of staff and accommodation.
31. Local authorities also want - and I shall be consulting about this - to move towards everyone adopting a standardised set of terms and conditions for coroners and staff, with regularised appointment criteria and procedures. But this will take time and consultation. It does not mean that coroners will become Chief Officers or like Chief Officers. Coroners will retain their judicial independence, their unique judicial role, quite unlike any other. But they will work within the financial and administrative framework which is set up and run collaboratively between coroner and local authority (and also police authority).

#### Area flexibility

32. The Act also provides an increased flexibility as between areas, but only to a limited extent. In England all coroners will be area based (although deputies and assistants may be attached to more than one area). As now (under the transfer provisions of Section 14 of the Coroners Act 1988) a coroner may make a request for a coroner of another area to conduct the investigation into the death. The addition to this is that the Chief Coroner will have to be notified of every request and its outcome. And in any case the Chief Coroner can require any other coroner to conduct the investigation. In other words the Chief Coroner can direct in a particular case (or even types of cases) that the investigation will be carried out by a named coroner or a coroner taken from an approved list to deal with specific types of investigation. I shall return to this topic shortly.
33. The Secretary of State was rarely if ever invited to intervene in transfers; the Chief Coroner, however, will, I believe, be closer to the transfer process and will be able to influence a greater level of flexibility. That does not mean that I will want to intervene on a regular basis. I will not. Coroners should know when I will be likely to intervene so I shall consult for the purposes of giving guidance.
34. In the same way, I as Chief Coroner will have the power to step in and take over an investigation at any stage. I do not intend to do that frequently, only very occasionally. And I would prefer to do it by consent. Any senior coroner should feel free to ask - there is no stigma in doing so - for assistance from the Chief Coroner where appropriate.

#### Investigation

35. I have used the word 'investigation' because the new Act uses it extensively. The provisions of the current Act, the 1988 Act, centre around the inquest itself. But as all coroners know the inquest is just a small (albeit significant) part of the process. The 2009 Act therefore is framed to reflect largely current practice. The inquiry and the inquest therefore become all part of the process

of 'investigation'. Once an investigation is commenced there is a duty to hold an inquest, unless the investigation can be discontinued for good reason.

36. If the investigation is not completed within a year from the day on which the coroner is made aware that the body is within the coroner's area, the coroner must notify the Chief Coroner who must keep a register of notifications. The Act does not say so, but it is implied, that the notification must include reasons why the investigation has not been completed. Unreasonable delay (and I emphasise the word 'unreasonable') in completing investigations is bad justice. Those of you who are timely in your work will understand that. But I remind others that unreasonable delay may be a disciplinary offence.
37. The process of investigation is triggered by familiar but slightly amended words. The coroner must have reason to suspect that the deceased died a violent or unnatural death, or the cause of death is unknown, or the deceased died in custody. There are two changes here. The word 'sudden' has been removed from the existing Section 8 wording of 'a sudden death from which the cause is unknown', and instead of 'death in prison' (which included inmates, prison staff and visitors) we now have the more limited death 'while in custody' but with the addition of the words 'or otherwise in state detention'. Those words are defined in the interpretation section as a person 'compulsorily detained by a public authority' within the meaning of the Human Rights Act, which specifically includes immigration detention centres and secure mental health hospitals.

Scope of inquests; 'determinations' not 'verdicts'

38. The Act is not entirely silent on the scope of inquests. It makes brief reference to the wider scope of an Article 2 inquest '*where necessary* in order to avoid a breach of any Convention rights'. It does not define 'where necessary'. Guidance on that thorny issue will have to come from elsewhere, probably from the courts and also from me.
39. You will also have noted that there are to be no more 'verdicts'. The Brodrick Committee suggested that there should be 'findings'. Instead the 2009 Act replaces 'verdicts' with 'determinations' on the questions of who, how, when and where, and refers to 'findings' as to the particulars for the purposes of registration.

Jury inquests

40. Is a jury required for an inquest? The simple answer is that the coroner still has a broad discretion, but more limited than before: a coroner may hold an inquest with a jury if he or she 'thinks that there is *sufficient* reason for doing so', as opposed to '*any* reason' (the present wording). An inquest must be held with a jury in a limited number of circumstances. The main change is that there need no longer be a jury if the deceased was in custody or state detention and that death was from natural causes.
41. I have of course been picking and choosing which aspects of the new Act to emphasise for this brief summary. There is much more in the Act. I have not mentioned, for now, post mortem examinations; medical examiners; entry, search and seizure; and the abolition of the office of coroner of the Queen's household. It is all important; we shall all have to return to the Act in detail later.

## **(2) Rules and Regulations**

42. In order to make sense of the implementation of the 2009 Act it will be necessary to introduce new Coroners Rules and Regulations. Regulations under Section 43 of the Act will be made by the Lord Chancellor for regulating the practice and procedure of investigations, examinations and exhumations. Rules, to be referred to as Coroners Rules, will be made under Section 45 'for regulating the practice and procedure at or in connection with inquests'.
43. In view of the short timetable between now and the anticipated implementation of the Act next June, the Coroners Rules process will be in two stages. In the first stage the existing Coroners Rules 1984 will be updated, but only to update the wording in terms of the basics of the Act. But in due course, probably with the aid of a Rules Committee, a completely fresh set of Rules will be drafted. That second stage will take considerably longer.

## **(3) Training**

44. The training of coroners and coroners officers will be taken over by the Judicial College (formerly the Judicial Studies Board). I have a specific duty under the Act to make regulations about training and to make provision for the kind of training to be undertaken and the amount and frequency of training.
45. Training will continue under the present regime of the Coroners' Society as planned and agreed until the end of March 2013. I would like to pay tribute to the work of the Society on training and to thank all members of the Coroners' Training Group and others who have committed considerable time and effort to their highly successful courses. I am not going to name names today, because inevitably somebody would be left out. You all know who you are, and you should be congratulated. The current training will found the basis for future training.
46. After March the Judicial College, who have already started their work, will develop a new comprehensive programme of training. Training for all coroners will be compulsory. There will be some one day courses before next June on the detail of the Act, coupled with written guidance about the Act. And under the Judicial College there will be a full training scheme comprising induction courses, development courses and special courses. Course directors will be appointed and I would encourage applications for these posts.
47. As part of the training needs analysis of the Judicial College you will all be asked to complete a coroner training questionnaire. Your answers will be invaluable for the future.

## **(4) The law**

48. I am keen to provide as much assistance to coroners in their work as possible. I am aware that although longer and more complicated inquests are only a small part of your total workload, coroners nevertheless find some aspects of inquest work difficult. Therefore in addition to training, for all coroners, and integrated with it, there will be two further development strategies. First, there will be an amended and updated Benchbook, building upon the invaluable work to date. This should be of particular use to new coroners.

49. Secondly, I want to produce Law Sheets. These will each cover a particular topic, in one or two pages, summarising what I believe the law to be, with reference to cases but without going into detail. The topics will include, for example, when a verdict has to be left to a jury for their consideration (the so-called *Galbraith*-plus test), or Article 2 borderline cases. I am aware that the law is not always entirely straightforward, but it is important for coroners to get the law right as best they can. That is important for the justice of the process. But it is also important so that unnecessary appeals are avoided. Appeal by way of judicial review is a lengthy, costly, and sometimes distressing process. If it can be avoided it should be avoided.
50. As part of this ongoing process of legal guidance I shall also sit, as I have already been doing, in the High Court (the Administrative Court or the Divisional Court) giving decisions on claims for judicial review of coroner decisions, and giving guidance, where appropriate, on the practical application of the law.

### **(5) Practical guidance**

51. I shall also produce from time to time practical guidance notes on issues such as case management, disclosure, hearing dates, the need for pre-inquest hearings, when to instruct counsel, contact with the media and so on. These are just a few of the topics which call for guidance. I shall consult coroners and others before guidance is given and I will monitor the effect of any guidance. The aim is to provide minimum standards which can be incorporated later into a Practice Direction or National Protocol of Good Practice. Some of this will in due course be incorporated into the updated *Guide to Coroners and Inquests* and the *Charter for Coroner Services*.

### **(6) Special groups**

52. I am considering developing a number of specially trained coroner groups. The greater flexibility in the new Act over coroner areas and the possible movement of coroners by way of an extended transfer system, coupled with new training, provides the opportunity to develop and apply specialist groups of coroners.
53. The groups could include a cadre of specially trained service death coroners who, if necessary, would travel to the area of the next of kin to investigate and hold the inquest. I shall consult, as I have already begun to, with, amongst others, the Ministry of Defence through the Defence Inquests Unit, the Royal British Legion and other service organizations and experienced coroners and local authorities who have worked in this field.
54. Great value is placed upon expertise in this area. It is expected, and rightly expected, that bereaved families of military personnel who die on active service for their country should be afforded the greatest consideration in the investigation into every single death. I have a special duty under the Act to monitor investigations into service deaths and to ensure that coroners conducting such investigations are suitably trained for the purpose. I intend to carry out that duty to the full.
55. Specialist groups of coroners may include a group, perhaps defined on a regional basis, of treasure coroners. There will be no new Coroner for



Treasure for the time being. Nor will there be, at least for now, Deputy Chief Coroners and a Medical Adviser and Deputy Medical Advisers to the Chief Coroner - all creatures devised in distant days. Similarly there will be no inspection of the coroner system as was envisaged in the Act.

56. Another group could include coroners specializing in deaths in custody or even particular types of deaths in custody such as asphyxia from restraint.
57. But I need to consult more about this. Whatever system is devised it will have to be cost-neutral. In difficult financial times central Government and local Government cannot normally be expected to provide any additional funding. That is an inevitable restraint under which I, and indeed all of us, must work.
58. I need also to review the arrangements for circumstances of mass fatalities. Much good work has been done in this area in recent years. The '7/7' bombing inquests under Lady Justice Hallett demonstrated how big inquests can be conducted effectively. However, the findings of the Report of the Hillsborough Independent Panel require careful scrutiny. I do not propose to say more today about the tragic events of Hillsborough; a legal process is in train. But I will consider the report carefully and if lessons are to be learned they will be learned.

#### **(7) Notifications to the Lord Advocate**

59. In the past there has been no adequate procedure for transferring from England and Wales to Scotland an investigation into a service death abroad, even though it would have been more appropriate to hold the inquiry in Scotland, particularly close to the home of the next of kin. With the consent of the Lord Advocate, the Scottish Government, the Ministry of Justice and the Ministry of Defence that gap in procedure has now been remedied, by the implementation of Section 12 of the 2009 Act, headed 'Investigation in Scotland'. Section 12 will come into force on Monday 24 September.
60. I have been involved in the agreement of a Protocol and (under Section 12) I, as Chief Coroner, will be able to notify the Lord Advocate if I think it appropriate for the circumstances of the death to be investigated in Scotland under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 (which has at the same time been amended accordingly).
61. There are, as you know, no coroners in Scotland, which for these purposes is a different legal jurisdiction. But a Sheriff may be asked by the Procurator Fiscal to investigate under the 1976 Act. Those of you who recently attended (as I did) at the Ministry of Defence coroners course at Warminster will have realized that a number of sheriffs attended for that purpose.

#### **62. (8) Rule 43 Reports**

63. I shall review the whole process of Rule 43 Reports which are designed to prevent future fatalities. The practice in issuing them (or not issuing them) and their content has been somewhat variable. The Act promotes the significance of Rule 43 reports from the Rules to the Act itself (paragraph 7 of Schedule 5). That reflects the fact that Rule 43 Reports are capable of having a considerable impact upon changes for the better, with a view to saving lives, an aspect of coroner work which is of great significance.

## **(9) Complaints procedure**

64. On a different note the Act provides that all coroners (senior coroners, area coroners and assistant coroners) shall be subject to the same disciplinary code and complaints procedures as judges listed in Schedule 14 of the Constitutional Reform Act 2005. In other words all coroners (not just senior coroners) will come under the jurisdiction of the Office for Judicial Complaints. Any complaint about a coroner's 'personal conduct' (including unreasonable delay) will be considered by that office.
65. At one stage, and hand in hand with the Chief Coroner's now repealed appellate role, there was a suggestion that the Chief Coroner was going to take responsibility for the handling of complaints. I do not believe, and I believe the Lord Chief Justice does not believe, that that would be a good idea. It could place the Chief Coroner in the invidious position of having to lead, guide and encourage coroners with one hand and discipline them with the other. But I shall work with the OJC on the procedure to be adopted under the Act.

## **(10) The Coroners' Courts Support Service**

66. Finally, I would like to be able to arrange permanent office space for two members of the very splendid Coroners' Courts Support Service. Westminster has been very generous in the facilities provided, but at times of extreme temperature the portakabin is not exactly perfect. I have seen for myself how valuable their work is, so I shall do my best.
67. That is my short list of 10 points. I have a longer list, but not for today. Short list or long list, what I really want to emphasise is the importance of working together. The working partnership between coroners, coroners officers and staff, and local authorities, as well as police authorities, not forgetting medical examiners (a topic all of its own), will be absolutely critical to the well-being and development of the coroner service.
68. When somebody once wrote that death was 'The certain end of all pain and of all capacity to suffer pain', they were not thinking of those left behind. The bereaved rightly expect justice from the coroner system. I shall listen closely to them - and to the organisations for the bereaved - so as to understand better their concerns. They should be at the heart of the process. We must therefore all work together to provide justice and a better coroner service. Not only for bereaved families but for the wider public. So let us be positive about it. I certainly shall be. My job is to lead the coroner service and to take it in the right direction. I can only do that with your help, your commitment and your professionalism. I am convinced that we will work well together.
69. Thank you for your warm welcome and your generous hospitality.

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