Agenda Item No: 5

Cambridgeshire and Peterborough Coroner Service Annual Report

To	Communities, Social Mobility and Inclusion Committee
Meeting Date:	19 October 2023
From:	Service Director of Regulatory Services
Electoral division(s):	All
Key decision:	No
Outcome:	For members of the Committee to be provided with an update on the Coroner service and to receive assurance around the delivery of service's statutory duties and responsibilities.
Recommendation:	The Committee is recommended to: Note the contents of the report.

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1. Background

1.1 The Cambridgeshire and Peterborough Coronial Jurisdiction was formed in 2015, since which David Heming has been the judicially appointed Senior Coroner. The service has an office base at Lawrence Court in Huntingdon and utilises facilities across the jurisdiction to conduct Inquest hearings.

1.2 Coroners conduct investigations into deaths that are unexpected or unexplained; including those where it is suspected 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. Coroners will determine the identity of the deceased together with how, when and where the deceased came by their death.

1.3 The duties of the coroner and the statutory duties of the service and the local authority are set out in the Coroner and Justice Act 2009. Coroners are independent judicial office holders, with appointments requiring the consent of the Chief Coroner and Lord Chancellor.

1.4 The jurisdiction is nationally one of the more complex in terms of its cases, with four main hospitals, two of which, Addenbrookes and Papworth, are specialist. Many of the cases from these are complex and time consuming, requiring nationally renowned, and sometimes world-renowned, experts to provide evidence as part of the investigation. There are also three prisons in the area, which is unusual and adds to service demand.

1.5 The total number of deaths referred to the service in 2022 was 3,186, representing an increase of 10% from the year before. There was also a 10% rise in the number of inquests opened from the year before. The impact of the pandemic is a contributory factor in these figures, and although death due to Covid-19 had decreased from 2020, there were more cases where delayed hospital treatment was a factor.

1.6 Assurance with regards the performance of the judicial functions of the service is provided by the Chief Coroner, whose office reviews cases and submits annual performance data. The Chief Coroner is appointed by the Lord Chief Justice, in consultation with the Lord Chancellor, and is the judicial head of the coroner's system. Key responsibilities of the Chief Coroner include:

- To provide support, leadership, and guidance for coroners.
- In conjunction with the Judicial College, to put in place suitable training arrangements for coroners and coroners' officers.
- To approve coroner appointments.
- To keep a register of coroner investigations lasting more than twelve months.
- To publish Prevention of Future Death reports and responses.
- To exercise global case management powers (including directing transfers of Inquests between coroner areas in certain circumstances and requesting the Lord Chief Justice and Lord Chancellor to appoint judges in certain high-profile or complex inquests).
- To provide an annual report on the coroner system to the Lord Chancellor, to be laid before Parliament.
- To monitor the system where recommendations from inquests are reported to the appropriate authorities to prevent further deaths.

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

1.7 Coroners are independent judicial office holders, like all judges. For this reason, the Chief Coroner is unable to comment on, review or otherwise intervene in the individual decisions of coroners. Similarly, matters of judicial conduct are for the Judicial Conduct Investigations Office (JCIO).

1.8 The Chief Coroner has personally given a vote of confidence in Cambridgeshire and Peterborough's ability to handle complex and sensitive cases, having asked the jurisdiction to take over the Hertfordshire case outlined in paragraph 2.2.3 of this report.

2. Main Issues

2.1 National picture

2.1.1 The total number of registered deaths in England and Wales fell in 2022 compared to the previous year, whilst the number of deaths reported to coroners rose by 7% (from 195,000 to over 208,000) in that same period. Deaths reported to coroners as a percentage of registered deaths increased by 3% (from 33% to 36%), gradually returning to the pre-Covid-19 levels.

2.1.2 In 2022, coroners opened the highest number of inquests since reporting began, with an increase in recorded conclusions and post-mortems. Around 17% of deaths reported to coroners proceeded to an inquest and, of the 36,000 inquest conclusions recorded, natural causes, accident/misadventure and unclassified conclusions were the most prevalent, with increases from 2021 of 40%, 14% and 7% respectively.

2.1.3 Suicide conclusions have gone up year on year since 2016, except for 2020. The highest number of suicide conclusions were recorded in 2022, driven by an increase in male suicides which went up by 3% to its highest recorded level since records begun.

2.1.4 The majority of inquests (57%) completed in 2022 were for those aged 65 years and above at the time of death, compared with 5% relating to persons under 25 years of age.

2.2 Case studies

2.2.1 This year has seen the service conclude several high-profile cases and investigate numerous deaths that have led to the issuing of Prevention of Future Deaths reports. In addition to the duty that coroners must determine the cause of death, they must also, where appropriate, report a death with a view to preventing future deaths. Such reports, when issued, must state the coroner's concerns, and what action should be taken to prevent future deaths. The report must be sent to the person or organisation who the coroners believe has the power to act.

2.2.2 Since 1 January 2022, the service has issued seven Prevention of Future Deaths reports. Of these reports, two concern highways safety (roads within Peterborough), two concern clinical procedures and medical management, one is alcohol, drug and medication related,

four relate to child deaths, two concern mental health related deaths and one is categorised as other. These reports often cross over more than one of the categories.

2.2.3 The Senior Coroner was asked by the Chief Coroner to hear an inquest following the apparent suicide of a young mother in Hertfordshire who, prior to her death, had been the victim of controlling and coercive behaviour. Owing to procedural irregularities, the original inquest conclusion was quashed, and Cambridgeshire conducted the second inquest, funded by Hertfordshire County Council. There were several Pre-Inquest Review Hearings (PIRH), and the matter was listed for a 2-week jury inquest in July 2023. The jury returned a landmark ruling that the young mother was unlawfully killed, a conclusion which in effect means that abuse that leads to suicide can amount to an unlawful act of manslaughter within England and Wales. There was intense press coverage around this case, not least because of the family's plea that the police consider this as a charge when investigating and prosecuting other unexplained deaths in the context of domestic abuse.

2.2.4 The service also heard two connected cases in November 2022, following deaths linked to contaminated water supplies at the newly constructed Papworth hospital. Following the conclusion of the inquests, a Prevention of Future Deaths report was issued to the Secretary of State for Health and Social Care, with concerns set out in relation to the construction of new hospitals and the increased risks for contamination which ought to be mitigated.

2.2.5 In July 2023, a case was concluded where a young child was killed when a vehicle being driven by an elderly driver crossed lanes and collided with a van, causing the van to mount a kerb and kill the young child and badly injure the child's mother. The driver was found to have undiagnosed dementia at the time of the accident, and a prosecution against them failed on the grounds of insanity. Motorists aged 70 or over are required by law to renew their driving licence every three years. The driver in this case had renewed their licence as they approached their 70th birthday, applying online and declaring that they were medically fit to drive. Due to the pandemic, their three-year licence was extended until June 2021, after the collision. The coroner in the inquest said that he was concerned about self-certification of driving licences for the over-70s, and he is raising the matter with the Department for Transport in a Prevention of Future Deaths Report.

2.3 Organ Donations

2.3.1 There are currently approximately 7,000 people on the UK transplant waiting list and in 2022/23, the NHS Blood and Transplant Service was able to facilitate almost 4,600 transplants. In every case of organ donation, the coroner is contacted to see whether they wish to place any restrictions on retrieval. This could mean that no organ donation is possible or alternatively, that this is limited, and much needed transplants do not proceed. Nationally, there has been some hesitation from coroners, as they have not wanted to jeopardise any investigations (whether criminal or coronial) following the death of the person and have erred on the side of caution with permission to retrieve. This has a huge impact on the living and those critically ill patients on the transplant waiting list.

2.3.2 The Senior Coroner has long been an advocate for facilitating organ donations wherever possible and has previously assisted the Chief Coroner with the drafting of Chief Coroner Guidance No. 26 in respect of organ donations. This year, the Senior Coroner went further, and this guidance was updated to facilitate as many unrestricted organ donations as

possible.

2.3.3 This national guidance sets out practical steps and measures which can be undertaken to provide coroners around the country with sufficient confidence to be able to give unrestricted permission far more than has been the case historically. The Senior Coroner also held a training event at the Royal Society of Medicine in London aimed at clinicians, coroners, the police, and law makers, with a view to increasing confidence in permitting unrestricted organ donations to proceed.

2.3.4 The service regularly receives communications from the NHS Blood and Transplant Service, setting out how the organs for which permitted retrieval was granted have been used to help save and improve lives. This continues to be something that the jurisdiction leads the way on and has a direct, positive impact on the community, both locally and nationally.

2.4 Faith Deaths

2.4.1 The service has led the way in terms of facilitating faith considerations, as appropriate, in relation to deaths referred into the service.

2.4.2 In some faiths, there is a stipulation that a burial ought to take place within a very narrow timeframe. The service operates an out-of-hours facility so that, where appropriate, these timescales are adhered to.

2.4.3 The service has worked hard to foster positive working relationships with local religious communities, which has had a positive impact. This is not the case nationally and when this issue is raised for national discussion as an area for improvement, the Cambridgeshire and Peterborough jurisdiction is referenced as one of the services that gets the approach right.

2.5 Performance

2.5.1 Coronial services are required to report annually, as of 30 April each year, the number of cases over twelve months to the Chief Coroner as part of a national performance return.

2.5.2 Table 1 indicates the number of cases reported for the previous three years.

Year	Total number of cases over twelve months old	Cases concluded that were over twelve months old
2022/23	278	182
2021/22	297	108
2020/21	256	37

Table 1: Cases over twelve months as reported to the Chief Coroner.

2.5.3 There was a 6% decrease in the number of cases over twelve months old in 2022/23, while there was a 21% increase in the number of cases opened in the same year.

2.5.4 In the same reporting period, there was an increase of sixty-nine cases over twelve months that were concluded, this is an increase of 392% from 2021. The oldest cases continue to be a focus for the service, and a number or particularly complex cases have now been

concluded.

2.5.5 The aim of the service is to continue this trend, with regular monitoring in place to ensure that this remains achievable. The service is in a better position and is on track to exceed last year's performance.

2.5.6 Cases over twelve months are split into the categories shown in Table 2. This data relates to 1 May 2021 to 31 April 2022:

Reason	2021/22	2021/2020
Delayed due to complexity (i.e., awaiting specialist reports)	85%	46.8%
Suspended and therefore were outside of the control of the service (i.e., while criminal investigations take place)	12.6%	9.4%
Deaths that occurred abroad (i.e., awaiting evidence from overseas)	2.4%	1%

Table 2: Reason for cases over twelve months

2.5.7 During the reported period, 660 inquests were closed. Of these, 40% were less than six months old, 29% were six to twelve months old and 31% were more than twelve months old. This is demonstrative of the service's commitment to tackling the backlog whilst ensuring that due attention is given to those less complex Inquests which continue to be referred.

2.5.8 Increasingly, inquests are being delayed due to the lack of availability of the necessary experts and professional witnesses, many of whom are from the medical profession, which understandably is under pressure to recover from the pandemic and reduce patient waiting times.

2.5.9 The annual performance data for 2022/23 is shown in Table 3.

Indicator	2022/23 Performance	2021/22 Performance	Increase
Number of cases opened	3,488	2,880	21%
Number of cases closed	3,519	2,628	34%
Number of inquests open	593	532	11%
Number of inquests closed	638	512	25%

Table 3: Annual Performance

2.5.10 If the performance continues along the trajectory of Quarter 1 in 2023/24, the service is on track to close 852 cases during the year.

2.6 Finance and Contracts

2.6.1 Though coroners are judicial appointments, councils have the statutory responsibility to fund the service. The Council has influence and control over contract awards, service

support costs and staffing, but not costs associated with coronial decisions, such as investigations required to determine a cause of death. There continue to be discussions at a national level regarding whether the existing funding model is right, or whether coronial services should be funded nationally.

2.6.2 The budget for the service for 2023/4 is just over £3,199,892, 65% of which is funded by Cambridgeshire County Council and 35% by Peterborough City Council due to the area being a joint coronial jurisdiction.

2.6.3 Core costs for the service are shown in Table 4, in which the figures reflect the cost for Cambridgeshire only.

Category	Cost
Staffing (including Area and Senior Coroners)	£1,011,450
Assistant Coroners	£117,066
Pathologists	£257,470
Body removals	£94,000
Testing (Toxicology)	£111,800
Hospitals:(Northwest Anglia in Peterborough and Cambridge University Hospital	£429,000
Experts Costs (reports and court attendance	215,217

Table 4: Core service costs

2.6.4 Pathologist costs are still impacted by Covid-19, as they continue to operate under high level infectious control measures, as per the guidance issued by The Royal College of Pathologists and UK Health Security Agency (previously Public Health England), therefore completing fewer examinations per day at a higher cost. These additional costs are passed to the service. Nationally, there is a reduction in pathologists, which is putting financial pressure on local authorities to use private companies to conduct coronial postmortems. Fortunately, the service has not been put under the same pressure as most other jurisdictions in the country and has been able to maintain existing arrangements.

2.6.5 The service has faced unavoidable cost increases resulting from contract renewals and inflationary costs. Contract costs currently equate to approximately £977,000 of the service costs, and therefore any increase in these continue to have a significant impact on service delivery costs.

2.6.6 The service takes action to mitigate against rising costs where it can. Work in this respect includes closely reviewing all invoices to ensure contractors are only charging for costs agreed within the respective contract terms and challenging invoices where necessary.

2.6.7 In the 2022-23 financial year, £155,248.82 was awarded from the Contain Outbreak Management Funding (COMF), due to increased pathologist costs (as described in paragraph 2.6.4 of this report) and mortuary costs. Mortuary costs were increased due to additional storage costs, use of Personal Protective Equipment and time taken to prepare the diseased following the pandemic.

2.6.8 The cost of experts has increased by nearly 29% from previous years. With the introduction of the Medical Examiner Scheme in hospitals, the medical cases which are referred to

coroners are more medically complex. Due to the complexity, independent expert reports are required to comment on the appropriateness of treatment and whether any short fallings have contributed to the death.

2.6.9 In the last year, the service has awarded contracts for mortuary services in the north of the region, (awarded to Peterborough Hospital), body removals (awarded to Peasgood and Skeates, Smiths, and Co-op) and toxicology services (awarded to Leicester hospital). These contracts were awarded at a time when inflation is particularly high. The costs of these contracts have been fixed for the next three years.

2.6.10 The re-tender process for the contract held by Addenbrookes Hospital will commence this year with an award for the period 1 April 2024 to 31 March 2027. The contract will ensure there is provision in the south of the county to undertake post-mortems and other tests as part of coroner's investigations.

2.6.11 The service has continued to avoid external venue hire costs by using both Cambridgeshire County Council and Peterborough City Council facilities, saving in excess of £40,000 as outlined in Table 5.

Venue	Number of hearings held (including PIRH)
Peterborough Town Hall	419
Lawrence Court	597
New Shire Hall	15

Table 5: Court space used 1 April 2022 – 31 March 2023

2.7 Law Changes

2.7.1 The Medical Examiner Scheme, a layer of independent scrutiny for all deaths, currently operates for hospital deaths only. However, as of April 2024, this will extend to all deaths in the community referred via a General Practitioner.

2.7.2 As with the roll of out of the hospital Medical Examiner Scheme, its anticipated that the number of referrals received will decrease but they will be more complex cases. This will likely mean cases will take longer to conclude.

3. Alignment with ambitions

3.1 Net zero carbon emissions for Cambridgeshire by 2045, and our communities and natural environment are supported to adapt and thrive as the climate changes.

The following bullet points set out details of implications identified by officers:

- The service operates from venues in the north and south of the county, reducing the need to travel unnecessary distances for staff, families and interested persons.
- Hybrid hearings enable families, interested persons and expert witnesses to join Hearings virtually if required, reducing the need to travel. For expert witnesses this could be a considerable distance as they are often based outside of the county.

3.2 Travel across the county is safer and more environmentally sustainable.

There are no significant implications for this ambition.

3.3 Health inequalities are reduced.

The report above sets out the implications for this ambition in 2.2.

3.4 People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.

There are no significant implications for this ambition.

3.5 Helping people out of poverty and income inequality.

There are no significant implications for this ambition.

3.6 Places and communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.

The report above sets out the implications for this ambition in 2.2.

3.7 Children and young people have opportunities to thrive.

There are no significant implications for this ambition.

4. Significant Implications

There are no significant implications as the report is for information only.

5. Source Documents

5.1 Responsibilities of the Chief Coroner

5.2 Coroners Statistics 2022 (England and Wales)

5.3 Prevention of Future Deaths Reports

5.4 Coroner and Justice Act 2009