Agenda Item No: 6

Cambridgeshire and Peterborough Coroner Service Annual Report

To:	Communities, Social Mobility, and Inclusion Committee
Meeting date:	5 December 2024
From:	Executive Director of Place and Sustainability
Electoral division(s):	All
Key decision:	No
Executive Summary:	This report provides the Committee with an update on coronial service delivery over the last twelve months, focusing on trends, legislative reform, collaborative arrangements, performance, finance and contacts. In addition, the report provides assurance around the delivery of the statutory duties and responsibilities of the service.
Recommendation:	The committee is recommended to: Note the contents of the report.

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1. Creating a greener, fairer and more caring Cambridgeshire

1.1 This report details proposals that would impact on the following ambitions of the Council.

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

1.2 The following 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 for staff, and others attending inquests, to travel unnecessary distances.
- Hybrid hearings, where permitted, enable virtual attendance, reducing travel and carbon emissions.

Ambition 4 – People enjoy healthy, safe, and independent lives through timely support that is most suited to their needs.

1.3 The service contributes to this ambition in several ways. Coronial statistical data provides valuable public health insight in terms of case numbers, trends, and trajectories. Data is shared through a wide range of partnerships to inform policies and practices to help keep people healthy and safe. In addition, the Prevention of Future Death Reports help ensure lessons are learned from cases to prevent similar occurrences in the future.

Ambition 6 – Places and Communities prosper because they have a resilient and inclusive economy, access to good quality public services and social justice is prioritised.

1.4 Working collaboratively with partners in the development of services helps to ensure those provided are both carefully considered and of good quality. Listening to the needs of communities also ensures that services are shaped to take account of their needs, increasing inclusivity and access to services.

2. Background

2.1 This report is the annual update on coronial service delivery for the Cambridgeshire and Peterborough Coronial Jurisdiction, and it provides assurance around the delivery of the statutory duties and responsibilities of the service.

2.2 The Cambridgeshire and Peterborough Coronial Jurisdiction was formed in 2015, since which David Heming has been the judicially appointed Senior Coroner. As part of the inhouse core team, Mr Heming is supported by three Area Coroners, and 26.45 full time equivalent members of staff. The service has an office base at Lawrence Court in Huntingdon and uses facilities across the jurisdiction to conduct inquest hearings.

2.3 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.

2.4 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.

2.5 The jurisdiction is one of the more complex nationally in terms of its cases, with four main hospitals, two of which (Addenbrookes and Papworth) provide specialist services. 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.

2.6 The total number of deaths referred to the service in 2023 was 3197, an increase of 42 cases from the year before.

2.7 Assurance with regards the performance of the judicial functions of the Service is provided by the Chief Coroner, whose office reviews cases and the submitted 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, put in place suitable training arrangements for coroners and coroners' officers;
- Approve coroner appointments;
- Keep a register of coroner investigations lasting more than 12 months;
- Publish Prevention of Future Death reports and responses;
- 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);
- Provide an annual report on the coroner system to the Lord Chancellor, to be laid before Parliament;
- Monitor the system where recommendations from inquests are reported to the appropriate authorities to prevent further deaths; and
- By convention, the Chief Coroner also sits in the High Court hearing some of the most important judicial and statutory review cases concerning coroners.

2.8 The Chief Coroner is unable to comment on, or otherwise intervene in the individual decisions of coroners. Similarly, matters of judicial conduct are for the Judicial Conduct Investigations Office (JCIO).

2.9 Her Honour Judge Alexia Durran has been appointed as Chief Coroner of England and Wales, in succession to His Honour Judge Thomas Teague KC. The appointment started on 25 May 2024 for a three-year term.

3. Main Issues

3.1 National Picture

3.1.1 In the 2023 calendar year, the number of deaths reported to coroners in England and Wales reached its lowest level since 1995, reflecting a decline of 3% compared to the previous year.

3.1.2 The proportion of inquests opened relative to the deaths reported to coroners was at its highest in 2023 since 1995, with an 11% rise in inquest conclusions recorded since 2022.

3.1.3 The average duration to complete an inquest increased by 1.3 weeks, reaching 31.5 weeks this year. The primary contributors to the rise in inquest conclusions were unclassified conclusions and death by misadventure, which together constituted half of all inquest outcomes. Unclassified conclusions are those which do not easily fit any of the standard conclusions, and narrative conclusions. Death by misadventure is where an individual deliberately undertook an action which resulted in their death.

3.1.4 Suicide conclusions reached their highest level since 1994, with a more significant increase among females (11%) compared to males (7%). It is important to note that conclusions are documented post-inquest, meaning conclusions each year may relate to deaths from that year or prior years. The age specific rate was highest for males aged between 45-49, and for females aged between 50-54.

3.1.5 In 2023, 569 Prevention of Future Death reports were issued, constituting 1% of all concluded inquests and representing a 41% increase compared to 2022. Where appropriate, coroners must report a death with a view to preventing future deaths. When issued, such reports 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.

3.1.6 Compared to the national picture over the last year, the Service has seen: -

- An increase of 62.5% in the number of Prevention of Future Deaths reports issued (from 5 to 8), which is in keeping with the national trend.
- A reduction of 2 weeks in the length of time taken to process an inquest (from 41 to 39), which is against the national picture, where there has been an increase, but still a little higher than the national average.
- Just over half of the conclusions are unclassified and/or by accident or misadventure, which is in keeping with the national trend.

3.1.7 Looking forward, the service will explore whether there are comparable coronial jurisdictions to benchmark data against to support the evaluation of coronial case outcomes.

3.2 Death Certification Reforms

3.2.1 The largest legislative change to the death certification process in England and Wales for many years occurred in September 2024. The Medical Examiner Scheme, a layer of independent scrutiny for deaths, was expanded to cover all deaths, not just hospital deaths. Now, every death is scrutinised by either a Medical Examiner or Coroner, regardless of the

type of death or where the person has died. This extra layer of scrutiny was borne out of the Shipman Inquiry and the need for additional safeguards within society.

3.2.2 Through detailed planning and a high level of collaboration with key stakeholders, including medical examiners, registrars, the police, ambulance service and funeral directors, the Council was able to put into place a system which placed the service (and by extension, the wider community) in the best possible position when the changes were implemented in September 2024. This demonstrates the service's commitment to the Council's Ambition 6, providing access to good quality public services.

3.2.3 The Coroners service is working well with the regional medical examiner offices, along with their staff, to ensure that the service routes referrals to the correct entity for scrutiny (whether that is the Medical Examiner or the Council) in a timely and sensitive manner. The service is also continuing to work closely with its software provider to ensure that it is maximising the use of technology to be able to work as efficiently as possible in the new statutory landscape.

3.2.4 Due to the level of collaboration in place, the Regional Medical Examiner has confirmed that arrangements at the Xouncil for implementing the death certification reforms are working well and have not presented issues experienced in other coronial areas.

3.3 Faith Deaths

3.3.1 The service has led the way in terms of facilitating faith requirements in relation to deaths referred into it, increasing inclusivity and access to services (Ambition 6). Following the death certification reforms, the service has expanded this to core hours through collaboration with the Medical Examiner, to provide rapid assistance in processing the paperwork for planned burials or oversees transfers where the Medical Examiner service is unable to resource matters so promptly. Out of hours, the coronial team continues to offer a 24/7 service through excellent working relationships with the various faith communities and their appointed funeral directors, which means that in most cases when a faith death occurs outside normal working hours, the on-call coroner can give approval for same day burials, easing the burden on bereaved families.

3.4 Collaboration

3.4.1 Collaboration has been a key theme for the service this year, with existing relationships strengthened and new partnerships formed. An example has been the Death Certification Reforms, where the Coroners service brought together key stakeholders in advance of the legislative changes. There were several meetings, the creation and sharing of data, the benchmarking of ideas with other Coronial jurisdictions and an agreement with partners as to the way forward, all of which was subsequently communicated to those within the death certification process. The effective roll out was almost entirely due to the planning and collaboration which took place in the lead up to the reforms, with necessary adjustments being made in a timely and respectful manner.

3.4.2 The service has continued to share information with the Suicide Prevention Team within the local authority, with a view to informing their research and to put in place measures to help reduce the risk of suicide for those within the community. This contributes to Ambition 4, helping people enjoy healthy, and safe lives.

3.4.3 The Service has provided similar information contributing to Ambition 4 to the Alcohol and Drug Mortality Review Team, which has recently been extended to the Probation Service, to try and identify vulnerable people within the Criminal Justice system who might otherwise not be known.

3.4.4 Presentations have been delivered to a variety of organisations, including End of Life Doulas UK and the Coroners Society of England and Wales, where the Senior Coroner's focus on organ donation remains a national priority for change. Whilst Cambridgeshire leads the way as a coronial service in respect of approving organ donation requests, this is not the case nationally. All the Coroners within this jurisdiction are committed to empowering other Coroners to be able to approve organ donation, where appropriate.

3.4.5 A strong relationship has been formed with Mesothelioma UK, a charity which provides support to those people affected by the industrial disease. A Coroner's officer sits on a regional panel to inform the discussions from a Coronial perspective and to understand the lived experiences of the people who have encountered the Coroner's service (even if it is not this jurisdiction). This partnership has been mutually beneficial, with the service using what has been learnt to improve future service delivery.

3.4.6 The service continues to work closely with the NHS, and attends Child Death Overview Panel meetings, where specific cases are analysed from a variety of viewpoints to assess whether any lessons can be learnt. Meetings take place with the Integrated Care Board, and the service has representation at their Morbidity and Mortality meetings, sharing mutual findings and learnings which help to inform both services.

3.5 Performance

3.5.1 Each Coronial jurisdiction is 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. The Chief Coroner did not request the return this year, suggesting instead their future wish to align the reporting window with the Ministry of Justice report, which is for the calendar year.

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

Year	Total number of cases over 12 months old	Cases concluded that were over 12 months old
2023/24	242	159
2022/23	278	182
2021/22	297	108

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

3.5.3 There was a 13% decrease in the number of cases over twelve months old in 2023/24, while the national trend is an increase in cases for the second year running.

3.5.4 The oldest cases continue to be a focus for the service, and a number or particularly

complex cases have now been concluded, including significant jury and complex medical inquests, often sitting for multiple weeks at a time.

3.5.5 The service is working hard to continue the trend of decreasing cases over twelve months, and regular performance monitoring is in place to help achieve this. The service is on track at present to exceed last year's performance.

3.5.6 During the reported period, 656 inquests were closed. Of these, 46% were less than six months old, 24% were six to twelve months old and 30% were more than twelve months old. This demonstrates the service's commitment to tackling the backlog whilst ensuring that due attention is given to those less complex inquests that continue to be referred.

3.5.7 There are several factors that can result in cases taking longer to conclude at inquest, including the provision of appropriate and dedicated courtroom facilities, the complexity of some cases requiring expert input into the investigation stages, and the availability of professional witnesses, many of whom are busy clinicians understandably under pressure to recover from the pandemic and reduce patient waiting times.

3.5.8 There are certain categories of cases which by law must be concluded by juries, rather than coroners sitting alone. This tends to increase the duration and complexity of a case and requires careful preparation and guidance to enable jurors to perform their civic duty. The jurisdiction has more jury inquests than most comparable areas, due to the number of cases involving deaths in state detention because of the number of prisons in the area.

3.5.9 The inquest conclusions by Coroners are as follows:

- 3 lawful and unlawful killings (up from 0 the previous year; 300% increase)
- 87 suicides (up from 80 the previous year; 9% increase)
- 48 drugs/alcohol related (up from 39 the previous year; 23% increase)
- 30 road traffic collision (down from 31 the previous year; 3% decrease)
- 26 from industrial diseases (up from 24 the previous year; 8% increase)
- 157 by accident or misadventure (up from 152 the previous year; 3% increase)
- 101 from natural causes (down from 155 the previous year; 65% decrease)
- 3 open conclusions (down from 7 the previous year; 43% decrease)
- 177 from all other conclusions (up from 165 the previous year; 7% increase)

3.5.10 Annual case data for 2023/24 is shown in Table 2.

Indicator	2023/24 Performance	2022/23 Performance	Change
Number of cases opened	3,222	3,488	8% decrease
Number of cases closed	3,280	3,519	7% decrease
Number of inquests open	519	593	12.5% decrease
Number of inquests closed	576	638	10% decrease

Table 2: 2023/24 Annual Case Data

3.5.11 In broad terms, the performance reflects the decrease in the number of cases being referred into the service. It is anticipated that this number will continue to fall in line with the Death Certification Reforms, as set out in section 3.2 of this report.

3.5.12 If performance continues along the trajectory of Quarter 2 in 2024/25, the service is on track to close 3,196 cases during the year, which is a decrease of 3.5% but is broadly in line with the decrease of the number of cases referred into the service.

3.5.13 During 2024, the service has concluded several high-profile cases and investigated numerous deaths that have led to the issuing of eight Prevention of Future Deaths Reports, including road safety and medical safety.

3.6 Human Resources

3.6.1 Following an external recruitment campaign during 2024, Caroline Jones was appointed as an Area Coroner with the Service, having had previous experience as both an Assistant Coroner, and practising barrister. Miss Jones acts as deputy for the Senior Coroner, David Heming.

3.6.2 Sarah Abbott has been appointed as Head of Coroners and Registration services, having previously been the investigations manager within the service.

3.7 Finance and Contracts

3.7.1 Councils have a statutory responsibility to fund Coroner services. 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.

3.72 The Council's budget for the service for 2024/25 is £2.2m. The core costs for the service are set out in Table 3, with the figures only reflecting costs for Cambridgeshire (they do not include Peterborough).

Category	Cost
Employees (including Area and Senior Coroners)	£1,175,188.30
Pathologists	£232,821.55
Body removals	£139,750.00
Testing (Toxicology)	£91,978.90
Hospitals:(Northwest Anglia in Peterborough and Cambridge University Hospital	£422,500.00
Experts Costs (reports and court attendance	£152,750.00

Table 3: Core service costs

3.7.3 In the last year, the service has awarded a contract for mortuary services for the south of the coronial arear to Cambridge University NHS Trust. This contract was awarded at a time when inflation was particularly high, and the contract has been fixed for the next three years.

3.7.4 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. In 2023/24, due to improved contract terms and scrutiny of invoices, £100,000 of savings were made from the contract for the north of the coronial area with North West Anglia NHS Foundation Trust.

3.7.5 To conform with new procurement legislations, the service has worked in partnership with the Council's procurement team to follow the new Provider Selection Regime (PSR) 2023. The PSR scheme follows a set of rules for procuring health care services in England by organisations termed relevant authorities. This has meant that the service has been able to agree fixed rates for pathologists, resulting in increased financial control.

3.7.6 As part of the Council's asset review, strategy plans are being developed for the relocation of the service. This removal is subject to the necessary approvals and internal governance requirements, and the aim is to provide better office accommodation for collaborative working, improved and additional court space, as well as enhanced staff safety when holding inquests.

3.7.7 The utilisation of accommodation for inquests from 1 April 2023 to 31 March 2024 is detailed in Table 4.

Venue	Number of hearings (including PIRH)
Peterborough Town Hall	203
Lawrence Court	710
Other	21

Table 4 - Venues used for inquest hearings 1 April 2023 – 31 March 2024

3.8 Case studies

3.8.1 This year, the Senior Coroner heard four joined, historical cases which were linked by an anaesthetist involved in their care, with questions arising around the appropriateness of the treatment in the time leading up to their respective deaths. The case attracted significant media attention, where it was reported locally and nationally after a General Medical Council hearing originally found the clinician fit to practice. The Coroner concluded the evidence after a three-week hearing, including evidence from more than twenty-five live witnesses, and is due to report on his findings in December 2024.

3.8.2 Also this year, Area Coroner Caroline Jones concluded a long-running inquest into a death at HMP Whitemoor maximum security prison, which involved the untimely death of a prisoner who had been transferred from Rampton high security hospital, where he had been treated over many years for complex mental health and personality disorders. As a case involving a death in state detention, the matter had to be heard by a jury that was empanelled to sit for a week at Peterborough Town Hall to hear from psychologists, mental health nurses and prison officers involved in the deceased's care. The jury concluded that prison was not the appropriate setting for someone with such complex psychosis and self-harming behaviours and that insufficient steps were taken to secure his return to hospital for adequate treatment prior to his death, although the death itself was not avoidable. This follows several high-profile jury inquests following deaths in state detention, and is a

common feature of the coronial workload due to the number of prison and secure premises in the jurisdiction.

4. Conclusion and reasons for recommendations

4.1 The service has successfully implemented the legislative change resulting from the Death Certification Reforms, and enhanced collaboration with a range of partners. The length of time to complete an investigation and associated inquest has been reduced by two weeks, and the number of cases over twelve months has been reduced for the third year in a row. Discussions to secure alternative office and inquest accommodation in Huntingdon are progressing well.

4.2 As there are no decisions required resulting from this report, Members are invited to review and scrutinise the report in relation to the delivery of the Service.

5. Significant Implications

5.1 There are no significant implications resulting from this information report.

6. Source Documents

6.1 Courts and Tribunals Judiciary Office of the Chief Coroner – Chief Coroner Responsibilities

6.2. Ministry of Justice- Coroners Statistics 2023

6.3 Courts and Tribunals Judiciary – Prevention of Future Deaths