

## Cyngor Sir CEREDIGION County Council

**REPORT TO:** Corporate Resources Overview and Scrutiny Committee

**DATE:** 19 December 2022

**LOCATION:** Hybrid

**TITLE:** Report on Ceredigion Senior Coroner's 2021 Statistical Return

**PURPOSE OF REPORT:** For information - to provide the Committee with an opportunity to review the information contained in the Senior Coroner's 2021 Statistical Return

**REASON SCRUTINY HAVE REQUESTED THE INFORMATION:** Not requested

### **BACKGROUND:**

The Senior Coroner for Ceredigion prepares an annual report ('Statistical Return') on deaths reported to the Coroner, which is sent to the Ministry of Justice for publication as part of the Coroners' Statistics on the UK Government website. (2021 statistics available at <https://www.gov.uk/government/statistics/coroners-statistics-2021>)

The Report of the Chief Coroner to the Lord Chancellor (combined Report of the Sixth Annual Report 2018-2019 and Seventh Annual Report: 2019-2020) (available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/932518/chief-coroner\\_s-annual-report-1920.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932518/chief-coroner_s-annual-report-1920.pdf)) includes a Model Coroner blueprint. This recommends that the Senior Coroner also presents a brief annual report ('Local Authority Report') to the Chief Coroner and the Council each July, which should be published on the Council's website, and include relevant statistics on current/concluded cases (with comparison figures for previous years), an update on Coroner work and relevant issues, a summary of the Coroner's team and staffing arrangements, and any future plans. This report was not presented to the Council by the Senior Coroner for last year due to workload commitments, court sitting availability and a staff vacancy.

At the 14 October 2021 meeting of this committee, it was decided that the Statistical Return should be published on the Council's website annually, following the publication of the National Statistics publication by the Ministry of Justice. (14/10/21 report agenda and minutes available at <https://council.ceredigion.gov.uk/ieListDocuments.aspx?CId=141&MId=218&Ver=4&LLL=0>)

The Coroner's Officer was contacted to request an update on when this year's Senior Coroner's Local Authority Report to the council would be provided, however the report has not been provided.

## CURRENT SITUATION:

The Statistical Return was published on the Council's website on 12 July 2022 following the publication of the National Statistics publication by the Ministry of Justice. The return is presented to the committee for information (**Appendix 1**). The committee should note that sensitive personal information has been redacted from the Statistical Return.

An update has been provided from the Coroner's Office on their work on organ donation:

"A successful multiple organ donation was orchestrated by Mr Steve Lloyd, Coroner's Officer, Dyfed-Powys Police, who worked with the Welsh Specialist Nurses for Organ Donations and Mr Jason Shannon, Wales' first Lead Medical Examiner. Mr Lloyd's exceptional efforts and expertise resulted in multiple lives saved, including that of an 8 month old baby. The experience and knowledge gained from this recent incident places Ceredigion's coroners on an even better footing for future opportunities to facilitate organ donation and to save lives."

The Senior Coroner's Local Authority report will be presented to this committee at the first available opportunity after it is received from the Coroner's Officer.

**Has an Integrated Impact Assessment been completed? If not, please state why**

**Summary:** This report does not represent a change in policy or strategy.

## WELLBEING OF FUTURE GENERATIONS:

**Long term:**

**Integration:**

**Collaboration:**

**Involvement:**

**Prevention:**

## RECOMMENDATION (S):

That the Committee:

1. Notes the contents of the Ceredigion Senior Coroner's 2021 Statistical Return

## REASON FOR RECOMMENDATION (S):

Monitoring of the annual information relating to deaths reported to the Ceredigion Senior Coroner.

## Appendices

**Appendix 1 – Ceredigion Senior Coroner's Statistical Return 2021**

**Contact Name:**

Elin Prysor

**Designation:**

Corporate Lead Officer - Legal & Governance (and Monitoring Officer)

**Date of Report:**

21/11/22

**Acronyms:**

N/A



# DEATHS REPORTED TO CORONERS

JANUARY – DECEMBER 2021

**PLEASE READ THE NOTES CAREFULLY BEFORE COMPLETING**

Please complete and return this spreadsheet by 1 March 2022 to:  
**Matteo Chiesa**  
[Coroners>Returns@justice.gov.uk](mailto:Coroners>Returns@justice.gov.uk)

If you have any problems about how this spreadsheet should be completed, please refer to the “Instructions” worksheet, or contact Matteo Chiesa at [Coroners>Returns@justice.gov.uk](mailto:Coroners>Returns@justice.gov.uk) or alternatively contact 07967 595014

**PLEASE ENTER DETAILS HERE AFTER COMPLETION**

<b>NAME:</b> <input type="text" value="Stephen Lloyd"/>	<b>ADDRESS:</b> <input type="text" value="Police Station&lt;br/&gt;Aberystwyth&lt;br/&gt;Ceredigion&lt;br/&gt;SY23 1PH"/>
<b>DATE:</b> <input type="text" value="23&lt;sup&gt;rd&lt;/sup&gt; February 2022"/>	<b>E-MAIL ADDRESS</b> <input type="text" value="Steve.lloyd@dyfed-powys.police.uk"/>
<b>TELEPHONE</b> <input type="text" value="07966 648 812"/>	
<b>SOFTWARE PROVIDER</b> (Please select from dropdown options) <input type="text" value=""/> ↓	<b>FURTHER DETAILS – OTHER PROVIDER:</b> <input type="text" value="Please select software provider from the dropdown list"/> <input type="text" value="XXXXXXXXXXXXXXXXXXXX"/>
Please return the completed spreadsheet by 1 March 2022 to: <b>Matteo Chiesa</b> <a href="mailto:Coroners&gt;Returns@justice.gov.uk">Coroners&gt;Returns@justice.gov.uk</a>	

Thank you

# DEATHS REPORTED TO CORONERS

January to December 2021

**FULL NAME OF CORONER'S AREA**

**CEREDIGION**

*PLEASE READ THE NOTES CAREFULLY BEFORE COMPLETING AND READ THE CHECKS SUMMARY BEFORE SUBMITTING*

## SECTION A: New Casework

### SECTION A: DEATHS REPORTED TO CORONER IN 2021

	With post mortem			Without post mortem			TOTAL		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
(i) Deaths reported to the coroner which will not result in an inquest (whether or not a certificate of any sort is issued)	73	43	116	78	72	150	151	115	266
(ii) Deaths reported to coroners on which inquests are to be or were opened (even if not concluded)	13	2	15	0	0	0	13	2	15
(iii) Deaths reported to coroners on which inquests are under investigation and is not yet known if an inquest will be opened	7	5	12	0	0	0	7	5	12
<b>TOTAL: (i) + (ii) + (iii)</b>	<b>93</b>	<b>50</b>	<b>143</b>	<b>78</b>	<b>72</b>	<b>150</b>	<b>171</b>	<b>122</b>	<b>293</b>
(iv) Number of cases transferred out of area under Section 2 or 3 of the Coroners and Justice Act 2009 (not to be included above, even if they include a post mortem before transfer)									0
(v) Deaths reported or referred to the coroner requiring neither inquest nor the issue of any certificate <b>MUST BE INCLUDED IN THE "NO INQUEST NO MOST MORTEM" box above, along with cases where certificates were issued. For cases where sex of deceased not known, please indicate the number of such cases in the yellow cell on the right</b>									0

**POST-MORTEM EXAMINATIONS** – NOT to include cases that were later transferred out (if more than one on the same body, only details relating to the FIRST PM should be included in this section)

Number ordered at STANDARD RATE	141
Number ordered at NON-STANDARD RATE	2
<b>Number</b> of PMs which included HISTOLOGY	9
Number of PMs which included TOXICOLOGY	25
Number of PMs conducted using External Examination, Imaging, Test on Samples – (Toxicology/Histology if not part of an Autopsy)	0
Number of PMs conducted not including an Autopsy	0
Number of PMs conducted by a HO forensic pathologist	2

Number of second PMs conducted following request by defence lawyer	<b>0</b>
<b>N.B. we do not require any further details of any second or subsequent PM ordered in the same body to be recorded here</b>	
Number of Out of England orders made	<b>0</b>
Number of deaths abroad (give details on separate page please)	<b>0</b>

**For deaths in state detention (or within seven days of release from State Detention) reported to the coroner in 2021,**

**Please provide a count of new cases in each of the following definitions:  
(For further details, if required, see the sheet “State Detention definitions”)**

1. Prison Custody	<b>0</b>
2. Police Custody	<b>0</b>
3. Immigration removal centres	<b>0</b>
4. Mental Health Act detention	<b>0</b>
5. Residents of Probation Approved Premises	<b>0</b>
6. Secure training centre	<b>0</b>
7. Local authority secure children’s homes	<b>0</b>
8. Release on temporary licence (ROTL)	<b>0</b>
9. Release from custody within previous seven days	<b>0</b>
<b>TOTAL</b>	<b>0</b>

N.B. Please be aware that this data is cross-checked with National Offender Management Service. Please check these figures as any discrepancies will cause delay in processing your return

**SECTION B, C and D: Casework completed during the year**

<b>SECTION B: CONCLUSIONS RECORDED AT INQUESTS IN 2021 (including inquests with juries)</b>			
	Numbers of conclusions (not treasure inquests)		
	Male	Female	Total
Killed unlawfully	<b>0</b>	<b>0</b>	<b>0</b>
Killed lawfully	<b>0</b>	<b>0</b>	<b>0</b>
Suicide	<b>9</b>	<b>1</b>	<b>10</b>
Attempted or-induced abortion	<b>0</b>	<b>0</b>	<b>0</b>
Cause of death aggravated by lack of care, or self-neglect	<b>0</b>	<b>0</b>	<b>0</b>
Alcohol/Drug Related	<b>0</b>	<b>0</b>	<b>0</b>
Road Traffic Collision	<b>0</b>	<b>0</b>	<b>0</b>
Want of attention at birth	<b>0</b>	<b>0</b>	<b>0</b>
Deaths from industrial diseases	<b>1</b>	<b>0</b>	<b>1</b>
Deaths by accident or misadventure	<b>4</b>	<b>1</b>	<b>5</b>
Stillbirth	<b>0</b>	<b>0</b>	<b>0</b>
Deaths from natural causes	<b>0</b>	<b>0</b>	<b>0</b>
Open	<b>1</b>	<b>0</b>	<b>1</b>
Disasters (where inquest resumed after adjustment under Sch.1 of Coroners and Justice Act 2009)	<b>0</b>	<b>0</b>	<b>0</b>
Unclassified (including narrative conclusions)	<b>0</b>	<b>0</b>	<b>0</b>
<b>TOTAL (All conclusions)</b>	<b>15</b>	<b>2</b>	<b>17</b>

<b>AGE OF DECEASED IN INQUEST CONCLUSIONS:</b>	
Number of inquest conclusions returned in 2021 where age of deceased at time of death was:	
Under 1 year	0
1 to 14 years	0
15 to 24 years	2
25 to 44 years	4
45 to 64 years	4
65 years and over	7
Age not known	0

<b>SECTION C: INVESTIGATIONS SUSPENDED under Schedule 1, Paragraphs 1, 2, 3 and 5 of the Coroners and Justice Act 2009 which it has been decided NOT TO RESUME DURING 2021</b>					
	Subsection under which Suspension occurs (under near regulations)				
	Sch.1 Para.1	Sch.1 Para.2	Sch.1 Para.3	Sch.1 Para.5	T
Murder	0	1	0	0	1
Manslaughter	0	0	0	0	0
Infanticide	0	0	0	0	0
Charges of causing death contrary to RTA 1968	0	1	0	0	1
Aiding, abetting, counselling or procuring suicide	0	0	0	0	0
Corporate manslaughter	0	0	0	0	0
Other criminal charges	0	0	0	0	0
Inquiry under inquiries Act 2005 (no charge)			0		0
General power to suspend (no charge)				0	0
<b>TOTAL</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>2</b>

<b>Section D (X): INQUESTS in 2021</b>			
	With juries	Without juries	TOTAL
Number of inquests (excluding treasure)	0	19	19
Of which: inquests held by order of the High Court			0
Inquests quashed or amended by the High Court			0
<b>Section D (X): EXHUMATIONS IN 2021</b>			
The number of exhumations ordered under Schedule 5 paragraph 6 of the Coroners Act 2009			0
<b>Section D (X): TREASURE FINDS in 2021</b>			
Number of finds reported under the TREASURE ACT 1996			0
Number of inquests concluded (see note below)			0
Of which: Number of conclusions of treasure			0
Number of inquests on treasure Trove (only inquests on finds made before 24 Sept 1997 should be reported here)			0
<b>Section D (X): PREVENTION OF FUTURE DEATHS REPORTS SUBMITTED IN 2021</b>			
The number of Prevention of Future Deaths Reports issued in 2021 (Regardless of inquest conclusion date)			1

## Notes

1. The number of inquests into treasure concluded during 2020 must be equal to or greater than the number of verdicts of Treasure recorded in the box below it.

Sch.1, Para.1: Criminal charges/service charges may be brought

Sch.1, Para.2: Criminal charges/service charges have been brought

Sch.1, Para.3: Inquiry under the inquiries Act 2005

Sch.1, Para.5: Suspended for other reasons

## SECTION E: TIME SPENT ON CASES

### 1. Deaths investigated in 2021 where there was no inquest i.e. deaths reported at section A (i) (top row + 'sex not known')

Number of cases reported at section A (i) in which certificates were issued within:

One week or less		<b>197</b>
Over a week and up to one calendar month	+	<b>33</b>
Over one calendar month <sup>1</sup>	+	<b>36</b>
All deaths investigated where a certificate was issued, but there was no inquest	<b>Subtotal</b>	<b>266</b>
No certificate issued (in section A these will have been included in the "no inquest, no PM" part of A (i)) +	+	<b>0</b>
All deaths reported in 2021 where there was no inquest, i.e. Section A (i) + cases where sex not known	=	<b>266</b>

### 2. Deaths in 2021 on which inquests are to be or were opened (even if not yet concluded) i.e. all deaths reported at Section A (II)

Number of cases reported at section A (ii) in which disposal certificates were issued within:

<u>Deaths in England and Wales</u>	One week or less		<b>4</b>
	Over a week and up to one calendar month	+	<b>9</b>
	Over one calendar month <sup>1</sup>	+	<b>2</b>
	TOTAL CASES – England and Wales	<b>Subtotal</b>	<b>15</b>
Deaths elsewhere	TOTAL CASES – Elsewhere	+	<b>0</b>
All deaths in 2021 on which inquests are to be or were opened i.e. Section A (II)	=	<b>15</b>	

### 3. Deaths investigated in 2021 where it is not yet known if there will be an inquest i.e. deaths reported at section A (III)

**Please note, this should be a snapshot of investigations open at the end of 2021**

Number of cases reported at section A (III) in which certificates were issued within:

One week or less		<b>7</b>
Over a week and up to one calendar month	+	<b>4</b>
Over one calendar month <sup>1</sup>	+	<b>1</b>
All deaths where a certificate was issued, but it not yet known if an inquest will be held	<b>Subtotal</b>	<b>12</b>
No certificate issued (in section A these will have been included in the *no PM* part of A (III))	+	<b>0</b>
All deaths reported in 2021 where it is not yet known if there will be an inquest i.e. Section A (iii)	=	<b>12</b>



**4. Deaths on which inquests in 2021 were: (a) concluded or (b) not resumed following adjournment under Schedule 1, Paragraphs 1, 2, 3 or 5. (i.e. all conclusions in section B plus all charges in section C)**

Number of cases where the inquest was either concluded, or adjourned under Schedule 1, Paragraph 1, 2, 3 or 5 within:

<u>Deaths in England and Wales</u>	One month or less <sup>2</sup>		<b>0</b>
	One to three months <sup>2</sup>		<b>2</b>
	Three to six months <sup>2</sup>		<b>6</b>
	Six to twelve months <sup>2</sup>		<b>7</b>
	Over twelve months <sup>2</sup>		<b>4</b>
	TOTAL CASES – England and Wales		<b>19</b>
Deaths elsewhere	TOTAL CASES – Elsewhere	<b>+</b>	<b>0</b>
All deaths on which inquests were held in 2021 i.e. total of Section B and C			<b>= 19</b>

**5. Inquests still open or in progress at the end of 2021 (i.e. neither concluded, nor adjourned under Schedule 1, Paragraphs 1, 2, 3 or 5)**

Please indicate the number of inquests in progress for the following time periods:

	<b>Deaths in England and Wales</b>	<b>Deaths Elsewhere</b>
1. Less than 6 months	<b>5</b>	<b>0</b>
2. Over 6 months but no more than 12 months	<b>3</b>	<b>0</b>
3. Over 12 months but more than 2 years	<b>0</b>	<b>0</b>
4. Over 2 years	<b>0</b>	<b>0</b>
Start date <sup>3</sup> of oldest case in each column	<b>15/04/2021</b>	
Please give brief descriptions of the two cases reported in the row immediately above:	<b>delays with device examination</b>	

**Footnotes to Section E**

1. To include cases for which certificates had not been issued by 31 January 2021.
2. For cases adjourned under Schedule 1, Paragraphs 1, 2, 3 & 5 and not resumed, time should be measured up to the date when Form 120 was issued.
3. Please check the dates are correct according to your case files. In particular, ensure the month and day have not accidentally been reversed (e.g. 4 May 2021 should appear as 04/05/21 (or 4 May 2021) and not as 05/04/2021).









**Brief details of inquests closed after 12 months or more (from the date the death was reported to the coroner)**

**Inquests closed between 1 January 2021 and 31 December 2021**

Supplementary to Question 4 of Section E

Please enter reported dates in format dd/mm/yy

Please check the overall average weeks figure in cell J6 for your area and consider if this is in line with your understanding before submission

<b>Inquests Concluded</b>	<b>Date Death Reported</b>	<b>Name</b>	<b>Country of Death</b>	<b>Date inquest concluded</b>	<b>No. of days between the start date (second column) and date inquest concluded (fifth column)</b>	<b>Average Weeks</b>
Case No.						
140/20			Wales		442	63.14286
20/20			Wales		639	91.25871
291/20			Wales		372	53.14286
34/20			Wales		398	56.85714

<b>Overall Av Weeks</b>	66.107143
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