HM Senior Coroner Andrew Hetherington

Senior Coroner for North Northumberland and

Acting Senior Coroner for South Northumberland

Annual Report

May 2023

Contents

Introduction

1. This is my second annual report.

2. COVID-19 has had a significant impact on all areas of life including the coronial system and the families and organisations with whom we interact. As restrictions have eased and we have moved to a recovery phase with a return to pre-pandemic working practices.

3. Many of the provisions of the Coronavirus Act 2020 expired at midnight on 24 March 2022. Some provisions were extended by the Coronavirus Act 2020 (Delay in Expiry: Inquests, Courts and Tribunals, and Statutory Sick Pay) (England and Wales and Northern Ireland) Regulations 2022, SI 2022/362 until 24 September 2022. Some provisions have been set in legislation including extending the time period within which an attending doctor must have seen the deceased before death from 14 to 28 days and suspension of the requirement for a confirmatory medical certificate (known as Cremation 5 Form) before cremation.

4. In Northumberland the Coroner's Office worked throughout the pandemic as near normal as possible respecting the restrictions in place and adapting practices in line with temporary easements that were introduced. That was not the case for all Coroner's areas in parts of England and Wales who entered the recovery phase of the pandemic with a large backlog of cases and inquests that must be heard. Some areas were unable to hear any inquests at all and were struggling to deal with day to day referrals. The resources in coronial areas throughout England and Wales vary. Coronial areas implemented plans in order to achieve recovery. I am pleased to confirm that in Northumberland we leave the pandemic (although COVID remains with us) with no backlog of cases and have been able to clear cases, many involving juries that pre-dated the pandemic.

5. I would like to thank Northumberland County Council for their continued support and acknowledge the hard work and dedication of those who work in the Coroner's Office together colleagues locally within the Council, Registration and Bereavement Services, NHS and organisations who we have contact with.

Contents of report

6. I have provided an overview of the current position with regard to the coroner service in Northumberland following my last review in 2021 with a comparison of neighbouring areas, the number of deaths referred to Northumberland over the period, notable trends and patterns, an update on the area and the road ahead.

Statistics

7. The Ministry of Justice publish coroner statistics annually for the period January to December which are then published in the month of May of the following year. The annual statistics for 2021 (period January 2021 to December 2021) can be found here:

Coroners statistics 2021: England and Wales

Coroners statistics 2021: England and Wales (statistical tables)

Annual statistics for England and Wales 2021

8. For England and Wales, the statistics showed the following: **195,200** deaths were reported to coroners in 2021 (in the period January to December 2021), the lowest level since 1995. This figure was down 5% (10,258 deaths) compared to 2020.

9. 33% of all registered deaths were reported to coroners in 2021.

10. There were **580** deaths in state detention reported to coroners in 2021, up 7% on the previous year (which was up 18% compared to 2019). Seven state detention deaths were reported in Northumberland in 2021.

11. There were **84,599** post-mortem examinations ordered by coroners in 2021, a 7% increase compared to 2020. Post-mortem examinations were carried out on 43% of all deaths reported in England and Wales in 2021, an increase of 5% compared to the previous year.

12. **32,800** inquests were opened in 2021, up 2% compared to 2020. The estimated average time taken to process an inquest increased from 27 weeks in 2020 to 31 weeks in 2021.

Annual statistics for North and South Northumberland 2021

13. In 2021 the total number of deaths referred to the Coroner in Northumberland (North and South) were **1,918.** This represents an increase of **10**% for deaths referred for 2021 as compared to 2020.

14. The increase in the number of referrals was anticipated. Northumberland (North and South) as a coronial area is the only one in the Northumbria Police sphere to have a prison and there are two secure mental health hospitals. The law provides there must always be an inquest following a death in custody or a death in state detention, even if the death is of natural causes. If the death is unnatural, the Coroner will be required to sit with a jury.

15. Northumberland contains a section of the A1 motorway as well as several major A-roads, the east coast main rail line to/from London as well as the east/west rail link to/from Newcastle to Carlisle. In this area I hear a number of deaths following Road Traffic Collisions.

16. The primary hospital within this area is the Northumbria Specialist Emergency Care Hospital (NSECH) at Cramlington. This opened in 2015 and continues to expand being the first vanguard, purpose built specialist emergency care hospital

in England. NSECH's influence and capacity receiving seriously unwell people from all over the region (let alone this area) is increasing.

17. Northumberland has a large NHS trust being Northumbria Healthcare NHS Foundation Trust which also has Alnwick Infirmary, Berwick Infirmary, Blyth Community Hospital, Haltwhistle War Memorial Hospital, Hexham General Hospital, Morpeth NHS Centre, Rothbury Community Hospital and Wansbeck General Hospital located within this area.

18. There were **213** post-mortem examinations ordered in North Northumberland (32% of deaths reported) and **464** post-mortem examinations were ordered in South Northumberland (37% of deaths reported). This represents a total number of post-mortems for both areas of **677**. This is an increase in the number of post-mortem examinations by 17% for North Northumberland and a 19.8% increase for South Northumberland compared to last year.

19. The average post mortem rate for England and Wales is 43% of deaths referred. The post mortem rate as a percentage of deaths referred in Northumberland (North and South) is 35%. Overall we have the lowest post mortem rate locally.

20. Please see Table 1 below. As a comparator with the neighbouring coroner's areas (Newcastle and North Tyneside are due to merge), Northumberland (North and South) have the second highest number of deaths referred to the coroner and concluded the second highest number of inquests.

Table 1: Comparison of statistics Coroner's areas in the North East of England January 2021 to December 2021

Coroner's area	Number of Deaths reports 2021	% change in reports deaths	Inquests opened	Post Mortem Examinations	Post Mortem rate as % of referrals
Newcastle upon Tyne	2112	+ 22%	352	835	40%
North Tyneside	963	-9%	95	345	36%
Sunderland	1203	+ 5%	157	442	37%
Gateshead and South Tyneside	1725	-53%	223	697	40%
North Northumberland	667	+7%	62	213	32%
South Northumberland	1251	+13%	161	464	37%
TOTAL Northumberland	**1918**	**+10%**	**228**	**677**	**35%**

21. **62** inquests were opened in 2021 in North Northumberland and **161** inquests were opened in South Northumberland.

22. **97** inquests were concluded in 2021 in North Northumberland and **234** inquests were concluded in South Northumberland.

23. The estimated average time taken to process an inquest in North Northumberland increased to **27** weeks (from 21 weeks in 2020) and in South Northumberland the average time increased to **25** weeks (from 18 weeks in 2020).

Cases over 12 months

24. Annually it is my responsibility to submit a return detailing cases over 12 months to the Chief Coroner who has in turn a statutory duty to report those cases to the Lord Chancellor.

25. There are a number of reasons why some cases are outstanding. For instance, if there are ongoing police enquiries, criminal investigations and prosecutions, investigations overseas, Health and Safety Executive (HSE) or Prisons and

Probation Ombudsman (PPO) inquiries, Independent Office of Police Complaints (IOPC) inquiries or investigations by one of the specialist accident investigation bodies. In those instances, the coroner's inquest is put on 'hold' pending the outcome of those enquiries or investigations. In some cases, those other investigations are very lengthy. This can result a delay sometimes amounting to years.

26. In addition, for many Coroner's areas the impact of the COVID-19 pandemic has seen an increase in the numbers of death referrals to coroners and a reduction in the ability of coroners to hold inquest hearings. The period of lockdown has meant that many inquests have had to be adjourned or postponed. Some court rooms were not suitable for holding anything but the most straightforward of inquest hearings because they are too small. The Chief Coroner issued guidance to assist with the holding of remote hearings, but there are some large or complex inquests that can only be held with all participants present.

27. Many jury inquests had to be postponed. A jury is required by law in certain inquests, including non-natural deaths in custody or other state custody or where the police forces were involved. Holding inquests with juries has been a particular issue during the pandemic due to social distancing requirements, especially where for coroners whose area, such as Northumberland which includes a prison and secure mental health hospital.

Cases over 12 months in Northumberland 2021

28. In North Northumberland there were **17** cases that are over 12 months. In South Northumberland there was **34** case over 12 months. All cases over 12 months have been concluded.

Annual statistics for North and South Northumberland 2022

29. I am seeing an increase in the number of deaths referred to Northumberland year on year. Please see table 2 below for a comparison of neighbouring areas.

30. In England and Wales 208,430 deaths were reported to coroners in 2022, the highest level since 2019. This is an increase of 13,250 (7%) from 2021.

Table 2: Comparison of statistics Coroner's areas in the North East of England January 2022 to December 2022

Coroner's area	Number of Deaths reports 2021	% change in reports deaths	Inquests opened	Post Mortem Examinations	Post Mortem rate as % of referrals
Newcastle upon Tyne	1977	-6%	266	754	38%
North Tyneside	960	0%	70	370	39%
Sunderland	1084	-10%	138	451	42%
Gateshead and South Tyneside	1591	-8%	167	744	47%
North Northumberland	800	+20%	88	242	30%
South Northumberland	1228	-2%	182	490	40%
TOTAL Northumberland	**2028**	+6%	**270**	**732**	**35%**

31. In Northumberland in 2022 we saw a 6% increase in death reported as compared to 2021 The total number of deaths referred to Northumberland was **2,028.**

32. The Annual Statistics can be found here: Coroners statistics 2022 - GOV.UK (www.gov.uk)

33. Since 2020 the number of deaths referred in Northumberland has increased by 17% (1737 deaths referred in 2020 with 2028 deaths referred in 2022).

34. There are a number of reasons for the increase. Firstly I am satisfied that deaths are now being appropriately referred and captured. Secondly the growth, reach and expansion of NSECH receiving seriously unwell people from all over the region who previously are likely to have attended hospitals outside of Northumberland in other (coronial) areas (and therefore formed part of their reported deaths).

35. There were **242** post-mortem examinations authorised in North Northumberland (30% of deaths reported down from 32% in 2021) and **490** post-mortem examinations were ordered in South Northumberland (40% of deaths reported up from 37% in 2021). This represents a total number of post-mortems for both areas of **732**. Overall the post mortem rate has remained at 35% despite a 6% increase in the number of deaths reported.

36. **88** inquests were opened in 2022 in North Northumberland (up 42%) and **182** inquests were opened in South Northumberland (up 13%).

37. The estimated average time taken to process an inquest in England and Wales decreased from 31 weeks in 2021 to 30 weeks in 2022. The estimated average time taken to process an inquest in North Northumberland remained at **27** weeks and in South Northumberland the average time increased to **26** weeks (from 25 weeks in 2021.

Cases over 12 months in Northumberland 2022

38. In North Northumberland there were **17** cases that were over 12 months. In South Northumberland there were **34** cases that were over 12 months. All of those cases over 12 months have now been concluded.

Notable trends and patterns

39. As above, in 2021, 32,300 inquest conclusions were recorded in total in England and Wales, up 4% on 2020. The number of suicide conclusions increased by 8% to 4,820 compared to 2020, to the highest level since 1995. The increase was higher in females (16% compared to 2020) than males (which increased by 5%) compared to 2020.

40. In Northumberland in 2021 we also saw an increase in suicide conclusions returned in line with the observed tend in England and Wales.

41. Reflecting on previous years, I have considered the annual returns dating back to 2018/2019 (please see Table 3 below). In Northumberland in 2019 the number of suicide conclusions returned were 18. (This was a decrease of 33% compared to 27 suicide conclusions returned in 2018). From 2019, the number of suicide conclusions increased by 66% to 30 suicide conclusions. In 2020 there were 44 conclusions of suicide retuned being an increase of 47% from 2020 as compared to 2021.

42. In England and Wales Suicide conclusions have gone up year on year since 2016, except for 2020. The highest number of suicide conclusions was recorded in 2022 driven by an increase in male suicides which went up by 3% to its highest recorded level since records begun. However, it is worth noting that in 2022 we have seen the number of suicide conclusions (post *Maughan*) return to the level seen in 2019 (being a decrease of 52%).

Table 3: Suicide conclusions returned in Northumberland over the period 2019 to 2022

Year	**Suicide conclusions**	**Increase/decrease from previous year as %**
2019	18	- 33%
2020	30	+ 66%
2021	44	+ 47%
2022	21	-52%

43. There are a number of explanations for the increase in suicide conclusions. Firstly the increase may be a consequence of the change in the standard of proof established by the Supreme Court in the case of *Maughan*.

44. On 13 November 2020 the Supreme Court gave judgment in the case of *Maughan* (R (on the application of Maughan) v. HM Senior Coroner for Oxfordshire [2020]

UKSC 46). By a majority of three to two the Supreme Court ruled that all conclusions in coronial inquests, whether short form or narrative, are to be determined on what is known as the civil standard of proof i.e. the balance of probabilities. This is a test that coroners are used to dealing with as they (and juries directed by them) apply in many inquests. The legal rule had previously been that a conclusion of suicide could only be returned if the coroner or jury were satisfied to the criminal standard (i.e. beyond reasonable doubt).

45. Secondly although the inquests in England and Wales concluded in either 2021 or 2022, some of the deaths occurred prior to 2021 and their respective inquests were delayed for a number of reasons in particular the restrictions in place due to COVID and lockdown.

46. It remains unclear the extent to which the COVID-19 pandemic, the restrictions that were in place and any anguish and concern may have had on this trend. A lot of work is being undertaken now that we return to 'normality' following the pandemic through data returns and some clarity may flow from the public inquiry. Certainly, in some inquests that I heard in the last three years where a conclusion of suicide was returned, in some matters it was not uncommon for the deceased prior to their death to have expressed anguish regarding COVID-19, a fear or concern of contracting COVID-19 and falling ill themselves or a concern of passing COVID-19 to a family member or loved one. In other instances, a deceased person had expressed feelings of loneliness or despair during periods of lockdown.

47. Whilst I am unable to comment on specific cases where the inquest has not yet concluded and where evidence has not been heard in open court, I have identified a worrying trend involving the number of potential self-inflicted deaths in younger persons where a conclusion of suicide is a likely conclusion.

48. One inquest that I am able to refer to in anonymised terms involved the death of 12 year old young person who died in October 2020 and whose inquest concluded in October 2022. I returned a conclusion of suicide.

49. I heard that the young person had suffered with low mood and anxiety relating to several factors including the restrictions in place due to COVID-19, relationship difficulties with peers and other influences. The young person had also suffered bullying in the period leading up to death through electronic means. The young person had also had two known previous instances of self-harm. On one occasion the young person had attended accident and emergency after an incident of self-harm and having been assessed was referred two and seen by the psychiatric liaison team. The young person wanted support with anxiety and low self-esteem and to learn positive coping strategies for times of emotional distress due to several factors. A referral was made to the Young Persons Universal Crisis Team and was assessed by them but at that time did not meet the criteria for referral to Children and Young Peoples Services.

50. In evidence I heard that in 2020 if the criteria had been met for referral to Children's Adolescent Mental Health Services there would have been a triage of the child or young person within 8 weeks, treatment within up to 19 weeks with the number of referrals at that time being 1595.

51. At the time of the inquest in 2022 subject to meeting their criteria for referral there would be a triage of the child or young person within 3 weeks but that the waiting time for treatment had increased from up to 19 weeks to up to 63 weeks with the number of referrals being 2,275.

52. In evidence from the school where the deceased was a pupil, I heard that since the death they have strengthened their support for children suffering from anxiety and other mental health issues by increasing the mental health team employing two emotional literacy teaching assistance, a mental health and

wellbeing practitioner, another Thrive Practitioner and increased the number of deputy safeguarding leads to five.

53. I also heard from a Paediatric Nurse Practitioner based in the Accident and Emergency department who told me that in 2020 it was the case that they would see a referral from a child or young person struggling with emotional distress, anxiety, mental health difficulties and instances of self-harm and overdose once a week but that since the coronavirus pandemic the incidence of assessments for children and young people with those issues has risen from once per week to once per shift.

54. The mental health trust told me that in May 2020 they would see 100 referrals a month from children experiencing anxiety and mental health difficulties but by May 2022 the number of referrals had increased to 300 children per month. The reason for the referrals were complex but included the impact of the pandemic with staff seeing an increase in demand in the numbers of young people suffering with anxiety, low self-esteem, body image OCD and instances of self-harm and overdose.

55. Sometimes a coroner's investigation will show that something could be done to prevent other deaths. If the coroner considers this to be the case the coroner must write a report bringing it to the attention of an organisation or a person who may be able to take action to prevent future deaths. This is known as a "report to prevent future deaths" or a "Regulation 28 Report". The organisation or person must send the coroner a written response, within 56 days, to the report, saying what action it will take as a result.

56. In light of the concerns I heard during the course of the inquest given the increase in the number of children and young people who were being seen with regard to their emotional well-being, psychological distress and mental health difficulties having impacted on them requiring support and assessment since the

coronavirus pandemic and the delays that now exist before they receive treatment and support, I wrote to the then Secretary of State for Health.

57. In light of the evidence I had heard I asked for consideration to be given for an assessment of the services and resources that can be offered to meet the increasing demand in the number of children and young people seeking support with regard to their emotional well-being, psychological distress and mental health difficulties which have impacted on them since the coronavirus pandemic and to reduce the delay in receiving early support in order to avoid her mental health crisis.

58. The Minister with responsibility for Mental Health at the Department of Health and Social Care provided a response in conjunction with NHS England and the Care Quality Commission (CQC).

59. In that response there was recognition of the increase in probable mental health conditions amongst children and young people, that it has increased in the context of, firstly, historical underfunding for mental health services and the COVID-19 pandemic.

60. I was referred to the NHS Long Term Plan and the NHS Mental Health Implementation Plan 2019/20 – 2023/24 which commits to an additional £2.3billion a year for mental health services by 2023/24. This will see an additional 345,000 children and young people able to access mental health support in 2023/24 compared to the number accessing support in 2018/19. A large part of the increase in funding for mental health will be made through integrated care board (ICB) baselines and will increase in line with the Mental Health Investment Standard, which requires ICBs to increase investment in mental health services in line with their overall increase in allocation each year. In 2021/22, 100% of ICBs met the Mental Health Investment Standard.

61. It is acknowledged that the pandemic has had an effect on the mental health and wellbeing of children and young people and that prevalence of probable mental health disorders is increasing, with 18% of children aged 7 to 16 years in 2022 having a probable mental disorder, compared to 17.4% aged between 6 and 16 in 2021 with a probable mental health disorder, which is itself an increase 11.6% in 2017. Whilst not every person with a probable mental disorder has needed, or will want to access, mental health services, it is nevertheless clear that there is increased demand.

62. I am informed there is additional funding with an additional £79 million to expand children's mental health services in the 2021/22 financial year allowing around 22,500 more children and young people to access community health services and 2,000 more to access eating disorder services. The response included "*…..over 689,000 children and young people under 18 had at least one contact with NHS-funded mental health community services in the twelve months to July 2022. This is a 12% increase from the same period to July 2021 when over 615,000 children and young people were supported by services*.

63. An additional £79 million in funding also supported a faster increase in the coverage of mental health support teams (MHSTs) in schools and colleges, which we committed to rolling out to 20-25% of the country by 2022/23. This was part of the Government's 2018 response to the Green Paper consultation on the transformation of children and young people's mental health provision, which was published in 2017. MHSTs support the mental health needs of children and young people in primary, secondary and further education and use an evidence-based approach to provide early intervention on some mental health and emotional wellbeing issues, such as mild to moderate anxiety. MHSTs now cover 26% of pupils in England and this will increase to cover around 35% of pupils by April 2023. There are 21 MHSTs in operation or being set up across the North East and North Cumbria Integrated Care System, with another five planned (as of May 2022) for 2023/24.

64. The Department for Education has committed to offer all state schools and colleges a grant to train a senior mental health lead by 2025, enabling them to introduce effective, whole school approaches to mental health and wellbeing.

65. With regard to increasing access and reducing waiting times, I am informed that in joint working with NHS England the next steps are to introduce a range of new mental health waiting time standards, including four for children and young people, which NHS England consulted on as part of its Clinically-led Review of NHS Access Standards. The four standards for children and young people are:

- For an 'urgent' referral to a community based mental health crisis service, a patient should be seen within 24 hours from referral, across all ages;
- For a 'very urgent' referral to a community based mental health crisis service, a patient should be seen within four hours from referral, for all age groups;
- Patients referred from Accident and Emergency should be seen face to face within one hour, by mental health liaison or children and young people's equivalent service; and
- Children, young people and their families/carers presenting to community-based mental health services, should start to receive care within four weeks from referral.

Update - The Coroner Service in Northumberland

66. I have discussed below the changes and developments in the coroner's service in Northumberland since my last report.

Appointment of four Assistant Coroners

67. There was a joint recruitment between Northumberland County Council, Newcastle City Council and North Tyneside Council to appoint four new Assistant Coroners to support myself as the Senior Coroner in North and South Northumberland and the Senior Coroner in the City of Newcastle and North

Tyneside across the full range of coroner duties in order to deliver a high-quality coroner service to the people of Northumberland, Newcastle upon Tyne and North Tyneside.

68. The interviews were held at County Hall, Morpeth on Monday 19th and Wednesday 21st July 2021. The interview panel comprised of HM Senior Coroner Karen Dilks, Senior Coroner for the City of Newcastle upon Tyne and North Tyneside, Karen Lounton, Service Manager Registration, Coroner and Archives – Northumberland County Council and myself.

69. There were 45 applications and following the sift, 15 candidates were taken forward to interview following approval from the Office of the Chief Coroner.

70. As above, the interviews were held across two days on 19th and 21st July 2021.

71. All candidates completed a declaration in writing confirming they are not subject to or have had findings made in respect to disciplinary proceedings or criminal proceedings. At interview, all candidates were asked to declare if there was anything they believe should be brought to the attention of the local authority.

72. Four candidates were appointed as Assistant Coroners in the areas of North and South Northumberland, City of Newcastle and North Tyneside as follows:

- James Thompson
- Tom Crookes
- Kirsten Mercer
- Georgina Nolan

73. The consent of the Chief Coroner was received on 26 July 2021 and the consent of the Lord Chancellor was received on 29 July 2021.

74. Under the terms of the Coroners and Justice Act 2009 the compulsory retirement age for these posts will be 70 years, unless the post-holder chooses to resign or is removed by the Lord Chief Justice and Lord Chancellor prior to their 70th birthday.

Cross-jurisdictional appointments

75. On 5 March 2021 I requested the consent of the Chief Coroner to the appointment of HM Senior Coroner Derek Winter, the Senior Coroner for City of Sunderland (and Deputy Chief Coroner) and HM Senior Coroner Karen Dilks, the Senior Coroner for City of Newcastle and Acting Senior Coroner for North Tyneside to be appointed as assistant coroners in North Northumberland and South Northumberland. The appointments were a consequence of the need to provide additional judicial resource and resilience for Northumberland. I continue to be appointed as an Assistant Coroner in those areas and the appointment of all Senior Coroners with cross jurisdictional authority provides resilience in the event of a mass fatality or major incident.

76. Karen Dilks retired as HM Senior Coroner City of Newcastle and North Tyneside in January 2023. Following an open competition Georgina Nolan was appointed HM Senior Coroner for City of Newcastle and North Tyneside as of 26 January 2023. She continues to be an Assistant Coroner in Northumberland (as I continue to be an Assistant Coroner City of Newcastle and North Tyneside) for resilience and cross jurisdictional working.

Coroner's Officers

77. Coroner's Officers in Northumberland are employed by Northumbria Police.

78. I am sorry to see some departures. Coroner's Officer Michael Allen retired after 46 years employment with Northumbria Police in December 2021 and 17 years as

a Coroner's Officer. Keith Lamb also retired in June 2022 after 47 years service with Northumbria Police and 15 years as a Coroner's Officer. Karen Edger took early retirement and left in June 2022.

79. In October 2022 we were joined by Sarah Abrahams and in January 2023 Rebecca Moss joined the team.

80. I am grateful for the continued support from Northumbria Police and recognise the considerable budget pressures placed upon them. However, I have requested greater resourcing.

81. As above, Northumberland is getting busier, we are stretched, there is a disparity in the number of Coroner's Officers deployed in Northumberland as compared to other areas locally. The number of deaths referred to this area has increased considerably over the short term (17% over the period 2020 to 2022) while the number of coroner's officers has remained the same. The number of in person inquests has also increased. There is a prison and two secure mental health hospitals. The law provides there must always be an inquest following a death in custody or state detention, even if the death is of natural causes and if the death is unnatural, I will be required to sit with a jury.

82. This is discussed below but when the Chief Coroner visited our area I submitted my concerns to him and he has endorsed my proposal that there should be 6 coroner's officers allocated to this area.

Treasure inquests

83. Northumberland is a county of treasure. In 2022 there were 8 reported treasure finds and I concluded 3 treasure inquests.

84. The Department of Digital, Culture, Media and Sport are responsible for the Treasure Act 1996. The department is proposing to introduce an additional class of treasure based on what they term 'significance', and to redraft the Code of Practice. Their aim is to ensure important finds that are currently not Treasure because they are not made of precious metal become available for museums to acquire. The Code of Practice has not been updated for 15 years.

Recovery from the COVID-19 pandemic

85. Throughout the pandemic the Coroner's Office in Northumberland worked as near normal as possible in line with the guidance and restriction in place. Unlike other Coroner's areas in England and Wales, I am pleased to confirm that we have been left with no backlog.

86. The coroner's service in Northumberland has been able to function well due to the modern facilities we have available to conduct inquests, IT provision and the capacity to hold remote hearings, the systems we have in place including Civica and referrals through the Portal. But importantly thanks to the hard work and resilience of the Coroner's Officers and Coroner's Administration staff.

87. We benefit from a large court room that can be well ventilated with capacity to hold juries (of 7 – 11 persons). We have from the outset used IT and conducted remote hearings with families from Hong Kong and New Zealand who were able to actively participate inquests.

Discontinuing an investigation

88. Prior to the recent amendment, coroners could not discontinue an investigation unless a post mortem examination revealed a natural cause of death. That meant that if a natural cause of death became clear after an investigation had commenced, the coroner either had to order an unnecessary post mortem or proceed with an inquest.

89. On 28 June 2022, section 4 Coroners and Justice Act 2009 ('CJA') was amended to enable coroners to discontinue an investigation when a death from natural causes becomes clear before inquest, even where there has been no post mortem examination. Corresponding amendments were also made to The Coroners (Investigations) Regulations 2013, The Cremation (England and Wales) Regulations 2008 and Form Cremation 6.

90. The amendment has widened the circumstances in which discontinuance can occur. However there is an exception where the death occurred in custody or state detention, an inquest must still be held.

91. This means that investigations can now be discontinued either where there has been a post mortem or where there has been no post mortem but the cause of death has become clear by other means.

Remote hearings

92. With the principle of open justice, legal hearings including those in the coroner's court are to be transparent and open to scrutiny. Coroners must ensure that there is appropriate public access to all hearings, including those that are conducted using remote means.

93. On 28 June 2022, section 85A of the Courts Act 2003, and the Remote Observation and Recording (Courts and Tribunals) Regulations 2022 ('the Regulations') came

into effect. These provisions allow the remote observation of proceedings in any court, tribunal or body exercising the judicial power of the State, including coroners' courts. As a result it is lawful to use video/audio livestreaming to transmit proceedings to the public and/or press, either to premises designated by the Lord Chancellor, or to specific individuals.

94. A coroner must be physically present in a courtroom when conducting hearings. Individuals have the option of either observing hearings in person, or applying for permission to observe hearings remotely. No-one has the right to observe a hearing remotely. Individuals are entitled to apply for permission (explaining why it is in the interests of justice to allow them to observe a hearing remotely when there is the option to attend in person) applications are considered on a case-by-case basis and may be refused. Individuals include interested persons, witnesses and legal representatives.

95. It is now open to members of the press/media to apply for permission to attend an inquest remotely.

96. As the law currently stands, the coroner and any jury must be physically present in the courtroom.

97. Remote participants are remined that they are attending a formal hearing, and to dress and act accordingly despite the informality of their own surroundings. Warnings are also given should be given, for example that witnesses should not confer on their evidence.

98. As previously outlined, from its inception the Coroner's Court at County Hall was "future proofed" and ready for legislative changes to enable the wider use of remote inquests. It may be the case that if applications from the press or media are received a dedicated live stream camera would need to be installed. This will be kept under review.

Inquests in writing and Rule 23 evidence

99. On 28 June 2022, new provisions came into effect allowing inquests to be held in writing. Section 9C Coroners and Justice Act 2009 creates a new power for coroners to decide that an inquest will be held in writing. When conducting an inquest in writing under Section 9C, inquests will be opened in the usual way, but then no further hearing will be required.

100. There are many straightforward and uncontentious cases in which a hearing in writing might be appropriate. The benefits include avoiding a stressful hearing for the family and saving witnesses the stress and inconvenience of having to give oral evidence.

Implementation of the Statutory Medical Examiner Scheme

101. The Written Ministerial Statement published on the 27th April 2023 sets out the Government's commitment to implement a statutory medical examiner system from April 2024. The non-statutory scheme will continue for the time-being. We continue to work closely with medical examiners as the implementation work develops.

The Chief Coroner - His Honour Judge Thomas Teague QC

102. The Chief Coroner - His Honour Judge Thomas Teague QC, the third Chief Coroner of England and Wales, and his office visited every Coroner's Area in England and Wales

103. In Northumberland we welcomed the Chief Coroner and his office to County Hall on 10 February 2023. The Chief Coroner met with Councillor Glen Sanderson, Gill O'Neil, Nigel Walsh, representatives of Northumbria Police and the Coroner's Officers and Coroner's Administration Team.

104. The Chief was very impressed by the Court facilities, offices and accommodation. He also offered an insight as to the expected number of deaths in the next few years which he anticipates will increase. In line with this anticipated increase the Chief recommended to Northumbria Police that that the provision of Coroner's officer be increased to six.

Conclusions

105. This is my second annual report. It has been a challenging time for all. We have moved into a period of recovery from the COVID-19 pandemic, and, unlike many coronial areas in England and Wales, Northumberland left with no backlog of COVID cases.

106. Towards the end of 2022 and into 2023, we experienced exceptional winter pressures which increased stress on mortuary capacity. In Northumberland in 2022 we saw an increase in the number of deaths referred (which reflects the position in England and Wales). In England and Wales 208,430 deaths were reported to coroners in 2022, the highest level since 2019. The early data being proffered suggests the potential for a larger cohort of excess deaths in 2022 than in any of the pandemic years with the numbers of registered deaths in 2022 maybe having jumped to around 650,000.

107. I continue to seek improvements and work to provide the best Coroner's service for the deceased and bereaved in Northumberland. There have been significant changes with staff leaving the Coroner's service and there has been the impact of the pandemic but also enormous positive advantages: settling into new dedicated offices and Court accommodation, the co-location of Coroner, Coroner's officers and Registration Services, a case management system Civica, portal reporting for the electronic reporting of deaths by authorised agencies and the future; the recruitment of Assistant Coroners and the potential for improved pathology services locally for the benefit of the bereaved in Northumberland.

108. The COVID-19 pandemic has increased the need to use technology in enabling remote participation in Coroner's hearings. In using technology and with the benefit of the modern facilities that have been provided by Northumberland County Council, the Coroner's service has been able to reduce delays in some inquests and minimise what would have been a greater backlog in overdue cases.. There will continue to be improvements and developments to benefit all of those who encounter the Northumberland Coroner's service.

109. At the local Authority Conference in March 2023 the Chief Coroner said "*Almost universally, behind every well-run coroner area is a good Local Authority that understands the unique needs of coroner service and does its best – with increasingly limited resources – to provide the senior coroner and the officers and staff with everything they need*". I would like to take the opportunity to thank the enormous contributions made by those within Northumberland County Council, the Coroner's Office, Registration and Bereavement Services, NHS colleagues, neighbouring councils through Local Resilience Forums and stakeholders for all their hard work, support and co-operation.

Andrew Hetherington

HM Senior Coroner for North Northumberland and Acting Senior Coroner for South Northumberland

Signed……

Dated……