Adult Social Care Inquest Panel update

Committee considering report:	Health and Adult Social Care Scrutiny Committee
Date of Committee:	10th March 2026
Portfolio Member:	Councillor Patrick Clark
Date Head of Service agreed report: ***(for Corporate Board)***	24 02 26
Date Portfolio Member agreed report:	
Report Author:	Melanie O'Rourke
Forward Plan Ref:	N/A

1 Purpose of the Report

To advise Health Scrutiny Committee on the current position regarding Inquests concerning adults known to Adult Social Care.

2 Recommendation(s)

None. For information only.

3 Implications and Impact Assessment

Implication	Commentary
Financial:	Financial costs would be incurred in the event of requiring legal counsel to represent the Local Authority. During 2022 – 26 this has occurred on one occasion, However, a further 2 are coming up where we have instructed counsel. Further financial implications would potentially include costs to changing systems, to implement lessons learnt / recommendations of independent reviews or safeguarding adult reviews.
Human Resource:	Coroners are appointed by local authorities. In West Berkshire the Berkshire Coroner's Office is hosted by Reading Borough Council. A member of Adult Social Care senior management team was on the recruitment panel for a new Assistant Coroner in 2024.

	The amount of information requested by the coroner can vary and staff input can be required at short notice Staff may be required to attend some inquests. There can be an impact on staff emotionally, depending on the circumstances of a death or relationship with the deceased. Due to this and importance of understanding what happened in some cases, higher level of staff involvement with management oversight?
Legal:	Coroners are judicial office holders and investigate deaths that have been reported to them (usually by a medical practitioner or the Police). This may happen if: • The death was violent or unnatural. • The cause of death is unknown; or, • The person died while detained by the state e.g. under the Mental Health Act 1983. The coroner may decide to investigate the death. Inquests are intended to be inquisitorial, rather than adversarial and are not intended to apportion blame for a death. The coroner cannot make any decisions as to civil or criminal liability and follows different rules. An Inquest is designed to find out and conclude who the deceased was, where, when and how the death occurred. In terms of the 'how' the Coroner can reach the following conclusions: *Natural causes, accident or misadventure, suicide, unlawful killing (or lawful killing), alcohol, drug related, industrial disease, road traffic collision, neglect (usually contributing to another conclusion e.g. natural causes, and with a different legal definition to civil/criminal actions around negligence/neglect), a narrative conclusion describing briefly the circumstances by which the death came about or an open conclusion (meaning that there is insufficient evidence to decide how the death came about and the case is left open in the event further evidence appears).* On the conclusion of an Inquest, the Coroner may made a 'Report to Prevent Future Deaths' to person(s) or organisations where the coroner believes action should be taken to prevent future deaths. If such a report is made to the Council, action should be taken and can be indicative of legal risk for the Council. The Council may be contacted by the coroner, as part of their inquiries, to provide information, to provide evidence because the Council is (or employs) a Witness of Fact or because it is an Interested 'Person'. The Council (and its staff) are legally required to comply with requests from the coroner. Being an Interested Person attracts rights to participate in the investigation and the Inquest

	Hearing. The Council may have an interest due to its involvement in the deceased's life or due to its broader statutory responsibilities, for example in relation to safeguarding adults. The Council's involvement or the issues that arise during an Inquest may therefore be relevant to other legal functions e.g. for Adult Social Care, under the Mental Health Act 1983, Mental Capacity Act 2005 and Care Act 2014. A legal instruction form for Inquests concerning Adult Social Care is available for staff to refer cases to Legal Services, for the right level of legal support depending on the Council's level of involvement. An Inquest is a legal process and there is a "Bench Book" issued by the Chief Coroner (updated January 2025) covering all aspects of court inquest work. Legal Services provide advice and assistance to Adult Social Care (and other Council departments) to navigate the inquest process and instruct Counsel to represent the Council as appropriate and seek to assist in identifying legal risks in areas of the Council's work implicated. Laura Knowles, Principal Lawyer – People Team 26.02.2026
Risk Management:	The Council's involvement in an Inquest or a request for information from a Coroner may not present a risk to the Council. It most commonly arises because of Adult Social Care's statutory functions and being an organisation which holds information about adults for the purposes of providing social services/coordinating with health bodies. Although an Inquest cannot make civil or criminal findings, it may lead to separate legal risks for the Council depending on the Council's role. In turn, there are potential financial risks; the Council has insurance in place for any civil claims but other ancillary payments, such as waiving care charges costs, are not. If applicable, the Council may be able to recover care costs it has incurred from providers under contractual arrangements. Each matter is considered on a case-by-case basis. The outcome of an inquest could result in reputational risk to the Local Authority.
Property:	N/A
Policy:	N/A

	Positive	Neutral	Negative	Commentary
Equalities Impact:				
A Are there any aspects of the proposed decision, including how it is delivered or accessed, that could impact on inequality?		X		
B Will the proposed decision have an impact upon the lives of people with protected characteristics, including employees and service users?		X		
Environmental Impact:		X		
Health Impact:	X			The purpose of the panel is to learn from the deaths and apply learning and preventative measures where possible.
ICT Impact:		X		
Digital Services Impact:		X		
Council Strategy Priorities:		X		Council priority - support for those who need it most?
Core Business:		X		
Data Impact:		X		The primary role we have in inquests is providing information about our service users to the coroner. A key action has been to make a change to record keeping in care homes.

Consultation and Engagement:	

4 Executive Summary

4.1 In 2022, due to an increased number of cases in which West Berkshire Council was being approached by the Berkshire Coroner's Office for information and/or identified by the investigating Coroner as an Interested Person in Inquests an Inquest panel was set up to strengthen internal processes relating to these matters.

4.2 A summary of recent/current Inquest activity is provided below.

5 Supporting Information

5.1 The panel meets 4 times a year and is chaired by the Service Director for Adult Social Care. The panel requires representatives from ASC operational and safeguarding functions, Legal, H&S, and Insurance as a minimum. With a focus on providing corporate oversight of cases which have either been submitted to the coroner or whereby a person has died and due to the complexities of the case strategic oversight is required, and a coroner's inquest *may* be called.

5.2 Where the Coroner has asked for information and/or those which are more complex and to consider if a Lessons Learned piece should follow/how learning from the Inquest process can be captured and disseminated. The panel therefore also provides a useful method of monitoring cases which have identified areas of development, particularly with partner agencies.

5.3 At the point at which the last report was presented to Health and Adult Social Care Scrutiny there have been 13 deaths where we were approached for information.

5.4 Activity table:

	2023 / 24	2024 / 25	2025 / 26
Coroner inquest undertaken	1	2	2
Coroner request for information	1	2	2

Coroner's inquest we have been asked to attend.	0	0	1
Panel aware due to nature of death but no coroner involvement	5	0	10
Total	7	4	15

5.5 The time between an enquiry from the coroner's office to a conclusion can be a significant number of months, and in some cases over 1 year. The panel provides the opportunity to track progress and identify opportunities to improve services provided by the Council, health bodies, and partner agencies / providers to safeguard adults for whom West Berkshire is responsible for.

5.6 Of the 5-coroner inquests undertaken in only 1 situation a recommendation was made, for WBC owned care homes to review their recording system. As a result of this a new system was procured.

5.7 2025 / 26 has seen an increase in the number of deaths discussed at the panel. This has not been due to an increase in coroner referral / input or because of a Safeguarding Adults Review. The reason has been to capture learning opportunities to improve practice.

5.8 There is no direct pattern to the deaths considered at the panel as they come in peaks and troughs. However, deaths occurring during Covid-19 lockdowns seemed to trigger the coroner asking us for information as a matter of course from 2021/2022 onwards, and possibly Covid-19 lockdowns also led an increase in family members asking the coroner to investigate.

5.9 Due to the potentially identifiable nature of the deaths, themes and learning described relate to all circumstances not just inquests.

5.10 Several deaths have involved people who have actively engaged with substances prior to their death. West Berkshire Public Health Team have been invited to the membership to ensure that issues can be captured and ensure active engagement with VIA. Training for staff has been undertaken and further training to be scheduled.

5.11 Arrangements are now in place for closer joint-working between ASC/ Housing/ VIA and Public Health in response to the deaths where homelessness/ social care needs and substance use were a feature.

5.12 Safeguarding Adult Reviews (SARs) were considered in three situations. This provides an opportunity for partner agencies to identify whether there is any collective learning. In all three occasions they were rejected.

5.13 In the event of issues relating to a care provider the ASC Care Quality Team will work directly with the provider to ensure actions identified are completed.

6 Conclusion

6.1 The panel meetings create the opportunity for organisational oversight and alert to any potential patterns concerning vulnerable people in our area. The frequency to remain as quarterly panel meetings.

6.2 The introduction of Public Health Team at the meeting to have oversight of death relating to substances will enhance potential areas of learning and working with our substance misuse provider effectively.

7 Appendices

None.

Corporate Board's recommendation

*(add text)

Background Papers:

*(add text)

Subject to Call-In:

Yes: ☒ No: ☐

The item is due to be referred to Council for final approval ☐

Delays in implementation could have serious financial implications for the Council ☐

Delays in implementation could compromise the Council's position	☐
Considered or reviewed by Overview and Scrutiny Management Committee or associated Task Groups within preceding six months	☐
Item is Urgent Key Decision	☐
Report is to note only	☒

Wards affected: All Wards affected.

Officer details:

Name: Melanie O'Rourke
Job Title: Service Director – Adult Social Care
Tel No: 01635 503499
E-mail: melanie.orourke1@westberks.gov.uk

Document Control

Document Ref:		**Date Created:**	
Version:		**Date Modified:**	
Author:			
Owning Service			

Change History

Version	Date	Description	Change ID
1			
2			