Agenda Item No: 6

Cambridgeshire and Peterborough Coroner Service Annual Report

To:	Communities, Social Mobility and Inclusion Committee
Meeting Date:	1 November 2022
From:	Assistant Director of Regulatory Services, Peter Gell
Electoral division(s):	All
Key decision:	No
Outcome:	To provide members with an update on the Coroner service and the opportunity to recommend any priority areas to focus on.
Recommendation:	The committee is asked to: Note the contents of the report.

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1. Background

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

1.2 Coroners conduct investigations into deaths that are unexpected or unexplained, including those where it is suspected that the deceased died a violent or unnatural death, where the cause of death is unknown, or where the deceased died while in custody or otherwise in state detention. Coroners will determine the identity of the deceased together with how, when and where the deceased came by their death.

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

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

1.5 The total number of deaths referred to the service in 2021 was 2,905, which is an increase from 2020. It has been recognised by the Chief Coroner that the complexity of cases has increased, and therefore cases are taking considerably longer to investigate and conclude.

2. Main Issues

2.1 Coronial appointments and staffing

2.1.1 The appointment of Area Coroners and Assistant Coroners in early 2021 has now provided the service with a level of consistency and stability. The Area Coroners (one full-time and one part-time) are contracted to work daily within the service, while the Assistant Coroners are appointed to complete complex cases referred to the service.

2.1.2 Despite an increased capacity in respect of Coroners, during the midst of the Covid-19 recovery, the service had a shortfall of coroner officers, who manage the coronial cases. This shortfall, resulting from a combination of sickness absence, maternity leave and staff departures, meant the service was operating below establishment for a significant period while steps were taken to address the shortfall.

2.1.3 This provided an opportunity during subsequent recruitment to bring in high calibre officers with extensive investigative skills, reflecting that the role of a coroner officer has become more demanding in recent years as cases have become more complex. These officers have required training in coronial law to provide the legislative and technical knowledge

specific to the role, having come from different investigatory backgrounds. At the time of writing this report, all the vacant posts are filled, with the latest appointment joining the service in early 2022.

2.1.4 Training and staff development is a key focus in order to maximise service performance and job satisfaction. The annual Coroners' Society training resumed this year, after a two-year break due to the pandemic. Officers and coroners have attended a two-day training course, and training remains an important part of team meetings. Officers also have individual training plans.

2.1.5 Work with the service's software provider, WPC, identified ways to streamline and improve efficiency through better use of the software, and consequently training for all staff was rolled out, with additional training planned to coincide with future software developments.

2.1.6 As of 1 September 2022, staff started to return to work regularly in the office. This supports collaborative working and assists with team training and meetings. With the introduction of new staff, having the ability to work together with colleagues in the office is an important part of their development.

2.1.7 As the role of coroner officers is also emotionally challenging at times due to the cases they see, ensuring there is sufficient oversight for their welfare is important. This is also easier to monitor in person. Staff work from home for part of the week when it is beneficial.

2.2 Partnerships

2.2.1 As with previous years, the service continues to build important relationships with agencies with shared interests, both nationally and locally. Processes are in place to ensure that relevant information can be readily shared with the Child Death Overview Panel, Healthcare Safety Investigation Board and the Learning Disabilities Mortality Review, with a view to improving processes and ultimately prevent future deaths. The service also attends multi-agency meetings for harm reduction, drug-related death mortality, suicide prevention and cluster groups, providing any insights or trends that the service identifies, in order to support these wider services.

2.2.2 The service has worked closely with the police over the last six months in order to improve the quality of the initial investigation they carry out upon attendance of a sudden death, and the subsequent coronial paperwork that follows. The police have now produced a 'Sudden Death' e-book for their officers, with hyperlinks to coronial processes that the service drafted. Part of this book also covers faith deaths and the separate processes that ought to be followed if someone with strict religious beliefs dies in the community. This has been very well received by both the service and police, and shared nationally by them.

2.2.3 Volunteers from the Coroners Court Support Service work with the service to offer emotional support and practical help to bereaved families, witnesses and others attending an inquest at a coroner's court. They often bridge the gap between the service and the bereaved families and have proved invaluable.

2.3 Technology

2.3.1 Following the pandemic, the service offers those attending an ieither nquest the option to

attend in person or remotely. The majority of professional attendees, such as legal representatives and medical experts, who are required to attend hearings, continue to do so remotely in order to save time in traveling and waiting in court. This has meant a reduction in reimbursement for those travelling to court, and for clinicians it has meant that they can now continue to operate their clinics without having to take a whole day out. Most families still attend in person, but the option is always there for remote attendance if preferred. The reduction in attendees at inquests has been a positive development from a carbon reduction perspective, and has also been beneficial from a service accessibility perspective.

2.3.2 Court ushers have been an essential resource in support with the technology and the efficient running of each hearing, enabling the Coroner to focus on conducting the hearing.

2.3.3 The service continues to be innovative with the use of technology, and has identified and implemented efficiencies through better use of available software functionality and equipment to enable remote hearings.

2.4 Venues

2.4.1 The service has worked hard over the year to reduce expenditure on external venue hire for inquests by 89%, which equates to a saving of £41,500. This has been possible by maximising use of Lawrence Court, Peterborough Town Hall and New Shire Hall. The service does not have sole use of any of these facilities and must coordinate and plan use with others, as is the case with any dual-use facility.

2.4.2 Unfortunately, space that appeared to be available in Huntingdon Court quickly became unavailable. In order to ensure facilities booked can be relied upon to remain available, the service has focused on council facilities, with external venues now only being used in exceptional circumstances.

2.4.3 The Communities, Social Mobility and Inclusion Committee was previously advised of the service's desire to explore a purpose built, or re-purposed facility designed to better meet the wider needs of the service. Lawrence Court is an old, listed building and consequently the service fits around it, rather than the design and layout reflecting how it may be best used by the service.

2.4.4 Since that point, the Committee was also updated on the work supported by the transformation team exploring facilities in other areas. This work identified that it was best that pathology facilities remained at hospital locations, for both financial and practical reasons.

2.4.5 It was identified by the Council's Property Services that, with existing use, there was no available accommodation within the Council's portfolio that could be repurposed for the service to use as an office and inquest facility. Since that point, many of the Council's services have adopted a more flexible approach to service delivery and office working as a result of the pandemic experience. Property Services are therefore now undertaking a further review of usage across the portfolio which may identify future opportunities.

2.4.6 With the service having been able to source more capacity to hold inquests, albeit on different sites, there is no longer the same urgency to identify a new office location with Inquest facilities. The service is also mindful of the financial climate at present, and as such

a pragmatic view is being taken, considering the difficult financial decisions the Council is having to make to achieve a balanced budget for 2023/24.

2.5 Performance

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

2.5.2 Table 1 indicates the number of cases reported for the previous 2 years.

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

Table 1 – Reported Cases

2.5.3 The number of cases reported to the Chief Coroner marginally increased in 2021/22, from 256 to 297 (16%), however, this is in line with a national trend that reflects the impact of the Covid-19 pandemic on operational delivery.

2.5.4 In the same reporting period, the number of cases over twelve months old that were concluded rose from 37 to 108, an increase of 192%. The oldest cases have been a focus for the service, and a number or particularly challenging cases have now been concluded.

2.5.6 For cases over twelve months, the Council is required to split them into the categories below in the report to the Chief Coroner. The following data relates to the period from 1 May 2021 to 31 April 2022:

- 46.8% of cases were delayed due to complexity (i.e. awaiting specialist reports) (55% last year)
- 42% of cases were delayed due to Covid-19 (21.5% last year)
- 9.4% of cases were suspended and therefore were outside of the control of the service (i.e. while criminal investigations take place) (12.1% last year)
- 1% of cases were deaths that occurred abroad (i.e. awaiting evidence from oversees) (6.5% last year)
- 0.6% of cases were an investigation or prosecution by an external authority

2.5.7 During the reported period, 50% of inquests were conducted within six months of opening and 80% within twelve months. Despite the pandemic, the service was able to hear five jury inquests, and seven complex cases, totalling 488 siting hours. Many other jurisdictions were unable to undertake any during this period.

2.5.8 The officer resourcing challenges previously referred to added to pandemic-related delays with regards to progressing cases as quickly as the service would have liked. The service could not cover vacancies through temporary or agency staff, due to coroners being such a niche service and candidates being unavailable on the market. The service consequently has operated below its 100% establishment for the last twelve months.

2.5.9 Partnership agencies have also reported similar staff challenges, and increasingly inquests are being delayed due to the lack of availability of the necessary experts, many of which are from the medical profession, which understandably is under pressure to recover from the pandemic and reduce patient waiting times.

2.5.10 The performance data reported to the Committee for Quarter 1 for 2022/23 is included in Table 2.

Indicator	**2022/23 Quarter 1 Performance**
Number of cases opened	800
Number of cases closed	766
Number of inquests open	162
Number of inquests closed	169
Active open inquests at close of Quarter 1	264

Table 2 – Performance Data

2.5.11 If the volume of cases seen in Quarter 1 continues for the rest of the year, the service will receive approximately 3200 cases, a significant increase of 295 from the 2905 received the previous year. Without this increase, the service would have closed more cases in Quarter 1 than were opened.

2.6 Contracts

2.6.1 The Service has contracts with Addenbrookes Hospital and Peterborough City Hospital for mortuary and pathology services. The Addenbrookes Hospital contract was renewed in April 2022 for a period of three years. The re-tender process for the contract held by the Northwest Anglia NHS Trust commences this year, with an award for the period from 1 April 2023 to 31 March 2025. The contract will ensure there is provision to undertake post-mortems and other tests as part of coroner's investigations in the north of the County.

2.6.2 The Council will be preparing to go through a procurement exercise for toxicology services, and is currently at the contract award stage. Following a procurement exercise for body removal and storage, three contractors are expected to receive contract awards.

2.7 Changes to the Law

2.7.1 During the year, interim measures implemented nationally during the pandemic regarding the conduct of coronial operations have reverted, with some amendments to pre-pandemic legislative requirements. The changes have provided some challenges to coronial jurisdictions due to the relatively sudden adjustment. Familiarisation and re-training have been required, and some of the new additions have included ambiguous elements.

Furthermore, there isn't consensus regarding the application of NHS guidance material for medical practitioners associated with death certifications, and these will likely be the subject of clarification by the Chief Coroner in their guidance over time.

2.7.2 Recent Chief Coroner Guidance regarding remote hearings and discontinuing an investigation have meant some practical changes and efficiencies for the service. The service is now able to discontinue an investigation without having to hold a post-mortem. This means that there is no longer a requirement to proceed with paper inquests where the cause of death is natural and there are no other reasons for holding an inquest.

2.7.3 For the service, this has manifested itself in two ways:

(i) Faith deaths
The service operates an out-of-hours service and routinely facilitates faith burials, opening an Investigation in order to produce disposal paperwork and then dealing with this by way of a paper inquest when the offices open. It is now possible for a doctor to issue a medical certificate of cause of death (MCCD) and discontinue the investigation when the office opens, thereby negating the need for an inquest and the administrative processes and additional work that this brings with it.

(ii) GP unable to issue the MCCD
Another example is where Dr A could not issue the MCCD as they had not seen the patient in person or during their last illness. Dr B, who could issue, was on leave and not back for a number of weeks. In this scenario where the cause of death is clear and natural, the service could now run this as an investigation and discontinue it. Dr B could issue an MCCD on their return which would then lead to an A form and a certified death.

2.8 Finance

2.8.1 Though Coroners are judicial appointments, councils have the statutory responsibility to fund the service. The Council has influence and control over contract awards, service support costs, and staffing, but not costs associated with coronial decisions,, such as investigations required to determine a cause of death. There are discussions at a national level regarding whether the existing funding model is right, or whether coronial services should be funded nationally.

2.8.2 The budget for the service for 2022/23 is just over £2.9m, 65% of which is funded by Council and 35% of which is funded by Peterborough City Council, due to the area being a joint coronial jurisdiction. The cost for the Council is therefore approximately £1.9m. Table 3 presents the cost for Cambridgeshire.

Staffing (including Area and Senior Coroner)	£975,000
Assistant Coroners	£114,400
Pathologists	£247,000
Body removals	£68,900
Testing (Toxicology)	£104,000
Hospitals	£390,000

Table 3 – Core costs for the service

2.8.3 Hospital pathologist costs continue to be impacted by Covid-19, as they operate under high level infectious control measures, therefore completing fewer examinations per day at a higher cost. These additional costs are passed to the service, and hospital charges have increased this year by 3% and 3.5%.

2.8.4 The service is facing unavoidable cost increases resulting from contract renewals as the inflationary costs are coming through in the bid submissions. Contract costs currently equate to approximately £800,000 of the service costs, so increases on these has a significant impact on service delivery costs.

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

2.8.6 Due to the use of New Shire Hall and Peterborough Town Hall, costs for the use of external facilities for inquests has reduced from £46,000 in 2020/21 to less than £5,000 in 2021/22, with the service on target for a further reduction by the end of 2022/23.

2.8.7 The use of Assistant Coroners has been reduced since the appointment of the Counil's Area Coroners. Increasing efficiency, they are now used primarily for specialist and complex cases.

2.8.8 The use of Contain Outbreak Management Funding (COMF) to invest in technology has enabled the service to operate remote hearings, providing expert witnesses, as well as friends and family of the deceased, the choice of travelling to inquests or attending remotely. This has been particularly beneficial for expert witnesses, who predominantly opt for remote attendance, leading to reduced costs for the Council.

2.8.9 Tight controls ensure that overtime is only agreed in exceptional circumstances, where it is a necessity from a service delivery perspective.

3. Alignment with corporate priorities

3.1 Environment and Sustainability

The report above sets out the implications for this priority in 2.3.1

3.2 Health and Care

The report above sets out the implications for this priority in 2.2.1 and 2.2.2

3.3 Places and Communities

The report above sets out the implications for this priority in 2.2.3

3.4 Children and Young People

There are no significant implications for the priority.

3.5 Transport

Through investigations, preventable deaths can be identified, and recommendations on processes and ways to prevent future avoidable deaths can be made to those that manage highways, to ensure Cambridgeshire roads are safer for all.

4. Significant Implications

There are no significant implications, as this report is for information purposes only.

5. Source Documents

5.1 Coroner and Justice Act 2009

5.2 Chief Coroners Combined Annual Report 2018-2019 and 2019-2020

5.3 National Coroners Statistics 2021