Agenda Item No: 8

CAMBRIDGESHIRE AND PETERBOROUGH CORONER SERVICE ANNUAL REPORT

To:	**Highways and Community Infrastructure Committee**
Meeting Date:	**10th July 2018**
From:	**Graham Hughes - Executive Director, Place and Economy**
Electoral division(s):	**All**
Forward Plan ref:	**N/A**
Purpose:	• **To update the Committee on the work of the Coroner Service over the past 12 months** • **To present future plans, issues and considerations for the following 12 months.**
Recommendation:	**To note the report and continue to support the work of HM Coroner and the Coronial Service.**

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1. BACKGROUND

1.1 The Cambridgeshire and Peterborough Coronial Jurisdiction was created on 1st August 2015 when the Senior Coroner, David Heming was appointed. The service is based at Lawrence Court in Huntingdon. HM Coroner conducts 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. HM Coroner will determine the identity of the deceased and how, when and where the deceased came by his or her death. The duties of HM Coroner and the statutory duties of the service and the local authority are set out in the Coroner and Justice Act 2009. An update report was presented to this committee in 2017, and it was agreed to keep the Committee updated on an annual basis. There have been some notable successes over the past year, however there are also significant pressures on the service.

2. CASELOAD, FUNDING AND RESOURCES

2.1 Since the creation of the combined jurisdiction that covers both Cambridgeshire and Peterborough, the number of referrals made to the coroner service has risen considerably. The table below sets out these increases, comparing the full year prior to the merger, with 2017. The table also shows the national increases for the same period across England and Wales.

Year	Cases Referred	Inquests Opened	Post Mortems
2014	3532	307	996
2017	4094	476	1173
Percentage increase	16%	55%	18%
National percentage increase	3%	22%	-5%

(source: Ministry of Justice Annual Report Statistical Tool 2014/2017)

2.2 The work of HM Coroner falls into two areas, all referrals are investigated and once the initial work has been completed, including post mortems if required, the body of the deceased can be returned to the family funeral director. This is referred to as the day to day work and usually takes up to five working days to complete. If the death is considered unnatural an inquest is necessary and additional investigations are required. An inquest takes considerably more time. The figures in the table above show that not only have the overall number of referrals increased, but the level of complexity of cases requiring inquests has increased.

2.3 The funding available at the point of merger supported the referral levels experienced in 2013/4 which were significantly lower than our current numbers. The significant increase in referrals was not expected, beyond the level of demography bids projected in the Council's business plan.

2.4 In addition there is a pressure on payroll costs for Coroners. Since 2012 the Local Government Association and the Coroner Society have sought to agree a national pay

structure for Coroners and Assistant Coroners and guidance has now been produced on this.

2.5 With these combination of factors, we are projecting a £290k overspend on the Coroner's budget in 2018/19 (this is the CCC portion of an overall pressure of £446k, which is split with Peterborough on a 65:35 ratio). Whilst we are looking to cover the in-year pressure within existing budgets in P&E, work is underway to re-base the budget as part of business planning for 2019/20 onwards.

2.6 Although ultimately the number of cases referred to the coroner is not something that can be controlled, efforts are being made to reduce referrals where possible. Over the past 12 months the Senior Coroner, David Heming, has worked closely with the Medical Referee to reduce the number of unnecessary referrals. This is proving successful in preventing an even larger increase in referral numbers, however it also means that the proportion of complex cases in relation to the whole workload is much higher than previously (see table above).

2.11 In April 2017 the requirement to report all deaths where a Deprivation of Liberty Order was in place, ceased. In 2016 106 such cases were referred to the Coroner so this has helped a little. Coroners Officers have delivered training to newly qualified hospital doctors so that they understand the referral process and appreciate when a referral is necessary. Mr Heming will also be delivering information sessions for GPs to increase their awareness of the death process and the role of HM Coroner.

3. INQUEST BACKLOG

3.1 In addition to rising workloads, the service also has a backlog of historical inquests. The Chief Coroner's Guidance requires Inquests to be heard within 12 months and preferably within six months of the date of referral. In 2017 603 inquests were heard, reducing the backlog by 127 cases. The service needs to achieve a similar performance level in 2018 to achieve a performance level within the Chief Coroner's requirements by March 2019.

3.2 The table below sets out the number of cases opened each year and the number of inquests closed:

	2009	2010	2011	2012	2013	2014	2015	2016	2017
Cases Opened	344	347	373	375	353	307	359	468	476
Cases Closed	339	334	363	333	341	328	391	461	603
Balance	5	13	10	42	12	-21	-32	7	-127

3.3 The service made significant progress to reduce the backlog during 2017, closing 127 more cases that we opened. This was a significant achievement in difficult circumstances. We currently have 20 Inquest cases that are over 2 years old; 43 cases between 12 and 24 months; 59 cases between 6 and 12 months; and 124 cases under 6 months.

4. CASE MANAGEMENT SYSTEM

4.1 A replacement case management system was purchased in July 2017. This has made it possible to introduce electronic signatures and therefore simplified processes. Use of paper and the level of case storage space required in central records management has significantly reduced. Bereaved families, the Registration Service, Funeral Directors and

Hospital partners have all directly benefited from the improvements resulting from the new processes.

4.2 During 2018, the service is launching the roll out of a partner portal as part of the case management system. This will allow hospital doctors and GPs to refer cases to HM Coroner electronically. We are the first jurisdiction in the country to introduce this solution. It will remove the need for our staff to double key information as well as simplifying the referral process for our partners. Once established we will look to expand the use of the portal to police, pathologists, registrars and other partner services.

5. ACCOMMODATION

5.1 The service is currently located on the first floor at Lawrence Court, Huntingdon. This is an attractive historic listed building shared with the Huntingdon Registration Service. Since 2015 there has been an on-going issue with the strength and safety of the floors on the 1st and 2nd floor levels resulting in the need for acrow props to be in place to support the 1st floor.

5.2 Colleagues from our Facilities Management Team have been working with conservation planners at Huntingdonshire Council to agree a plan of works to resolve this issue. Unfortunately progress has been slow and, despite support from Senior Management, a permanent solution is not yet in place. Due to the timescales, building challenges and changing service requirements, the facilities team are also developing an options paper to consider alternative venues in Huntingdon. Should an alternative option be suggested, an appropriate paper will be presented to the committee for consideration.

6. MEDICAL EXAMINERS

6.1 The Coroner and Justice Act 2009 (CJA2009) placed a new statutory duty on local authorities to introduce Medical Examiners Schemes (ME). In March 2016 the Secretary of State for Health set an implementation date of April 2018, this was later extended to April 2019. More recent statements have confirmed that the scheme will now be introduced via Health Trusts including Hospital deaths only. The changing plans and potential for short-notice implementation creates challenges for the authority.

6.2 The Service has already made preparations for the introduction of ME and we are in a strong position when ME requirements are introduced. Our case management system has the necessary capability, accessibility and flexibility to include, or work with, an ME Service. In addition to the benefits for the Coronial Service, the roll out of the portal to hospital doctors and GPs will provide the ability to share information quickly between doctors, HM Coroner and the ME. This will be key for an effective ME solution. The service will now be working closely with Hospital Trust colleagues to develop joint or aligned working solutions so that we are prepared for any eventuality.

7. HEALTH TRUST CHANGES

7.1 Historically we have worked with four main hospitals with separate arrangements. During 2017 Hinchingbrooke Hospital and Peterborough City Hospital came together under one trust. Similarly the Royal Papworth Hospital will move to a new site at Addenbrooke's later this year. The Royal Papworth will share the existing mortuary services at Addenbrooke's

and therefore we will only require one agreement moving forward. With no additional mortuary facilities included in the development plans, the Coroner Service will need to develop alternative plans across the county for body removals and storage as the available mortuary space will not be sufficient to continue as is.

8. ORGAN DONATIONS

8.1 It is estimated that approximately three people die each day due to a national shortage of organs needed for life saving transplant operations. In Cambridgeshire, the Royal Papworth Hospital and Addenbrooke's Hospital are world renowned for their clinical transplantation procedures. Mr Heming highlighted some issues to the Chief Coroner for England and Wales on coronial decision making and a lack of uniformity of approach in some coronial areas. As a result, Mr Heming was a contributor to the national guidance on organ donation issued by the Chief Coroner on the 1st December 2017 (Guidance No.26). The level of organ retrieval in this region in the first quarter of 2018 has seen astonishing clinical transplant activity, with many lives being saved. In February 2018, Royal Papworth carried out 5 heart transplants in 36 hours – a record.

9. FAITH DEATHS

9.1 One coronial area in London has suffered three judicial reviews at significant financial cost to the local authority. The arguments related to the application of Article 9 Human Rights Act – freedom to manifest one's religion. In Cambridgeshire we benefit from the close working relationships developed by Mr Heming with faith groups in the county, which has led to the creation of a swift and efficient service for local faith groups.

10. ALIGNMENT WITH CORPORATE PRIORITIES

10.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

10.2 Helping people live healthy and independent lives

Delivery of an efficient and professional Coronial Service directly impacts on the well-being of bereaved families.

10.3 Supporting and protecting vulnerable people

See 3.2 above.

11. SIGNIFICANT IMPLICATIONS

11.1 Resource Implications

The report sets out details of significant implications in 2.1

11.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The report sets out details of significant implications in 2.6

11.3 Statutory, Legal and Risk Implications
There is no significant implication.

11.4 Equality and Diversity Implications
There is no significant implication.

11.5 Engagement and Communications Implications
There is no significant implication.

11.6 Localism and Local Member Involvement
There is no significant implication.

11.7 Public Health Implications
The report sets our details of significant implications in 2.6.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Sarah Heywood – Significant resource implication.
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes or No Name of Officer: Paul White
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Debbie Carter-Hughes No issues
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Tamar Oviatt-Ham No issues

Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Sarah Silk No issues
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Tamar Oviatt-Ham No Issues
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Stuart Keeble No issues

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Source Documents	Location
Ministry of Justice Statistical tool 2014 and 2017	*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/427677/coroners-statistical-tool-2014.xls* *https://www.gov.uk/government/statistics/coroners-statistics-2017*