Agenda Item No: 4

CAMBRIDGESHIRE AND PETERBOROUGH CORONER SERVICE ANNUAL REPORT

To:	**Communities and Partnership Committee**
Meeting Date:	**3 September 2020**
From:	**Peter Gell, Assistant Director Regulatory Services**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To update the Committee on the work of the Coroner Service over the past 12 months and present future plans, issues and considerations for the following 12 months.**
Recommendation:	**The Committee is asked to:**

a) Note the work of the Coroner Service;

b) Ask the Transformation Team to explore by means of a business case the viability of the Council investing in its own dedicated mortuary, pathology and Inquest facility; and

c) Ask the Transformation Team to identify and evaluate technological enhancements that will improve the efficiency and effectiveness of the Coroner Service.

Officer contact:		**Member contact:**	
Name:	Peter Gell	Name:	Councillor Steve Criswell
Post:	Assistant Director of Regulatory Services	Post:	Chairman of Communities and Partnership Committee
Email:	Peter.gell@peterborough.gov.uk	Email:	Steve.criswell@cambridgeshire.gov.uk
Tel:	01733 453419	Tel:	01223 706398

1. BACKGROUND

1.1 The Cambridgeshire and Peterborough Coronial Jurisdiction was created on 1st August 2015 when the Senior Coroner, David Heming was appointed, and is based at Lawrence Court in Huntingdon. The area covered has a population of around 900,000.

1.2 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 together with how, when and where the deceased came by his or her death.

1.3 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. Coroners are independent judicial office holders, therefore though appointed by the local authority, they are not employed by it. Appointments require the consent of the Chief Coroner and Lord Chancellor.

1.4 There are four main hospitals within the jurisdiction, and as specialist hospitals, there are several exceptionally complex hospital deaths associated with Addenbrookes and Papworth in particular, that require an inquest. These entail specialist reports and witnesses meaning they can be difficult to investigate and conclude. These cases take up additional Officer and Coroner time that is not obvious in overall reported death statistics. Similarly, there are 3 prisons across the area. Over the past 12 months HM Coroner has opened inquests for 5 prison deaths. All of these are deaths in state detention and require jury inquests, whilst several are also Article 2 inquests where the State or 'its agents' have 'failed to protect the deceased against a human threat or other risk'. These are complex, high profile cases that require a significant time investment.

1.5 The number of deaths registered annually averages 4000 with approximately 14% of cases referred to the Senior Coroner. Post-mortem examinations are conducted at Addenbrookes and Peterborough City Hospital by hospital pathologists. In 2019, inquests were held for 16.75% of referrals and 43% of referred cases required post-mortem examinations. The Senior Coroner is expected to aim to keep post-mortem levels to 30% of reported deaths or below. However, as stated above, the somewhat unique complexity of those cases within the jurisdiction means that the service figures are a little higher than this suggested target.

1.6 A Coronial service update is provided to the committee annually.

2. MAIN REPORT

2.1 Successes

2.1.1 Medical Examiner Service

The National Medical Examiner Scheme (ME) was introduced across the county in April 2019. The scheme provides greater scrutiny of deaths, as well as offering a point of contact for bereaved families to raise concerns about the care provided prior to the death of a loved one. This is now live for Addenbrookes and Papworth hospitals. The Senior Coroner was involved in the interview process for the inaugural Medical Examiners in the area. The service has supported all of the incoming MEs both with training (Addenbrookes Medical

Examiner staff have visited the service to see how it works) and also with Information Technology (IT) and the roll out of the online referral portal, as per 2.1.2 below.

2.1.2 Coroner Case Management System Referral Portal

The new case management system was introduced in the service in 2017 and an online portal referral system, using the same software, was rolled out to Addenbrookes Hospital in 2018. In 2019, the portal was introduced to all 56 General Practitioner (GP) Practices in Cambridgeshire and Peterborough, meaning that GPs are able to refer cases to the service electronically removing the need to telephone them in. This has saved both GPs and the service a great deal of time. This has also helped referrers to comply with the new regulation that all referrals must be made in writing. The service are in the final planning stages of rolling this out to Peterborough City Hospital and Hinchingbrooke Hospital and hope to have this completed by October 2020.

2.1.3 Real time suicide surveillance - portal pilot

The service is working with Public Health on a multi-agency suicide surveillance portal so that they can gain a wider understanding and learning from suspected suicides, and to take appropriate actions. This portal is in the trial stage and the service was fortunate enough to be invited to take part. If this proves to be successful it will be rolled out nationally.

2.1.4 Partnerships

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 both the Child Death Overview Panel and the Learning Disabilities Mortality Review with a view to improve processes and ultimately, prevent future deaths. The service also attend multi agency meetings for Harm Reduction and Drug Related Death Mortality, providing any insights or trends that the service identify.

The service has established a relationship with the Crown Prosecution Service and now have a second trainee solicitor undertaking a secondment with the service as part of their training contract. They gain exposure and experience of working on some of the more complex inquests while the service gain legal experience and skills from lawyers at the beginning of their careers. It also means that the trainee solicitor can undertake some of the time complex and time consuming Inquests, thereby freeing up capacity for Inquest Officers. The service do not pay for these secondments and it has been an excellent incentive which has enriched the service, while at the same time saving the service money.

2.1.5 COVID-19, whilst presenting challenges, has also given the service the opportunity to evaluate and improve the way in which it works. The service has lost the attendance of the Coroner's Support Service Volunteers at Hearings as a result of the need for them to self-isolate. Whilst this is a loss to both the service and the families who attend our hearings, it has meant that Coroner's Officers have been bought back to court in order to support attendees and the Coroner. The feedback from attendees, Coroner's Officers and Coroners is that this has been a positive change. With Officers seeing cases right the way through from start to finish, they are able to build relationships with the families and support them at the Hearing itself. Not only does this bring job satisfaction to the Officers, for the families it has helped to alleviate pressure and stress on the hearing day itself.

2.2 Challenges

2.2.1 Backlog of cases

In the 2020 Chief Coroner return, 113 cases over one year old were reported. Of those cases, 14 mentioned COVID-19 as a reason for the delay. That therefore leaves 99 cases as at the end of April 2020 which were over a year old and not related to COVID-19. The service are working towards clearing as much of this backlog as possible by April 1st 2021. It is inevitable that some cases will not conclude within a year as it simply not possible, for example cases that have been suspended for police investigations. However, reducing this number is something that has been prioritised this year.

2.2.2 Assistant Coroner availability

The Service have three Assistant Coroners whom due to other commitments, will not be able to sit for the authority as of the end of 2020. The service are therefore in the process of recruiting more Assistant Coroners so that the backlog of cases can continue to be managed.

2.3 Accommodation

2.3.1 The Coroner Service is located at Lawrence Court, Huntingdon, and includes office facilities and a small court. Though the accommodation was not built with the Coronial Service in mind, redecoration, along with improvements to electrics, IT and security during 2019 have improved the facility. Due to the wide coronial jurisdiction, Huntingdon is well placed geographically. Courts used within the jurisdiction include Lawrence Court, Huntingdon Town Hall, Peterborough Town Hall and Huntingdon Law Courts, which provides the capacity to run inquests concurrently. The service has worked hard throughout July to secure Huntingdon Racecourse in order to continue to hold Inquests in Huntingdon, as the Town Hall lacks the technological infrastructure for Hearings.

The court facilities available have provided challenges for the service, with inquests cancelled short notice as urgent criminal matters take precedence. The service has mitigated this risk through securing reliable block bookings with alternative venues at a reduced rate.

2.4 Staffing

2.4.1 It was reported in March 2020 that a restructure in the Communities and Partnerships Service Directorate was resulting in the Coroner Service being positioned within the Regulatory Services Group within the same directorate. This move took place in April 2020. In addition, Regulatory Services includes Cambridgeshire Registration Service, Trading Standards, Environmental Health and Licensing, some or all of which are delivered for Cambridgeshire County, Peterborough City and Rutland County Councils. A structure chart can be seen in **Appendix 1** of the report.

2.4.2 The Area Coroners are independent judicial-office holders, and work as part of the Coroner Team led by the Senior Coroner, alongside 7 fee paid Assistant Coroners. The Area Coroners are expected to be the nominated deputies in line with the Chief Coroner's guidance. The Area Coroners will provide cover when the Senior Coroner is unavailable

due to leave, sickness, training etc. and as additional support in office and case work. Recruitment of two permanent Area Coroners has recently been completed, this process overseen by the countries Chief Coroner His Honour Judge Mark Lucraft QC.

2.4.3 Training and staff development continues to take place within the service including the annual Judicial College training for Officers. This has been postponed nationally this year owing to COVID-19. In October 2019, the service brought in an experienced external Coroners Service trainer in order to provide an intensive training course for both new and existing staff. Staff were trained in everything from the statutory framework of Coronial Law all the way through to medical causes of death, acceptable terminology on death certificates and how to communicate with bereaved family members. This is something that was completely new to the service and greatly benefitted all those that attended. The learning materials have been kept and the same training provided to all incoming Coroners Officers since.

2.4.4 With challenges and forced change to working practices within the service, it has been recognised that staff are working very efficiently remotely. The service are observing less staff sickness and increased productivity as people work from home. Home working also allows for a better work-life balance.

2.5 Finance

2.5.1 As a shared service both Cambridgeshire County and Peterborough City Council contribute to the service budget with a 65/35 ratio split. The Cambridgeshire County Council outturn position for 2019/20 was a £430k overspend, this due to the increasing complexity of cases being referred to the Coroner and the additional staffing required to handle them. Following a business case submission the base budget was increased for 2020/21 by £527k, this consisting of contributions from both councils.

Additional costs relating to COVID-19 are predicted to be approximately £250k. This includes additional post-mortem costs as well as costs associated with Assistant Coroner cover. There are also anticipated additional inquest costs although it is too soon to determine what this will equate to.

Rather than paying a high-risk rate for all post-mortems, the service negotiated a reduced high-risk rate for when COVID-19 hadn’t been excluded. This has helped to keep costs down as much as possible.

In April, May and June the Senior Coroner was involved in daily strategic planning meetings for COVID-19, therefore, was unable to be the duty Coroner for the day to day decision making. This meant that additional Assistant Coroner cover was required whilst the Senior Coroner supported the countywide COVID-19 effort.

2.6 Performance and Analysis

2.6.1 Last year, the service reported that the backlog of cases had built up and this continued to be the case for 2019, as detailed in table 1 below.

Table 1 – Caseload

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Closed Cases	347	372	375	353	307	359	468	476	443	482
Open Cases	334	363	333	341	328	391	461	603	449	545
Balance	5	13	10	42	12	-21	-327	-127	-6	-63

55.5% of the Inquests from 2019 were completed in less than 6 months from the date of referral. Further, 61% of those Inquests outstanding in 2019 were less than 6 months old at the time of the report.

The Service is starting to see benefits of the restructuring undergone in the last 12 months, which will culminate with the appointment of both the Area Coroners and a Special Projects Lawyer over the summer. These are new roles that have been created in order to introduce stability, support and specialist skills and knowledge to the service.

2.6.2 A total of 22 cases for which Hearings were listed had to be adjourned during lockdown. Table 2 below shows a breakdown of cases. Table 3 shows the number of cases, as reported in the 2020 Chief Coroner return which mention COVID-19 as a reason for delay.

Table 2 – Inquests adjourned during lockdown

	Number of cases	% of overall cases
Jury inquests	6	27
Cases longer than 1 day	9	41
Cases 1 day or less	13	59
	Average	**Total**
Sitting hours	1.75	230.5

Table 3 – Cases over one year old

COVID-19 reason for delay	Other reason for delay	Total
14	99	113

2.6.3 The service continues to see the complexity of the county as a major challenge. Work with partner agencies, and updated Chief Coroner guidance, has seen a reduction in straightforward cases that are referred in unnecessarily. This, together with the introduction of the ME system, means that those cases that are referred are now more likely to be complex and at the very least, require an investigation.

The service have had to restructure to accommodate this change and are starting to see the benefits of this now. It is hoped that with the incoming staff the service will be able to continue to allocate cases according to the specialisms of staff. Staff are also benefiting from thorough and detailed training programs which equips them with the skills necessary to succeed in their roles.

2.7 Impact of COVID-19

2.7.1 COVID-19 has had a large impact on service delivery in relation to restrictions preventing scheduled Hearings from taking place or new Inquests being listed, adapting the way in which cases are heard, whether that be virtually or in a COVID-19 secure manner, as well as financial implications as detailed in section 2.5. During the lockdown period, the majority of staff worked from home which put additional pressures on those still in the office.

2.7.2 During the lockdown 103 live hearings have taken place, including Pre-Inquest Review Hearings and Final Hearings, neither of which require a jury. Video conferencing technology has been used to facilitate remote hearings, and in 3 instances, Council facilities have been opened in order to hold hearings while maintaining social distancing.

There have been 111 cases opened since lockdown on 23rd March 2020. Despite only having access to one court room at Lawrence Court it has been possible to progress and close 41% of cases during lockdown.

Following an easing of restrictions by Government, from 1st July 2020, Peterborough Town Hall and Huntingdon Town Hall were reopened solely for Inquests. The service worked with building and facilities management to carry out risk assessments and ensure both venues were COVID-19 secure. The addition of these buildings has increased the capacity to hold Inquests concurrently by 300%.

To make full use of the additional venues, an Area Coroner has been employed on a full-time basis for 6 months to assist the Senior Coroner in managing the backlog while recruitment for the permanent position was underway, as well as providing continuity. The service is also working with the Senior Coroner and Chief Coroner to increase the number of Assistant Coroners available.

2.7.3 The number and type of deaths referred to the service has also been impacted by COVID-19. An increase in the amount of deaths received, particularly those which queried COVID-19 as a cause of death increased initially, although this has since petered out as clinicians are now confident in issuing COVID-19 death certificates without referring it to the service.

2.7.4 From the end of March, all post-mortems were seen to be high risk / infectious cases, as the hospitals were completing autopsies using full personal protective equipment. This followed national guidance provided by Public Health England and the Royal College of Pathologists. This meant that autopsies were going to take significantly longer than normal and is the basis for the enhanced fees charges for high risk cases.

2.8 Looking Ahead

2.8.1 Regulatory Landscape

In March 2020 Committee was advised that the Chief Coroner has stated that he is committed to reviewing the ‘Model Coroner Area’. The original Model Coroner Area framework was produced to “assist senior coroners, local authorities and police authorities as to the nature, scope and organisation of a model coroner area”. Wherever possible all should work together to try and achieve the aspirations of the model, and consequently that is reflected in the Service across Cambridgeshire and Peterborough. This national review is

an important piece of work, and it is hoped that it will recognise the significant increases in demand and workload being faced by Coroner services across the UK, and in particular the unique features of areas such as Cambridgeshire and Peterborough, which lead to a disproportionate increase in demand. The Senior Coroner for the service is closely monitoring the progress of this national work, though the position remains in that there is no clear indication yet of the timescale for its completion particularly given the inevitable implications of COVID-19.

The Business and Investigations Managers sit on a regional committee which the Ministry of Justice (MOJ) feeds in to. The MOJ have made it clear that many of the projects planned for 2020 have had to be postponed as staff and efforts were redeployed to help with COVID-19.

2.8.2 Service Ambitions & Developments

It remains a long term goal to have a local authority mortuary, pathology and dedicated Inquest facility for the service. As time progresses, the clear case to explore this option becomes more compelling as the service continues to incur costs effectively renting all of these services and spaces with little control over them. Member support is sought to ask the Transformation Team to explore, by means of a business case, the viability of the council investing in its own facility.

Long term, it is believed this would not only save the Local Authority money, it would also increase the efficiency and delivery of the service as a whole.

Since the pandemic local authorities have become more reliant on technology to aid service delivery. To ensure the Coroner Service is making best use of the technology available, Members support is sought to ask the Transformation Team to identify and evaluate technological enhancements that will improve the efficiency and effectiveness of the Coroner Service.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

The delivery of an efficient and professional Coronial Service directly impacts on the well-being and quality of life of bereaved families.

The work that HM Coroner undertakes to prevent future deaths, either through Section 28 notices following an Inquest or working with partners to identify trends, contributes to the wider quality of life of others.

3.2 Thriving places for people to live

There are no significant implications for this priority.

3.3 The best start for Cambridgeshire's Children

No specific alignment, although learning from cases can and should be used to prevent recurrences of avoidable circumstances.

3.4 Net zero carbon emissions for Cambridgeshire by 2050

Growing the capacity of our own in-house team will reduce the reliance on agency and locum staff, in turn reducing unnecessary travel to and from the county. In addition, having venues north and south of the county reduces travel for families and other parties when attending inquests.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The cost of third-party contracts for body removal and storage, pathology and mortuary services has increased and is adding to the uplift of costs for the service. There is very little or no choice of suppliers in these markets, especially when considering provisions are required for north and south of the county, hence the request for Committee to approve the exploration of in-house options. At present, current contracts have been reviewed and new contracts been entered into, making the costs more predictable for future years.

4.3 Statutory, Legal and Risk Implications

The Local Authority has a statutory duty to provide the necessary resource to support the work of HM Coroner. This is also a high-profile service and therefore carries reputational risk implications.

4.4 Equality and Diversity Implications

There are no significant implications for this priority.

4.5 Engagement and Communications Implications

There are no significant implications for this priority.

4.6 Localism and Local Member Involvement

There are no significant implications for this priority.

4.7 Public Health Implications

The Coroner Service works closely with Public Health in terms of providing mortality and morbidity data but also especially in the areas of substance misuse and mental health related deaths and associated implications for services. It provides a similar role of secondary and primary care health services.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Officer: Emma C Jones
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Gus De Silva
Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or LGSS Law?	Yes Name of Legal Officer: Fiona McMillian
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Adrian Chapman
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Amanda Rose
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Adrian Chapman
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Val Thomas

.

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