Agenda Item No: 4

CAMBRIDGESHIRE AND PETERBOROUGH CORONER SERVICE ANNUAL REPORT

To:	**Communities and Partnership Committee**
Meeting Date:	**8th August 2019**
From:	**Christine May, Assistant Director: Cultural & Community Services**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** **Key Decision: No**
Purpose:	**To provide an annual report of the work of the Coroner Service, highlighting service performance, issues and improvements.**
Recommendation:	**The Committee is asked to:**

a) Note the work of the Coroner Service; and

b) Support the service moving forward with increasingly complex workloads.

	Officer contact:	***Member contact:***
Name:	Amy Donovan	Name: Cllr Steve Criswell
Post:	Coroner Service Manager	Post: Chair
Email:	amy.donovan@cambridgeshire.gov.uk	Email: steve.criswell@cambridgeshire.gov.uk
Tel:	01223 703521	Tel: 01223 706398

1. BACKGROUND

1.1 The Cambridgeshire and Peterborough coronial jurisdiction was created on 1 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 annual report was presented to the Highways and Community Infrastructure Committee in June 2018, and it was agreed to keep the Committee updated on an annual basis. Responsibility for oversight of this function has now passed to the Communities and Partnership Committee. There have been some notable successes over the past year, however there are also significant pressures on the service. This report will set out these service improvements and challenges.

2. MAIN ISSUES

2.1 Service Improvements

2.1.1 *Medical Examiner Service*

The national Medical Examiner (ME) scheme was introduced across the country in April 2019. Originally ME schemes were to be the responsibility of the Local Authority, however following many reviews and consultations (from 2009 to 2017), the Department of Health and Social Care moved the responsibility to local Heath Trusts and also reduced the scope of the initial roll-out to Secondary Care providers (hospitals). The roll out for Primary Care providers (GPs) will follow at a later date yet to be confirmed. In Cambridgeshire and Peterborough we have 4 hospitals impacted by these changes. At a very early stage the coronial service recognised that, to achieve operational efficiencies, new schemes must align from a coronial perspective. We have hosted partnership meetings inviting MEs, bereavement teams, pathologists, mortuary services and registration services. We now have excellent working relationships with all of the MEs in our area who are also sharing lessons learnt. The ME Scheme at Addenbrookes Hospital is leading the way in terms of implementation, just ahead of Papworth. The partnership working between HM Coroner and the Addenbrookes ME is exceptionally effective and has been recognised nationally as an example of best practice. This allows us to be increasingly efficient with our processes as well as improving the experience received by bereaved families.

2.1.2 *Coroner Case Management System and Referral Portal*

In 2017 a new case management system (CMS) was introduced. This system has radically improved the end to end process for managing cases referred to HM Coroner, introducing electronic signatures and moving the vast majority of communications with partners to email rather than paper forms and post. The CMS also provides the opportunity to develop a portal based referral system for doctors, to replace the paper based telephone referrals previously received. The service has worked hard to develop the portal at Addenbrookes Hospital and it was first rolled out to a test site at the hospital in November 2018. This has

proved extremely successful, enabling doctors to refer cases at any time of the day or night without leaving the ward, and Coroners Officers can manage case distribution and investigation in a more planned and efficient way.

The portal has now been rolled out to the majority of medical areas at Addenbrookes Hospital along with all of Papworth Hospital and the Arthur Rank Hospice. We are prepared to roll out at Peterborough City Hospital and Hinchingbrooke Hospital as soon as they are ready, and also poised to continue the roll out to all GPs. HM Coroner has written to all GPs and we have been very pleased at the positive reception received from them. Over 90% of GPs provided the initial information required immediately. All GP information has now been gathered and the portal will be rolled out in a managed, staged process. This will allow GPs to refer cases to HM Coroner electronically. Cambridgeshire and Peterborough is the first jurisdiction in the country to successfully introduce this solution. It will remove the need for our staff to re- key information as well as simplifying the referral process for our partners.

2.1.3 ***Accommodation***

Local authorities are obliged to provide suitable accommodation for the Coroner Service. The current accommodation in Lawrence Court, Huntingdon has previously been overcrowded and in need of structural repair and maintenance. The Huntingdon Registration Service relocated from Lawrence Court to Huntingdon Library in March 2019, enabling the Coroner Service to address overcrowding in the offices and make use of some additional space to provide a small second court. HMC also negotiated free use of the Huntingdon Law Court facility for larger jury inquests. In 2015 structural issues were identified in the first floor of Lawrence Court (where the service is based) causing instability and the necessity for acro-jacks to be placed on the ground floor to support the upper floors from below. Work to resolve and repair the floors involved time-consuming negotiations with historical buildings experts, planners and architects, however work to fix the floors finally concluded in July 2019.

2.2 Service Challenges

2.2.1 The Coroner Service continues to face significant challenges due to several unavoidable pressures resulting in increasing workloads. Workload increases can be attributed to three main causes: the complexity of the coronial area; the increasing complexity of the cases referred; and the historic backlog that must be tackled alongside the other pressures.

2.2.2 ***Complexity of the Coronial Area***

There are four main hospitals in the area, and as specialist hospitals, there are a number of exceptionally complex hospital deaths associated with Addenbrookes and Papworth in particular that require an inquest. These entail specialist reports and witnesses, and 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 4 prisons across the area. Over the past 12 months (1 June 2017 – 31 May 2019) HMC has opened inquests for 15 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.

2.2.3 ***Increasing Complexity of Inquest cases***

Although the total number of referrals has not increased in 2018/19, this is due in part to the significant work that HMC and the service has done to reduce the number of simple cases that were being referred to HMC unnecessarily. HMC has worked closely with the newly set up Medical Examiners and other partners to provide advice, training and support to avoid unnecessary referrals. This means that, whilst the number of referrals has remained constant, there is an increase in the proportion of complex and highly complex cases. This is demonstrated to some extent by the changing percentage split of the conclusions at inquest. The percentage of inquests with a conclusion of a Suicide or Drug Related Death rose from 15.6% in 2017 to 21.6% in 2018; these deaths are often linked to mental health issues which require significant investigation. Inquests with an unclassified conclusion (where a narrative is required because they do not fit into the standard set of conclusions) also rose from 10.5% to 19.2%; these cases are often medically based, usually require significant investigation and are often highly complex. At the same time there was a significant reduction in the percentage of simpler Natural Cause conclusions (dropping from 38.3% to 17.2%). In the past few years there has been increased national and local media scrutiny of many of the inquests held by the Coroner; this has most recently been seen with the case of Rosa King. The number of media enquiries handled by the Council's Communications Team related to Coroner cases has risen from below 10 in each of 2014-16, to 133 in 2018.

2.2.4 ***Historic Backlog***

Prior to 2015 a backlog of cases had built up (see below). The Coroner and Justice Act 2009 requires that all inquest cases are heard within 6 months and HMC is required to provide an annual report to the Chief Coroner of England & Wales of all cases that remain open after 12 months. Despite making significant in-roads into the backlog numbers in 2017, in 2018 the increasing pressures outlined above meant that in April 2019 our area reported 86 cases open after 12 months. This is significantly higher than many coronial areas.

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Cases Opened	344	347	373	375	353	307	359	468	476	443
Cases Closed	339	334	363	333	341	328	391	461	603	449
Balance	5	13	10	42	12	-21	-32	7	-127	-6

2.2.5 ***Increasing costs of contracted services***

Through negotiation with suppliers and robust management we have avoided cost increases on contracts for several years. However as part of contract renewals cost increases are now inevitable:

(i) Body Removals Contract

In 2018 the body removals contract was required to be re-tendered. This has resulted in some increased costs, partly due to the relocation of Papworth Hospital to a shared Cambridge site with no mortuary facility. Although we have now secured

reliable local funeral directors for the storage of HMC community deaths, the additional requirements are reflected in increased costs.

(ii) Body Storage and Post Mortem Arrangements

Work previously undertaken at Papworth has been re-located to Addenbrookes and Peterborough City Hospital (PCH). The hospital Service Level Agreements for both Addenbrookes and PCH required review following these changes. The hospitals have also reviewed their costs as part of this process; PCH require a significant increase immediately and Addenbrookes will increase their charges in 2020.

2.2.6 ***Staff Issues***

Our ability to meet targets for investigating cases in the complex environment described above can sometimes be challenging, and the need for the service to be able to maintain staffing levels (by taking on additional staff to cover absences) to deal with the immediate referrals received and the rising levels of inquest work is of paramount importance. This inevitably adds to budget pressures.

2.3 Mitigations

2.3.1 The Assistant Director, HMC and Service Manager have reviewed the issues across the service. The transfer of the service to a new directorate will also enable the Service Director for Communities and Safety to review the issues in depth, and agree necessary mitigations. It is also the intention of the service to present to this Committee at regular intervals to ensure Members are kept fully informed of progress.

2.3.2 The service has already made a number of changes to manage the increased demand, including investing in triage staff who are able to carry out initial work to determine key facts about cases and to help determine whether or not a case needs to progress to inquest. Going forwards, a proposed revised staffing structure has been designed that meets the increased work resulting from the issues described above. In particular, we need to lower the ratio of cases to officers to reflect the increased complexity of cases and the time they take to investigate and bring to inquest.

2.3.3 The impact however of all these pressures above will result in costs exceeding funding leading to an in-year budget pressure for the service; the full extent of this pressure is being analysed and will be reported as part of the Committee's Finance & Performance Report in September.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

The following bullet points set out details of implications identified:

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

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

3.3 The best Start for Cambridge's children

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

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

Financial benchmarking suggest that this service is already an expensive service compared to that provided by our comparator group of local authorities, however this group does not necessarily reflect the same level of complexities in coronial terms. Additional funding of £194K was allocated to this year's budget on an ongoing basis to rebase the budget to ensure it was fully funded, and in future years an additional £20K pa is allocated for demographic pressures. The service is reviewing its current demands and will bring forward any additional resource implications as part of the finance and business planning reporting in September.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The report sets out details of significant implications in 2.2.5

4.3 Statutory, Legal and Risk Implications

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

4.4 Equality and Diversity Implications

There is no significant implication.

4.5 Engagement and Communications Implications

There is no significant implication.

4.6 Localism and Local Member Involvement

There is no significant implication.

4.7 Public Health Implications

The report sets out the benefits created from the service and public health colleagues working together.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Sarah Heywood
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 LGSS Law?	Yes Name of Legal Officer: Fiona McMillan
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: Sarah Silk
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
A Model Coroner's Office: the Chief Coroner's Recommended Model. Annex B to the Report of the Chief Coroner to the Lord Chancellor: Fifth Annual Report 2017-18 (p57-).	***https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/764720/report-of-the-chief-coroner-lord-chancellor-2017-18.pdf***