GROWTH, ENVIRONMENT AND RESOURCES SCRUTINY COMMITTEE	AGENDA ITEM No. 6
4 SEPTEMBER 2019	PUBLIC REPORT

Report of:	Adrian Chapman, Service Director - Communities and Safety	
Cabinet Member(s) responsible:	Councillor Marco Cereste - Cabinet Member for Waste and Street Scene and the Environment	
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CORONER SERVICE UPDATE REPORT

R E C O M M E N D A T I O N S	
FROM: David Heming - HM Senior Coroner for Cambridgeshire and Peterborough	**Deadline date:** N/A
It is recommended that the Growth, Environment and Resources Scrutiny Committee scrutinises and comments on the services described in this report.	

1. ORIGIN OF REPORT

1.1 The report is presented to the Growth, Environment and Resources Scrutiny Committee following a request from the Service Director - Communities and Safety and the Assistant Director - Cultural and Community Services.

2. PURPOSE AND REASON FOR REPORT

2.1 This report provides an update for Members on the Coroner Service and highlights the current issues and challenges facing the Service.

2.2 This report is for the Growth, Environment and Resources Scrutiny Committee to consider under its Terms of Reference No. Part 3, Section 4 - Overview and Scrutiny Functions, paragraph No. 2.1 Functions determined by Council:

10. Partnerships and Shared Services

2.3 The Coroner is an independent Judicial Officer. He investigates deaths that have been reported to him if there is reason to think:

- the death was violent or unnatural
- the cause of death is unknown, or
- the deceased died while in prison, police custody or another type of state detention

The service also works closely with partner organisations to support work to preserve life by providing statistical information and identifying areas where action can be taken to prevent future deaths. In this way, the Coroner Service links to the Council's following Strategic Priorities:

- Safeguarding vulnerable children and adults
- Keeping all our communities safe, cohesive and healthy
- Achieving the best health and wellbeing for the city

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	N/A

4. BACKGROUND AND KEY ISSUES

4.1 The joint Cambridgeshire and Peterborough coronial jurisdiction was created on 1 August 2015 when the Her Majesty's (HM) 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 determines the identity of the deceased and how, when and where they died. Around half of all deaths across the jurisdiction are referred to the Coroner. 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. Over the past year there have been some notable successes, however there are also significant pressures on the service. This report sets out these service improvements, issues and challenges.

4.2 Service Improvements

4.2.1 Medical Examiner Service

From April 2019 a new Medical Examiner (ME) scheme is being rolled out within hospitals in England and Wales. The ME scheme introduces a new level of scrutiny whereby *all* deaths will be subject to either a medical examiner's scrutiny or a coroner's investigation. These reforms follow various independent reviews and reports stemming from the Harold Shipman murders.

Originally ME schemes were to be the responsibility of local authorities. However, following many reviews and consultations (from 2009 to 2017), the Department of Health and Social Care moved the responsibility to local Health 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. Across this jurisdiction we have 4 hospitals impacted by these changes.

At a very early stage the Coroner Service recognised that, to achieve operational efficiencies, new ME schemes and coroner processes must align to ensure that bereaved families receive a timely and professional service and are not lost in the system. The Service has hosted partnership meetings inviting MEs, bereavement teams, pathologists, mortuary services and registration services to plan and discuss how the new service will operate and be integrated in the work of the partners including the Coroner Service. 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. Medical Examiners have been appointed at Peterborough City Hospital and they are planning the roll out of their scheme. 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, and will be of benefit as the scheme rolls out elsewhere.

4.2.2 Coroner Case Management System and Referral Portal

In 2017 a new case management system (CMS) was introduced. This system has radically improved the 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 an electronic 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. The Service is ready to roll out at Peterborough City Hospital and Hinchingbrooke Hospital as soon as the ME scheme launches. HM Coroner has written to all GPs and we have been very pleased with 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 that will be completed by November 2019. This will allow GPs to refer cases to HM Coroner electronically. Cambridgeshire & 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.

4.2.3 Accommodation

Local authorities are obliged to provide suitable accommodation for the Coroner Service. The current accommodation in Lawrence Court, Huntingdon, was previously shared with Huntingdon Registration Service. The 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. Work has also been completed recently to address some structural issues on the first floor of Lawrence Court and the building now has potential to be further improved for the Coroner Service. Managers are preparing a business case for funding for these improvements.

4.3 **Service Challenges**

4.3.1 Service Challenges

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.

4.3.2 Complexity of the Coronial Area

There are four main hospitals in the Area, and as specialist teaching hospitals, Addenbrookes and Papworth produce a significant number of exceptionally complex hospital deaths 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. During the period from 1 June 2017 to 31 May 2019 HMC opened inquests for 15 prison deaths. All of these are deaths in state detention and require jury inquests, 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.

4.3.3 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 analysing 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 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 related to Coroner cases has risen from below 10 in each of 2014-16, to 133 in 2018.

4.3.4 Historic Backlog

Prior to 2015 a backlog of cases had built up across the jurisdictions (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 most 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

4.3.5 Increasing costs of contracted services

Through negotiation with suppliers and robust management we have avoided cost increases on these 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, these additional requirements are reflected in the increased costs.

(ii) Body Storage and Post Mortem Arrangements

Work previously undertaken at Papworth has been relocated 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.

4.3.6 Staff Issues

The ability of the service 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.

4.3.7 Mitigations

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.

Additionally, a short term (12-month) increase in the service's budget has been agreed, to enable the backlog to be removed and to manage more effectively the increases in demand, whilst at the same time carrying out a review of the processes within the service. The service has already made a number of changes to manage the increased demand, including covering

absences due to maternity and long term sickness. 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.

5. CONSULTATION

5.1 The Senior Coroner and the Service Manager have contacted peers in other jurisdictions to identify best practice in order to inform process design and the redesigned structure of the service moving forward.

5.2 A consultation with staff working within the Service will be undertaken as part of the proposed structure changes.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 Feedback from Members of the Committee will help to ensure that the next phase of development and delivery of the service reflects their views.

7. REASON FOR THE RECOMMENDATION

7.1 Officers felt it was important for Members to be aware of the challenges facing the service, as well as recent modernisation achievements in the service.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 As noted above, work has been ongoing to make internal processes more efficient and streamlined. This is a demand-driven service, only the Coroner can make decisions about what reports and services are required as part of investigations, so alternative options are extremely limited.

9. IMPLICATIONS

Financial Implications

9.1 The service is reviewing its current demands and will bring forward any additional resource implications as part of finance reports and business planning. The budget for 2019/20 is £1.7M split on a 65:35 ratio (CCC:PCC).

Legal Implications

9.2 The Local Authority has a statutory duty to provide the necessary resource to support the work of HMC.

Equalities Implications

9.3 *There are no significant implications*

Rural Implications

9.4 *There are no significant implications*

Risk

9.5 This is a high profile service and therefore carries reputational risk implications.

10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 **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

11. APPENDICES

11.1 None