Open Report on behalf of Andrew Crookham, Executive Director – Resources

Report to:	**Public Protection and Communities Scrutiny Committee**
Date:	**08 December 2020**
Subject:	**Coroners Service Annual Report**

Summary:

This report sets out the Coroners Service Annual Report which is produced in accordance with the requirement of HM Chief Coroner for England and Wales.

Actions Required:

Members of the Public Protection and Communities Scrutiny Committee are requested to review and comment on the progress and performance of the service and consider timescales for further reports and actions.

1. The Role

It is the role of the Coroner to investigate, and if necessary to conduct an inquest, if the Coroner has reason to suspect that the deceased died a violent or unnatural death; where the cause of death is unknown; or where the person died in custody or state detention.

The Coroner may request a post mortem examination, where it is considered necessary, to enable the Coroner to decide whether the death is one where an investigation is required. A post mortem examination will be ordered if, for example, a registered medical practitioner is unable to give an opinion as to the medical cause of death.

An inquest is not to determine matters of civil or criminal liability, nor to seek to apportion blame for the death. The purpose is simply to answer four questions:

- Who is the person that has died?
- Where did they die?
- When did they die?
- How did they die?

“How” in coronial terms means “by what means”. This is extended only for those inquests where it is arguable that there has been a breach of Article 2 of the Human Rights Act 1998 (the right to life), to “how and in what circumstances".

1.1 Independence

The Coroner is an independent judicial officer, responsible to the Crown, who can only be removed from office by the Lord Chancellor with the agreement of the Lord Chief Justice for incapacity or misconduct. The local authority appoints the Coroner but they do not employ them, and this is an important distinction to maintain independence. The autonomy of the office is an important safeguard for society and a key element in the investigation of death.

1.2 Statutory Duties

The key piece of legislation covering Coroners and coronial activity is the Coroners and Justice Act 2009. Section 24 of this Act places a duty on the local authority to secure the provision of whatever officers and other staff are needed by the Coroner for the area to carry out their functions and also to provide accommodation that is appropriate to the needs of the Coroner in carrying out their functions. In deciding how to discharge its duties under this subsection, the authority must take into account the views of the Senior Coroner for that area. The Chief Coroner has published guidance in the form of a "Model Coroner's Area". That is updated from time to time.

1.3 Lincolnshire Coronial Jurisdiction

Since 2017 there has been a single Coronial jurisdiction for the county that is coterminous with the County Council and Police force area. The following features within Lincolnshire all reflect the complexity of the coronial workload:

- 3 main places of state detention (HMP Lincoln, HMP North Sea Camp and IRC Morton Hall) in addition to custody suites at Police stations, Courthouses and Ministry of Defence (MoD) bases.
- 15 sites operated by the Lincolnshire Partnership Foundation (mental health) Trust (LPFT) where people can be detained under the Mental health Act.
- 3 acute hospital sites operated by United Lincolnshire Hospital Trust (ULHT).
- Rural road network (the area has the second highest number of road deaths of all Coroner areas nationally).
- Several MoD bases.
- Long coastline.
- Large transient seasonal population.
- High number of treasure finds.

HM Senior Coroner for Lincolnshire was Timothy Brennand supported by Paul Smith as HM Area Coroner and 3 Assistant Coroners. Following a successful appointment to the Senior Coroner's role in Manchester West, Mr Brennand left Lincolnshire at the end of August 2020. Paul Smith is now the HM Acting Senior Coroner. Following advice from the office of the Chief Coroner, the post of

permanent Senior Coroner cannot be recruited until the matters of the potential merger with North and North East Lincolnshire are resolved.

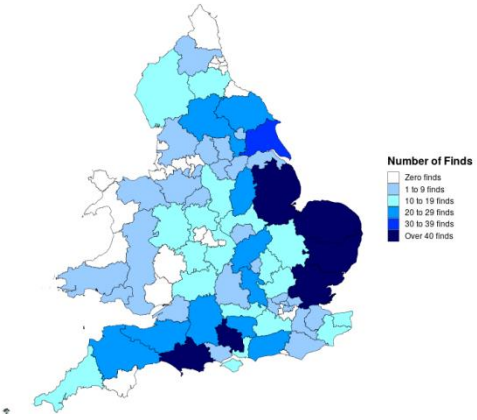
The Coroner is supported by a team of 8 fte officers and 4.18 fte business support personnel. Service management comes as part of the Registration, Celebratory and Coroners Service.

1.4 Coroners Statistics 2019

Analysis of Lincolnshire High Level Coroner Statistics

Coroner Service Analysis (Lincolnshire)							Coroner Service Average 2019 (England & Wales)
Coroner Service Analysis (Lincolnshire)	**2017**	**%**	**2018**	**%**	**2019**	**%**	**%**
Population of each area (thousands, as per ONS):							
Lincolnshire	751.2	100%	755.8	100%	761.2	100%	
Total (Lincolnshire coroner area)	751.2	1%	755.8	1%	761.2	100%	
Deaths registered by area of usual residence, of which:							
Lincolnshire	8,521	100%	8,750	100%	7,467	100%	
Total (Lincolnshire coroner area)	8,521	15%	8,750	16%	7,467	100%	
Deaths reported to coroner, of which:	3,389	40%	3,217	37%	3,242	43%	40%
Post-mortems	1,293	38%	1,253	39%	1,292	40%	39%
Inquests opened	347	10%	364	11%	411	13%	14%
Inquest conclusion category:							
Killed unlawfully and killed lawfully	0	0%	0	0%	2	1%	0%
Suicide	44	11%	46	12%	45	12%	15%
Drugs/Alcohol Related	38	9%	48	12%	41	11%	11%
Road Traffic Collision	31	8%	31	8%	34	9%	3%
Lack of care or self-neglect	0	0%	0	0%	0	0%	0%
Death from industrial diseases	37	9%	27	7%	29	7%	8%
Death by accident or mis-adventure	52	13%	89	22%	56	15%	25%
Deaths from natural causes	112	27%	45	11%	19	5%	13%
Open	29	7%	33	8%	18	5%	5%
All other conclusions	66	16%	80	20%	132	35%	20%
Total	409	100%	399	100%	376	100%	100%
Average time taken to process an inquest (weeks)	45.0		45.0		35		27

Treasure 104 reported finds in 2019



1.5 Challenges and Achievements 2019/2020

Even before the current pandemic, 2019 brought its own challenges. The absence of a dedicated court in Lincoln had been in part offset by the availability of the Cathedral Centre. The unilateral decision to close that facility, taken abruptly at the

end of January 2019, brought the issue of accommodation into sharp focus. A number of inquests hearings were vacated of necessity. Whilst other facilities, including the Ceremony Room at 4 Lindum Road and the Judges Lodgings, were pressed into service, there remained issues surrounding the suitability of both. More importantly, the absence of a venue suitable for larger numbers of attendees, or suitable for jury inquests, delayed final hearings. The Enterprise Centre at Boston proved a useful venue, but finding availability for several consecutive days was problematic.

The decision by the Cathedral to reopen the Cathedral Centre as a Court in October 2019 restored the status quo. Alongside the bookings already made with the Enterprise Centre, the provision of two fulltime Coroners, together with Assistant Coroner cover, enabled inroads to be made into the backlog. A total of 16 jury inquests were heard among a total of 397 inquests concluded.

The Senior and Area Coroners also worked to reduce the average time to inquest. Historically, and for a number of reasons, the jurisdiction had been one of the slowest nationally. The appointment of an Area Coroner in December 2017 coupled with the more proactive approach then taken to listing was reflected in the 2018 return. The area was one of only six jurisdictions nationally to maintain its timeliness against an almost universal increase in time taken to inquest. In 2019, by combining regular sitting patterns with that same listing approach the average time taken to inquest was reduced from 45 weeks to 35 weeks. Had full Court provision been made throughout the year it is likely that further progress would have followed.

The departure of key personnel within the service, notably the Head of Service, the Coroners Services Manager and Senior Coroners Officer, none of whom have yet been permanently replaced, alongside the departure of a number of Coroners Officers has left the management structure of the service very stretched on occasion. The outcome of the Coroner Service Transformation Project is eagerly awaited so that progress can be made to recruit for those vacancies.

The post mortem and mortuary services contract was renewed during summer 2020 on a one year basis. A full retendering exercise is already in the planning stages for 2021. The national shortage of pathologists creates challenges to ensure these services are delivered in an effective way.

1.6 Impact of Covid 2019

At the beginning of the outbreak the Chief Coroner published guidance on the Coronavirus Act 2020 to provide clarity that: *COVID-19 as cause of death (or contributory cause) is not a reason on its own to refer a death to a coroner under the CJA 2009.* This along with other guidance ensured that the service was not overwhelmed. In fact some of the measures to support all parts of the death management process that have been introduced, including additional medical examiner provision and changes to the death registration system, provided some efficiencies.

Even before the first lockdown was announced, several requests from families wishing to postpone hearings were received, as they were shielding. There was also increasing reluctance from the Cathedral authorities to allow use of the Cathedral Centre. Following lockdown all inquests were cancelled. By June, as the first lockdown eased, further guidance was published. It was possible to identify those inquest cases where no witness attendance was required, and where the families wish was for the matter to be concluded in their absence, rather than be delayed until physical attendance was possible. With that approach a number of "Documentary Inquests" were heard. These were public hearings but no attendance was anticipated and none occurred. Upon request a recording of the proceedings was provided to the next of kin, and also to the press. In August, Coroners Courts were set up in the Myle Cross Centre in Lincoln. The space within each court has allowed inquests to continue and much of the backlog has been cleared. The Courtrooms are limited by Covid assessments to 12 attendees so inquests where in excess of that number may be anticipated cannot be listed. It is not anticipated that jury inquests will resume until 2021. Exploration of suitable alternative locations and technology solutions to permit remote courts remain underway.

1.7 Looking forward - Transformation

In 2019 it was recognised that a wholesale review of the service would be useful to address:

- Remaining differences in processes across the merged central and south coronial areas.
- New leadership approach from HM Senior Coroner.
- New case management system.
- On-going difficulties with locations for inquests.
- Management vacancies.
- A potential to merge with the North and North East Lincolnshire to create a Greater Lincolnshire coronial area.

The transformation project is part of Lincolnshire County Council's wider Transformation Programme. All elements of the project are on track with improvement and change proposals timetabled for the new year.

Merger discussions with North and North East Lincolnshire are at an early stage. Dependent on negotiations and progress, the aim is to submit a business case to the Chief Coroner in March 2021.

2. Conclusion

Bereaved families and loved ones are kept at the heart of the Coronial process as stated by HM Chief Coroner in his latest report *"death and life are part of one continuum and we should aim for the quality of care in death as we would in life".*

Despite the challenges as stated in the report the Coroners Service has improved the time taken for an inquest to be heard, has received great feedback from families they have supported in finding closure of the sudden death of a loved one.

3. Consultation

a) Risks and Impact Analysis

Not Applicable

4. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Paul Smith, Acting Senior Coroner, and Sara Barry, Acting Assistant Director - Public Protection, who can be contacted on 07765 900899 or by e-mail at Sara.barry@lincolnshire.gov.uk