Lincolnshire COUNTY COUNCIL Working for a better future

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

Report to:	**Public Protection and Scrutiny Committee**
Date:	**14 December 2021**
Subject:	**Lincolnshire Coroners Service Annual Report**

Summary:

This annual report is in accordance with the requirement of HM Chief Coroner for England and Wales.

Actions Required:

The Public Protection and Communities Scrutiny Committee are requested to note the progress and performance of the service and consider timescales for further reports and actions.

1. Background

It is the role of the Coroner to investigate, and if necessary to conduct an inquest into a death, where 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 postmortem examination, where it is considered necessary, to enable the Coroner to determine a cause of death and whether the death is one where an investigation is required. A postmortem 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".

1.2 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.

1.3 Statutory Duties

The key piece of legislation covering Coroners and coronial activity is the Coroners and Justice Act 2009. That was introduced on 25 July 2013. 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.

1.4 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 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 ULHT
- Rural road network (the area has one of the highest numbers of road traffic 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.

1.5 Coroners Statistics 2020

Analysis of Lincolnshire High Level Coroner Statistics					
Coroner Service Analysis (Lincolnshire)					Coroner Service Average 2020 (England and Wales)
Coroner Service Analysis (Lincolnshire)	**2019**	**%**	**2020**	**%**	
Population of each area (thousands as per ONS):					
Lincolnshire	761.2	100%	766.3	100%	
Total (Lincolnshire Coroner Area)	761.2	100%	766.3	100%	
Deaths registered in Lincolnshire:					
Lincolnshire	7467	100%	8679	100%	
Total (Lincolnshire Coroner Area)	7467	100%	8679	100%	
Deaths reported to coroner, of which:	3242	43%	3275	38%	34%
Post-mortems	1292	40%	1279	39%	39%
Inquests opened	411	13%	416	13%	16%
Inquest conclusion category:					
Killed unlawfully and killed lawfully	2	1%	0	0%	0%
Suicide	45	12%	75	19%	14%
Drug/Alcohol Related	41	11%	50	12%	12%
Road Traffic Collision	34	9%	17	4%	3%
Lack of care or self-neglect	0	0%	0	0%	0%
Death from industrial diseases	29	7%	34	8%	9%
Death by accident or misadventure	56	15%	71	18%	24%
Deaths from natural causes	19	5%	17	4%	12%
Open	18	5%	12	3%	4%
All other conclusions	132	35%	129	32%	21%
Total	**376**		**405**		100%
Average time taken to process an inquest (weeks)	35		43		27

Figure 1 Coroner Service Analysis

A total of 43 Treasure finds were recorded.

1.6 Challenges and Achievements 2020

It is almost impossible to separate the demands faced by the service throughout 2020 from the pandemic, which had an impact on every aspect of service provision.

Whilst the pandemic did not drive any increase in the number of referrals received, the annual figure remaining broadly constant, it had a significant impact upon the performance of the service.

By February 2020, as the likelihood of a pandemic approached, we began to receive requests from families for hearings to be postponed. Many, particularly the elderly or

vulnerable were shielding and reluctant to expose themselves to the risk of catching Covid 19 by attendance at a public hearing.

The perennial issue of Coroner's Court accommodation became more acute in 2020. In March 2020 the first national lockdown was announced. The Cathedral Centre closed and with it our only regular Court facility. Referrals continued to accrue, and it was then that the remote working facility offered by our WPC software (introduced in late 2018) demonstrated its real worth. Despite the very great majority of staff working from home, referrals were processed in a timely manner, minimizing the impact of the pandemic, in that regard at least, upon the bereaved.

We were unable to conduct public court hearings. No hearings at all were possible for some 3 months, until June 2020. At that stage our only Court facility was at Lindum Road, which remained closed to the general public. An agreement was reached by the then Senior Coroner Timothy Brennand, which permitted that building to be used to conduct "Documentary" hearings at which no public attendance was anticipated, and very many smaller cases were concluded on that basis. Families were content to accept cases being concluded in their absence to secure early closure. Disclosure of witness statements was made, and an advance indication of the likely conclusion was given. A copy of the audio recording of the hearing was provided to families free of charge upon request. Cases involving some physical attendance, whether by families or witnesses, were delayed.

By September, some limited physical hearings were permitted. The service then had a backlog of almost 400 cases, an increase of roughly one third above its normal caseload. The current facilities at the Myle Cross Centre were made available, comprising two separate courtrooms together with waiting facilities. Protocols were introduced to reduce the risk of infection and those courts began to operate with limits on the numbers who may attend. In keeping with the guidance received from the Chief Coroner, several cases were completed remotely, with Interested Persons attending via Microsoft Teams. Orders were placed for the equipment necessary to permit the conduct of "hybrid" hearings, within which some persons attend in person whilst others attend remotely. That equipment was finally installed in April 2021.

By the end of 2020 that backlog had largely been cleared, the caseload returning to 300 cases. That was however something of an artificial picture, as those remaining were largely the more complex cases, or those requiring a jury, many of which had time estimates in excess of one day. No Jury cases were heard after March 2020 until they resumed in October 2021. At that stage the backlog of jury cases stood at 17 cases.

The yardstick of timeliness to inquest inevitably suffered, dropping back to 43 weeks. The Chief Coroner's April 2021 annual audit of cases in excess of 12 months old disclosed a total of 66 such cases locally, a rise below the national average. On year-to-date figures, it is likely that the 2021 data will evidence a significant improvement in timeliness to inquest, marking a return to pre covid levels.

Another major consequence of the pandemic was the inability to obtain reports and statements, particularly from hospitals, as part of a Coronial investigation. As the NHS dealt

with the various pressures posed by the pandemic, the withdrawal of administration time for clinicians was keenly felt by the Coroner's Service. Deadlines for the provision of statements were missed, and formal demands utilising the provisions of the Coroners and Justice Act 2009 to compel compliance did not sit comfortably alongside the greater pressures faced by clinicians. That continues to be an issue as does the ability to secure the attendance of medical professionals to give evidence. That has caused very real delays in our ability to complete investigations and to list cases promptly. I recently met with the new Medical Director at ULHT when that was discussed. The problem was acknowledged and there are ongoing measures being taken to address that issue, although it is unlikely to be resolved within the near future.

The absence of key personnel within the service remained an issue throughout 2020. Previous reports highlighted the pressures brought about by the enforced departures of the Head of Service, the Coroners Service Manager and Senior Coroners Officer as a consequence of ill health. Adding to that list, the departure of the Senior Coroner in August 2020 imposed further demands on the service. I was asked to step up from my role as Area Coroner to that of Acting Senior Coroner with effect from 1 September 2020 for an expected term of up to 12 months. That term has recently been extended by a further 12 months. The absence of a second fulltime Coroner can be managed in the short term by additional Assistant Coroner cover but has a much greater impact over the longer term, particularly when future planning for the service is considered.

The Postmortem and Mortuary Services contract was renewed in the summer of 2020 for an additional term of 1 year. A full retendering process was undertaken in early 2021. At the time of writing agreement has been reached in relation to changes in the provision of such services, but formal agreements are awaiting ratification.

1.7 Looking Forward

Against the background of a much-reduced management team, the Coroners Service Transformation Project began in mid-2020 and concluded earlier this year. Many positive developments resulted from that and were the subject of a specific report on 27 July 2021. Those include a permanent office and Court facility for the service, improved methods of working across the County, a new electronic referral system and improved communication with other stakeholders.

Recent appointments of a new Head of Service and Coroners Service Manager have been universally welcomed within the service and there is a clear shared energy to improve and drive the service forward.

Throughout 2020, the possibility of a merger of Lincolnshire Coroners Service with North Lincolnshire and Grimsby to create a Greater Lincolnshire Coroners Service remained. There were many discussions between the three Local Authorities and an agreed business plan for that potential merger was finally submitted to the Chief Coroner's office for approval earlier this year. A decision is currently awaited although no time frame for that has been given. As the implementation of many of our local initiatives is dependent upon that decision, not least the ability to appoint a permanent Senior Coroner and to fill any vacancy that may

arise because of such an appointment, the sooner that can be determined, the sooner we shall know in which direction we are to progress.

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 stated in the report the Coroners Service has faced the unprecedented challenges presented by the pandemic head on, has received positive feedback from families they have supported in finding closure of the sudden death of a loved one and it is to be hoped moves forward with renewed optimism in the future.

3. Consultation

No consultation was used to inform on this report.

4. Background Papers

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

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