Open Report on behalf of Glen Garrod, Executive Director Adult Care & Community Wellbeing

Report to:	**Public Protection and Scrutiny Committee**
Date:	**20 September 2022**
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 is invited to:

(1) review and comment on the contents of this report, the progress and performance of the service, and

(2) consider timescales for further reports.

1.1 The Role

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 post-mortem 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 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". The inquest does not determine whether or not a breach has occurred.

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 does not employ them. 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 discharge their function and also to provide accommodation that is appropriate to the needs of the Coroner. 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 August 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 HMP Morton Hall). The latter establishment was an Immigration Removal Centre until it returned to the Prison Estate in late 2021. In addition, there are custody suites at Police stations, Courthouses and MoD bases
- 15 sites operated by the Lincolnshire Partnership Foundation (mental health) Trust (LPFT) where people may 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

Until August 2020 HM Senior Coroner for Lincolnshire was Timothy Brennand. He was supported by Paul Smith as HM Area Coroner (fulltime) and by 3 sessional Assistant Coroners. Mr Brennand left Lincolnshire at the end of August 2020. Paul Smith was appointed HM Acting Senior Coroner. Following advice from the office of the Chief Coroner, the post of permanent Senior Coroner cannot be recruited until the issue of the potential merger with North Lincolnshire and Grimsby is resolved.

There were also changes to personnel within the service during 2021. As at December 2021 the Coroner was supported by a team of 8.2 FTE officers and 4.0 FTE business support personnel. Additional personnel have since been recruited. Service management comes as part of the Registration, Celebratory and Coroners Service.

1.5 Coroners Statistics 2021

Analysis of Lincolnshire High Level Coroner Statistics									
Coroner Service Analysis (Lincolnshire)									Coroner Service Average 2021 (England and Wales)
Coroner Service Analysis (Lincolnshire)	**2018**	**%**	**2019**	**%**	**2020**	**%**	**2021**	**%**	
Population of each area (thousands as per ONS):									
Lincolnshire	755.8	100%	761.2	100%	766.3	100%	768.4	100%	
Total (Lincolnshire Coroner Area)	755.8	100%	761.2	100%	766.3	100%	768.4	100%	
Deaths registered by areas of usual residence, of which:									
Lincolnshire	8750	100%	7467	100%	8679	100%	7781	100%	
Total (Lincolnshire Coroner Area)	8750	100%	7467	100%	8679	100%	7781	100%	
Deaths reported to coroner, of which:	3217	37%	3242	43%	3275	38%	2953	38%	33%
Post-mortems	1253	39%	1292	40%	1279	39%	1374	47%	43%
Inquests opened	364	11%	411	13%	416	13%	504	17%	17%
Inquest conclusion category:									
Killed unlawfully and killed lawfully	0	0%	2	1%	0	0%	1	0%	0%
Suicide	46	12%	45	12%	75	19%	70	16%	15%
Drug/Alcohol Related	48	12%	41	11%	50	12%	68	15%	12%
Road Traffic Collision	31	8%	34	9%	17	4%	30	7%	3%
Lack of care or self-neglect	0	0%	0	0%	0	0%	1	0%	0%
Death from industrial diseases	27	7%	29	7%	34	8%	34	8%	6%
Death by accident or misadventure	89	22%	56	15%	71	18%	98	22%	24%
Deaths from natural causes	45	11%	19	5%	17	4%	40	9%	11%
Open	33	8%	18	5%	12	3%	13	3%	3%
All other conclusions	80	20%	132	35%	129	32%	91	20%	26%
Total	**399**		**376**		**405**		446		100%
Average time taken to process an inquest (weeks)	45		35		43		36		31

- A total of 59 Treasure finds were recorded.

1.6 Challenges and Achievements 2021

It remains almost impossible to separate the demands faced by the service throughout 2021 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. The direct and indirect consequences of the pandemic were highlighted last year. A significant and immediate backlog of cases arose.

By the start of 2021 that backlog had largely been cleared, the caseload returning to c 300 open inquest 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 the outstanding cases had time estimates in excess of one day. No Jury cases were heard after March 2020 until they resumed in October 2021 with the creation of a designated jury court at Myle Cross. At that stage, the high-water mark of jury cases stood at 17 cases.

The Chief Coroner's annual audit of cases more than 12 months old in April 2021 disclosed a total of 66 such cases (against an "allowance" of 30), although the rise locally was below the national average. The April 2022 audit disclosed an increase to 89 cases. No national figures have yet been published to permit a comparison.

The yardstick of timeliness to inquest had inevitably suffered throughout 2020, dropping back to 43 weeks. Conversely, during 2021 despite the various delays precipitated by the various waves of the pandemic, and despite the unfilled fulltime Coroner position, our timeliness to inquest improved by 7 weeks to 36 weeks. That was achieved against a worsening picture nationally, the national average rising by 4 weeks to 31 weeks.

A major consequence of the pandemic was the inability to obtain reports and statements as part of a Coronial investigation, particularly from hospitals. 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 utilizing 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. That has caused very real delays in the ability to complete investigations and to list cases promptly. Meetings have been held with the 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 fully resolved within the near future.

That issue however masked an underlying trend, that of the increased caseload of the Coroner service. Throughout 2021 the caseload grew steadily, despite more cases than ever before being taken to inquest. Whilst the merger of South and Central Lincolnshire in August 2017, and the absence of a fully computerized system until September 2018, each obscure the beginnings of that trend, it is evident that there has been an increase in both post-mortem examinations and also the number of cases going to inquest in recent years.

The enforced withdrawal of GPs from face-to-face consultations during Covid meant that, despite a temporary relaxation of the rules relating to the issue of Medical Certificates of the Cause of Death (MCCDs), there were more cases within which no cause of death could be given without a post-mortem examination. Furthermore, the Medical Examiner (ME) system was rolled out in secondary care. The additional layer of independent medical scrutiny in hospital deaths introduced by the ME scheme undoubtedly increased the number and complexity of Coronial investigations, and consequently the number and complexity of inquests, despite a reduction in the total number of referrals received.

That increase in inquests is not immediately obvious from the statistics given above but lies in the detail. The MOJ data collated takes a snapshot of referrals in each calendar year. The number of inquests opened in each year reflects only the referrals received

within that same calendar year. Cases from the previous year that were at investigation stage but had not progressed to inquest at the date upon which the data was collected do not feature as inquests in either the year of referral or the year in which the inquest was opened. Consequently, there is a hidden increase. The figures in the table above show a modest excess of inquests opened over inquests concluded, year on year since 2019. Additionally, in each year there are approximately 20 cases which are the subject of a criminal prosecution following which the inquest is not resumed and is permanently suspended. That figure has remained broadly constant for several years. Those cases are not included within the total of concluded inquests

Accordingly, in 2021 504 inquests were generated from referrals received in 2021, plus an additional estimated 27 inquests from referrals received the previous year, giving a grand total of 531. Against that figure 446 inquests were completed with a further 20 cases permanently suspended. The net gain was therefore 65 cases. Provisional indications are that a similar pattern continues through 2022. That is reflected in our management system, WPC. The caseload of open inquests is currently c400, down from a peak of 420, that representing an increase of 120 inquest cases since January 2021. That reduction is likely due to seasonal factors. With a 40% increase in open inquests at every level the service is under pressure.

The absence of some key personnel within the Service was addressed during 2021. 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. Paul Smith was asked to step up from his 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 was extended by a further 12 months in September 2021 and has been further extended until September 2023. The absence of a second fulltime Coroner has been 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 outstanding issue of the merger with North Lincolnshire remains unresolved and has exacerbated that burden. The Acting Senior Coroner for North Lincolnshire retired in September 2021. They retained one single active part time Assistant Coroner. They had no one willing or able to fulfill the role of Acting Senior Coroner and approached Lincolnshire County Council for assistance. In the spirit of the proposed merger, that was agreed, Paul Smith taking that role. Likewise, one of the local Assistant Coroners agreed to sit there also. Since September 2021 Paul Smith has held the position of Acting Senior Coroner for both areas. His appointment with North Lincolnshire has also been extended to September 2023. He deals with their decisions remotely most days and physically attends Cleethorpes one day each week, reducing his physical presence in Lincoln to only 4 days each week. He remains the only fulltime Coroner in either area. By contrast, with the regular provision of two fulltime Coroners, Lincolnshire would enjoy 10 Coroner days each week, plus occasional Assistant Coroner cover. The current situation is not one which can continue indefinitely. It is likely to generate delays in the listing of more complex cases, particularly in North Lincs, and is unfair on the bereaved.

The Post-mortem and Mortuary Services contract is currently provided through a DPS framework for 1 year. This is being extended for a further year with both suppliers once pathologist provision has been secured. Discussions are taking place with a third supplier to allow for business continuity as the post-mortem requirement increases. An open tender is planned take place in the summer of 2023.

1.7 Looking Forward

The Coroner Service Transformation Project began in mid-2020 and concluded last summer. Many positive developments resulted from that and were the subject of a specific report on 27 July 2021. Those included identifying 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. All of those are now embedded although the move to a permanent home within the Myle Cross site has stalled. The existing courtrooms, established to provide a short-term solution to the absence of court facilities as the service emerged from the pandemic are looking rather tired and the move to a permanent home is needed urgently. The uncertainty regarding the extent and timing of the necessary construction work is a concern.

Recent appointments of a new Head of Service and Coroners Service Manager have been universally welcomed within the service and there is a clear energy to improve and drive the service forward. We meet regularly and there is a shared vision to work upon the improvements already made.

The merger of Lincolnshire Coroner's Service with North Lincolnshire and Grimsby to create a Greater Lincolnshire Coroner Service remains the elephant in the room for so many decisions. There were several discussions between the three Local Authorities and an agreed business plan for the potential merger was finally submitted to the Chief Coroner's office for approval last year. Amendments to the proposal were sought from both Lincolnshire and Hull and were submitted in the Spring. A decision remains awaited but no time frame for that has been given. It was hoped that a welfare visit by the Chief Coroner to Lincoln, Cleethorpes and Hull in early June, as part of a national tour of all coroner areas may precipitate some movement, but that appears to have been a false dawn. The ongoing delay is hurting both Lincolnshire and North Lincolnshire. Unless a sensible timeframe for a decision is announced shortly there is a compelling argument that Lincolnshire should be permitted to proceed with its own recruitment and to deal with the merger separately if or when it happens. It seems unlikely that such a delay was contemplated when the issue was first aired in early 2019.

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.

During his welfare visit in June 2022 the Chief Coroner acknowledged the delay the merger decision was causing, although he was clear to stress that the decision was not his but was to be made by the Lord Chancellor. He identified the service as a work in progress, but recognised the positive efforts made by everyone within the service throughout a very challenging time.

3. Consultation

a) Risks and Impact Analysis

N/A

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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