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

Report to:	**Public Protection & Communities Scrutiny Committee**
Date:	**25 July 2023**
Subject:	**Coroners Service Annual Report**

Summary:

This annual report is in accordance with the requirement of His Majesty Chief Coroner for England and Wales. Councillors are requested to note the progress and performance of the service and consider timescales for further reports.

Actions Required:

Members of the Public Protection and Communities Scrutiny Committee are 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 as required.

1. Background

It is the role of the coroner to investigate, and if necessary to conduct an inquest into any 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 to determine 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 provide the medical cause of death or where it is suspected that the cause of death may be unnatural.

An inquest is an enquiry rather than a trial. It does not determine matters of civil or criminal liability, nor does it seek to apportion blame for the death. The purpose is to answer four specific 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 a breach has occurred.

As a matter of law, other than for the purposes of making a formal report to prevent future deaths, a Coroner may not offer an opinion upon any other matter.

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 United Lincolnshire Hospital Trust (ULHT).
- Rural road network (the area has one of the highest numbers of road traffic deaths of all Coroner areas nationally).
- Several Ministry of Defence (MOD) bases.
- Long coastline.
- Large transient seasonal population.
- High number of Treasure finds.

Prior to 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 at that time, the post of permanent Senior Coroner could not be recruited until the issue of the potential merger with North Lincolnshire and Grimsby was resolved. In light of the delays within that process submissions were made regarding that recruitment in 2022. Consent to recruit was then given and Paul Smith was appointed permanently on 28 March 2023 following an open competition. The Area Coroner vacancy remains outstanding although it is anticipated that the open competition for that role will be launched later this year.

There were also changes to personnel within the service during 2022. An additional 2 Assistant Coroners were recruited, bringing the total up to 5. Each Assistant Coroner sits on approximately 20 days each year in addition to covering the Senior Coroner's leave.

As at December 2022 the Coroner was supported by a team of 9.3 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 2022

Analysis of Lincolnshire High Level Coroner Statistics							
Coroner Service Analysis (Lincolnshire)							Coroner Service Average 2022 (England and Wales)
Coroner Service Analysis (Lincolnshire)	**2020**	**%**	**2021**	**%**	**2022**	**%**	
Population of each area (thousands as per ONS):							
Lincolnshire	766.3	100%	768.4	100%	769.5	100%	
Total (Lincolnshire Coroner Area)	766.3	100%	768.4	100%	769.5	100%	
Deaths registered by areas of usual residence, of which:							
Lincolnshire	8679	100%	7781	100%	8377	100%	
Total (Lincolnshire Coroner Area)	8679	100%	7781	100%	8377	100%	
Deaths reported to coroner, of which:	3275	38%	2953	38%	3229	38%	36%
Post-mortems	1279	39%	1374	47%	1488	46%	43%
Inquests opened	416	13%	504	17%	495	15%	17%
Inquest conclusion category:							
Killed unlawfully and killed lawfully	0	0%	1	0%	2	0%	0%
Suicide	75	19%	70	16%	82	16%	14%
Drug/Alcohol Related	50	12%	68	15%	72	14%	11%
Road Traffic Collision	17	4%	30	7%	33	7%	4%
Lack of care or self-neglect	0	0%	1	0%	1	0%	0%
Death from industrial diseases	34	8%	34	8%	27	5%	5%
Death by accident or misadventure	71	18%	98	22%	154	29%	25%
Deaths from natural causes	17	4%	40	9%	41	8%	14%
Open	12	3%	13	3%	7	1%	3%
All other conclusions	129	32%	91	20%	105	20%	24%
Total	**405**		**446**		**523**		100%
Average time taken to process an inquest (weeks)	43		36		39		30

- A total of 56 Treasure finds were also recorded.

1.6 Challenges and Achievements 2022

Although 2022 marked the second anniversary of the pandemic, the practical issues arising from continued to have an impact on the service. The marked decrease in the number of referrals experienced in 2021, which was presumed to result from the increased rollout of the Medical Examiner (ME) scheme, was not repeated, the volume of referrals returning to the levels experienced in previous years. Conversely, the percentage of cases requiring an inquest, which had climbed significantly following the introduction of the ME scheme, remained. As a result, the pressures on the service, especially in taking cases to inquest, persisted.

By the end of December 2022, the service had 363 open inquests, down from a high-water mark of 420 open inquests earlier in the year. The service had 99 cases older than 12 months by January 2023, although that had reduced to 85 such cases by the end of April 2023. As last year, no national figures have yet been published since November 2020 to permit a comparison to be made with other areas.

A total of 7 jury cases were heard in 2022.

The timeliness to inquest in 2022 averaged 39 weeks against a national average of 30 weeks. By way of comparison, the national spread ranged widely between 9 weeks and 72 weeks.

In June 2022 two additional Assistant Coroners were recruited although conversely one of the existing Assistant Coroners retired. The new appointees were required to attend formal induction training and then needed to be introduced gently to their new role. In January 2023 a number of additional Coroners Officers were engaged. The impact of these additional resources is now becoming evident.

Currently, the current management data to 30 June 2023 hints at a significant improvement. At that date the service held 314 open inquests, down from 414 at the same point in June 2022. Of those cases 75 were over 12 months old, down from 90+ at the same time last year. The service completed 299 cases in the first half of the year, with a further 21 cases suspended for criminal process. The current timeliness is c37 week, a modest improvement on the previous year, despite the impact of the older cases being heard. A total of 6 jury cases have already been heard in 2023. The number of outstanding jury cases has reduced to c10 cases. Progress is therefore being made on all fronts.

The particular difficulties in obtaining hospital reports highlighted last year, have been addressed and as a consequence of the changes made the number of outstanding reports has fallen sharply. That is still however one of the major drivers of delay in getting cases to inquest.

These figures reflect not only the pressures under which the service operates, but also the success of the measures taken to alleviate those pressures. Following representations made to the Lord Chancellors Department last year, consent to recruit a permanent Senior Coroner was given. Paul Smith secured that appointment following an open competition

in March 2023. He works in Lincoln only 4 days each week, the remaining day being spent in North Lincs, where he remains Acting Senior Coroner. He continues to deal with all out of hours decisions for both areas. The Area Coroner role remains vacant, although an open competition for a full time Area Coroner is expected to launch later this year, with a prospective appointment date of January 2024. That will provide much needed resilience.

Some progress has also been made in relation to the proposed merger with North Lincolnshire and Grimsby. After extensive delay an updated Business Plan was requested. That has very recently been submitted and further progress is awaited.

The Post-mortem and Mortuary Services contract is currently provided through a Dynamic Purchasing System (DPS) framework, and the service is in the process of seeking a longer contract term of 5 years. Since last year a third supplier has been recruited, providing additional resilience for these services.

1.7 Looking Forward

The Coroner Service Transformation Project began in mid-2020 and the following year. 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 increasingly tired and the move to a permanent home is needed urgently. There are ongoing discussions in relation to the separation of the site among other agencies and it is to be hoped that a final decision will be taken in relation to those plans in the very near future.

The appointment of a 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. Two internal appointments of Coroners Officer Supervisors have been made to reinforce the internal structure. There is a shared vision to work upon the improvements already made, reflected in the improved figures discussed above.

Likewise, the appointment of a permanent Senior Coroner is a positive step, and the service is looking forward to the appointment of an Area Coroner. A second fulltime Coroner will bring the service up to the complement of fulltime Coroners that it needs, and which has been without, for almost 3 years.

The merger of Lincolnshire Coroner's Service with North Lincolnshire and Grimsby (NLG) to create a Greater Lincolnshire Coroner Service remains outstanding although it does seem that a final decision will be taken over the coming months. As described last year, NLG has suffered greatly from the prolonged uncertainty in relation to its future. If a merger with Lincolnshire is confirmed, then a great deal of hard work lies ahead.

2. Conclusion

Bereaved families and loved ones are kept at the heart of the Coronial process. As stated by HM Chief Coroner *"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 and its aftermath head on, it has received positive feedback from families supported in finding closure following the sudden death of a loved one and it is to be hoped moves forward with renewed optimism in the future.

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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