MIDDLESBROUGH COUNCIL

Agenda Item 6

OVERVIEW & SCRUTINY BOARD

13th NOVEMBER 2012

COMMUNITY SAFETY & LEISURE SCRUTINY PANEL REPORT INTO THE

CORONER'S SERVICE

PURPOSE OF THE REPORT

1 The purpose of this report is to present to the Overview and Scrutiny Board the enquiries, conclusion and proposals from the panel's Scrutiny into the Coroners Service.

OVERALL AIM OF THE SCRUTINY INVESTIGATION

2 The overall aim of the Scrutiny Investigation was to identify the difficulties encountered with the Coroner's Service, which contributed to the delays in concluding an inquest. The Panel was equally aware that the financial pressures presently placed on the Council meant that there was a need to ensure the cost effectiveness of the Coroner's service.

TERMS OF REFERENCE OF THE SCRUTINY INVESTIGATION

3 The Panel determined the Terms of Reference for this Scrutiny into the Coroner's Service at their meeting in August 2011. The intention was to address the issues which had both been brought to Members' attention through the press and also the need to address how financially efficient the service is. The following presents the Board's agreed Terms of Reference :-

- To assess the cause for the delays taken between death and the conclusion of an inquest with the intention of finding ways to reduce this time.

- To examine the funding structure of the Coroner's Office to ensure its cost effectiveness.

BACKGROUND

History of the Coroner's Service

4 It is considered that it is in the general interests of the community that any sudden, unnatural or unexplained deaths should be investigated. Consequently, the Coroner was formally established in 1194 and the position developed into an independent judicial officer charged with the investigation of sudden, violent or unnatural death. Sudden death in the community has always been considered important, especially to the Coroner's office who would undertake the investigation.

5 Over years the Coroner's fiscal responsibility has diminished and the Coroners Act of 1887 made significant changes, repealing much of the earlier legislation. Coroners then became more concerned with determining the circumstances and the actual medical causes of sudden, violent and unnatural deaths for the benefit of the community as a whole.

6 The Coronership at present responds to and investigates those deaths which have been referred to it for a wide variety of reasons (just over one third of all deaths in England and Wales at the present time), However, in the wake of Dr Shipman's conviction, there have been three separate inquiries looking at the way in which sudden death is investigated, and it is anticipated that there will ultimately be new legislation and subsequent changes to the way in which all deaths are investigated and the manner in which coroners carry out their duties.

7 The Coroners and Justice Bill was introduced into Parliament in January 2009, following extensive consultation, and became an Act on 12 November 2009. However the current law relating to Coroner's remains the Coroners Act 1988 (which is based upon the 1887 legislation) as the 2009 legislative provisions await implementation. Additionally, Common Law, Judicial precedent and the Coroners Rules of 1984 are factors to which the Coroner must give consideration.

8 In operational terms, the Ministry of Justice is responsible today for the law and policy governing coroners and deal with the operation of the current coroner system. Coroners are independent judicial officers appointed and paid for by the relevant local authorities. The Coroners

are responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause and deaths in custody that are reported to them.

The responsibilities of the Ministry are:

- cross-government liaison on coroner matters
- queries and advice to ministers, coroners, local authorities and the public
- liaison with coroners and bereavement groups
- training for coroners and their staff
- supervision of the amalgamation of coroner districts
- other statutory casework.

Why the Coroner's Service was selected for Scrutiny

9 Members of the Council had become aware of the media coverage regarding the Coroner's Service in Teesside and in particular the length of time taken for inquests to be completed and the distress this was causing to some families. Members were subsequently informed that a judicial enquiry into the Coroner's Service in Teesside had been carried out several years ago to address a backlog for concluding inquests at that time. The conclusion of that enquiry had resulted in an increase in the number of staff employed by Cleveland Police to address that problem. However this had only been a temporary measure and once again the length of time taken to conclude an inquest started to increase and now was considered excessive.

10 Due to the above, Members appreciated the distress this can cause on families. Therefore with the statutory powers invested in Scrutiny the panel determined that they would undertake a Scrutiny into the Coroner's Service in respect of delays and also the cost effectiveness of the Service. The second aspect while not directly under the Council's control, was that the budget provision could not be ignored when the Council was having to significantly reduce its Budgets and hence its services.

SCRUTINY

11 The Community Safety and Leisure Scrutiny Panel commenced a Scrutiny into the Coroner's Service. In undertaking this, the panel wanted to obtain a range of information from various organisations which would provide an accurate and also balanced picture of the problems associated with the delays in concluding some inquests.

12 To achieve this the panel established its Lines of Enquiry, which would identify the key stakeholders, and the sequence in which the evidence would be received. Some obvious organisations such as the Police, Coroner and NHS were key to the panel's enquiries. However, Members sought to commence by gaining a basic understanding of a

Coroner's Service from an independent source outside of the Teesside jurisdiction in order that it would have a foundation to compare and contrast. Other organisations were identified as having present or previous involvement with the Coroner's Service and had been referenced in the local press regarding associated aspects of the service.

EVIDENCE RECEIVED

Middlesbrough Council

13 The Head of Legal and Democratic Services provided an outline to the panel of the operation and structure of the Coroner's Office in Middlesbrough. Middlesbrough Council was the Lead Authority on behalf of Stockton and Redcar and Cleveland Councils in respect of matters relating to the Coroner. In addition to the Coroner, there was a Deputy Coroner and two Assistant Deputy Coroners. The Assistant Deputy Coroners did not currently receive payment. Application for remuneration for the Assistant Deputy Coroners had been submitted previously but was dismissed by Middlesbrough Council in December 2009.

14 It was conveyed to the panel that the current Coroner was employed as a part-time Coroner and therefore his salary was determined by the number of inquests he dealt with. The age of the Coroner had frequently received attention in the press and it was explained to the panel that while the present Coroner was over 80 years old, more recent legislation required Coroners to retire at 70 years of age. However this requirement did not apply to the present Coroner for Teesside,

15 It was highlighted that the cost of the Coroner's service had almost doubled in the last five years, with the last year's outturn (2010/11) being approximately £911,000. Local Authorities had little control over the Coroner's Office expenditure and it was noted that a greater number of toxicology and other tests and post mortems required by the Coroner had increased costs. It was also highlighted that in general, the costs produced by the Teesside Coroner were average in comparison to other services around the country.

16 Members agreed that the main issues for the Panel to explore were the timeliness of inquests and the rising costs. The panel enquired as to the use of a Charter for Coroner's services and was informed that examples such as Hertfordshire County Council's sets out the standards of performance which were to be expected from the Coroner's Service and what to do if something went wrong.

General perspective on the operation of a Coroners Service

17 The panel wanted to gain some background information on the operation of a Coroner's service from a jurisdiction, which was not attracting the adverse publicity as presently, associated with Middlesbrough. Consequently the panel engaged with the now retired Coroner from the Western Division of North Yorkshire jurisdiction.

18 It was presented to the panel that a Coroner was an independent judicial officer who, although appointed and paid by the Local Authority, held office under the Crown. A Coroner presided over a Court of Record within the English Judicial system and discharged his duties in accordance with the Coroners Act 1988, the Coroners Rules 1984 and other relevant legislation. It was conveyed to the panel that Coroners were generally qualified Solicitors or Medical Practitioners.

19 A Coroner was required to appoint a Deputy Coroner and Assistant Deputy Coroner, who would act during the Coroner's absence. It was explained that although there was no statutory provision for Coroner's Officers and practices differed across the country. Traditionally, experienced Police Officers had carried out the role, although there was now a move to using more civilians. Some Local Authorities employed their own Coroner's Officers. The number of Coroner's Officers required in a jurisdiction depended on the size of area and population. The Home Office and Coroner's Officers Association Working Party 2007 had recommended that there should be one Coroner's Officer for between 400 and 800 deaths. About 30% of registered deaths were reported to the Coroner. In some jurisdictions some of the Coroner's powers were delegated to Officers to make routine decisions such as discretion to organise a post mortem and other administrative, but not judicial, functions.

20 Coroner's Officers were becoming more professional and a National Centre of Excellence had been established at Teesside University to develop a programme of relevant studies for employees of the Coroner's Service.

21 Although the Coroner was appointed by the Local Authority, it had no control of the post holder and little influence over the work undertaken. Providing a Coroner was acting properly, expenses could not be denied or challenged. The system was well established in practice but the success with which it worked varied considerably between districts. The Local Authority was responsible for providing administrative staff and accommodation. Although Coroners were not bound by the Local Authority or subject to any budget reduction, as a guardian of public money a Coroner had to observe responsibility in spending it.

22 With regard to Central Government, the Ministry of Justice was the department mostly concerned with Coroners. The Lord Chancellor had the power to remove Coroners for misbehaviour, but played no special

part in administration. In 1999 the Home Office produced the Coroner's Service Model Charter which was intended to promote consistency in service delivery. The document was a mixture of information and suggested service standards, however it had no statutory basis.

23 An outline of some of a Coroner's duties were presented as follows

- To investigate the circumstances of the deaths of all persons whose bodies were lying within his jurisdiction where he had reason to believe that the death was violent, unnatural or of unknown cause.
- To decide whether a post mortem examination was necessary.
- To hold an inquest if appropriate.
- To notify the Registrar of Deaths of the findings of the inquest, or if no inquest was held, of the fact that the death reported did not need to be subject to an inquest. (In which instance the ascertained cause of death will be notified to the Registrar)

24 A death had to be referred to HM Coroner if:

- The cause of death was unknown.
- It could not readily be certified as being due to natural causes.
- The deceased was not attended by a doctor during their last illness or was not seen within the last 14 days or viewed after death.
- There were any suspicious circumstances or history of violence.
- The death might be linked to an accident (whenever it occurred).
- There was any question of self-neglect or neglect by others.
- The death had occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station).
- The deceased was detained under the Mental Health Act.
- The death was linked with an abortion.
- The death might have been contributed to by the actions of the deceased (such as a history of drug or solvent abuse, self-injury or overdose).
- The death may be due to industrial disease or related in any way to the deceased's employment.
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic.
- The death might be related to a medical procedure or treatment whether invasive or not.
- The death might be due to lack of medical care.
- There were any other unusual or disturbing features to the case.
- The death occurred within 24 hours of admission to hospital (unless the admission was purely for terminal care).
- It might be wise to report any death where there was an allegation of medical mis-management.

25 The panel was informed that there was no statutory definition of death and the Coroner decided (within the determination of the Registration Act) which deaths were reportable. The presence of the body within the Coroner's territorial jurisdiction rather than where the death occurred, determined the Coroner's involvement. However, a body returned from abroad would usually be dealt with in the area where the deceased was to be buried or cremated. Deaths abroad could present the Coroner with serious problems due to the differing laws of other countries.

26 Certification of death could only be determined by a General Practitioner or Hospital Doctor. Others such as nurses or ambulance staff could certify the fact of death but not the medical cause of death. Although the majority of deaths are registered without inquest, when an inquest is required, the matters considered by the Coroner are:

- Who was the deceased?
- When did they die?
- Where did they die?
- How did they die?

27 The question "how" was how the cause of death arose, the sequence of events that directly led to and caused the death. It was not an opportunity to examine the broad circumstances in which the death occurred. The inquest was a fact-finding exercise to ascertain how the deceased came by their death.

28 Where a person had been charged with causing someone's death, eg by murder or manslaughter the inquest would be adjourned until the person's trial had taken place. Before adjourning, the Coroner would ascertain who the deceased was, and how they died. The death would be registered and should no one be charged the inquest would be heard in full.

29 Most inquests take place without a jury. However deaths in prison, deaths in police custody or from injury caused by a police officer in the execution of their duty or deaths reportable to a government department, for example a workplace accident, and deaths concerning public safety, or death which occurred whilst detained under mental health regulations did require a jury. It was highlighted that the requirement to appoint a jury often caused delay.

30 It was reported that the average time for completion of an inquest nationally was currently approximately 27 weeks. However, inquests into Road Traffic Collisions often took longer as all files had to be passed to the Crown Prosecution Service to ascertain whether or not there should be a prosecution. This even applied in the case of a single person collision where someone had died. It was highlighted that there was now more of an investigation into how a person died and whether something could be learned from it.

POLICE

31 The Scrutiny panel was aware that the staffing resource to support the Coroner is essentially split into two areas. There are staff who are funded by the local authority and operate from the Coroner's office which basically consists of five staff in addition to the Coroner.

32 In addition to the five staff funded by the Local Authority there are eight full time staff who are funded by the Police and operate from Police Headquarters, essentially these are the Office Manager, four Coroner's Officers and one Administration Assistant and two Police Constables working full-time in the unit. All staff work under the direction of the Coroner and the Coroner's Officers secure the range of evidence as determined by the Coroner. The panel was informed that this level of staffing had been in place for approximately ten years and deals with the tasks for both Teesside and Hartlepool jurisdictions. The annual staffing budget was £287,573 with an additional budget of £20,637 for general running costs, giving a total budget of £308,201. The cost for accommodation had not been given a value as the unit was based within the Middlesbrough Police Headquarters. All staff are employed by Cleveland Police to work under the direction of the Coroner. The staff undertake work for the Coroners for Teesside and Hartlepool. However, it was conveyed that the majority of the work was undertaken for the Teesside Coroner.

33 The purpose for inviting the Police to the meeting was to receive information from representatives of Cleveland Police in relation to the support, costs and operation of the Coroner's Service. The panel was informed that the four Coroner's Officers liaised closely with GPs and hospital staff who reported deaths. Based on legal guidelines, a Doctor would either issue a death certificate or refer it to the Coroner for consideration of a post mortem examination. Post mortems were generally carried out either at James Cook University Hospital (JCUH) or North Tees University Hospital (NTUH). Following the post mortem, if appropriate, an inquest would be opened and adjourned. The body would then be released to the family for burial or cremation. The Coroner's Officer would request statements from all people involved. For example, if it was a post-operative death, statements would be required from the ambulance staff, surgeon, anaesthetists, nurses or other medical staff who had been involved in the care of the deceased. In some cases, toxicology and/or histology tests would be taken and tissue samples to assist in establishing the cause of death.

34 Once the statements were received and the reports were typed, the file would be sent to the Coroner for review. The Coroner would then decide whether there was sufficient information to go ahead with the inquest or whether further details were required. There was no time scale for the file to be returned from the Coroner and it could vary from one week to a couple of months.

35 The panel was informed that the two Police Officers worked solely on the setting down of inquests and attending court. This allowed the other staff to deal with all other enquiries. The Administration Assistant was generally the initial point of contact for members of the public, solicitors and medical staff. If the Administration Assistant was unable to answer a query, it would be passed to one of the Coroner's Officers. The panel was informed that outstanding reports were chased up on a regular basis by staff to prevent unnecessary delays.

36 Members raised the issue of a benchmarking report produced by Teesside University in April 2008. It was confirmed that this report was commissioned by Cleveland Police to review the effectiveness and efficiency of the Coroner's Officers and determine whether the staffing level was appropriate for the caseload. The report had examined a Home Office Coroner's Office Working Party report from 2002 on the provision of Coroner's Officers. The report acknowledged that staffing levels varied widely between jurisdictions while conveying that most Coroners districts had a ratio of one Coroner's Officer per 400 to 800 deaths. This ratio was conveyed to the panel as an optimum number depending on whether the jurisdiction was mainly rural or urban. It was also conveyed to the panel that the report indicated it would be reasonable to included secretarial and administrative staff in this ratio. On this basis, it would indicate that staffing levels were above the Home Office guidelines and higher than in other similar jurisdictions.

37 The panel was informed that Cleveland Police had recently introduced an administrative case tracking system within their Legal Services Department and it was considered that this electronic system could be used by the Coroner's Officers to improve efficiency. The system would produce a regular schedule of reports, which required chasing up, and the system would automatically generate reminders. Although there appeared to be advantages to having this system, operational agreement to implementing the new system had not yet been reached with the Coroner. The Coroner had expressed concern as to the security of information within the system as it could potentially be accessed by staff other than the Coroner's Officers. As the system was already in use by Cleveland Police, the additional costs for populating it for use by the Coroner's Officers would be minimal. At a subsequent meeting with representatives of the Police it was conveyed that further discussions would take place with the Coroner to address training needs and ensure the appropriate levels of security to maintain the confidentiality required could be incorporated.

38 In operational terms the panel was informed that all outstanding reports were chased up monthly and sometimes families or legal representatives would contact the Coroner's Officers to ascertain what stage a case was at. If two or three reports were needed from medical staff, this could take some time. The Coroner's Officers would liaise with the Legal Services Team at the hospitals and not directly with

medical staff. The deceased's medical notes would have to be passed to each member of staff for them to write their report. The average time for production of a report was two to three months, although in some cases it could take five to six months. In addition, medical staff sometimes moved on to other hospitals and it could take time to contact them. The average waiting time for the results of toxicology and other tests was six to eight weeks. Inquests into deaths in prison or through accidents at work generally took much longer to complete, as statements were required from many different sources.

39 The panel was also appraised that establishing a date for the inquest hearing contained a number of complications and it was very time consuming administratively in identifying a suitable date for the Coroner and all witnesses to be available.

NATIONAL HEALTH SERVICE

Pathology

40 The panel wanted information regarding pathology and the time required to undertake the process for inquest. From notification to submission of reports to the Coroner. Therefore invitation was sent to Pathology at the South Tees Hospitals NHS Foundation Trust on the issues of time, demands and numbers in relation to post mortems and other associated involvement of the Trust in the process for reporting to the Coroner.

41 The panel was informed that the Coroner's Service investigated sudden, unexpected, or unnatural deaths. By Coroner's law there had to be a post mortem and inquest to establish the cause of death and how it occurred. Teesside was a wide-ranging jurisdiction as it included the James Cook University Hospital (JCUH), which was a major training centre for cardiac surgery and also many patients involved in accidents were transferred there from other areas. With regard to post mortems, they were generally carried out at the hospital nearest to where the person had died. Occasionally a body might be transferred depending on the availability of a pathologist.

42 It was conveyed that during the current year (at date of meeting), 221 inquests had been opened out of over 2000 reported deaths. The number of outstanding inquests at the end of September was 289. Sixty-nine of the inquests had been outstanding for over 12 months and it was anticipated that the majority of inquests would not be completed in less than 12 months. Reference was made to statistical information produced by the Ministry of Justice in 2010, which measured against five bands for the length of time taken to conclude inquests, the longest being 'over 12 months'.

43 With regard to the length of time of inquests in Teesside, it was suggested that if the Coroner had more power to request statements and reports within a shorter time scale, this would speed up the information gathering process and therefore the overall time for completion of an inquest.

44 In operational terms the Trust's main interaction with the Coroner's Service was through the Legal Services Team. The Team liased with the Coroner's Office to organise witness statements and reports. This was time consuming and frequently patients' notes had to be passed from one witness to another. It was acknowledged that whilst notes could be photocopied, there were sometimes large volumes of notes and duplicating them would have resource implications. It was raised that the workload had increased dramatically over the last few years. In 2003 there were 62 inquests and in 2010 there were 126. The average number of reports requested per inquest in 2003 had been 2 and in 2010 this had increased to 5.

45 Pathologists generally use the NHS facilities privately for undertaking post mortems, which are usually conducted before, or at the end of the normal working day and therefore do not impinge on the Trust's operations. The cost for the use of the facilities was £230.16 per post mortem, which was not profit making from the Trust's point of view. The pathologist's rates for completing a post mortem are agreed nationally. Forensic examinations were much more costly at approximately £1200-£1500. In 2010 there had been 832 post mortems carried out, of which 26 were forensic.

46 It was noted that there had been an issue around the capacity of pathologists and the demand for post mortems and the reluctance of some pathologists to be involved. Whilst this issue had been raised, the Trust was not in a position to apply any pressure on pathologists as the work was undertaken in their own time. In addition, the Coroner was eager to validate the independence of inquests, for example if a death occurred during surgery at JCUH, a pathologist from NTUH would probably be asked to conduct the post mortem which the panel considered was a very good practice.

47 It is understood that the general view of most clinicians in the South Tees Hospitals NHS Foundation Trust was that the work of the Coroner's Office was very thorough. The Coroner's Service always demonstrated care for the deceased person's family and ensured they had the opportunity to discuss issues about the death. However, the Coroner usually directed people away from questions if he thought they were inappropriate. Also it was believed that some of the deaths for which inquests were arranged in Teesside, may not have been required in other jurisdictions. It was accepted that it was not easy to provide evidence of this perception. Post mortems were carried out quickly in order that a death certificate could be issued and it was acknowledged that there was often a long delay until the inquest was

held. The Trust suggested that the number of reports required by the Coroner and availability of witnesses to attend the inquest could be contributory factors to the delays in concluding inquests.

CARDIAC RISK in the YOUNG

48 The panel was aware, from a range of press articles, of an organisation called CRY and their specific involvement with an inquest case in Middlesbrough. The term CRY stood for Cardiac Risk in the Young and although the press had conveyed various general concerns regarding the delays encountered to conclude inquests. CRY had demonstrated their concern where these delays were associated with young people with an unidentifiable cause of death. Especially those who had a sibling, that in their opinion further examination to determine the cause of death had not been explored.

49 CRY was founded in 1995 to raise awareness of conditions that could lead to Young Sudden Cardiac Death (YSCD); Sudden Death Syndrome (SDS); and Sudden Arrhythmic Death Syndrome (SADS). CRY had produced guidelines regarding the necessity of post mortem heart examination and testing in cases of sudden adult death. The guidelines had been distributed to Coroners and Pathologists. As a result of CRY's awareness raising, Coroners in many areas were now contacting families at risk to advise them whether screening for other family members was required.

50 The panel was informed of an example in Teeside where the pathologist had stated that at the post mortem examination thickening of part of the heart muscle had been found, but had identified this as being normal. However an independent Geneticist had stated that thickening of part of the heart muscle was abnormal and the heart should have been examined further. CRY's concerns were expressed to the panel that had further investigation of the heart been undertaken this may have identified a genetic condition from which other members of the family could also suffer.

51 The panel was informed that these concerns had been conveyed to the Teesside Coroner by a representative of CRY but they had been disappointed with the response and service received. Consequently, CRY has expressed to the panel that from their knowledge and experience it was essential that young people who die from unexplained reason who have a sibling should automatically be screened for Cardiac disorder.

TEESSIDE UNIVERSITY

52 The panel was aware that research had been undertaken into the Coroner's Service by Teesside University and as a result a report

produced. Upon enquiry the panel found that this report had been commissioned by Cleveland Police and for Teesside University to undertake a benchmarking exercise. The purpose of the exercise was to review the efficiency and effectiveness of the Coroner's Officers to determine whether the staffing level was appropriate for their caseload. A report on the University's findings was published in April 2008.

53 Information conveyed to the panel was that Cleveland Police provided Coroner's Officers for both the Hartlepool and the Teesside Coroners and it was apparent that there was disparity in how the two Coroners functioned. The University was asked to look at how both Coroners operated which involved interviewing the Coroner's Officers where it was established that the Teesside Coroner required a lot more information and attention to detail than the Hartlepool Coroner. Unfortunately, the majority of staff who were directly involved with this exercise had now left the University. Therefore, the representative attending the panel meeting was unable to confirm whether there was any evidence, either quoted in the report or identified in the research which suggested that the information requirements of the Teesside Coroner contributed to the length of time it took to complete inquests or not.

54 The Panel examined the report commissioned by the Police and the response from the Coroner's Service and found little evidence that the research from the University identified any core reason for the delays in concluding inquests in Middlesbrough.

CAB

55 A representative from CAB had been invited to the meeting to provide the Panel with an indication of any concerns raised by their clients regarding the Coroner's Service in Middlesbrough. However CAB had contacted the Council to explain that they were unable to provide any direct or anecdotal information, as they had no records of anyone contacting them for advice regarding concerns over delays in concluding inquests. Consequently, CAB did not attend any meeting.

CORONER'S OFFICE

Coroner and Deputy Coroner

56 The panel had gained an understanding of the principles on which a Coroner's Office operates and the involvement and contribution from different organisations to support the Coroner function. From this understanding Members invited the Coroner and Deputy Coroner to attend in order to gain information specifically for Middlesbrough which contributed to the delays and associated costs.

57 In response the panel was informed that the Coroner's Service was reactive and the Coroner did not seek cases to investigate. There were duties in Common Law and statutory provisions for people to report deaths in certain instances. This included deaths that were sudden, unnatural, violent, or due to invasive treatment in hospital or industrial related diseases or accidents and where the cause of death was unknown. The Coroner's principal function was to record a correct and accurate medical cause of death and where appropriate to hold an inquest, which is a formal judicial process, held in public.

58 The Coroner confirmed that there were approximately 2,500 reported deaths within the Teesside jurisdiction, with an additional 600 from Hartlepool. The inquest process was a relatively small part of the overall function of the Coroner's Office. Approximately 11-12% of reported deaths required an inquest and therefore 88% of service users would not be involved in the inquest process. The Coroner strove to ensure that service users who were recently bereaved were treated with respect and dignity.

59 An area pursued by Members was the understanding through the media that too many inquests were held in Teesside. The Deputy Coroner stressed that this was not the case, and national statistics showed that over the last five or six years, Teesside had in fact held slightly less inquests than the national average. Members questioned how the Coroner's decisions could be challenged by judicial review and were informed that according to information published in regular Circulars produced by the Coroners' Society, there were nationally between thirty and forty judicial reviews annually. There had been a major increase in the number of judicial reviews, particularly since legal challenges had been brought where deaths in hospitals, prisons and institutional care were subject to greater public scrutiny. The average cost of a judicial review was £120,000 and the Local Authority underwrote these costs from public funds. In the last thirty-five years there had been only two judicial reviews of the Teesside Service and neither were critical of the Service or overturned any decisions made.

60 It was highlighted that the Teesside jurisdiction differed from others due to several demographic peculiarities and its social history. These unusual features were a contributory factor to the length of time that elapsed between a death and the conclusion of the inquest. Within the Teesside jurisdiction there were two regional hospitals which both received patients with serious injuries and illness from outside the Teesside area. Both Cleveland and North Yorkshire Air Ambulances airlifted patients involved in serious accidents to James Cook University Hospital (JCUH) for treatment. Sadly, if patients did not survive, their inquest would be held in Teesside, even though the accident may have occurred elsewhere. Whilst the Coroner could transfer a body to another jurisdiction, it was a complex procedure and rarely invoked. In addition, if a body were transferred, witnesses from Teesside, including medical staff, would then have to travel to another

area for the inquest. It was conveyed to the panel that JCUH was the largest single site hospital in Europe and specialised in spinal injuries and cardio-thoracic conditions. The Cardio-thoracic Unit was a Centre of Excellence and many high-risk surgical procedures were therefore associated with it. The University Hospital of North Tees specialised in respiratory diseases and many patients were referred for specialist treatment from areas other than Teesside.

61 National Statistics showed that year-on-year Teesside recorded a higher number of accident or misadventure verdicts than other jurisdictions and this was associated with hospital and post-operative deaths due to critical injuries. Teesside's industrial heritage also contributed to a higher than average number of people suffering from industrial related diseases and cancers. It was anticipated that the level of cases would fall eventually due to the depletion of heavy industry in the area, coupled with improvements in health and safety.

62 Another unusual feature in Teesside was that there were two prisons, Holme House and Kirklevington Grange. According to National Statistics, Holme House Prison had a greater number of reportable deaths than the national average. There had been two inquests for deaths from Kirklevington Grange Prison during the last two years. When a death occurred in prison, the State had a duty to demonstrate it had met its duty of care and inquests were held with a jury. The Coroner was obliged to examine in great detail the circumstances in which a person's death happened. Inquest cases referred from prison deaths were far more intensive and complicated to prepare, convene and hear. In addition, the Coroner's inquest could not be held until a Prison and Ombudsman's Service investigation was complete.

63 Also within the Teesside jurisdiction were two specialist mental health hospitals operating under National Health Service Trusts that cared for people with severe mental illnesses. Again any deaths occurring in these hospitals were reportable and these could lead to complex inquests.

64 The panel was informed that In the current year 273 inquests had been concluded and 269 opened. There were presently 300 outstanding cases and the Coroner and Deputy Coroner acknowledged that the situation with regard to the delay in conclusion of some of these inquests was unacceptable. The number of cases more than six months old was 162 and this needed to be addressed as a matter of urgency. In 2003/2004 there had been a similar crisis with the number of outstanding inquests. At that time the Deputy Chief Constable provided three additional Officers to support the Coroner's Service whilst a review of appropriate staffing levels was undertaken. Within a year the number of outstanding cases was substantially reduced, however, the three officers were subsequently removed and the number of outstanding cases started to rise again.

65 The Panel was informed that to date the Police had undertaken eight reviews of staffing for the Coroner's Office during which time the Coroner had produced a "Growth Bid Submission" for the Police consideration. However, the Deputy Chief Constable had been unable to provide any additional resource in response to the Coroner's submission.

66 The Deputy Coroner also raised the issue of the benchmarking exercise commissioned by Cleveland Police, which was carried out by Teesside University. Panel Members had examined a copy of the report and the Coroner's response at a previous meeting. Both the Coroner and Deputy Coroner expressed to the panel their disappointment at their lack of involvement they had had in the benchmarking exercise and indeed other reviews into the Coroner's Service and consequently considered some of the information provided within the Benchmarking report as inaccurate.

67 The Deputy Coroner confirmed to the panel that discussions with Cleveland Police regarding staffing levels were ongoing. However, Cleveland Police had stated previously to the panel that they could not provide additional staff at the present time but had agreed to have another review for which the Coroner and Deputy Coroner were in the process of drafting the Terms of Reference. The Coroner had already proposed the secondment of at least two additional officers on a short-term basis for one year to assist in addressing the outstanding cases. Thereafter, it was proposed to retain one additional officer on a temporary contract basis. However, in conflict with this proposal the Deputy Coroner had been informed of a proposal by the Police to remove two Coroner's Officers next year and possibly replace them with one civilian officer.

68 The panel was aware that Cleveland Police had many competing priorities as well as a huge reduction in its budget over the next few years. The Coroner's Office had a cordial relationship with the Police and in the past the Police had responded with help when the situation had been acute. However, due to budgetary constraints the Police no longer had a pool of restricted duties Officers available as they had now left the Police force. The Deputy Coroner stated to the panel that the Service was equally happy to work with civilian officers.

69 Members raised the range of adverse comments made in the press and also a recent question presented to the Prime Minister regarding the apparent delays in the conclusion of inquests in Teesside. The Deputy Coroner explained that there had not been any formal complaints received from the MPs, which the panel had referred to. However, the MP for Stockton South had visited the Coroner's Office and had apparently been impressed with the Service. The MP had submitted a Freedom of Information request to Cleveland Police, however the Deputy Coroner was not aware of whether a response had been received. The panel was again informed that the Coroner's

Service was under the control of the MoJ and the Coroner had sought their advice on many occasions with regard to criticism of the Service in the media. The MoJ had encouraged the Service not to become involved with media publicity and to concentrate on dealing with the bereaved of Teesside. The Deputy Coroner emphasised that their function was such that they do not promote the service or indeed engage with the press, as the issues they deal with are very sensitive. However, he did confirm that he had arranged to meet with two local MPs and the Chief Constable of Cleveland Police in March 2012, in order to seek a resolution to the current issues regarding the Coroner's Service.

70 Reference was made to the documentation submitted regarding inquests and how the Coroner would direct away questions which were not appropriate. The Deputy Coroner explained to the panel that on occasion families would come to an inquest wanting to make accusations and this was considered outside of the inquest. Indeed, efforts were made to reduce the formality of inquests and Coroners understood that it was an extremely difficult time for families and to see the relief in families' faces when their concerns were addressed and questions answered, provided some satisfaction.

71 Complaints regarding the Coroner's Service were dealt with through the Service's complaints procedure. Reference was also made to the Coroner's Charter, which the panel were informed had been written by the Teesside Coroner. It was noted that due to current resource issues, the Charter could not always be adhered to. The Charter included that witnesses should be interviewed at a time and place of their choosing. However interviews were often conducted by telephone by the Coroner's Officers in order to save time. In this regard the panel requested a copy of the Charter so they could be aware of the standards to be expected by families awaiting an inquest. At a subsequent meeting the panel was informed that a copy of the Guide to Coroners and a letter was given to relatives of the bereaved.

72 The Panel understood the number of reports requested by the Coroner following a post mortem had increased from approximately two to five over the past few years and queried whether this could also be a contributory factor to increasing both time and costs. The Deputy Coroner clarified that the reports referred to were witness reports and not tests conducted as part of the post mortem. The Pathologist would decide whether histology or toxicology tests were required, if the cause of death was not revealed by the post mortem examination. The number of post mortems commissioned was a judicial decision and there were fewer post mortems in Teesside than the national average. The number of post mortems nationally of the total reported deaths was 44% while the 39%, at Teesside was quite significantly below the national average.

73 The panel was informed that there were approximately three or four pathologists undertaking the Coroner's work in Teesside and confirmed that the post mortems had to be completed outside of their normal duties due to their NHS contracts. The Coroner was not in a position to compel Pathologists to undertake post mortems, particularly with post-operative deaths and consequently this could lead to delays in obtaining reports from medical practitioners. Also the demands on Surgeons' and Doctors' time, was an important element as they were very busy and consequently the completion of reports for the Coroner was often a lower priority than medical work. A reason why the reports could take a while is that patients have one set of medical notes and these are passed to each witness to assist with the writing of their report.

74 The panel's attention was drawn to the completion and submission of reports to the Coroner, with the aim, to hasten the holding and conclusion of an inquest. The Coroner informed the Panel that he had met recently with a senior hospital representative to discuss the length of time taken to return these reports to the Coroner's Officers. It had been made clear to the Coroner that hospitals were not prepared to photocopy patients' case notes in order to speed up the time taken for surgeons and consultants to prepare their reports. In addition, inquests relating to hospital deaths had to be booked more than six weeks in advance as clinical sessions were booked six weeks ahead. Changing schedules or cancelling operations to accommodate attendance at inquests would have an adverse affect on patients.

75 However, the Coroner had also met with one of the cardiothoracic surgeons, who had suggested that if it could be set down, that immediately following a death, the surgeon involved could write their report within 48 hours of the death, the case notes could then be sent to the Legal Department swiftly. It was anticipated that within a week, all of the Consultants' reports would be completed and reports from nurses and other medical staff could then be obtained and hopefully this would speed up the process. It had also been suggested to the Coroner that it may be possible to find time to attend inquests at less than six weeks' notice. The Coroner stated that if the proposals were supported by the Medical Director and implemented by all hospital departments, it could reduce the time spent on a number of complicated inquest cases.

76 In response to Members' enquiries regarding the time taken to establish an inquest hearing it was conveyed that due to the number of witnesses to post-operative deaths, there were often difficulties in setting a suitable date for an inquest. Whilst it is accepted that theoretically, the Coroner's Officers could set a date and compel witnesses to attend, this could force busy medical staff to have to cancel surgical lists in order to attend. The Coroner's Service is promoting the implementation of a process whereby when an inquest was opened following a post-operative death, one person involved in

the care of the deceased would attend. A date for the inquest would be agreed with that person and they would then ensure that all witnesses would prepare their reports within 48 hours. This idea was still under development and had not yet been approved by the Medical Directors at the hospitals.

77 Members had previously been informed of a new case-tracking system which was used within Cleveland Police's Legal Services and that this had been proposed by the Police to improve administrative procedures and general efficiency within the Coroner's Officer's unit. The system would produce a regular schedule of reports that needed chasing up and automatically generate correspondence. Unfortunately the system had not yet been implemented as the Coroner had initially expressed some concern with regard to the security of the system, although this had how been resolved with Cleveland Police and an agreement was in place. The system had yet to be populated with information and staff trained to use it. Whilst there were staff within the Legal Department who could train the Coroner's Office Manager, again there was an issue with the amount of time and resources available. The Police were hopeful that following the review, additional funding might be forthcoming to enable training to be undertaken. The Deputy Coroner agreed that the introduction of this software would help but there had been some initial concern on the Coroner's part as to the independence of the system as it was accessible by the Police. Further concerns related to the timing of any implementation due to the current crisis situation regarding the number of outstanding inquests as this could place additional demands on the service at this time.

78 At a subsequent meeting the Coroner and Deputy Coroner had requested that Dr Lowe a consultant Pathologist could attend to present evidence regarding the Coroner's Service. Members found that the information being presented by Dr Lowe at the Coroners request was a letter he had submitted to the Office of Judicial Complaints. Dr Lowe commented that he frequently attended inquests in Teesside and the number of medical witnesses called to give evidence was proportionate and necessary. Dr Lowe appreciated that there were delays and conveyed that in his opinion, more support with file setting would improve the time taken to complete inquests in Teesside.

79 The Panel was concerned at the time taken to complete some inquests and also the outstanding backlog. It was highlighted that the average time for conclusion of an inquest in Teesside was 43 weeks, whilst the national average was 26 weeks. Reference was made by the Deputy Coroner to the number of deaths in the two prisons within the Teesside jurisdiction as this had been stated as a contributory factor to the delays. To place a measure on the possible impact of these deaths in prisons it was confirmed that the total number of deaths in prison in Teesside during the last three years was nine. The Deputy Coroner explained that when a death occurred in prison, the Coroner has to await the conclusion of the Prison ombudsman's investigation and any

Police investigation. The Coroner may then start his own investigation before the inquest would be held. All such inquests had to be held with a Jury and a very high level of investigation was required. The Coroner stated that it could take up to two years for the ombudsman's investigation to be completed.

80 In response to the Panel's enquiries as to the cause of delays generally in Teesside they were informed that Coroner's Services were delivered in different ways around the country and it is extremely difficult to benchmark Teesside against another similar jurisdiction. The Deputy Coroner explained that in essence it is a staffing issue and referred again to the submissions of a Growth Bid, produced some years ago and presented to the Police for their for consideration. In response to that submission the Deputy Chief Constable had confirmed that at that time the Police were unable to provide any additional resource to assist the Coroner. More recently, the Coroner had prepared and submitted Terms of Reference to the Police for a new review of the service. The Deputy Coroner informed the Panel that during the last year the number of inquests outstanding had remained relatively static. However, he expressed concern that as he considers staffing to be the central issue in tackling delays he had now been informed that the two Police Officers in the Unit were going to be removed. This issue for clarification was then presented to the Police and the panel informed that Cleveland Police currently had some major financial issues to address. All Police Officers had warranted powers and within the Force a number of Police Officers were undertaking duties which did not require the use of their warranted powers, Coroner's Officer being one such role. In order to make savings; it was proposed that this role could be civilianised. Additionally, in the past there had been a pool of Police Officers on restricted duties. However, in the current climate, if Police Officers were not medically fit for front line duties the Police force is exploring the options of retirement in an endeavour to make savings.

81 Continuing with the staffing support provided for the Coroner the panel was told that there was a pool of civilian support staff who following some reorganisation did not have a role and were available for re-deployment. If there were staff within that pool who were suitable, it was proposed that they would replace the two Police Officers who were presently working as Coroner's Officers and therefore maintain the present staffing level. Police representatives stressed that there was no fixed time scale for this change in staffing and that there would be a cross-over period, during which the re-deployed civilian staff would work alongside the Coroner's Officers to receive the appropriate training and gain experience. If there was no suitable staff in the re-deployment pool, then the Police would look to external recruitment as they are aware that the present two police officers who deal with the file setting were experienced in the setting down of inquests, preparation of files, fixing dates for inquests and attending when required. It was highlighted that across the Cleveland Police Force

many departments' staffing levels had been reduced, whilst the Coroner's Office had been protected demonstrating the Police commitment to supporting the Coroner.

COMPARING and CONTRASTING

82 The Panel wanted to gain an understanding of the practices of other Coroners' Jurisdictions in order that it could compare and contrast with that of Teesside. In its endeavours to do this the panel found that there are a number of variables which directly influence the demands and expediency of an individual coroner's service. These would primarily focus on the environment of that jurisdiction and factors such as population, geography, age profile, hospitals (Which contained specialisms for treatment of life threatening issues), local industry etc that had an impact on the panel's endeavours to accurately compare.

83 However, the Ministry of Justice (MoJ) produce information on individual jurisdictions set against national average. In this regard the latest figures (June 2012) do suggest that in regard to the completion of inquests Teesside is clearly taking substantially longer than the National average.

For Example	2009	2010	2011
Nat average	25	26	27
Mbro	34	43	44

The latest figures produced by the MoJ convey that 80% of cases are taking more than 26 weeks. Additionally, that the oldest outstanding inquest in Teesside which was not completed, at time of the distribution of these figures in 2012 was actually opened in May 2008. This recent information only enhanced the concerns of the Scrutiny panel.

84 In contrast to these figures the 2010 statistics issued from the MoJ show that Teesside has the lowest number of inquests as a percentage of reported deaths of any jurisdiction in the North East at 12%. Additionally, Teesside has almost the lowest number of Post Motems of reported deaths in the North East at around 39% against the highest in the North East of 64%.

85 Consequently, with a low percentage of inquests and a low percentage of post mortems the panel was bemused as to how the conclusion of inquests in Teesside was taking so long with what would appear to be comparatively low demands

TERMS OF REFERENCE

86 The Panel addressed the two Terms of Reference during their lines of enquiry and an outline of their findings are as follows: -

- To assess the cause for the delays taken between death and the conclusion of an inquest with the intention of finding ways to reduce this time.

Comment

87 The panel found that there are a number of variables to consider. However, the statistics did not provide an obvious answer, indeed they compounded the problem by conveying low demand of inquests and post mortems yet there is an increased average time to conclude.

88 The panel did find the backlog concerning and explored the administrative procedures and their links to Police, witnesses and Pathologists. In doing so, some issues arose which the panel could identify would assist the process. However, the panel considers a key issue relates to the relationship and staffing levels between the Police and Coroner's Office.

- To examine the funding structure of the Coroners Office to ensure its cost effectiveness.

Comment

89 The panel received a range of information regarding the costs associated with the Coroner's Service. The panel was informed that the costs had almost doubled in five years with an outturn cost in 2010/11 of £911,000. The panel found that the increases over 5 years was indeed greater than inflation and that the Council has little control over the expenditure or the increases incurred by the Coroner. However, the panel could not evidence that the expenditure in Teesside was excessive in comparison with national figures or that it had doubled during that period. The statistics that were available for cost comparison with other jurisdictions showed so many variables that it was not reasonable for this to be used by the panel as worthwhile comparisons. However, the panel does believe a Value for Money exercise would be a worthwhile task to undertake.

90 The panel did find that a major reason for the increase in costs, especially in latter years, was driven by increases in the NHS charges and therefore outside of the Coroner's control. The panel was also informed that there are indications that NHS charges are expected to rise again which will place additional financial pressures on the Council. In light of this the panel considers additional analysis on the specifics of NHS charges should be undertaken.

91 The panel found that an area of potential expenditure is that of Judicial Reviews where the average cost was presented to be around £120,000. As with other costs associated with the Coroner's Service these costs would have to be covered by the Council, however, in thirty five years Teesside has only been exposed to two Judicial Reviews and neither were critical of the Service. Consequently, the panel believes the Coroner has not exposed the Council to excessive expenditure in these areas.

KEY ISSUES RAISED

92 **Site Visit -** The Coroner and Deputy Coroner had offered Members of the panel the opportunity to visit the Coroner's office during the working day, at which time they would receive a guided tour through the process undertaken in regard to their function. However, Members did not take up this opportunity and continued to receive detail directly at the meetings.

93 **Round Table Meeting –** The panel had received a range of information from various sources individually regarding the Coroner's service. In obtaining this detail and responding to enquiries the panel found some of the information conflicting. This may have been due to the perspective of different organisations, which may place a different emphasis on the issues, which influence the delays.

94 Consequently the panel decided it would hold a meeting which involved the key organisations which are considered central to the process for concluding an inquest and therefore the efficient delivery of a Coroner's service. The panel found this meeting which essentially involved Cleveland Police, the Coroner and Deputy, the Coroner's Officer, Clerk etc very beneficial as it provided the opportunity to clarify some key issues directly.

95 This meeting provided the opportunity for Members to see directly how both the Police and Coroner's service engaged and interacted with each other. The panel considered that there were obvious tensions if not friction, which emerged during the meeting. These appeared to focus on the resource levels being provided to the Coroner, which were different to the Coroner's expectations. Although this meeting provided information, which is outlined in the panels', findings and conclusions, the panel was concerned that if such tensions emerged at a meeting it is considered they would impact on the everyday working relationship.

CONCLUSION

96 A key factor, which instigated the Scrutiny panel to look into the Coroner's Service, was the number of references to the Teesside Coroner in the press. These articles had added to the concerns some

Members had on the service being provided to the residents of Middlesbrough by the Teesside Coroner. It was clear that the articles did not put this service in a particularly good light and it was clear that there were local if not national concerns regarding the delays encountered at Teesside.

97 The panel considered it was important to address these concerns and also to identify the issues behind the delays with the aim to find ways to improve the service generally. Consequently, during the course of this Scrutiny the panel received a range of evidence. Based on the information they received the Panel made a number of conclusions regarding the operation of the Coroner's Service in an endeavour to reduce the average time taken to conclude an inquest. These conclusions are outlined as follows and where appropriate are linked to the panel's recommendations.

98 **Staffing**. The panel required some foundation information regarding staffing levels, appreciating that the actual levels in a jurisdiction depend upon the size of area and population. The panel was informed that the Home Office and Coroner's Officers Association Working Party 2002 had recommended that there should be one Coroner's Officer for between 400 and 800 deaths depending on whether the jurisdiction was mainly rural or urban. The panel was informed that these figures included secretarial and administrative staff, and consequently the panel could identify the resource against workload in Teesside. On this basis, staffing levels in Teesside which were 8 funded by the Police (2 of which are Police officers and experienced in file setting) and 5 funded by the Council. These are in addition to the Coroner and Deputy Coroner and therefore above the Home Office guidelines when measured against the number of deaths. The panel was informed that to ease the demands on some Coroners some of their powers were delegated to Officers as generally about 30% of registered deaths were reported to the Coroner and such actions made the demands more manageable.

99 The panel considered that the Staffing levels were a key area to address and upon enquiry the panel was informed by the Coroner's service that fundamentally the key reason why there are delays in concluding inquests in Teesside relates to being under resourced. Obviously, from the panel's perspective these two pieces of information were conflicting (staffing levels above national average and view that under resourced) and the panel required further detail.

100 The panel was aware that the Ministry of Justice had statistical information, produced in 2010, which measured the conclusion of inquests against five bands for the length of time taken. To assess the present work demands on the Teesside Coroner the panel was informed that during the current year (at date of meeting), 221 inquests had been opened out of over 2000 reported deaths. The number of outstanding inquests at that time was 289. However, 69 of the inquests

had been outstanding for over 12 months and it was anticipated that the majority of inquests would not be completed in less than 12 months. As the highest of the five MoJ bands was a measure of inquests taking more than 12 months it was concerning to the panel that so many fell into that category in Teesside.

101 In addition to the numbers of inquests and staff ratio the panel's attention was drawn to process issues and the demands these have on staff time due to chasing NHS reports. An example of this was the length of time that the Coroner's Officers often had to wait for reports and the time spent on chasing them. It was presented to the panel that an inquest could be opened and adjourned within two days of a death and the relevant people contacted with a request for their written statement. However, it could sometimes be up to six or seven months until these reports was submitted, thus not only delaying the progress for concluding an inquest but placing additional demands on staff resource in pursuing the reports. As referenced elsewhere in this report it is anticipated that if those proposals are implemented for all Consultants' reports to be completed swiftly it would enable the reports from nurses and other medical staff to obtained relatively quickly. As the Coroner conveyed that it had been suggested to him, it may be possible to find time to attend inquests at less than six weeks' notice. The panel considers that although the time saving can not be easily identified the reduction in demands on staff would be beneficial and contribute to swifter conclusion of inquests.

102 The panel found there was some difficulty in addressing the staffing issue and identifying exactly the impact staffing was having on the provision of the Coroner's service. From information received the staffing levels appear good. There was no evidence presented to the panel that the staff do not work efficiently or effectively. Consequently, the panel determined it would hold a meeting involving the Police and Coroner's staff. At this meeting the panel focused on the delays and was informed that there were difficulties in setting down the post-operative deaths and time was needed to find witnesses, to hold the inquest etc. It was expressed to the panel that the Coroner deals with cases swiftly and once received the files for review they are dealt with within 5 working days and consequently delays are not attributed to the tasks undertaken by the Coroner.

103 In conclusion the panel found that there is clear evidence of an outstanding backlog in the order of 300. It was also clear that the average time for conclusion of an inquest in Teesside was 44 weeks, which is substantially above the national average of 27 weeks. Against this background there were fewer inquests of reported deaths in Teeside (11%) to the national average (14%) also that the number of post mortems of reported deaths in Teesside (36%) was lower than the national average (42%). It appeared that if the staffing structure is maintained then the service was well resourced. Although delays were being publicly directed to the Coroner, there was no evidence provided

that the Coroner's Service was instrumental in causing those delays. However, delays may not be instigated or developed by the Coroner's Service the panel found that there are clearly tensions between the Coroner and Police staff. This may be historic but it clearly does not bode well when such a sensitive service is being provided.

104 The Coroner's position does carry a high degree of autonomy and there appears little accountability for the delivery of a poor service. The panel considers that there is a need to ensure the communication improves and that a specific meeting should be convened at a high level between the Coroner and Police to address the backlog and time taken to complete inquests. The panel considers it is not simply a matter of staff numbers (except to remove back log) but that process, well trained staff, good working relationships and with other recommendations contained within this report would substantially improve the service generally. (Recommendation A)

105 **Prisons -** Another feature, which was expressed to the panel as contributing to the delays and why the average time in Teesside is substantially above the national average, was that Teesside has two prisons (Holme House and Kirklevington Grange). At the time of the meeting, the panel was informed there had been two inquests for deaths from Holme House Prison during the last two years.

106 The panel found that in the two years prior to this scrutiny there had been 8 deaths at Holme House and that Kirklevington had only one death in the preceding 5 years. Consequently, the panel found it difficult to balance how the nine deaths account or influence a 300 backlog. Especially when the time taken in Teesside is substantially above the national average and there are prisons and hospitals in many parts of the country.

107 **Coroner's Guide** – The panel had a strong view that there should be a Coroner's Charter for Teesside where all parties involved, know and understand their commitments and therefore the public could have a clear view of the expectations. When this was raised with the Coroner it was presented to the panel that there was indeed a Guide to Coroners and Inquests. Indeed it was conveyed to the panel that in every inquest opened, relatives of the bereaved were given a copy of the Guide, a covering letter and a form (PM2) with an explanation as to why histology was taken at a post mortem and what happened to it thereafter.

108 The panel recognised that in some cases other jurisdictions have constructed their own Charter which references the service to be provided and involves other agencies who contribute to this goal. Consequently, the panel considers that following discussions between the Coroner and other services involved a specific Charter be developed which includes information regarding the role of the Local Authority, the Police, the NHS and the Teesside Coroner's Service,

Illustrating the standards to be attained and the targeted time frame. The panel considers that once all parties agree and understand the expectations on them then this should have a direct impact on the average time taken to complete an inquest.(Recommendation B)

109 **Siblings** – During the enquiries the panel engaged with a representative from "Cardiac Risk in the Young", during which the panel appreciated the need to ensure that siblings, of young people who die from unexplained reasons, are screened to assess any potential genetic heart complaint. The panel was informed that these concerns had previously been conveyed to the Teesside Coroner although no action or procedure appeared to have been introduced by the coroner's office to address this. The panel concluded that prevention was a valuable step and that a facility, which may identify or indeed eliminate a cardiac problem in young people is a valued step forward. Consequently the ability to save a young life under these circumstances has led the panel to recommend that siblings should be automatically screened where the cause of death is inconclusive. (Recommendation C)

110 **Technology –** The panel found that Cleveland Police had a case tracking system within their Legal Services department, which could also be used within the Coroner's Service to produce regular reports and generate reminders. As the system was currently used within the Police the costs for extending this system to the Coroner's service is considered minimal. The panel considered this would assist in ensuring all outstanding reports were chased up monthly and provide up to date information to families making enquiries as to the position of an inquest. The panel is aware that the present waiting time for the return of medical reports can take up to six months, in this regard the panel considers that the tracking and reminder system, together with the encouragement for early completion of medical reports, would assist in speeding up the process. The panel found that the system had not been implemented as the Coroner had initially expressed some concern with regard to the security of the system. Although this had how been resolved with the Police and an agreement was in place, the system had yet to be populated with information and staff trained to use it. The panel was advised that there are staff within the Legal Department who could train the Coroner's Office Manager and while there are issues regarding available resources the panel considers this system should be implemented and operational swiftly. (Recommendation D)

111 **Finance -** One of the Panel's Terms of Reference was to look at the funding structure and the cost effectiveness of the Coroners Service. The panel obtained some initial costings and was informed that the costs of the Coroner's service had almost doubled in the last five years. Upon further investigation the panel found that the cost had risen from £688K (2005/6) to £911K (2010/11) which was an increase of over

30% in the 5 year period. The panel found that the increase of 30% over this period was indeed above the level of inflation in both RPI and CPI measures and this in itself is a concern. However, the panel could not find any evidence to suggest that the increase in budget was due to any unnecessary expenditure actioned by the Coroner. The panel recognised that the vast majority of costs associated with the Coroner's Service are basically due to increases with the NHS and beyond the Coroner's control. It is also understood that the NHS are in the process of increasing costs further in 2011/12 and in such times of austerity it is concerning to the panel that the Council will have to carry such additional costs which will inevitably place additional pressures on the already reducing resource.

112 The panel found that the council funds the Coroner's service on an indemnity basis and therefore there is no risk of the council expending money in advance of works being undertaken. It was also highlighted that in general, the costs expended by the Teesside Coroner were average in comparison to other Services around the country. In addressing this information the panel found that there were so many variables and that the way each jurisdiction presented its costings provoked more questions than it answered. Consequently that panel considers that Internal Audit look specifically at the expenditure and rate of increase associated with this service. The panel also considers that the Council and the Coroner make every effort for discussions to be undertaken with the NHS on their charges. (Recommendation E) (Recommendation E and F)

113 **Agreed deadlines –** The panel was informed by the Deputy Coroner that there are 5 pathologists who undertake past mortems. The Coroner's service recognises these are very busy people with other commitments and are continually chased by coroner's officers for the submission of their reports. However, the speed in which reports are submitted to the coroner's office is considered not to be impressive.

114 The information derived from the post mortem is essential to the Coroner and yet the Coroner is not in a position to compel Pathologists to undertake post mortems. The panel found that, particularly in the case of post-operative deaths there was a tendency that these circumstances could lead to delays in obtaining reports from medical practitioners. It was clear that the Coroner recognised the demands on Surgeons and Doctors was high and consequently the completion of reports for the Coroner's service was often a lower priority than the medical work to be undertaken. The panel found that a reason why the reports could take a while is that a patient has one set of medical notes and these are passed to each witness to assist their report writing. The Coroner conveyed that this was an area that could be improved if there were more Coroner's Officers available to chase up reports although the base indications are that the delay lay more with the medical staff and their commitment to complete and submit the report.

115 Upon enquiry the panel found that the Coroner's service was considering implementing a process whereby once an inquest was opened following a post-operative death, one person involved in the care of the deceased would attend. A date for the inquest would be agreed with that person and they would then ensure that all witnesses would prepare their reports within three months. This idea was still under development and had not yet been approved by the Medical Directors at the hospitals.

116 The panel was also informed that the Coroner had indeed met with one of the cardiothoracic surgeons who had suggested that if an inquest could be set down immediately following a death, the surgeon involved could write their report within 48 hours of the death. The case notes could then be sent to the Legal Department swiftly. It was anticipated that within a week all the Consultants' reports would be completed and reports from nurses and other medical staff could then be obtained.

117 The panel had found that the demands for reports had increased dramatically over the recent years and that in 2003 there were 62 inquests and in 2010 there were 126. Additionally the average number of reports requested per inquest in 2003 had been 2 and in 2010 this had increased to 5.

118 In conclusion, the panel can not determine what is right or indeed best in relation to medical staff who's skills are in demand elsewhere within the NHS. However, the panel remains concerned that the Coroner, and therefore the process for concluding an inquest, has to wait for the report. The panel therefore recommends that a meeting be convened with the relevant people to establish a service agreement based on the discussions already commenced by the Coroner. Essentially that reports are completed and submitted to the Coroner within two to three months depending upon the complexity of the case. (Recommendation H)

119 **Immediate Fix –** The panel required information on the number of cases handled by the Coroner's Service annually and also the number of outstanding cases presently. The panel is aware that the reason for an outstanding case can vary and that these reasons can impact on an early conclusion by adding weeks or in some cases months to a cases conclusion. In response to the panel's enquiries as to the present backlog it was informed that it was currently in the order of 300 cases. The panel concluded that the present back log can have an effect on processing new cases and potentially delaying the time for relatively straight forward cases to be concluded. Consequently, it is the view of the panel that the back log must be addressed as a specific task to ensure the flow of cases arriving is manageable. The panel was informed that a similar situation happened many years ago and the Police responded favourably to assist the Coroner and provided enhanced short term support, simply to remove the back log. In view of the present position and the effectiveness of the Police service in its

previous support to remove the back log the panel will recommend that the Police, once again, provide one off short term support to reduce the outstanding back log to manageable numbers which ensure the free flow of cases through the Coroner's system (Recommendation I)

120 **Public Perception** The panel is clearly aware that there are many press articles, which portray the Teesside Coroner's Service poorly. It would be easy for the public to perceive the Coroner's service was dismissive of many of the public who were associated with bereaved families. The panel found that there are many demands placed upon the Coroner and that there was a range of information that the Teesside Coroner recognised the importance of his role in Teesside and placed a very high professional value on the tasks and responsibilities undertaken. The panel did however find that there is clearly an issue of public perception, which needs to be positively addressed. The panel does believe this could commence with a vast improvement in reducing the average time for concluding an inquest and with this some positive publicity regarding the improvement. Another aspect the panel considers would assist in improving public perception would be to ensure that families are fully informed of the reasons why an inquest is taking time, especially when the family may consider the delay unreasonable. The panel considers the implementation of other recommendations contained within this report may directly improve this perception issue. (Recommendation G)

121 **Unification -** The panel was informed that there is one Coroner's section provided by Cleveland Police, which is dedicated to supporting both the Teesside jurisdiction and the Hartlepool jurisdiction. The Coroner's officers operate from one building and under the same management. The panel was also informed that the demands on Coroner's Officers from Hartlepool is significantly lower than that of Teesside and indeed has reduced in recent years. In consideration of this the panel found that the demands on officers working on cases across Teesside and Hartlepool had reduced bringing the ratio of cases down to approximately 400 cases per officer per year. This figure aligns with the minimum of the band identified in the 2008 report from the University of Teesside. This report stated that in most Coroner's districts there was a ratio of one Coroners officer per 400 – 800 deaths (Home Office 2002).

122 Although the panel did not find any evidence of conflicting demands from the two Coroners being placed onto the Police staff the panel considered that the potential for this could exist in times of high demand. Additionally, the panel is conscious of the cost effectiveness of having two jurisdictions with the number of cases being addressed. Consequently, in operational terms the panel concludes that there will be significant benefits in harmonising these two jurisdictions. Therefore the panel would recommend that the Ministry of Justice give serious consideration to merging the Teesside jurisdiction with the Hartlepool jurisdiction and establish one Coroner's service, which is coterminous

with the Cleveland Police district, which is supported by one group of Coroner's officers. (Recommendation J)

123 **Operational Relationships** – As referenced earlier in the report the panel had detected the differing views on issues relating to the Coroner's service from the Police and the Coroner's office. This may have been driven by frustration from both parties at the length of delays, the poor publicity about the service and the staffing resource being applied.

124 When the panel held its round table meeting, which involved both organisations it became evident that there are tensions between these parties. Although endeavours by representatives of the Police to suppress such, in a meeting open to the public, they clearly existed. The panel considered these tensions are no doubt driven by operational frustration but have a strong potential of impacting on service delivery. Indeed there are indications that the Coroners Office may have concerns with the NHS for the swift submission of reports, however this was not quantifiable by the panel. Consequently, the panel strongly believes that the relationship between the Coroner's office and the Police must be improved. (Recommendation K)

RECOMMENDATIONS

125 The Panel recognises that when families engage with the Coroner's service it is generally a very emotional experience for them and needs to be handled sensitively. In undertaking this Scrutiny the panel were conscious of those sensitivities while recognising that this Scrutiny was initiated because of the concerns regarding the time taken for a number of inquests to be concluded which in itself can enhance the anxiety of families and indeed only add to those sensitivities. In the panel's endeavours to identify cause or causes for such delays and to look for solutions which would bring the performance closer to the national average. The panel received a range of evidence from representatives of various organisations who have dealings or connections with the Coroner's service.

126 Once the panel commenced on this task and looked at comparators it became evident that there are a range of variables which prevent direct like for like comparisons. However, the panel could still not find any clear reason why such delays occur in Teeside. It did however, recognise that there are some issues which occur in Teesside and may contribute to these delays which the panel consider could be improved.

127 Consequently, The panel has identified a number of recommendations, which it believes will make a significant difference and contribute to a swifter conclusion for inquests.

128 A (Conclusion Paragraphs – 98 - 104)
Staffing levels and experience are major factors in processing an Inquest swiftly. The 8 staff presently allocated is found to be greater than the indicated norm expected. However, it is understood that only two of these staff are qualified field officers. It is therefore recommended that greater emphasis is placed on ensuring that all staff are trained and capable of undertaking this function which would provide improved flexibility of this resource.

B (Conclusion Paragraphs – 107 - 108)
A Guide to Coroners and Inquests is presently available. However the Panel considers that a Coroner's Charter which is specifically targeted to Teesside, detailing the roles and expectations of the Local Authority, NHS and Police within the Teesside Coroner's Service should be developed. It is therefore recommended that a Charter is developed in agreement with the partner organisations.

C (Conclusion Paragraph - 109)
The issue of young people dying from unexplained causes is a concern. From information received the panel recommends that in such cases where a young person dies from unexplained reasons and has a sibling that the sibling should automatically be screened for Cardiac disorder. The panel recommends that this action be introduced immediately and contained within the proposed Coroner's Charter

D (Conclusion Paragraph - 110)
Improved technology is already operating with Cleveland Police which is believed would assist the administrative process of the Coroner's Service. Acknowledging there are issues of confidentiality and training to be addressed the panel recommends that this system be introduced swiftly which would track and automatically generate the appropriate reminders and correspondence.

E Conclusion Paragraphs- 111 - 112)
The analysis and information received relating to financial information and charges to the Coroner by the NHS were found to contain a number of variables. Consequently, the panel recommends that the Council's Auditors undertake a Value for Money exercise into the Coroner's Service. To ensure, that in such times of austerity the charges and costs are not excessive and not out of line with other jurisdictions.

F Conclusion paragraph - 111)
As the increase in costs over the five year period are above the level of inflation and place additional pressures on the Council it is recommended that the Council and the Coroner meet with the NHS to discuss their charges and moderate future increases.

G Conclusion paragraph - 120)
That the Teesside Coroner engages with the Ministry of Justice and agree a process for engaging with the local press for the purpose of producing some positive publicity about the Coroner's Service. Also that the Coroner's office ensures that families are regularly appraised of the reasons of a delay when the inquest is taking longer than the expected time. (The national average should be a benchmark to alert families of the reasons for the present position which is beyond that benchmark).

H (Conclusion Paragraphs – 113 - 118)
Consideration has been given to implementing a process where an inquest is opened following a post-operative death. The panel recommends that this practice outlined to the panel be implemented and that discussions be concluded with Medical Directors of the Hospitals involved. The principle being that a date is agreed with the appropriate people which ensures all witnesses or organisations are aware that reports are to be prepared and submitted within two to three months.

I (Conclusion Paragraph - 119)
Presently, the average time for the conclusion of an inquest in Teesside is substantially greater than the National Average. In addition to this the panel is aware that there is a substantial backlog of inquests to be concluded. Consequently, the panel recommends that arrangements are made through the Chief Constable for Cleveland Police to immediately apply a short term additional resource to substantially reduce this back log of cases to a manageable level.

J (Conclusion Paragraphs – 121 - 122)
As Cleveland Police provide the Coroner's Officers for Teesside and Hartlepool and are managed within one unit. It is recommended that the Ministry of Justice give serious consideration to the merging of the Teesside Coroner Service with the Hartlepool Coroner Service and making the Coroners jurisdiction coterminous with the Cleveland Police support area and thereby improving the efficiency of the service.

K (Conclusion Paragraphs - 123 – 124)
There are clearly operational tensions between the Coroner's office and the Police. The panel considers these tensions are no doubt driven by operational pressures, however they must be addressed. The panel therefore recommends that a meeting involving the Chief Constable and Coroner and operational staff be convened to openly address and resolve these differences.

L The panel recognises there is not one solution to resolve the delays in Teesside. Consequently, the panel recommends that detail is presented to the panel in six months which outlines the time taken, backlog, staffing levels and action against each recommendation to assess the progress achieved.

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G Fell	Retired Coroner
R Pinkney	Cleveland Police (Coroner Office Manager)
J Hatton	Cleveland Police (Head of Legal)
I Henry	Cleveland Police (Coroner's Officer)
R Wilson	South Tees NHS Foundation Trust (Professor)
S Ainsworth	Cardiac Risk in the Young (CRY)
H Pepper	Teesside University
M Sheffield	Coroner
T Eastwood	Deputy Coroner
C Bailey	Assistant Deputy Coroner
G Walls	Coroner's Clerk
Dr J Low	Consultant Pathologist

BACKGROUND PAPERS

130 The following background papers were consulted or referenced to, during this Scrutiny and in the compilation of this report:

(a) Panel Minutes of 10th and 31st August, 12th October, 2nd November, 7th and 21st December 2011, 8th and 29th February, 21st March, 11th April 2012.
(b) Growth Bid Submission Teesside Coroner 2004
(c) Benchmarking Report – Teesside University 2008
(d) Internal Audit Report 2008 – 09
(e) Ministry of Justice Charter for bereaved people 2009
(f) Ministry of Justice -- Coroners Statistics 2010

(g) Hertfordshire Coroner Service Charter 2010
(h) Ministry of Justice Guide to Coroners and Inquests 2010
(i) Submission from Teesside Coroner 2011
(j) Various Press Releases

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