

MIDDLESBROUGH COUNCIL SCRUTINY REPORT HER MAJESTY'S CORONER FOR TEESSIDE

MAYOR'S RESPONSE

I have examined the Scrutiny Report in relation to the Coroner's Service in some detail. I should say from the outset, that the subject matter is complicated and contains evidential fact as well as professional opinion, with much of the latter being conflicting and contradictory. In addition, it is clear that many variables within the process are present and this, coupled with the entrenched positions of certain key people within the process, has made the scrutiny process all the more difficult.

Notwithstanding this, the Chairman of the panel, Councillor Frances McIntyre, together with her Councillor colleagues and Scrutiny Officers, have been able to formulate a report which paints an accurate picture of the present position. In addition, the recommendations contained within the report are both appropriate and reasonable.

I would like to commend Councillor McIntyre and all of her Councillor colleagues and council officers for their contribution throughout the process. I do hope their work will assist in progressing the Coroner's Service as a whole over the coming months and indeed years.

Until recently, the general public and also elected representatives had little understanding of the Coroner's Service, as it was a service that received little media coverage and was only engaged in any detail by the bereaved.

On the other hand, I believe that I am extremely familiar with the Coroner's Service and the role of Her Majesty's Coroner Mr Sheffield, due to my involvement with the service in my previous profession, as a Senior Police Officer, when dealing with the subject of homicide.

I am therefore in the unique position of being able to comment on this subject, due to the experience I have gained over many years.

The scrutiny process and subsequent report were commissioned due to severe criticism of Her Majesty's Coroner, Mr Michael Sheffield, by members of the public and elected representatives, for his failure to conclude inquests within a reasonable timescale.

The Terms of Reference for the scrutiny process were as follows:

- i) To assess the cause of the delays taken between death and the conclusion of an inquest with the intention of finding ways to reduce this time.
- ii) To examine the funding structure of the Coroner's Office to ensure its cost effectiveness.

I do not intend to rehearse all of the information contained within the report, which runs to 32 pages and 130 paragraphs. However, I do intend to comment on particular sections, which I believe are relevant, in progressing the subject of the Coroner's Service and the agenda as a whole.

I should say at this point, that I do believe that all of the investigations performed by the Coroner's Service are of a high standard. In addition, the conduct of Mr Sheffield within the Coroner's court, together with his decision making, are sound and should not and cannot be criticised.

The centrepiece of the scrutiny report is the evidential fact that the average length of time for an inquest to be heard within the Teesside jurisdiction is 44 weeks, whereas nationally, it is 26 weeks. A number of reasons for this have been suggested, with the most prominent being:

- a) A failure of the Police to provide adequate resources.
- b) A failure of the National Health Service to provide written statements and other documentation within a reasonable timescale.

In so far as a) is concerned, paragraph 32 of the scrutiny report indicates that the total budget provided by the Police is £308,201 and includes 8 Police members of staff, all of whom operate from Cleveland Police Headquarters. In addition, a further 5 members of staff funded by the local authorities, operate from another location and according to paragraph 36, staffing levels are above the Home Office guidelines and higher than in similar jurisdictions. In addition, the overall funding for the Coroner's Service stands at £911,000 per annum, a rise of £223,000 since 2005/2006.

I am concerned at the rise in costs, particularly when one considers the financial cuts being imposed upon the Police as well as local authorities, by the Coalition Government. I see no evidence that Her Majesty's Coroner has attempted to cut costs and this is a cause for concern.

Furthermore, there is little or no evidence within the scrutiny document that indicates that any attempt has been made to adopt new working practices, so as to enhance the service delivery of the Coroner's Service. If anything there appears to be a reluctance for "change", and "no change" appears to be the order of the day.

If my assessment is correct, then this is entirely unacceptable in an ever-changing financial and social environment, which is now geared to providing the best service at the cheapest cost.

I acknowledge there has been discussions within the last year concerning the subject of new ways of working but on the evidence available to me, I am of the opinion that much of this is far too late and is no more than a reaction to the criticism made of the Coroner's Service in recent times.

All public sector organisations are subject to rigorous cost cutting and this includes the criminal and civil courts. The Coroner's Service is not immune to budget savings, and the reluctance of Mr Sheffield to reduce costs and proactively adapt to the changing environment, is regrettable to say the least.

Due to the financial climate, Cleveland Police are in the process of cutting their budget by 20% and I cannot emphasise the potential effect this will have upon policing within our force area. However, from my discussions with Jacqui Cheer the Chief Constable, I am absolutely satisfied that she is doing everything possible so that front-line policing will be protected. For every extra pound spent by the Police on the Coroner's Service, it is one less pound spent on policing the streets of Cleveland.

It is therefore unreasonable for Mr Sheffield to request more resources, without first examining new ways of working, as further Police resources for the Coroner's Service would have an adverse effect on the Police budget, which is stretched to the limit.

I refer you to paragraphs 31-39 but in particular paragraphs 31, 34, 36 and 37 within the scrutiny report, the contents of which, leads me to the conclusion that I should reject the argument for the Police to provide more resources.

In so far as b) is concerned, I do believe that the Coroner's Court is a court of law and without referring to Her Majesty's Coroner's powers, I do believe that National Health Service professionals have a civic and moral duty, as well as a duty in law, to provide Coroner proceedings with evidence and information that are relevant to the particular death. The suggestion that the National Health Service are failing in their duty to provide the Coroner with information without delay, is a serious assertion.

I do not intend to rehearse the arguments concerning the National Health Service but I refer you to paragraphs 44-47, which make interesting reading. In addition, I note that Mr Sheffield informed the panel that he had recently met with a senior hospital representative to discuss the length of time taken to forward reports to the Coroner's Officers. The scrutiny report does not indicate if any remedy was achieved. I am also unaware of the date that Mr Sheffield had the meeting but clearly the situation had deteriorated over a long period of time. If this was such an issue, then I fail to understand why meetings had not taken place with the National Health Service many years prior, bearing in mind that inquest delays in the jurisdiction have been in question since at least 2004.

If the National Health Service are a particular issue, then I do believe that solutions can be found, by the use of Her Majesty's Coroner's powers or the Chief Executive of the relevant National Health Service hospital or body, creating a system in consultation, with the Coroner, to alleviate the present position.

From reading the scrutiny report, I am not sure whether a counter argument has been put forward to that of Mr Sheffield by the James Cook University Hospital in particular, or other National Health Service professionals. In the interests of fairness, I feel sure that such organisations would be grateful for the opportunity to make their case in response to the obvious criticism from Mr Sheffield.

Furthermore, I doubt that the National Health Service as a whole in the Teesside jurisdiction, are any different to other National Health Service professionals across the country in preparing and submitting written statements and documents for the Coroner's Service. This leads me to question whether the assertion made by Mr Sheffield in respect of the National Health Service, is particularly relevant, as the issue seems to have been advanced by Mr Sheffield within the recent past. This is supported by the fact that a meeting between Mr Sheffield and representatives of the National Health Service occurred recently, but I have seen no evidence that similar meetings had taken place historically.

On the evidence that I have seen, I cannot determine whether the subject of late submission of written documentation from the National Health Service to the Coroner's Service, is a significant contributing factor. However, as I have already stated action can be taken to remedy the situation when this should occur without delay.

The scrutiny report is detailed and comprehensive, with evidence of fact but also professional opinion with even the power of perception becoming evident. To a large extent it is easy to become embroiled in conjecture, but what is clear to me is that Mr Sheffield is Her Majesty's Coroner for Teesside and he is responsible for administering the process as a whole, which entails both the administrative and operational elements of the service.

In simple terms, Mr Sheffield asserts that the inquest delays are due to a lack of Police resources and a failure of the National Health Service to provide him with written statements and documentation, within a reasonable timescale.

I have already rejected the call for further Police resources and I do question the validity of the argument put forward in relation to the National Health Service. That does not mean to say that I am right or wrong, only time will tell.

Due to the complexities of the subject matter, people will draw their own conclusions based on the information before them, but I note that Mr Sheffield has not accepted any fault for any aspect of the delays and has blamed others rather than his-self.

In layman's terms, Her Majesty's Coroner for Teesside is responsible for investigating the circumstances and actual medical causes of sudden, violent and unnatural deaths. Although the 13 members of staff, which form the Coroner's Service, are funded by the Police and local authorities, all staff members work under his direction and are functionally accountable to him as Her Majesty's Coroner, which is covered in paragraph 32 of the scrutiny report. In this instance, Mr Sheffield is responsible for the operational and administrative effectiveness and efficiency of the Coroner's services as a whole.

I do believe that the position I have laid out is unequivocal, and I am saddened that Mr Sheffield has not accepted any criticism or attempted to advance a modernisation agenda for the Coroner's Service, which would enhance the efficiency and effectiveness of the service as a whole.

I feel that he has been defensive in his submissions with particular arguments being scant, conflicting and to some extent contradictory. This is disappointing to say the least. I have concluded that he believes that the delays in concluding inquests have nothing to do with his performance whatsoever, but have everything to do with other agencies. I do not accept his position.

In 2004, Mr Sheffield was criticised by a number of people for the delay in the conclusion of inquests. I was one of the few people who came to his defence. I recall stating that he had been an outstanding Coroner since his appointment in 1972 and that it was important that the issues affecting inquest delays be addressed by all parties, which included the Police and the question of adequate Police resources being provided.

I had separate meetings with Mr Sheffield and the previous Chief Constable Sean Price, to discuss the position. To an extent and for a period of time, things did improve.

However, within the last year or so there has been a great deal of adverse publicity concerning Mr Sheffield and the Coroner's Service, with the focus being towards the delay in inquests being concluded. The main thrust of such criticism has been the fact that inquests take an average of 44 weeks to be concluded in the Teesside jurisdiction, in comparison to an average of 26 weeks in the remainder of the country.

The Members of Parliament for our area, which include Iain Wright, Tom Blenkinsop, Alex Cunningham, Ian Swales and James Wharton, have all commented in the media and also within Parliament, with regard to the Coroner's Service and the role of Her Majesty's Coroner Mr Sheffield. I do believe however, the most striking comments are those made by Alex Cunningham and James Wharton. Alex Cunningham, whilst speaking in Parliament on the 14 July 2011, described Mr Sheffield's performance as "appalling". He also said "The days of making excuses for the appalling performance of the Teesside Coroner's office are long gone". In addition, on the 26 October 2011 during a session in Parliament, Alex Cunningham called on Mr Sheffield to be sacked claiming he was "incompetent".

On the 14 July 2011 James Wharton spoke within Parliament and called on Mr Sheffield to reconsider his position. He said "I am very worried about the impact of any backlog on families who have lost loved ones, and who are waiting for the answers and a sense of closure that inquests can provide. The bottom line is that the problem needs to be dealt with. Mr Sheffield should consider whether he is the best person to do this".

I believe that all of the Members of Parliament have acted with a high degree of restraint and are absolutely right in raising their concerns within Parliament, and also with the public at large.

I have recently spoken to 4 Members of Parliament, which includes Andy MacDonald the new Member of Parliament for Middlesbrough. All have serious concerns with regard to the Coroner's Service and the performance of Mr Sheffield. I will leave it to them to comment on the scrutiny report and also the comments I am making today.

As a result of my analysis of the situation concerning the Coroner's Service and that of the performance and position of Mr Michael Sheffield, I met with him and his Deputy Coroner Mr Tony Eastwood, who was also acting as his Legal Adviser, at 11.00am on Monday 5 November 2012.

I informed Mr Sheffield that I had held him in the highest regard when I was a Police Officer and that I believed he had been an outstanding Coroner over many years standing. In addition, I also reminded him that I had supported him in 2004, when he was criticised for the

delay in concluding inquests and that I had been a peacebroker between him and the Police, concerning his suggestion that he had not received adequate Police resources at that time.

I then pointed out to him that for him to be Her Majesty's Coroner for Teesside, he required the confidence of the public but unfortunately it was clear to me that the public, as well as many elected officials, had lost confidence in him to perform his role.

I informed him that I too, had lost confidence in him and that I believed he was now bringing his office into disrepute.

I then informed Mr Sheffield that I required him to resign as Her Majesty's Coroner, as I believed his position was now untenable.

I also explained to him that the service needed to be modernised under new leadership, which I did not believe he could provide. I pointed out to him that his departure was in the public interest and for the service to move forward, he had to go.

I then informed Mr Sheffield that I would write to him formally requesting him to resign within the near future, which I did on the 12 November 2012.

I subsequently received a letter of response from Mr Sheffield dated the 15 November 2012, but he did not indicate whether he would resign or not.

At 11.30am on Monday 26 November 2012, both I and Richard Long, the Head of Legal and Democratic Services for Middlesbrough Council, attended a meeting with Mr Sheffield and his Deputy Coroner and Legal Adviser, Mr Tony Eastwood.

I informed Mr Sheffield again that I required him to resign and that I would be grateful if he would inform me of his decision by Monday 3 December 2012. I have not received any communication in this regard.

I believe on the evidence available that the Coroner's Service requires modernisation, and for this to occur an Independent Review of the fundamental elements forming the service needs to be conducted. It should encompass not only the Coroner's Service, but also the agencies that contribute to the service such as the Police, the National Health Service, as well as local authorities and others.

Although I cannot provide compelling evidence regarding my assertion that the Coroner's Service has failed to "embrace change", I strongly suspect that this is the case, when one considers the defensive mode, which has clearly been displayed by Mr Sheffield over a long period.

I also believe it to be relevant to highlight the assertion that has been made to me by numerous people, that Mr Sheffield is now over 80 years of age and that he should have retired on the grounds of age some years ago. Personally, I do not believe that age is a barrier to a person performing particular roles. I note however, that new legislation recently introduced requires Her Majesty's Coroners to retire at the age of 70, but the legislation cannot require a Coroner appointed prior to the implementation of the legislation to retire. In other words, Mr Sheffield can continue without reference to his age for as long as he sees fit.

During my conversations with Mr Sheffield, he indicated that he wished to remain in his role until 2014, but I dismissed this suggestion on the basis that his position is untenable and also that a new appointment to the position would bring new ideas, so as to modernise the Coroner's Service as a whole. I also pointed out that he had been Her Majesty's Coroner for 40 years and it was now time to leave the post with dignity, which I believe he deserves.

The service requires dynamic leadership from a person who has the necessary creative thinking, so that the Coroner's Service can be a fit for purpose organisation, which has the confidence of the public at large as well as the elected representatives and other partner organisations.

I therefore recommend the following:

- i) That Mr Sheffield resign as Her Majesty's Coroner for Teesside with immediate effect.
- ii) If he resigns his position, then an Independent Review should be commissioned, in the terms I have previously outlined.

In conclusion, I would now like to share with you some further personal thoughts, which I do believe are relevant when one considers Mr Sheffield's overall tenure, as Her Majesty's Coroner for Teesside.

He has been the Coroner for 40 years, and during this time, he has performed the function of conducting inquests in an outstanding manner. It saddens me greatly that he has remained too long in his post, which has resulted in a decline in his administrative responsibilities outside of the Coroner's court process.

As a Police Officer, I attended many inquests and he was always highly professional and sensitive when dealing with professional witnesses, such as Police Officers and also with bereaved families.

I have often described Michael Sheffield as a gentleman, because he is always courteous, personable and dignified. Even when I have spoken to him in the strongest terms over recent weeks, he has indicated that he was grateful for my honesty and I can say without fear of contradiction that I learned a great deal from him, particularly in my younger years and I know that many Police Officers are grateful to him for his counsel, when dealing with him as Her Majesty's Coroner for Teesside.

I still hold Michael Sheffield in the highest regard, and I have immense respect for him as the Coroner, and as a man.

I do not intend to allow the unfortunate circumstances that we find ourselves in to affect the standing of Michael Sheffield, as he has devoted 40 years of his life to public service, and this should not be forgotten.

However, I now call on Mr Sheffield to resign his position with immediate effect, as it is in the interests of the public and the Coroner's Service as a whole for this to occur.