Force Management Statement : Coroner's Office

Cheshire Constabulary

The Coroner's Service in Cheshire comprises of two teams:

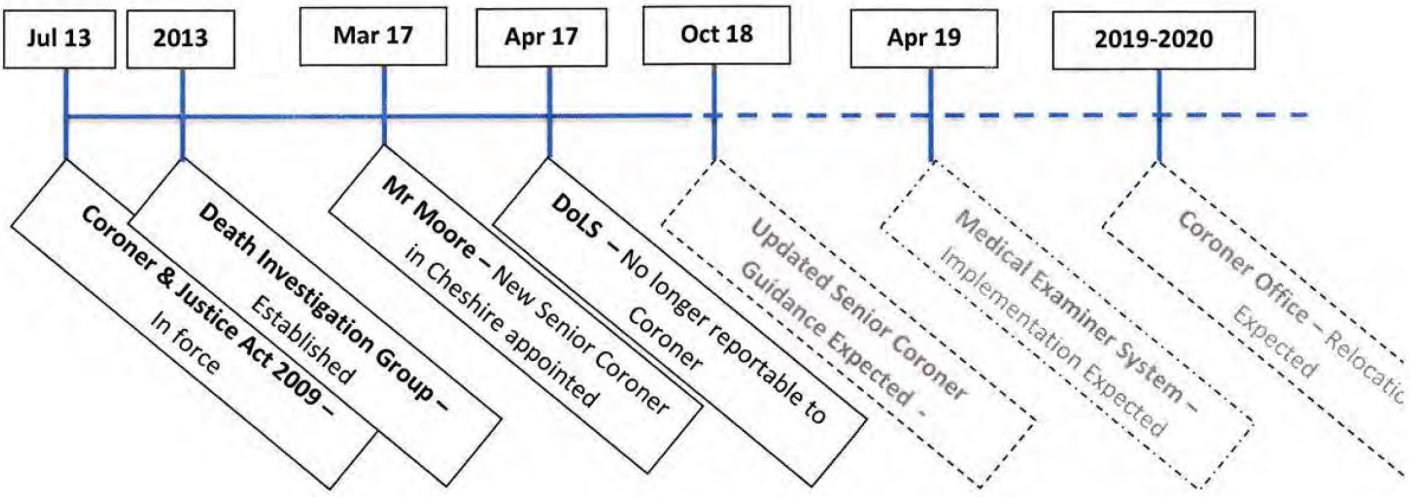
Senior Coroner and his administration staff: Funded by the local authority and located in council accommodation.

Coroner's Officers: Funded by Cheshire Constabulary and located in council accommodation.

On 25/07/2013 the Coroner's and Justice Act 2009 came into force and the key changes in the Act were:

- Introduction of Chief Coroner
- Introduction of the Coroner's Investigation
- Inquest hearings to be heard within 6 months (where possible)

Following the Act a number of key milestones in respect of the Cheshire Coroners position have been identified and will be explored further within this review:



Step 1: Current Demand

Cases reported to the Cheshire Coroner:

Below the number of deaths referred to the Cheshire Coroner via the Coroner's Officers over the past five years;

Includes Do LS INQUESTS

Year	2013	2014	2015	2016	2017	*Predicted* 2018
Total number of Deaths	4828	4866	5524	5534	4155	3500
Inquests	700	655	845	965	717	600
% Vs Deaths	*14%*	*13%*	*15%*	*17%*	*17%*	*17%*
Investigations	127	283	301	267	226	250
% Vs Deaths	*3%*	*5%*	*5%*	*5%*	*5%*	*7%*
Inquests + investigations	**827**	**938**	**1146**	**1232**	**943**	**850**
% vs Deaths	***17%***	***19%***	***21%***	***22%***	***23%***	***24%***

Scene of Death

Police attended
1633 39%*

No Police attendance
2522 61%*

Inquest Files

Police completed
250 per annum 35%*

No Police involvement
467 65%*

**2017 Data*

Sudden Death

Cases of sudden death are reported to the coroner via a number of means (GP, Hospital, Death Abroad, community etc.). The cases include but not limited to

- Cause of Death unknown
- Violent, unnatural, sudden or unexplained
- Medical Practitioner not visited, Med Cert not available
- Death during operation.
- Industrial disease/poisoning suggestion on Med Cert.

The coroner may decide :

- Cause of Death is clear
- Post Mortem required

Following the Post mortem a coroner may decide to hold an inquest if the cause of death is still unknown or the person died a violent or unnatural death or in prison/police custody.

On average in Cheshire the Coroners Office will deal with 70 sudden deaths every week

Inquests Demand

Prior to 2017 the high case numbers are partly due to DoLS (Deprivation of Liberty Safeguards) which was no longer defined as state detention and therefore not reportable to the Coroner. Additionally in July 2017 the criteria of deaths that doctors needed to report to the Coroner was reduced in line with Chief Coroners guidance.

It is important to note that it is not just about the total case numbers. The majority of Coroner's Officers time is spent dealing with day-to-day cases, incoming queries from the public and on inquest files. The ratio of inquests to case numbers is also something to note; where the national average is **14%** and Cheshire's inquest percentage is higher at **17%**.

Cheshire has been well documented as being one of the busiest coroner's jurisdictions in the country and the ratio of inquest numbers compared to overall case numbers still remains high. Cheshire is renowned for its high quality practice and processes, and the Chief Coroner wants to raise national standards to a similar level.

The timescales for dealing with inquest & Investigation files for the Coroner are **"within 6 months of death".** Cases over 6 months are reportable to the Chief Coroner and over 12 months are reportable to the Lord Chancellor. However for some cases delays are unavoidable i.e. deaths abroad, HSE deaths, Article 2 deaths etc.

On average in Cheshire the Coroners Office will deal with NEW 16 Inquests/Investigations every week.

Hidden Demand

The demand in the coroners office cannot be articulated in case numbers alone as the support and advice the unit provides for both relevant professionals and bereaved relatives presents a significant proportion of the demand within the unit.

Telephone consultations, statement taking, day to day queries have been analysed utilising the telephone logging system and are estimated to be over **920 every week**.

The skill set required to provide a consistent, professional and compassionate service is unique in its requirement and the teams ability to maintain this high quality provision is an asset to the Force.

Additionally the diligence needed in this area to ensure that policies, Memo of understanding, protocols and training (Senior Coroner Officer /Assistant Senior Coroner Officer)

Prioritising Demand

The demand in the coroners office are dealt with in death order, however caveats to this provision may consider cultural aspects (for example some religions require burials to take place within 24 hours). High Profile Cases, multiple fatalities and inquest deadlines may also influence how cases are managed on a day to day basis.

All of the deaths have full consideration of the Next of Kin prompt and appropriate communication requirements to ensure they are fully informed throughout the process.

Step 1a: Future Demand

In Autumn 2018 the Senior Coroner is expected to issue updated guidance to Coroner's Officers outlining his expectations in respect of demand:

- Coroner's Officers to take more ownership over Coroner's files (with specific exception's still to be defined). Currently approximately 35% of inquest files are 'sent out' to police officers to investigate, even though the circumstances of the death are deemed non-suspicious. Following this guidance the Coroners Officer will have additional influence and oversight in respect of any investigation strategy.

- The Coroner's Officers should obtain all Next of Kin statements, with Police officer assistance obtaining additional witness statements. This will also negate the need for Police Officers to complete witness lists and to submit a completed file to the LPU DI for a QA check. Instead Coroner's Officers will submit their completed file to the Senior Coroner's Officer for quality checking. The Coroner's Officers will be busier on their inquest files but having the reduction in doctor referrals (July 2017 Guidance) will greatly assist the resource level in the department.

In April 2019 there will be a National implementation of the Medical Examiner System. This is a system where all deaths and medical certificates will be independently scrutinised. Pilots in other areas have demonstrated that this system is likely to increase complex inquest workload for the Coroner, but at the same time could reduce the number of deaths inappropriately reported to the Coroner. Overall it is envisioned that coronial workload may increase but to what extent is not yet currently known.

Sometime in 2019/2020 the Coroner's Officers will relocate to more fit-for-purpose building (funded by the Local Authority) so that they will be in the same building as the Coroner and his staff. It is envisaged that by being in the same building there will be an increase in efficiencies i.e. one copy of the file instead of two, and utilising the same coronial IT system instead of inputting into two separate systems.

The Coroners Office also support contingency planning to ensure that they are fully prepared in the event of a mass fatality incident or flu pandemic. The Cheshire

Resilience Forum have published a Multi-Agency Response Manual updated in Nov 17 which sets out the co-ordinated response of agencies across Cheshire including the Coroners Office).

Step 1b: Performance

The Coroners Office produces monthly analysis to monitor the caseload of Coroner Officers to ensure that backlogs, capacity and case equity is managed effectively.

In 2017 the average CO Case loads per FTE officer were as indicated below:

- Investigation/Inquest — 17.8 per Officer *(19.8 in 2016)*
- Read only Inquest — 31.6 per Officer *(35.5 in 2016)*

The Coroners Office have a Quality Assurance process on inquest files to ensure that they are progressing effectively and in a timely manner.

The feedback received from the Coroner, Senior Management and families (positive and negative) is assessed and considered to ensure that continuous improvements are embedded within the team.

The geographical spread of deaths reflects the population of the associated Local Authorities, the area groups listed below mirror the geographical spread of Cheshire's main hospitals (not the Local Authority mapping) :

Area		NFA	PM (Natural)	Investigations	Inquests (All)	Total Deaths
Chester *(Inc Ellesmere Port)*	2017	572	241	71	192	1076
	2016	*837*	*284*	*100*	*183*	*1404*
	Variance	*↓32%*	*↓15%*	*↓29%*	*↑5%*	*↓23%*
Crewe *(Inc Northwich and Winsford)*	2017	631	317	38	164	1150
	2016	*902*	*319*	*48*	*274*	*1543*
	Variance	*↓30%*	*↔*	*↓21%*	*↓40%*	*↓25%*
Macclesfield	2017	441	209	20	138	808
	2016	*711*	*168*	*37*	*239*	*1155*
	Variance	*↓38%*	*↑24%*	*↓45%*	*↓42%*	*↓30%*
Warrington *(Inc Halton)*	2017	517	285	97	223	1122
	2016	*696*	*385*	*82*	*269*	*1432*
	Variance	*↓26%*	*↓26%*	*↑18%*	*↓17%*	*↓21%*
TOTAL	**2017**	**2161**	**1052**	**226***	**717**	**4155**
	2016	*3146*	*1156*	*267*	*965*	*5534*
	Variance	***↓31%***	***↓9%***	***↓15%***	***↓26%***	***↓25%***

* *NB This does NOT include those investigations that then proceeded to inquest so this finding must be used with caution*

The main influencing factors of the numbers above are that DoLS was no longer reportable from April 17 and the Reportable death criteria reduced in July 2017.

Step 2: Workforce & Assets

The Coroner's Officers Service in Cheshire work to the direction of the Senior Coroner but because of the nature of daily business, it is line managed by the Cheshire Constabulary Major Crime Directorate.

The budgeted amount set by the Constabulary to fund the Coroner's Officers' salaries for financial year 2018/19 is **£** I&S

In 2018 the Coroners Office consists re now the following employees:

1	Senior Coroners Officer	Scale PO 1/2
1	Assistant Senior Coroner's Officer	Scale SO 1/2
11	Coroners Officers	Scale 6
2	Coroner's Administration Officers	Scale 3

In 2016 the Chief Coroner made recommendations for Coroner's Officers (who do not attend scenes), they should be dealing with between **350 and 450** deaths, of which **45-50** would be inquests.

Following procedural changed outlined previously the number of cases per Coroner's Officer to (approx.) predicted for 2018 are **320 deaths** and (approx.) **55 inquests** each.

The unpredictability of death rates is challenging to consistently manage workloads and also because of the specialist nature of the role it means that recruitment and training of a Coroners Officer is not a quick and easy process, reliance options are therefore limited. On occasion previously retired staff have been called in to support the team.

Managing absence of a relatively small unit is critical to ensure caseload management does not adversely impact on staff morale and the quality of the case reviews undertaken.

Coroner's Officers' Accommodation

The existing cost of accommodation is currently borne by the Local Authority. This also applies for when the Coroner's Officers move to new accommodation in 2019/20 and the only predicted cost to Cheshire Police will be to logistical relocation of the technology , fixtures and fittings for the move itself. This move will positively improve communication opportunities and minimise process duplication between the Senior Coroners team and the Coroners Office.

Step 2a: Wellbeing

Prior to 2017 Cheshire experienced high levels of inquest demand and large numbers of deaths reported to the coroner. At this time stress levels were high in the department and some Coroner's Officers were working excess hours to keep up with the demand. In addition long-term sickness was quite prevalent which caused additional stress on remaining members of staff, some of whom developed stress-related chronic illnesses. In addition the Coroner's Officers time was spent on natural cause death referrals rather than pro-actively investigating inquest cases, and a lot of assistance was required from police officers. Therefore, it was a much needed and welcome respite when in April 2017 DoLS stopped being referable; and in July 2017 doctors did not need to report as many deaths as they did. This eased the pressure on the department where Coroner's Officers were no longer spending the majority of time processing deaths that in reality did not need to be reported, and it has paved the way to look at how Coroner's Officers can now proactively spend their time. In addition long term sickness in the department has since significantly reduced.

Step 3: Planning for the future

Across the UK some Coroner's Officers are employed by the police, some by the council, and some have joint funding where those employed by the council deal with straight forward cases (i.e. natural cause deaths) and those employed by the police have a more investigative role and deal with inquests and investigations.

In 2014 The Ministry of Justice (MOJ) Guide to Coroners and Inquests stated:

"The costs of providing a local coroner's service are usually met by the local authority for that area. In some areas the local police force employs the coroner's officers. However the officers' work is always carried out under the authority of the coroner who works independently from both the local authority and the local police force."

The discussions at national level are now seeking to address the present situation in a proportionate and balanced manner as there is presently little consistency around the UK with regard to the issue of Coroner's Officers. Several forces have passed their Coroners Officers Service entirely to the Local Authority in recent years under Transfer of Undertakings (Protection of Employment) Regulations (TUPE) arrangements, whilst some retain the same structure as that presently adopted in Cheshire.

The impact of changes to the Medical Examiner System (April 2019) are yet to be fully determined, this may create a reduction in form A cases but a possible increase in Post

Mortems and in medical inquest cases, however until the system has been fully embedded certainty in the levels of change are unknown.

Legislation under consideration currently (Civil Partnerships, Marriages and Deaths (Registration ETC) Bill 2017-19) which proposes arrangements to be made for a report on whether, and if so how the law ought to be changed to enable or require coroners to investigate still-births. This would increase the demand into the Coroners Office and progression of this bill is being monitored closely.