	AGENDA ITEM 5
	CSC/17/17

Corporate Policy & Scrutiny Committee	
Report title: An overview of the Essex Coroner Service	
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1. Purpose of Report

To provide the Scrutiny Committee with an overview of the Essex Coroner Service.

2. Recommendations

None – the report is for information and discussion.

3. Background

3.1 The Office of Coroner

Coroners who trace their office back to the Middle Ages are independent judicial office holders, accountable to the Lord Chancellor. Although appointed and paid for by the Local Authority, they are not employed by Local Government. The *Coroners and Justice Act 2009* provides the statutory framework.

Coroners investigate deaths that have been reported to them if it appears that

- the death was violent or unnatural
- The cause of death is unknown
- Or the person died in prison, police custody or another type of state detention.

In the words of Lord Thomas Bingham *"It is the duty of the coroner as the public official responsible for the conduct of inquests whether he is sitting with a jury or without to ensure that the facts are fully, fairly and fearlessly investigated…. He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is*

evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory…"

In addition to investigating suspicious deaths, the coroner is also responsible for holding inquests into treasure finds.

3.2 The Essex Coroner jurisdiction

On 31 July 2013 the Essex, Thurrock and Southend coroner areas merged to form one jurisdiction. Essex County Council is the lead authority working closely with the Unitary Authorities of Thurrock and Southend.

Since the merger the Essex Coroner district has become the busiest and it is one of the most complex in the country. Last year some 7100 deaths were reported and around 763 resulted in inquests.

Essex has everything – a major HM Prison with a Young Offenders Institution, 2 major airports and a number of air-fields, 5 acute hospital trusts, motorways, busy roads, heavy industry, a long coastline, 2 major ports, heavy industry, an army garrison and rural areas. Inquest conclusions include drug overdoses, accidents from road traffic collisions, air crashes, drownings, falls, industrial disease, suicides, and lack of care in medical settings. If a death occurs abroad and the body comes into Essex, a coroner's investigation is required.

4. The Service

The coroner team in Essex consists of Caroline Beasley-Murray, the Senior Coroner; Eleanor McGann, the Area Coroner; and three assistant coroners who are utilised on request.

Supporting the Coroners is an operational team of local authority officers, consisting of coroner and support officers and a small management team.

There is a Coroners Court Support Service, a registered charity, manned by specifically trained volunteers who attend all inquest hearings to assist in the smooth running of the court. This team, led and co-ordinated by Laura Logan-Wood MBE has been operating in Essex since 2006 and currently consists of 8 volunteers.

Together the Coroners and their support staff seek to serve the people of Essex, and in particular the bereaved.

The Coroners and their team work together in Seax House, where there is also a dedicated court room. The coroners and their team accommodate numerous visits to Court from people such as nursing students, trainee journalists, and police officers who greatly appreciate this valuable opportunity. The service deals with hundreds of requests each year from insurance companies and solicitors in relation to life insurance policies and pensions along with litigation enquiries. The inquest archives date back to 1939, and so the service deals with many requests from people tracing their family history.

The Senior Coroner and her team work closely with Emergency Planning Teams in Essex and Southend to ensure they have input into the appropriate plans such as a Mass Fatality Plan and the Local Resilience Forum Extra Death Plan. The Essex Coroner Service has emergency mortuary plans ready to handle some 200 fatalities in the case of a major disaster or event.

The service works closely with the Strategic Child Death Overview Panel, keeping them notified of child deaths, issues that may relate to Serious Case Reviews and the final outcome of inquests.

The service provides information to a variety of statutory agencies to assist with the prevention of drug related deaths, road traffic accidents, industrial disease, accidents and suicide prevention.

The Coroner Service has an extraordinarily high profile. There is intense local and national interest in the Coroner's jurisdiction. All hearings are held in open court, and publicised on the Coroner Service web-site, which is part of the Essex County Council web-site.

In addition to overseeing the coroner team, the Senior Coroner provides regular training, for instance, to Senior Investigating Officers and other police; to doctors, registrars and pathologists; to staff working in mental health institutions and hospices. As a member of the national Disaster Victim Investigation cadre the Senior Coroner has wider responsibilities beyond Essex; she also serves on committees of the Coroners Society of England and Wales, and will be President of the Society 2018-2019.

The Senior Coroner is on duty 24/7 – save for those times when she delegates that responsibility to her Area or Assistant Coroners. Supporting the coroner outside office hours are always two coroners' officers (on rotation) – one responsible for the North of the county, and the other for the South.

In order to exercise her duty, Essex County Council also maintains contracts for body removal services, toxicology and histology services and utilises mortuary provision at the five NHS Trusts. Additionally, the coroner instructs pathology services with both independent and NHS pathologists upon her direction to carry out post mortem examinations on her behalf.

5. Data

Performance figures for the Coroner Service are compiled during an Annual Return to the Ministry of Justice. The Annual Statistics report details for each of the 92 Coroner Areas. Table 1 on the next page outlines the number of cases referred to Essex Coroner's Service against the total number of deaths registered in Essex and the comparison with the national average of referral rates.

Table 1: Volume of deaths referred to Essex Coroner Service.

Year	Deaths registered in Essex	Number of deaths reported to Essex Coroners Service	% of registered deaths referred to Essex Coroners Service	% of UK and Wales deaths referred to the Coroner Services
2016	14,275	7100	49.74%	46.05%
2015	14,261	6869	48.17%	44.73%
2014	13,594	6432	47.31%	44.74%
2013	13,203	6373	48.27%	45.08%
2012	13,319	6253	46.95%	45.70%

Table 2 provides the detail of the Essex Coroner Service performance against national averages.

Year	Total Deaths Reported	Inquests Opened	Post Mortems	% Inquests	% Post Mortems
NATIONAL					
2016	2,741	439	983	16%	36%
2015	2,686	373	1,014	14%	38%
2014	2,544	294	1,021	12%	40%
2013	2,591	340	1,073	13%	41%
ESSEX					
2016	7,100	763	3,008	11%	42%
2015	6,869	781	2,974	11%	43%
2014	6,432	569	3.341	9%	52%
2013	6,373	570	3,469	9%	54%

Table 3 demonstrates the performance of Essex Coroner Service against similar Coronial Districts. Kent consists of four coroner areas with Sussex having three coroner areas.

Table 3.

	Total deaths reported to the Coroner	Inquests Opened	Post mortems	% Inquests	% Post mortems
Essex	7,100	763	3,008	11%	42%
Surrey	4,444	504	1,982	11%	45%
Kent	7,939	1,138	3,206	14%	40%

Sussex	5,656	738	2,298	13%	41%
Preston	2,539	352	1,007	14%	40%
Southampton	2,193	299	843	14%	38%

The Chief Coroner Report to the Lord Chancellor also reports on the number of cases not completed or discontinued within 12 months and Inquest timeliness. Essex has recorded pleasing results with the estimated time for an inquest to be held reducing from 40 weeks in 2013, 34 weeks in 2014, 16 weeks in 2015 and 12 weeks in this year's Chief Coroner Annual Report. This compares favourably with the national average of 18 weeks for an Inquest to be held. Essex also performs strongly with only 3% of cases open after 12 months, with 12% being the national average.

There is a high inquest rate for the number of deaths reported: this is the result of a post-mortem examination rate of 25% in 2016 (average of 36% nationally) and an average inquest time of less than 12 weeks from the death report (average of 18 weeks nationally). Up to 25% of investigations of reported deaths are concluded based on clinical history and exclusion of unnatural causes as opposed to invasive autopsy. This enables the limited resources to be targeted on those unnatural and state detention deaths which require the most investigation.

In Essex all investigations directions are timetabled/mentioned by the Senior Coroner as to when evidence should be filed and dates are set by the Senior Coroner, as to when an investigation will be reviewed or an inquest opened or an inquest to be concluded.

Essex has a higher than national average number of jury inquests in the light of the complexity of the jurisdiction – this arises not least because of the presence of the prison and several psychiatric units, as well as health and safety issues relating to the County's heavy industry.

Recent legislation relating to those who die whilst under a Deprivation of Liberty Safeguarding Order (DoLs) resulted in an increase in the number of deaths reported to the coroner, for all of which inquests were to be held and an increase in the 'death from natural causes' conclusions as this was the majority of DoLs inquest conclusions. This legislation was updated on 3 April 2017, so that from that date only deaths which would normally be reported to a coroner, would need to be reported, even if they are under a DoLs order.

Regulation 28 of the *Coroners and Justice Act 2009* provides coroners with the duty to make reports to a person, organisation, local authority or agency where the coroner believes that action should be taken to prevent future deaths. In 2016 the Senior Coroner generated 18 Regulation 28 reports. These were addressed to NHS bodies including Mental Health Services, prison Services, Highways England, and Secretaries of State, covering a wide variety of issues from health-care provision within state detention settings to improving communication between local mental health services providers to implement road safety measures and clearer information documentation protocols.

6. Horizon scanning

The current Essex Coroner Service case management system requires attention. Steps are being taken to explore the sourcing of an up-to-date forward-looking electronic case-management system. The aim is to use portals for information-input and to achieve a less paper dependant office process.

There are pressures upon the mortuary provision in the five acute hospital trusts and the service works collaboratively with supporting services, including funeral directors, to manage this.

In a jurisdiction which holds a higher than national average number of jury inquests the jury accommodation within Seax House could be more appropriate.

The service will be honoured by a visit from the Chief Coroner, His Honour Judge Lucraft, on 12 January 2018. Councillors would be most welcome to attend.

The Chief Coroner has advised that coroner jurisdictions should have a strong working team of assistant coroners. Essex, as a large jurisdiction, intends to ensure that it has sufficient resilience in this area.

Reforms to the death certification process were introduced in Chapter 2 of Part 1 of the *Coroners and Justice Act 2009*, which has yet to enter into force. The primary legislation provides the legal framework for proposing a unified system of scrutiny by independent medical examiners of all deaths in England and Wales that are not investigated by a coroner. A number of pilots of a Medical Examiner role were conducted across the UK, with Mid Essex Hospitals Service NHS Trust continuing to use the role of the Medical Examiner in reviewing death processes. Although proposed some while ago, the introduction of a national role of Medical Examiner and the corresponding changes to cremation and Registration regulations has yet to be introduced with no clear timeline for any implementation.

Developments within the examination of bodies after death include the use of non-invasive post mortem examination technology. The digital technology allows the scanning of a body with the interpretation of the results by a Pathologist in determining a medical cause of death. Whilst the technology can offer a cause of death within a short period of time and reduces family members' distress from more invasive techniques, the digital nature of non-invasive post mortems also satisfies requirements within certain religions and addresses a national clinical shortage in pathologists.

7. Expressions of appreciation

7.1 Compliments received

Each year we receive many compliments from bereaved families which demonstrate our commitment to putting them at the heart of the service. Some examples are:

‘Thank you for all the help and support you have given me over the months. you have ability to put people at ease. Also thank you for being so kind when we attended court on 4 May’

‘We would like to thank you for everything you have done since the death of our Dad. We wouldn’t have been able to manage it as well as we did without your help. you were so professional and empathetic and went through everything we needed to know and made sure we received our letter before we had to catch our flight back to Ireland. We are all so grateful and you will forever be in our thoughts for your kindness.’

‘I wanted to thank you both again for the professionalism, care and attention in my Dad’s case’.

7.2 A final word

The Senior Coroner would like to express gratitude to Essex County Council for its ongoing support to the Coroner Service in so many different ways. She would also like to express her gratitude to the Area Coroner and to her assistant coroners; and her heart-felt thanks to everyone involved in the service.