	Agenda Item 7
	ES/048/11
Committee:	**Executive Scrutiny Committee**
Date:	**19 July 2011**
Coroners Service	
Enquiries to:	**Hannah Cleary, Governance Officer** **01245 430526** **hannah.cleary@essex.gov.uk**

Introduction

At its meeting on 24 May 2011, the Executive Scrutiny Committee (the Committee) considered report ES/030/11 (attached as Appendix 1 to this report) and received a presentation from Ms Alex Hallam, Deputy County Solicitor, in relation to the Coroners Service.

This report sets out the evidence taken by the Committee and the Next Steps for the continuation of the review.

Action

The Committee is invited to consider and agree the report and next steps.

Evidence

The Committee were advised that the responsibility for the Coroners Service (the Service) transferred from Essex Police Authority (the Police) to the Council in 2008. The Police continue to make a contribution to the budget for the Service, and Ms Hallam agreed to provide financial information at a future meeting, including the sources of budget income, and a map of Coroner jurisdiction areas.

Whilst the Council had the financial responsibility for the Service, Coroners are appointed by, and responsible to, the Lord Chancellor and are one of the few judicial appointments who conduct enquiries.

Cases dealt with by the Coroner fall broadly into two categories – ‘day-to-day cases’ and ‘cases for inquest’. Day to day cases tended to require the intervention of the Coroner as the deceased may not have seen a medical professional before their death and in these instances the Coroner is required to release the deceased to their family within a set number of days in order to enable funeral arrangements to be made. The Coroner deals with approximately 6,000 to 6,500 cases for inquest each year. Rudimentary calculations had been undertaken to devise the cost per case to the Council. In recent times, these

costs had fallen, although it was important to note that simpler cases were more likely to cost less, on average, than complex ones. In response to a question the Committee were advised that costs incurred were not re-charged to any other organisation, and were fully met by the Council. Ms Hallam agreed to provide information about how Southend and Thurrock were charged for the services they received from the Service.

Complex cases often required evidence and involvement from other agencies, such as the Health and Safety Executive, Ministry of Defence, or the requirement to undertake detailed toxicology or pathology reports. In some instances, the collection of such evidence could take months, and until such evidence had been collated, cases could not be brought to inquest. Other cases required translation/interpretation services, and the Service spent over £10,000 per year on this provision.

The Service had experienced a backlog of cases and had worked hard to resolve this by running new cases consecutively with older cases to reduce the backlog. New case manager software had been installed that would enable improved tracking of cases, compliments and complaints, along with a new telephone system to improve customer service. The Coroners had the authority and an annual allowance to appoint Deputy Coroners, and these had been utilised to the fullest extent. Coroners Service support staff were managing the backlog by using short term contracts to employ extra staff, which would be reviewed once the backlog had been cleared. A pilot scheme was underway in Basildon to utilise the skills of a Medical Examiner who could undertake a case filtering exercise to ensure the Coroner only received the most appropriate cases. There was scope to simplify the procedure for deaths at home, for example through terminal illness, where people were receiving palliative care at home. In some instances family members had not been aware of the process in relation to the involvement of the Coroner, and the impact this could have on funeral arrangements. It was recognised that improved liaison with the NHS and Ambulance Services may be beneficial in this area.

Objectives for the Service were under development to ensure referrals were dealt with within certain time frames and changes to the information shared with families of the deceased had been improved, for example, if a death occurred over a bank holiday, the Service would advise the family about the potential for delays. National performance monitoring for all Coroners Services was undertaken by the Ministry of Justice.

The Committee asked how the Service ensured that faith or religious requirements in respect of funeral or burial arrangements were met. The Service ensures that as far as is practicable, all faith and religious needs are met, with staff on call 24 hours a day.

Day-to-day management of the Service was undertaken by Ms Hallam, whilst judicial queries were referred to the Coroner. The potential for the appointment of a Chief Coroner was introduced in the Coroners and Justice Act 2009, although it was unclear if this would taken forward.

Next Steps

That the following information be brought to the 29 November meeting so that the Committee may agree findings and recommendations in relation to this review:

1. A map showing the jurisdictions of the Coroners for Essex, Southend and Thurrock
2. Sources of budget income for the Coroners Service
3. The impact of the Coroners and Justice Act 2009 on the Service
4. The charging structure for body storage

Appendix 1

Committee	Executive Scrutiny Committee	**AGENDA ITEM 8** **ES/030/11**
Date:	24 May 2011	

Coroners Service

Enquiries to		Extn	Telephone no
Alex Hallam	**Deputy County Solicitor**		**01245 506790**

Coroners Service – brief for Executive Scrutiny Committee

1 Costs of providing the service over the last 2 years

	2009/10 £m	**20010/11 £m**
Original Budget	1.62	1.26
Adjusted Budget*		1.62
Income	0.9	1.15
Expenditure	2.7	3.04
Outturn	-0.18	-0.27

*Additional year in funding

The increase in costs in 2010/11 relates to an 8% increase in the number of deaths referred to the Coroner, across both Jurisdictions, over the previous year and progress made in addressing the inherited inquest backlog, including holding a number of complex and therefore expensive inquests.

The effect of addressing the backlog of inquests and the increase in deaths referred has been an increase in expenditure for the Service however the underlying "cost per case referred" figure indicates that costs decreased from £445 per case in 2009/10 to £436 last year.

2 Performance standards

The Ministry of Justice (and formerly the Home Office) collates an annual return for all coroners' jurisdictions in England and Wales. This allows a benchmarking of

performance in areas such as time taken from referral of a death to release of the body, delay between opening and hearing an inquest and number of post mortems requested. It should be noted that these standards are not enforceable and to date jurisdictions performing poorly have not been actively commented upon by the MoJ.

During the tenure of the current coroners, the delay for conducting inquests the Essex and Thurrock jurisdiction has been 35 – 38 weeks and for Southend around 26 weeks; the national average has remained around 26 weeks. However, data management for the Southend jurisdiction has not been undertaken by ECC from their data in previous years.

In 2009, the delay for Essex & Thurrock was 44 weeks and for Southend 26 weeks. The data for 2010 has been submitted to the MoJ, but as yet the final statistics have not been produced. Initial analysis of the figures shows that the delay for Essex & Thurrock is expected to have decreased to around 37 weeks and for Southend increased to around 30 weeks.

For Essex & Thurrock, new inquest cases are being dealt with in a significantly shorter timescale – as little as 18 days – but the average for the year remains higher due to the level of backlog cases over 3 years old; these will be completed during 2011 and so future annual average delays will be greatly reduced. For Southend, the increased figure may reflect more accurate data capture.

3 Legal context and duties of the service

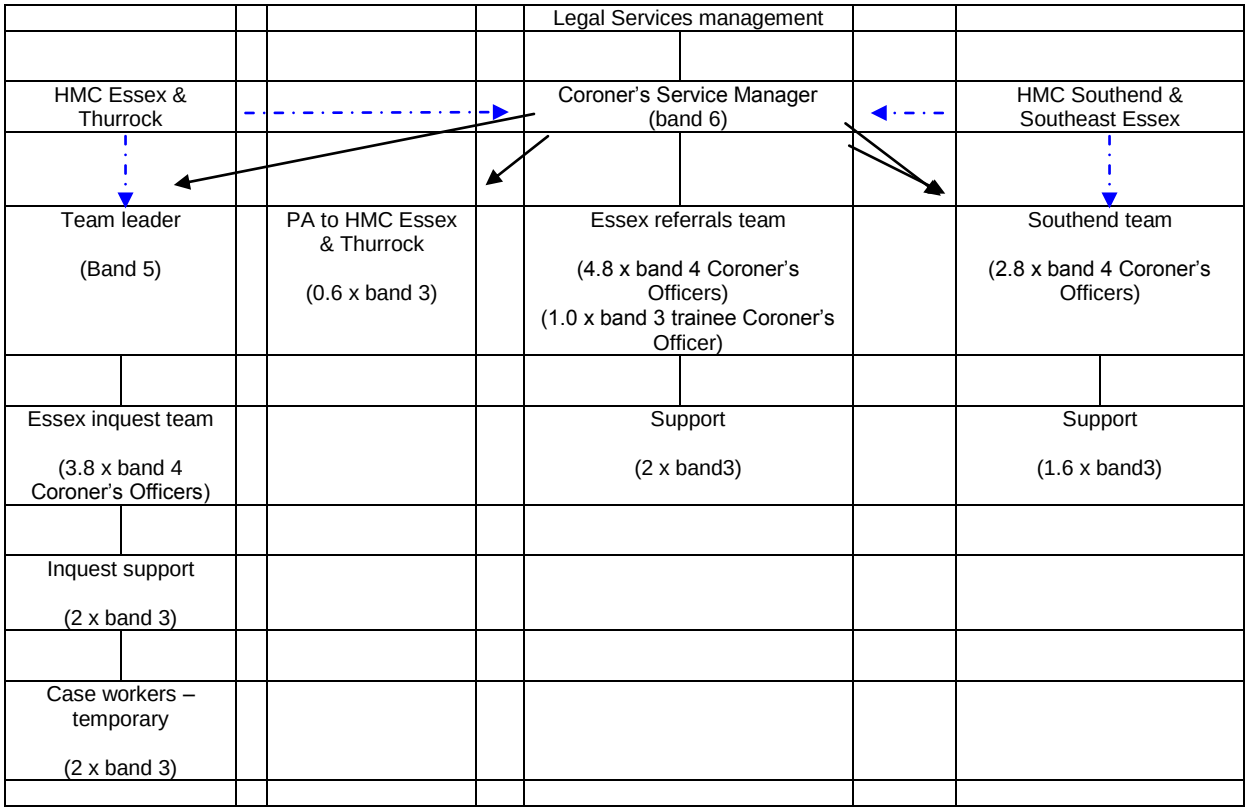
The Coroner's Service is managed and funded by Essex County Council and works to HM Coroners for Essex & Thurrock and Southend & South East Essex respectively. The coroners are independent judicial officers; there is no relationship of accountability between the coroners and the County Council.

The coroners are advised and assisted by Coroner's Officers, who are in the employment of Essex County Council. The service is also supported by a Service Manager and administrative officers.

Prior to its move to New Bridge House, the Coroner's Service had two separate offices located at the police headquarters in Chelmsford and in Hadleigh, Essex; staff and accommodation was provided by the Essex Police Authority. Historically there was some sharing of facilities and the administration of the two jurisdictions merged when responsibility for the Coroner's Service transferred from the Police Authority to Essex County Council in December 2008.

At the time of the transfer there were a number of staff vacancies and disparate working practices between the teams that had been based in Chelmsford and Hadleigh. Additional tensions were created by the transfer date coinciding with the peak death referral season and the "inherited" back log of inquest work for both the Essex & Thurrock and the Southend & South East Essex jurisdictions that was transferred. This backlog amounted to about 550 cases for Essex & Thurrock and 119 for Southend & South East Essex.

4 How the service is organised – staff, structures and responsibilities



Coroner's Service Manager – manage staff and financial resources, produce management information, develop business plans, strategic planning, operational management of referrals, handle complaints / FOI requests.

Team Leader – deputise for Service Manager, operational management of inquests, ensure standards of case preparation for inquests.

Coroner's Officers – conduct investigations on behalf of HM Coroner to establish cause of death and provide evidence for inquests.

Support – call handling for service, receive and log death referrals, prepare relevant forms to allow registration of the death / funeral, incoming / outgoing mail, filing and archiving, making accommodation arrangements for inquests, establishing and managing juries, disclosure.

Case workers – support Coroner's Officer in the preparation of inquest case files, arrange and minute family meeting ahead of inquests.

5 Body storage costs – Essex

Storage costs can be subject to quite significant price increases. Following a 40% increase in charges imposed by the Mid Essex Health Trust in 2009, charges have remained constant in 2010. We are looking at ways to reduce storage costs by using Service Level Agreements with the Health Trusts in Essex and improving working practices to reduce storage time.

6 Body storage costs – comparison with other jurisdictions

This data is of limited value at the time of writing, further work will be undertaken by the Service on this aspect.

7 Impact of new legislation on the service

In the context of the impact of the Shipman Inquiry and the passing of the Coroner and Justice Act on 12th November 2009, there are expected to be significant changes to the coronial system nationally. A national level programme – *Tell Us Once* – aims to transform the way in which citizens inform the government of a major event in their life or change to their circumstances; the basic premise being that a citizen should only have to inform government of that event once.

These changes present a significant challenge in terms of the service's current position, but should be viewed as an opportunity for reform in order to position the service for Essex, Thurrock, Southend and South East Essex as an exemplar for other coroners' services.

The Service is working towards the development of robust, standardised working practices within the service and establishing the partnerships that will be required in the future to take account of the coroner's reform and programmes such as *Tell us once*.

In November 2009, the Coroners & Justice Act 2009 was granted Royal Assent; this further emphasises the need to create a more effective, transparent and responsive coroner's service for bereaved families. It places responsibility for the coroner's service with local authorities and it is essential that productive and progressive working relationships are further developed between HM Coroners (HMC) and local authorities if the service is to accord with the draft charter for the bereaved that accompanies the Act.

In the context of the impact of both the Coroner's and Justice Act and the Shipman Inquiry, there are expected to be significant changes to the coronial system nationally.

Although many elements of the Coroner's and Justice Act may now not be implemented due to the financial cuts being made by all departments in national government, it is expected that coroners will be made more personally accountable for service delivery. Changes to the death registration processes, including the introduction of Medical Examiners, is expected to take place in April 2013. The Essex and Thurrock jurisdiction is piloting the use of medical examiners at Broomfield Hospital.