APPENDIX 1

BIRMINGHAM CITY COUNCIL
REGULATION AND ENFORCEMENT

CORONERS AND MORTUARY SERVICE PLAN 2016/2017

1. Introduction to Coroner's and Mortuary and the Service Plan

1.1 Statutory requirements

The Coroner's and Mortuary Service provide the statutorily required Coroner's service for Birmingham (and Solihull) together with the statutorily required Public Mortuary facilities for the city.

All of our work is required by statute supported by guidance from the Chief Coroner for England and Wales.

The Coroners and Justice Act 2009 places a statutory duty on the city council to appoint and pay a Senior Coroner and where appropriate an Area Coroner together with self employed Assistant Coroners to discharge the functions of the Coroner. The Senior Coroner's statutory duty is to establish the cause of and circumstances of deaths in their area where:

- The deceased died a violent or unnatural death.
- The cause of death is unknown.
- The deceased died in custody or state detention (including those under a Deprivation of Liberty Safeguard (DOLS)).

The Senior Coroner orders Post Mortems, conducts investigations and enquiries into the death which are presented at inquests in the Coroner's Court, authorises bodies to be taken out of England and makes recommendations based on their findings with a view to improving health and wellbeing.

The statutory duties on the city council in relation to the Senior Coroner are to:

- Secure the provision of whatever officers and other staff are needed by the Senior Coroner to carry out the function – it is the Senior Coroner who dictates what these requirements are and the local authority cannot interfere with the judicial role of the Senior Coroner and, therefore, has to provide and pay for what is asked for. In the case of Birmingham this has included the provision of Birmingham City Council staff.
- Provide accommodation that is appropriate to the needs of the Senior Coroner – the Coroner's Courts and offices to accommodate the Senior Coroner, Area Coroner and Assistant Coroners together with BCC staff.
- Maintain the accommodation.
- Pay the expenditure associated with the Senior Coroner and cannot refuse to pay the expenditure incurred by the Senior Coroner.
- Provide proscribed performance information in the form of statutory returns to the Ministry of Justice.

The statutory duties on the city council under the Public Health Act 1936 include:

- The provision of the mortuary for the reception and storage of bodies of people who have died in Birmingham and Solihull where the Senior Coroner orders a Post Mortem.
- Additionally the Human Tissue Act 2004 regulates how these Post Mortems are conducted and the security of the bodies and associated tissues.

1.2 **The services provided for the Senior Coroner by BCC include:**

- Appointment of the Senior Coroner and Area Coroner, including salary/pension and Assistant Coroners who are paid a daily rate.
- Provision, maintenance and management of the Coroner's Court in the city centre (and availability of a second court) together with associated office accommodation, administrative services, IT, etc required by the Senior Coroner and BCC staff.
- Receipt of all deaths notified to the Senior Coroner and their entry onto the CIVICA system for processing.
- Conducting all investigations required to enable the Senior Coroner to perform her legal duties.
- Provision of a front desk to assist all callers to the coroners, in person and by phone.
- Word Processing resources for all staff in preparing files for investigations, opening inquests, all in one inquests and inquests.
- Full secretarial support for the Senior Coroner, Area Coroner and Assistant Coroners.
- Setting of all inquests – ensuring all witnesses are summoned to attend.
- Operating the Coroner's Courts – ushering the inquests and dealing with all correspondence and administration relating to inquests.
- Presenting evidence to the Coroners in inquests.
- Dealing with witnesses and their fees including those of pathologists and expert witnesses.
- Arranging and supporting juries for inquests.
- All administrative support for the Senior Coroner, Area Coroner and Assistant Coroners.
- Liaising with Register Offices, hospitals, lawyers, families, police, emergency services, prisons and the military in relation to coronial matters.
- Dealing with all certification resulting from coronial involvement – death certification and removals out of England.
- Management of all processes.
- Providing statutory information required by the Ministry of Justice on performance.

1.3 **The service provided by the mortuary staff includes:**

- Admitting and properly handling bodies with dignity, respect and traceability.
- Arranging the attendance of pathologists and assisting them in undertaking post mortems.
- Taking blood and tissue samples for analysis and administering their processing through to disposal in accordance with HTA requirements.
- Preparing bodies to facilitate viewings and identifications of the deceased by the bereaved and release to undertakers.
- Providing a 24/7 call out service to accept bodies in liaison with police, ambulance, hospitals etc.
- Securing personal belongings.
- Release of bodies to funeral directors.
- Cleaning of the mortuary and laundry of clothing used.

1.4 **Birmingham and Solihull Coroner's Service**

The Coroner's and Mortuary services are provided by Birmingham City Council for the Birmingham and Solihull Coroner's Area. Solihull Metropolitan Borough, through agreement, is not involved in the management of the system but contributes to the net cost of the service by an annual payment based on the relative population of the Borough – currently Solihull MBC pays 16.2% of the net cost of the services provided. All figures in this Service Plan include deaths in Birmingham and Solihull.

1.5 **Service Plan**

This Service Plan details the work undertaken by the service, both in terms of quantity and quality, how this contributes to, and supports, the high level intended outcomes of the City; customer feedback; intended improvements; financial, people, IT and accommodation resources; and details what service will be provided

1.6 **Planned Service Improvements in 2016/2017 and beyond**

- To make effective and economic use of the newly installed WiFi system in the Coroners Court to decrease the need for witnesses from great distances to attend court and to enable use of electronic media in court.
- To ensure efficient and effective systems are in place to manage the expected increase in numbers of inquests caused through DOLs.
- To respond to any increase in demand for the use of non-invasive post mortem services for the bereaved where appropriate.
- To make increasingly effective use of the service's new IT case management system, CIVICA, to reduce the need for paper and to produce lean processes.

1.7 Current Organisational Assessment

Significant changes occurred in 2015 with the appointment of a full time Area Coroner to assist the Senior Coroner.

In July 2015 West Midlands Police transferred their responsibilities in relation to the Coronial Service to BCC together with five staff under a TUPE transfer.

In October 2015 a new case management system was introduced to the service - CIVICA

The service clearly and directly supports the **City's Community Strategic Outcomes –**

- **Stay safe** - the investigation of deaths notified to the Senior Coroner, whilst not a criminal investigation, is intended to thoroughly scrutinise the circumstances of a death to ensure that crime does not go undetected – a fundamental requirement to staying safe.
- **Be healthy** – the causes of death recorded by the Coroner are used by government to prioritise where health spending is directed to reduce early deaths. Additionally the Coroner makes statutory recommendations to improve the health of society by identifying issues that have arisen in relation to deaths which if addressed will lead to a healthier, safer city. The work undertaken in the mortuary ensures that the public health risks from bodies are effectively managed.

The service also directly supports the **Council Business Plan 2015+ Priorities** of 'A Fair City' where people are safe and where older people are cared for with dignity. The work of the Coroners directly impacts on this as their investigations ensure that people are kept safe – they make recommendations to prevent instances that have led to preventable death from recurring. The Coroner's service is also in place to uncover crimes, in the last 12 months cases of identity fraud have been identified through the coronial processes and are currently under police investigation. The results of Inquests on occasions provide the ability for the bereaved to take action against negligent care or practices that contributed to a death.

Recommendations made by the Coroners are intended to reduce the risk of life shortening events and their work ensures that where vulnerable people are able to remain in the community they are safeguarded. The new requirements around DOLs provided further protection for the vulnerable as any deaths under DOLs are now subject to an inquest.

1.8 Quantity of work

The following tables indicate the workload of the service:

1.9 Number of deaths notified to the Coroner

Year	Number of deaths notified to the Coroner	Year on Year increase	Increase on 2010 baseline
2010	4,680	-	-
2011	5,112	9.2%	9.2%
2012	5,603	9.6%	19.7%
2013	5,395	- 3.7%	15.3%
2014	4,284	-20.6%	- 8.5%
2015	4,805	12.2%	2.7%

The number of deaths notified to the Coroner had shown a steep increase from 2010 until mid 2013, not reflecting any increase in death rate but increased demands from the Coroner for deaths to be notified. Toward the end of 2013 with the appointment of the new Senior Coroner this trend was reversed and this trend continued through 2014. 2015 saw a 12.2% increase in notified deaths. The figure of 4,805 represents 40.9% of all deaths registered in Birmingham and Solihull – in line with national figures.

1.10 Number of inquests completed

Year	Number of inquests
2010	1,082
2011	1,195
2012	1,191
2013	1,113
2014	1,135
2015	601

This shows that the level of inquests has fallen remarkably since 2014, a fall of 47%. This is due to the approach taken by the Senior Coroner in deciding which reported deaths require to be inquested. The figures for 2014 under the Senior Coroner were high because she had to deal with the backlog of cases that had built up in previous years. There was an expectation that the number of inquests would be significantly increased by Deprivation of Liberty Safeguard (DOLS) cases but to date this increase has been relatively small (66 cases in 2015) although the potential for a very significant increase remains.

Great improvement shave been made in the speed with which inquests are held – in 2013 only 46% were completed within 6 months of death, due to dealing with the backlog the figure fell to 43% in 2014 but in 2015 93% of inquests were completed within the target 6 months. This figure was even higher for deaths notified in 2015 – it was brought down by a few long standing inquests remaining from the backlog.

Similar improvements were made in relation to the number of inquests that were over 12 months old, this fell from 57% in 2014 (due to the backlog) to 2% in 2015 and these were the tail end of the backlog, all new deaths in 2015 were or will be completed within 12 months of death.

1.11 The number of Post Mortems carried out

Year	Number of Post Mortems	% of PMs with toxicology	% of PMs with histology
2010	1,870	20.3	13.4
2011	1,700	22.5	16.7
2012	1,609	25.0	18.4
2013	1,622	27.3	16.4
2014	1,562	19.2	12.9
2015	1,702*	16.0	10.5

*This is the number of PMs carried out at the central mortuary – additional Forensic PMS are carried out elsewhere for the coroner

The number of Post Mortems being carried out fell from 2010 until 2014 but increased by 9% in 2015 reflecting the increase in the number of deaths referred to the service. The numbers of post mortems continued to fall through 2015. In addition 3 minimally invasive CTPMs were carried out on the order of the Coroner.

1.12 The number of Out of England Forms

Year	Number of Out of England Forms Issued
2010	159
2011	259
2012	220
2013	151
2014	141
2015	176

1.13 Percentage of notified deaths resulting in inquest

Year	% resulting in inquest	National average%
2010	23	13
2011	24	14
2012	21	14
2013	21	13
2014	14	Not known
2015	12	Not known

1.14 **The aims for 2016/2017 and subsequent years are**:

- To maintain the death notification rate close to the national average- that would represent about 4,700 notifications annually. This figure will inevitably rise with the new requirement to refer all deaths where the deceased was subject of a DOLS to the Senior Coroner - it is not yet clear what number this is likely to be as the DOLs system is new and not yet fully implemented but based on information from the Health and Social Care Information Centre the number of referrals will rise somewhere between 500 and 750 a year.
- To maintain the % of notified deaths that result in inquest close to the national average currently that would represent about 600 – 650 inquests per annum. However, it is appreciated that there will be an additional number of inquests resulting from DOLS the figures above suggest the increase will be between 500 and 750 per year if the DOLS system is fully operational. This figure is a best guess and will be reviewed on a regular basis
- To ensure that at least 95% of inquests are held within six months of death.
- To maintain levels of customer satisfaction at current levels and to introduce new questionnaires for deaths that result in the issue of an A or B Form.

1.15 **Key Performance Indicators**

National Indicators – these are figures required to be submitted by each Coroner Area to the Ministry of Justice – they cover a calendar year.

Indicator	**Year**	**Birmingham and Solihull**	**National figure**
% of all deaths notified to Coroner	2011	46.9	45.9
	2012	49.8	45.6
	2013	46.6	45
	2014	36.6	45
	2015	40.9	
% of notified deaths that result in inquest	2011	24	14
	2012	21	14
	2013	21	13
	2014	14	12
	2015	12.5	
% of notified deaths that are subject to PM	2011	39	42
	2012	34	42
	2013	30	41
	2014	36	40
	2015	37	
% of PMs with toxicology	2011	22.5	13
	2012	25.0	13
	2013	27.3	14
	2014	19.2	15

	2015	16	
% of PMs with histology	2011	16.7	19
	2012	18.4	20
	2013	16.4	20
	2014	12.9	21
	2015	10.5	
% of inquests completed within 6 months of death	2011	54	63
	2012	57	65
	2013	46	Not known
	2014	43	Not known
	2015	93	
% of inquests over 12 months from date of death	2011	15	10
	2012	18	10
	2013	31	Not known
	2014	57.1	Not known
	2015	3	
% of bodies released to families within 5 days of notification (where no inquest required)	2011	95.8	Non available
	2012	96.8	Non available
	2013	96.3	Non available
	2014	90.7	
	2015	89.7	

1.16 **Benchmarking**

The figures tabulated above provide benchmarking information against national KPIs set by the Ministry of Justice.

In addition there are local indicators that we see as KPIs – in 2013 we introduced a questionnaire for families attending Inquests to establish their satisfaction with the services provided – results tabulated below.

1.17 **Tabulated results for Customer Satisfaction with Inquests**

Question	**% positive**		
Pre Inquest	**2013**	**2014**	**2015**
Were the reception staff polite and courteous at all times?	98	100	96
Were the Coroner's Officer/Investigators polite and courteous at all times?	100	100	97
How satisfied were you with the speed of initial contact from the Coroner's Officer/Investigator?	93	90	97
Were you dealt with sensitively at all times by all staff with whom you had contact?	91	100	99

How satisfied were you with the timescale in investigating the case and getting it to inquest?	66	93	94
How satisfied were you with the information that you received before the inquest and the arranging of the date of the inquest date and time?	93	98	90
At inquest			
How satisfied were you that the inquest tried to be fair to everyone who was involved?	98	100	94
Were you dealt with sensitively at all times?	94	97	97
Do you feel that the inquest provided a robust and fair presentation of the matters surrounding the death?	92	97	98
How satisfied were you with the outcome of the inquest?	91	100	95
Did the inquest process overall help you in dealing with the death of your loved one?	68	71	72

1.18 **Customer Research and Feedback**

Customer Knowledge:
The service provided by Birmingham City Council since 1837 has continually changed to reflect and meet the changing expectations and requirements of legislation and most importantly the customers. The main requirement of customers in 2016 onwards is to have an efficient, effective and economic service that provides closure for the bereaved in a timely manner whilst meeting the legal requirements placed on the Senior Coroner. This is common across all groups in the city and the service provision reflects this with service provision that is the same for all customers regardless of their cultural, ethnic or religious background but provided in cognisance of the particular expectation from some communities that the dead should be buried or cremated as soon after death as is possible. Our services ensure that this need is met for all customers and 90% of all bodies are released by the Coroner for burial or cremation within 5 days of the death being referred to the Coroner where there is no inquest required.

Customer Questionnaires :
Very high levels of satisfaction in relation to the people, processes, court facilities and inquest process.

Chief Coroner :
The changes to Coronial legislation that were introduced in July 2013 and guidance issued by the Chief Coroner were designed to address feedback from across the country that inquests were taking too long to be heard after death. This was reflected in the changes to legislation and guidance that inquests should be heard within 6 months of death and any over 12 months

old must be reported to the Chief Coroner with a causal explanation. The Chief Coroner's guidance that all DOLS deaths must be inquested will be followed.

1.19 Likely Future Developments

- The requirement for all DOLS deaths to be notified to the Senior Coroner and to be inquested will have a very significant impact on workload, especially in relation to the number of inquests required to be undertaken - a rise from 600 to between 1,100 and 1,350 appears quite possible – the figure will be monitored closely. This depends upon the performance of Birmingham City Council and Solihull MBCs in processing DOLS applications – currently they have been very significant backlogs which has lessened the expected impact on the service. The DOLS issue is to be reviewed by legislators to decide if it should remain in its current format with the Coroner's services
- The Chief Coroner is expected to continue to publish guidance documents for Coroners that they are obliged to follow – in his attempt to 'standardise' coronial services he may introduce requirements that will impact on the service, just as he did with the 6 month time limit for inquests.
- It is expected that there will be an increase in the number of requests for the use of CTPM digital minimally-invasive post mortem techniques for Coronial PMs. To date the demand from the bereaved has been very small but the service has processes in place to deal with any requests received.
- The proposal to introduce Medical Examiners is still ongoing and if implemented will impact on the Coroner's service, especially in relation to the ability of the Senior Coroner to control which deaths are notified to her. It is not expected that the introduction will be in 2016 but more details may emerge of its potential impact on workloads and procedures, IT issues and associated costs.
- We will look for opportunities to earn income from the public mortuary – new legislation allows bodies to be transferred across authorities for Post Mortems to be conducted. We will establish potential interest for other authorities and undertake a business case for taking on such work.

1.20 Financial and People Resources

The Coroners and Mortuary Service had a net budget of £1.451m in 2013/2014. This is to reduce to £0.93 in 2016/2017. This represents a reduction of 44% in the last five years.

Year	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Net Budget £m	**1.662**	**1.451**	**1.261**	**1.025**	**0.93**	**0.93**

The service is provided by the Senior Coroner together with an Area Coroner who are both salaried and Assistant Coroners who provide cover in the absence of the Senior and Area Coroners and are paid a daily rate.

The Senior Coroners and her Assistants are supported by 4 Coroner's Investigators, 3 Coroner's Support Officers and 6 Administrative Officers. There are 4 Mortuary Technicians who provide the Public Mortuary Service to the Senior Coroner and the citizens of Birmingham and Solihull.

1.21 IT Resources

The main operating system within the Coroners and Mortuary Service is 'CIVICA' which is a relatively new system which provides benefits over the previous bespoke system.

1.22 Partners

The Coroners and Mortuary Service is delivered by the City Council with the West Midlands Police paying the salaries of 6 staff, Coroners Investigators and Coroners Officers who undertake investigations on behalf of the Coroner.

1.23 **Service Delivery**

Service Objective 1 **To provide a full support service to the Coroner to enable the Coroner to deliver her statutory role**			**Mission Statement** – 'Locally accountable and responsive, fair regulation for all – achieving a safe, healthy, clean, green and fair trading city for residents, businesses and visitors.'	
Council Plan Strategic Outcomes • A Fair City			**Lead Officer** Operations Manager Coroners and Mortuary	
Task	**Outcome**	**Measure**	**Target**	**Method**
• To enter all notified deaths onto the CIVICA system on day of receipt	• To protect the health and well-being of citizens	• % of notifications entered on day of receipt • Customer satisfaction with timeliness of service*	• 100% • 80% of customers to be satisfied with speed of service	• Flexibility of staff to ensure this is achieved • Customer satisfaction surveys.
• To provide the support required by the Senior Coroner to ensure that inquests are held in a	• To protect the health and well-being of citizens	• % of inquests held within 6 months of death • % of deaths inquested	• 95% of those deaths notified in 2016 • 100% of deaths	• Processes in place to ensure sufficient court availability , expedient communications with witnesses and flexibility of staff to prioritise inquests • Appropriate IT operating systems

timely manner		within 12 months of death	notified in 2016 (not S11)	
• To provide support to enable the Senior Coroner to achieve KPIs in line with national averages	• To protect the health and well-being of citizens	• % of deaths notified • % of deaths inquested • % of deaths resulting in PM	• Within 10% points of national averages	• Processes and communications to ensure the requirements of the Coroner are met by staff and witnesses
• To provide all statutory returns to the Ministry of Justice as required	• To protect the health and well-being of citizens	• Timely return of statistics	• On time	• PDR objective

Service Objective 2 **To provide a full Public Mortuary service to the Coroner to enable the Coroner to deliver her statutory role**			**Mission Statement** – 'Locally accountable and responsive, fair regulation for all – achieving a safe, healthy, clean, green and fair trading city for residents, businesses and visitors.'	
Council Plan Strategic Outcomes • A Fair City			**Lead Officer** Operations Manager Coroners and Mortuary	
Task	**Outcome**	**Measure**	**Target**	**Method**
• To undertake all Senior Coroner ordered PMs as instructed by the Senior Coroner	• To protect the health and well-being of citizens	• Number of PMs completed within a timescale to ensure 90% of bodies released within 5 days of notification	• All carried out within 5 days of order from Senior Coroner	• Procedures
• To retain Human Tissue Authority Accreditation for PMs	• To protect the health and well-being of citizens	• Retention and implementation of Quality procedures	• Retention	• Procedures