APPENDIX 1

BIRMINGHAM CITY COUNCIL
REGULATION AND ENFORCEMENT

CORONERS AND MORTUARY SERVICE PLAN 2017/2018

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 2017/2018 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 respond to an expected increase in demand for the use of non-invasive post mortem services for the bereaved where appropriate. The expected increase is based on the expectation that angiography in CTPMS will be available enabling the more common causes of death to be identified through the CTPM process
- 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. It is hoped that a portal system will be introduced during 2017 enabling hospitals and Doctors to enter death

notifications directly onto the Civica system reducing the need for double entry.

- Undertake feasibility studies on setting up a Birmingham based CTPM facility within a multi-disciplinary setting and secondly of establishing a new medico legal centre in the city which would house two Coroner's Courts, all the required staff, a new public mortuary with CTPM facilities
- To improve the provision of the weekend and bank holiday Out of England Service for bereaved people who want to repatriate bodies rapidly.
- To provide a second court to ensure that the increasing number of inquests (and increasing number of long jury inquests) can be accommodated within the 6 month target for completion.

1.7 Current Organisational Assessment

2016 was a year of consolidation for the Senior Coroner and her Area Coroner together with Assistant Coroners. It was the first full year of the Civica IT system which led to significant process improvements in the service. An additional three staff were provided through funding agreed by the council to address the increasing demands on the service. There was a steady reduction through the year in the time taken to release bodies for families where no inquest was required.

The service directly supports the **Council's Financial Plan 2017 priority** of 'Health – so Birmingham's a great city to grow old in' The work of the Coroners directly impacts on this as their investigations ensure that people are kept safe and healthy– they make recommendations to prevent instances that have led to preventable death from recurring. The Coroner's service also directly supports criminal investigations undertaken by the police. 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 2014 baseline
2014	4,284	-	-
2015	4,805	12.2%	12.2%
2016	5,080	5.7%	18.6%

The number of deaths notified to the Coroner had shown a sharp increase in the last two years, a trend which has continued into 2017. The figure of 5,080 notified deaths represents 43.9% of all deaths registered in Birmingham and Solihull – in line with national figures. The increase is far greater than any increase in the death rate – indicating an increasing percentage of deaths are being notified to the service.

1.10 Number of inquests completed

Year	Number of inquests
2014	1,135
2015	601
2016	746

The very high number of inquests completed in 2014 under the Senior Coroner was due to dealing with the backlog of cases that had built up in previous years. The 2015 figure represented a closer fit to expectation and the increase to 2016 resulted from the increased number and complexity of referral to the service. There was an increase in the number of DOLs cases, all of which required inquests from 66 in 2015 to 92 in 2016 and there have been further increases in 2017

There have been very significant improvements in the time that the bereaved have had to wait for inquests to be held. In 2013 only 46% of inquests 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 a figure equalled in 2016.

Similar improvements were made in relation to the number of inquests that were completed more than 12 months from the death, this fell from 57% in 2014 (due to the backlog) to 3% in 2015 and only 1% in 2016.

1.11 **The number of Post Mortems carried out**

Year	Number of Post Mortems	% of PMs with toxicology	% of PMs with histology
2014	1,562	19.2	12.9
2015	1,702	16.0	10.5
2016	1,542	20.3	14.4

The number of Post Mortems being carried out reduced in 2016 despite the increase in deaths reported. The percentage of reported deaths resulting in post mortem reduced from 37 to 30% reflecting the desire of the Senior Coroner to conduct Post Mortems where no other avenue is available to establish the cause of death. This figure is well below the national average which was 38% in 2015. In addition 3 minimally invasive CTPMs were carried out on the order of the Coroner, reflecting the low level of demand for this service from the bereaved.

1.12 **The number of Out of England Forms**

Year	Number of Out of England Forms Issued
2014	141
2015	176
2016	227

1.13 **Percentage of notified deaths resulting in inquest**

Year	% resulting in inquest	National average%
2014	14	14
2015	12	14
2016	15	

1.14 **The aims for 2017/2018 and subsequent years are**:

- To ensure that at least 95% of inquests are held within six months of death.
- To maintain levels of customer satisfaction at current levels.
- To maintain the improvements made in 2016 in relation to the average time taken to release the deceased to their families in respect of A and B form deaths (2.2 days for As and 4 days for Bs)

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	2014	36.6	45
	2015	40.9	45
	2016	43.9	
% of notified deaths that result in inquest	2014	14	14
	2015	12.5	14
	2016	15	
% of notified deaths that are subject to PM	2014	36	40
	2015	35	38
	2016	30.4	
% of PMs with toxicology	2014	19.2	15
	2015	16	Not known
	2016	20.3	
% of PMs with histology	2014	12.9	21
	2015	10.5	Not known
	2016	14.4	
% of inquests completed within 6 months of death	2014	43	
	2015	93	
	2016	93	
% of inquests over 12 months from date of death	2014	57.1	Not known
	2015	3	
	2016	1	
% of bodies released to families within 5 days of notification (where no inquest required)	2014	90.7	
	2015	89.7	
	2016	90.7	

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	**2014**	**2015**	**2016**
Were the reception staff polite and courteous at all times?	100	96	100
Were the Coroner's Officer/Investigators polite and courteous at all times?	100	97	100
How satisfied were you with the speed of initial contact from the Coroner's Officer/Investigator?	90	97	93
Were you dealt with sensitively at all times by all staff with whom you had contact?	100	99	93
How satisfied were you with the timescale in investigating the case and getting it to inquest?	93	94	93
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?	98	90	87
At inquest			
How satisfied were you that the inquest tried to be fair to everyone who was involved?	100	94	100
Were you dealt with sensitively at all times?	97	97	93
Do you feel that the inquest provided a robust and fair presentation of the matters surrounding the death?	97	98	100
How satisfied were you with the outcome of the inquest?	100	95	100

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 2017 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. The average time to release a body to the family for an A form is 2.2 days (ranging from 1.6 – 3.3 days dependent on the month) and for a B form is 4 days (ranging from 2.9 – 4.8 days)

The service is advised by community leaders that there is a clear demand for non – invasive post mortems to be carried out and this service has been provided for families, at their expense, since 2015. However this expected demand has not yet materialised in requests for the service. With the increased availability of angiography in combination with CTPMs it is expected that this demand will increase.

Customer Questionnaires :
Very high levels of satisfaction are achieved 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 until legislation is changed.

1.19 **Likely Future Developments**

- It is expected that a legislative change will be introduced, although still requiring all DOLS deaths to be notified to the Coroner, only those that are unnatural deaths will require an inquest. This will not impact on the number of deaths notified but should reduce the number of inquests required to be heard. However the number of DOLS referrals will depend on the efficiency of the local authorities in the administration of DOLS.
- 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. This increase is likely to come from the potential increase in the availability of CTPMs with angiography which will increase the number of deaths that are suitable for such CTPMs.
- 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. There has been a consultation on the national ME scheme which was expected to publish its findings in late 2016, however there has been no such report. The latest date for the introduction of the scheme is October 2018.
- It is expected that the inquests into the 21 deaths in the Birmingham Pub Bombings of 1974 will be held in 2017 – this will not impact on the ongoing work of the Coroner's service as it is being managed by a Coroner who is working outside the service.

1.20 Financial and People Resources

The Coroners and Mortuary Service net expenditure and budget allocation is tabulated for each year below. The figure for 16/17 is a forecast and the figure for 17/18 is the available budget for the service.

Year	**2014/15**	**2015/16**	**2016/17**	**2017/18**
£m	**1.262 actual** **1.261 budget**	**1.227 actual** **0.955 budget**	**1.486 actual** **1.145 budget**	 **1.196 budget**

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 6 Coroner's Investigators, 3 Coroner's Support Officers and 7 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 • Health			**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 release the deceased to families expeditiously having regard for the judicial	• To protect the health and well-being of citizens	• Monthly average times for release of the deceased	• To improve on the figures for 2016 (based on an equal number of	• Triaging of cases and management of staff. Civica report.

function of the service			incoming deaths)	
• To provide the support required by the Senior Coroner to ensure that inquests are held in a timely manner	• To protect the health and well-being of citizens	• % of inquests held within 6 months of death • % of deaths inquested within 12 months of death	• 95% of those deaths notified in 2017 • 100% of deaths notified in 2017 (not S11)	• Processes in place to ensure sufficient court availability , expedient communications with witnesses and flexibility of staff to prioritise inquests • Appropriate IT operating systems
• 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 • Health			**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