Lincolnshire COUNTY COUNCIL
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Regulatory and Other Commmittee

Open Report on behalf of Dr Tony Hill, Executive Director of Public Health and Community Wellbeing

Report to:	**Audit Committee**
Date:	**25 January 2016**
Subject:	**Audit of Coroners Service – Update on Progress**

Summary:

This report provides an update on the actions arising from the Corporate Audit of the Coroners Service undertaken in Spring 2014. This report is provided for information purposes and to up date on progress and the direction of travel.

Actions Required:

Prepared for information and comments would be welcomed.

1. Background

1. The County Services Manager (CSM) for Registration and Celebratory Services and the Coroners Service has raised a number of significant concerns regarding the efficiency and effectiveness of the Coroners Service in Lincolnshire for some time. To provide external verification of the service a number of reviews have been commissioned or have been received, including the Corporate Audit published in June 2014.

2. The Corporate Audit highlighted issues around financial management, Coroners' workloads, compliance with financial procedures, budgeting and a lack of consistency in working practices.

3. This report aims to provide a summary of the progress following the audits and other reviews which have been undertaken on the Service.

4. The Chief Coroner for England and Wales recognises the challenges encountered by all agencies arising from the 'triangle of responsibility'. The Coroner as an independent judicial officer; the Police Authority who often employs the Coroners Officers or are the initial point of contact for sudden death; and the Local Authority who funds the service and yet has no line management control over the Coroner or, in Lincolnshire, the Coroners Officers.

5. The financial elements have or are largely being addressed, although there are still some challenges for those elements outwith the control of the CSM. Changes to staffing, structure and the introduction of Agresso have all proved to be extremely helpful in providing a consistent framework for the raising of purchase/requisition orders. However, the Agresso budget monitoring elements are still in development corporately. Monthly budget monitoring is completed with support from a financial officer and budget projections are now based on better analysis, invoice reconciliation and improved contract monitoring.

6. The uncertainty around the financial liability for long inquest payments continues and the development of a mechanism for 'validating' long inquest payments as requested in the original audit remains a challenge. Advice has been received from the Chief Coroner on this aspect and numerous requests have been made of the Senior Coroner to ensure timely and accurate updates on the financial impacts of these inquests. In addition, alternative structures were explored via consultation with the Coroners in Spring 2015. This remains work in progress and therefore the financial risk associated with the long inquests continues.

7. Structure – The original Audit Report suggested looking at the viability of merging coronial areas. Options for the provision of increased support to the Coroners (which could be via the use of additional Assistant Coroner support; the employment of a full or part time Area Coroner to cover both coronial areas; a move to a single coronial area (the Chief Coroner's preferred option) or maintain the status quo) was consulted on with the Coroners and Assistant Coroners in June and July 2015. The aim of the options paper was to identify a way forward which would have provided the additional support both Coroners needed to reduce their working hours and to better manage the financial risk of long inquest payments which are difficult to budget for. These options are being reconsidered as part of the current corporate budget review procedures and a paper will be taken to the Informal Executive in February 2016 for consideration. The need to review the current configuration has taken on more urgency due to the pending resignation of the South Lincolnshire Senior Coroner.

8. Standardisation – The Audit Report raised issues around consistency, working practices and the clarification of roles and responsibilities. This is being addressed as part of the actions arising from this Corporate Audit and an external 'Peer Review' of the Coroners Officers, which was commissioned by the CSM in February 2015. It also links into a report on suicides completed by the Child Death Overview Panel.

9. An e-referral system has been developed, which provides a standardised mechanism for reporting a death to the Coroner. It is a comprehensive on-line system which is providing Coroners Officers with information in a more timely manner and in many cases, the quality of the information received at this first point of contact is vastly improved. This is unique in England and Wales and has been positively received by health care professionals and is evidence of national best practice being initiated by Lincolnshire staff.

10. Policies and Processes – There is now a clear process for developing and reviewing policy documents for the service, supported by a comprehensive induction guide. Policies also include payments to Assistant Coroners. A standardised process for Juror and Witness expenses was introduced in 2014 and continues to be reviewed. This provides improved information to individuals and a clear framework for processing and auditing claims for expenses.

11. Governance – This element continues to be work in progress. To support the governance of the service, quarterly meetings are held with the two Coroners. There is a standard agenda, with budgets and support agenda items. Regular meetings are held with the Coroners Officers and police colleagues and the council continues to benefit from the support of Assistant Director, Mark Housley, as strategic lead for the Coroners Officers and resulting communications within the senior leadership group of Lincolnshire Police.

12. Case Management – Whilst significant strides have been made to try and introduce a case management system this is still in development as different approaches are made and revised to meet the individual requirements of the Coroners. In addition, a standardised file structure has been suggested to Business Support colleagues, however has not yet been fully adopted. Additional resources have been allocated to support these developments.

13. Customer Satisfaction – In 2014 a specific questionnaire was sent to families who had experienced a death to follow their bereavement journey. This included the initial contact with the Coroners Officers, the service provided by the contracted funeral director, and then by the Registration Office. This has been supplemented by a question in the annual survey (2014/2015) by the Registration Service. The results are summarised below:

Q16 If registering a death, and the Coroner was involved, how would you rate the Coroners service overall?

Number of Responses	Excellent	Very Good	Satisfactory	Poor	Very Poor
45	49%	27%	22%	2%	0

98% rated the Coroners Service overall as 'satisfactory' or better. This is an increase compared with the 2014 survey when 92% rated the Coroners Service overall as 'satisfactory' or better.

14. Complaints – All complaints are investigated thoroughly and entered onto the corporate complaints system. Lessons learned are introduced where relevant, and training opportunities provided if required.

15. Operational Support – The operational support to the Coroners has developed, however continues to require further discussion and consideration in relation to clarity on roles and responsibilities. Business Support took responsibility for the administrative staff early in 2014. Developments for early in 2016 include the transfer of line management for the Coroners Officers to Lincolnshire County Council. This will provide a further opportunity to streamline communications, processes and work allocation. In addition, we hope to utilise the support of volunteers through the Coroners Court Support Service (CCSS) which aims to provide pastoral support to help bereaved families on the day of an inquest. Additional duties for the CCSS may include support to the Coroner through the use of recording equipment and the reading of witness statements.

16. Contracts – There are currently two formal contracts in place. The contract for Mortuary and Post Mortems was retendered in 2015, with the new arrangements in place wef 01 September 2015. This was fully supported by Procurement Lincolnshire and the contract is progressing well. The Coroners Body Removal Contract also operates smoothly. There are regular quarterly contract meetings and we have had the opportunity to work closely with these external colleagues on new developments such as Deprivation of Liberty Safeguarding, Winter Planning and Infection Prevention and Control. A Toxicology Contract is progressing well and should provide a regional framework in 2016-17 and beyond.

17. Risk Management – There is a service risk register and business continuity plan which is reviewed regularly. There is active engagement with the Emergency Planning Team in relation to Excess Deaths and Temporary Mortuary planning. Project risk registers are developed on initiation of a new project/contract and reviewed regularly.

18. Future Planning – There is a Service Plan for Registration, Celebratory and Coroners Services, which is published on the council's website. In

addition, there is a strategy document and supporting action plan which provide a focus for key project areas.

19. In a recent corporate audit assurance review, comments on the Coroners Service were:

'The Coroners Service has continued to respond to new guidance from the national Chief Coroner. The demands on the service especially in relation to Deprivation of Liberty Safeguarding Authorisations have remained high, particularly noticeable due to a higher death rate in 2015. The Service Improvement Plan following a comprehensive internal audit of the Coroners Service continues with a number of recommendations firmly embedded in the service. A further 'Peer Review' was completed in Spring 2015, which has been helpful in providing feedback on service delivery and opportunities for further developments. The service continues to look at ways to improve, which will result in enhanced support to bereaved families, the Coroner, and the remit to continue to improve efficiency and timeliness of Coroners' caseloads. In addition, budget monitoring is fully established to review expenditure and aid budget projections.'

2. Conclusion

The past two years have seen significant work completed to reduce the risks within the Coroners Service. However, complications of the existing structure, interpretation of judicial independence of the Coroner, and multiple lines of accountability and communication mean some developments are taking longer to develop and embed. Standardisation and consistency are key themes of the Chief Coroner and there will continue to be new opportunities to both work on existing work streams but also to develop new improvements.

The CSM and senior managers remain committed to improving the service to bereaved families in Lincolnshire; however this cannot be completed in isolation of the Coroners. The support of Councillors with these initiatives is greatly appreciated.

3. Consultation

a) Policy Proofing Actions Required

n/a

4. Background Papers

The following background papers as defined in the Local Government Act 1972 were relied upon in the writing of this report.

Document title	Where the document can be viewed
Corporate Audit Report dated 24 June 2014	Please contact Donna Sharp on 01522 554052 or at donna.sharp@lincolnshire.gov.uk
Audit Committe Report dated 22 September 2014	Please contact Donna Sharp on 01522 554052 or at donna.sharp@lincolnshire.gov.uk

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