CORPORATE RESOURCES OVERVIEW AND SCRUTINY COMMITTEE

Date of Meeting	Thursday 15th December 2022
Report Subject	Work of the Coroner's Office
Cabinet Member	Cabinet Member for Governance and Corporate Services including Health and Safety and Human Resources
Report Author	Chief Officer (Governance)

EXECUTIVE SUMMARY

The position of coroner dates back to at least the 12th century. Its role is to hold inquests into the cause and manner of certain deaths within an area. Coroners are judicial office holders appointed locally subject to national scrutiny. Policy and coronial law are controlled by the Ministry of Justice but operational and financial responsibility sit with the local authority.

The role of the coroner is to establish the identity of a deceased person and the time, manner and cause of their death. They have investigatory powers including the powers to summon witnesses, and hold special court hearings call inquests.

The coroner's district of North East Wales covers the areas of Conwy, Denbighshire, and Flintshire and Wrexham Councils. The coroner, John Gittins, and his office are hosted by Denbighshire County Council on behalf of the other three Councils. We contribute to the cost of the office on a per capita basis.

The coroner will give a presentation to the Committee on his work on behalf of the four Councils.

RECOMMENDATIONS	
1	That the Committee thanks the Coroner for his work and receives further reports on an annual basis.

REPORT DETAILS

1.00	EXPLAINING THE ROLE OF CORONER
1.01	The office of coroner is one of the oldest judicial appointments in England and Wales dating back to at least the 12th century and possibly the 11th century (to just after the Norman Conquest in 1066). The role has evolved over the intervening 800+ years but its core function is still to identify the cause and manner of certain deaths within its coronial area (called a "coroner's district").
1.02	The office of coroner fulfils an important societal function in establishing the cause of death and can lead to recommendations on how to prevent other deaths occurring in the future. At a personal level, it is also an important service for families and friends who want to understand the loss of a loved one.
1.03	Responsibility for coroners is split between national and local government. The Ministry of Justice sets coronial law and policy, including, deciding on the size and extent of coroners' districts. Recruitment is a local function subject to scrutiny and approval of the selected candidate at a national level. Operational and financial responsibility sits with the local authority. The coroner also receives support from the Police.
1.04	The North East Wales coroner's district covers the four Councils of Conwy, Denbighshire, Flintshire and Wrexham. The Councils share the costs of the office on a per capita basis. Denbighshire County Council hosts the coroner on behalf of the other three Councils, and employs a small office to provide administration etc. It has recently constructed a coroner's court within the Shire Hall buildings at Ruthin. This suite of rooms contains modern facilities for bereaved families and witnesses attending inquests.
1.05	The majority of deaths are not investigated by the coroner. The coroner will not investigate where the deceased has been under medical care or has been seen by a doctor within 28 days of death. However, if the deceased died without being seen by a doctor, or if the doctor is unwilling to make a determination, the coroner will investigate the cause and manner of death. The coroner will also investigate when a death is deemed violent or unnatural, where the cause is unknown, where a death is the result of poisoning or industrial injury, or if it occurred in police custody or prison.
1.06	The coroner holds hearings called inquests which receive evidence on the identity of the deceased (if not known), the time, manner and cause of death. The coroner has power to summons witnesses and to direct that investigations such as a physical post mortem or toxicology report are carried out. The coroner is assisted in these enquiries by the Police and his office.
1.07	A coroner's investigation is different from a criminal investigation. If a coroner investigates, it does not mean there is suspicion of a criminal act or of any wrong doing. The coroner's findings may be critical of what

	happened but the coroner cannot blame individuals or organisations or find them responsible for the death. That will be for the criminal or civil courts. The coroner can also write a report to help prevent future deaths. They will send this report to the organisations involved in the death for them to take action on the recommendations.
1.08	There is published guidance on the role of the coroner and the process of investigating a death (here). There are expected standards of performance for coroners (e.g. how long it takes to conclude an inquest). Accountability for those standards is to the Ministry of Justice.
1.09	The coroner works with the local authorities within his district, and the Executive Office acts as the point of liaison. During the pandemic the coroner has a statutory role to ensure that there is adequate provision for the expected levels of mortality including mortuary space and interment provision. He was therefore closely involved in strategic planning meetings during the response phase.
1.10	The coroner, John Gittins, gave a presentation to the Committee in 2021 explaining his role and work. As the membership of the Committee has changed since then he will again give an overview of his role, and he will also address current issues facing the coroner's service and the four counties that he serves.

2.00	**RESOURCE IMPLICATIONS**
2.01	Our contribution towards the budget for the service is based on our population share across the coroner's area, which is 31%. There are core costs to the service (such as salaries, rooms, IT) and there are variable costs based on the number of deaths and investigations (e.g. post mortems, toxicology reports) that need to be undertaken. For Quarter 1 for 2022/23 is £40,379. The overall cost for previous years has been as follows: **Annual Cost** 2019/20 £257,924 2020/21 £248,905 2021/22 £321,614

3.00	**IMPACT ASSESSMENT AND RISK MANAGEMENT**
3.01	The role of coroner is statutory. The work of the coroner's office, amongst other things, helps to identify potential hazards that might lead to further deaths. It thereby helps to make society safer.

4.00	CONSULTATIONS REQUIRED/CARRIED OUT
4.01	None required.

5.00	APPENDICES
5.01	None.

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	None.

7.00	CONTACT OFFICER DETAILS
7.01	**Contact Officer:** Gareth Owens, Chief Officer (Governance) **Telephone:** 01352 702344 **E-mail:** Gareth.legal@flintshire.gov.uk

8.00	GLOSSARY OF TERMS
8.01	None.