Classification: UNCLASSIFIED

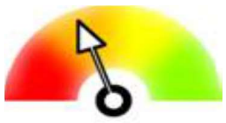
Final Internal Audit Report

08032024

CORONERS SERVICE

This audit review is linked to the following Council priority(ies) and corporate risk(s):

- Foundations
- Failure to respond effectively to civil emergencies and maintain business continuity in business-critical DEGNS services
- Failure to balance the Directorate budget

Assurance Opinion		Identified Recommendations	
Limited Assurance		**Priority 1**	0
		Priority 2	6
		Priority 3	4
Date of last review:	FIRST REVIEW	**Direction of travel**	N/A

Distribution List

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Statements & Disclaimers

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EXECUTIVE SUMMARY

1. BACKGROUND

1.1 There are many separate and distinct coroner areas in England and Wales, each locally funded and resourced by Local Authorities. The coroner system is headed by the Chief Coroner employed by the Ministry of Justice, with overall responsibility and providing national leadership for coroners. The coroners' duty is to investigate deaths due to violence, unnatural, sudden or unknown cause or occurring whilst in legal custody and use the information discovered during the course of an investigation to help prevent future deaths, where appropriate.

1.2 The coroner is appointed by Local Authorities to investigate certain types of deaths, holding inquests when required to determine who has died, how, when, and where.

1.3 Berkshire Coroner's Office is responsible for investigating sudden deaths across Berkshire, with inquests held at Reading Town Hall. Reading Borough Council (RBC) is the lead authority, managing all staff, with the exception of the Senior Coroner who is an independent judicial office holder and eight Assistant Coroners appointed in Berkshire who are also independent. RBC also provides day-to-day services such as premises and HR. Members of staff (Coroner's Officers, administrative staff and Court Officers employed directly by RBC) work under the direction of the coroner, making inquiries about the circumstances of the death, supporting the inquest process, and providing a link between the coroner's service, the bereaved and witnesses.

1.4 Berkshire Coroner's Office service costs are apportioned across six authorities, with RBC paying approximately a third of the total.

2. OBJECTIVES & SCOPE OF THE AUDIT

2.1 The purpose of this audit was to review the arrangements the Council had in place to support the Coroner and assist in providing assurance to stakeholders.

2.2 The review encompassed the following areas to ensure:

- roles and responsibilities were clear and well understood.
- contracts with third parties complied with contract procedure rules and delivered value for money.
- service performance was as required.
- financial management processes and controls were robust.
- effective information governance arrangements were in place.

2.3 This audit was conducted at the request of the Assistant Director, who had highlighted a number of concerns within this area.

EXECUTIVE SUMMARY

3. CONCLUSIONS

3.1 This audit review concluded that only limited assurance could be provided on the Coroners Service. There were significant weaknesses within the governance and decision-making processes. An historic SLA between the six Berkshire authorities is in place which lacks clarity and equity, and associated documented policies and procedures, particularly around the apportionment of costs between the authorities, with a greater liability allocated to Reading Council. A summary of key findings is provided below, and more detailed findings are provided in sections 4.1-4.5.

3.2 Roles and responsibilities were detailed in job descriptions and summaries, although they, together with the organogram, would benefit from review and updating to reflect the revised staffing structure. Whilst there were no clearly agreed and documented roles and responsibilities in relation to information governance for either RBC staff or independent judiciary postholders, including relating to the case management system and appropriate and authorised access to data., internal audit was informed that staff would indicate if they had a personal connection to a case so that access to that record could be removed, with discussions on appropriate/authorised access to and management of data discussed at team meetings and one-to-ones.

3.3 There was a lack of clarity around the governance process for decision-making, monitoring and reporting on the coroner's service across the six Berkshire unitary authorities. The SLA between them dated to 2013 and had not been updated since, for example, to reflect changes in the method of cost apportionment between the authorities.

3.4 Officer workload was reviewed at one-to-one meetings with allocation and balance of cases between officers overseen by the Principal Coroner's Officer. Various risk management processes were in place, although several would benefit from updating. Recently agreed changes to Coroner's Service staff had not yet been fully implemented to allow an assessment of their effectiveness. Over the last three months, the average number of inquest cases per officer was 43; the Chief Coroners model from 2019/20 details that this should be approximately 25 depending on the complexity of the case.

3.5 The Council's Contract Procurement Rules (part of the Council's constitution) should be followed for coroner's service contracts. Contracts were in place for removals, toxicology and mortuary services, although, due to the limited market, this was often at a significant cost to the coroner's service. There was no contract in place for the provision of pathology services, which was subject to a national shortage, leaving the coroners exposed to short-notice price increases and associated budget pressures.

EXECUTIVE SUMMARY

3.6 Various measures were in the process of being considered for implementation to try to reduce reliance on limited or sole suppliers, including the provision of a regional mortuary service and tendering/retendering of contracts. It was, however, unclear at present whether these would prove successful in alleviating the problems. An extension appeared to have been exercised on the mortuary contract although no formal approval or documentation to confirm this had been seen at the time of the audit.

3.7 Contracts signed by both the supplier and RBC were not observed and did not always contain KPIs against which the provider could be measured. Contract management, including regular reporting against KPIs and review meetings to discuss service provision, was not conducted for all contracts.

3.8 The fees for some specialist services provided by other laboratories (one of whom was a sole national supplier) did not appear to have been agreed in advance of tests being conducted or the Council being invoiced.

3.9 There was a service plan in place for the Coroner's Service, although it did not include KPIs.

3.10 The current basis of apportionment of costs between the Berkshire authorities did not reflect what was detailed in the SLA and there did not appear to be clarity as to how/on what basis this was calculated. A template was used to calculate the relevant amounts; there were no documented policies or procedures in place detailing the process. The Berkshire Treasurers Group had agreed to move to a more equitable method of allocating costs after the 2023/24 financial year, phased over a three-year period. At present, Reading Borough Council was paying significantly more than the other Berkshire authorities.

3.11 Net amounts due or payments due to be received by RBC on a quarterly basis in relation to all joint arrangements had been made/received in a timely manner.

3.12 The coroner's budget was based on rolling forward the majority of the previous year's costs and the budget was not amended in-year to reflect any known/agreed changes. Whilst significant costs relating to the Forbury Gardens inquest were reflected in the budget, it was very difficult to ensure accurate budgeting and forecasting as, whilst the Public Protection Manager authorised the expenditure, he had no knowledge or control over it.

MANAGEMENT ACTION PLAN

Control Objective	Roles and responsibilities are clearly defined and documented so there is clarity between the Local Authorities and the independent postholders.

Risk	Lack of clearly documented, consistent, and understood management structure, line management and deputies for key posts, increasing the risk of lack of accountability and poor resilience.		
Rec No	1	**Risk Priority**	3
Audit Recommendation			
Job descriptions, organogram, business continuity plan, and mutual support procedures need to be reviewed and updated to ensure they reflect current practice including up-to-date reporting/management lines, staffing, and contact details.			

Management Response	**Responsible person**
New JDs have been evaluated for the following posts: Coroners Officers Senior Coroners Officer Principal Coroners Officer The following posts have been updated and will be evaluated as part of phase 3 of the workforce review in Public Protection (due March 2024): Court Officer Coroners Administration Assistant Organogram has been updated in job descriptions. Business Continuity plan has been reviewed and signed off by the Service Manager which includes mutual support procedures. The plan has been sent to Emergency Planning.	Public Protection Manager **Target date** **01/05/2024**

MANAGEMENT ACTION PLAN

Risk	Lack of clarity between the Local Authorities in relation to expectations, roles, and responsibilities, and inequitable treatment of cost apportionment resulting in financial loss and associated reputational damage to the Council.		
Rec No	2	**Risk Priority**	2
Audit Recommendation			
Consideration should be given to reviewing and updating the SLA in place between the six Berkshire Local Authorities, as appropriate. The review should also include clarification of the governance processes for decision-making and reporting on the coroner's service within the six Berkshire Local Authorities.			
Management Response		**Responsible person**	
Joint Arrangement is being reviewed with instructions sent to Legal Services. This will consider options for improving the governance structure, for example, to include a recommendation for a separate board chaired by another Berks LA to provide effective scrutiny. Confirmation will be sought as to whether existing monitoring through Berkshire Treasurers and reports on the service will continue through Berkshire Public Services Network. Review of JA to include how costs are apportioned. Director of Finance to lead at Berkshire Treasurers.		Public Protection Manager / Director of Finance **Target date** **01/10/2024**	

MANAGEMENT ACTION PLAN

Control Objective	There are contracts in place with suppliers of key services to the Coroner, which follow contract procedure rules and ensure best value is obtained.

Risk	(Signed) contracts are not in place, leaving the service susceptible to price fluctuations with minimal warning and/or challenges of inequitable treatment, meaning best value is not achieved and leading to financial loss and reputational damage.		
Rec No	3	**Risk Priority**	2

Audit Recommendation

Signed contracts (including details of KPIs) should be in place for all key services following the Council contract procurement rules, with fees for services agreed in advance of them being provided. Sufficient time should be allowed prior to the end of a contract for appropriate tendering/ retendering/agreement of an extension to ensure there is appropriate authority and a formal agreement in place before the contract ends.

The case management system contract should be retendered to ensure that an appropriate system is in place and that value for money is being achieved.

Consideration needs to be given to how to address the shortage of providers for key coroner's services contracts (where not already in progress) resulting in the awarding of contracts to either the incumbent or sole providers, as this is unlikely to lead to best value.

There should be signed contracts in place with all Assistant Coroners, which are explicit for example in terms of what could be claimed in travel expenses, and employment status.

Management Response	Responsible person
Signed contracts are now available for: Mortuaries (extension of contract currently being finalised (have moved into extension period) Removals Toxicology Case Management System The service acknowledges that the timing for contract tendering, retendering, and extensions has been challenging and this has in part been related to turnover with suppliers, staffing and elongated discussions between legal teams; however, with better officer support now in place following restructuring and recruitment and contracts now being reviewed under the Service Contracts Board, improvements are being made. Consideration of tendering for pathology services in year. MoJ currently conducting a review of statutory fees which could affect contract value. On rare occasions, there is a requirement to source specialist providers outside of contracts for some services that the suppliers cannot provide. The fees for these are agreed separately. CMS – this was a joint procurement with Thames Valley authorities, will seek advice from legal/procurement as to retender. All Assistant Coroners have signed contracts. 2 ACs are on previous terms and do not want to move on to new terms and conditions. Will seek legal advice as to whether they can be moved. Interim contract for the removals contract has been agreed and approval being sought from Berks LAs to introduce an in-house service.	Public Protection Manager / Principal Coroner's Officer **Target date** **01/03/2025**

MANAGEMENT ACTION PLAN

Risk	Poor, inconsistent and lack of appropriate contract management resulting in poor or non-delivery of contracted services and associated financial and reputational damage.		
Rec No	4	**Risk Priority**	2
Audit Recommendation			
There should be appropriate contract management of all contracts, with regular review meetings held and KPIs provided, assessed, discussed, and challenged as relevant.			

Management Response	**Responsible person**
A review of KPIs on current contracts has been undertaken. KPIs – Removals to attend scene within hour – monitored through data provided by supplier. As this moves into an internal service, it will either be monitored under an SLA or direct by the service. Toxicology – reports received within 30 days. Mortuaries – is a service-based contract, not performance. There are no KPIs – regular interaction with mortuaries on capacity issues and contingencies. Meetings are currently held with all contract providers. All meetings will be planned and documented going forward.	Principal Coroner's Officer **Target date** **01/04/2024**

MANAGEMENT ACTION PLAN

Risk	Payments are not made in a timely manner, are at the incorrect rate, or are paid more than once, leading to financial loss and reputational damage.		
Rec No	5	**Risk Priority**	2

Audit Recommendation

Appropriate checks should be undertaken on invoices received to ensure that the correct and agreed rates have been charged, and for the services agreed. All rates for services carried out should be formally agreed upon in advance of the service being provided. Payments should be made in a timely manner.

There should be clarity and consistency both within and between Assistant Coroners' contracts. Claims should be made in a timely manner i.e., within a month of being incurred.

Management Response	Responsible person
A further review of systems in place has been undertaken. Toxicology – follow a schedule of fees within the contract. Each case has different costs depending on the number and type of tests conducted and agreed by the Coroner and Pathologist. Checks are undertaken to show the correct charges are being implemented. Removals and mortuaries have a schedule of fees and are checked through the data provided by the supplier. On rare occasions there is a requirement to source specialist providers outside of contracts for some services which the suppliers cannot provide. The fees for these are agreed separately. POs are raised for all purchases. Action to ensure that all costs are made clear and agreed prior to work being approved.	Principal Coroner's Officer **Target date** **31/03/2024**

MANAGEMENT ACTION PLAN

Control Objective	Service performance is as required.

Risk	Policies and procedures do not reflect current practice, leading to confusion and inconsistencies.		
Rec No	6	**Risk Priority**	3
Audit Recommendation			
Policies and procedures should be reviewed on a regular basis to ensure that they are up to date and reflect current practice. **It should be ensured that access to SharePoint sites is granted to groups only, not individuals, so that the ICT Team has oversight over who has access and to what and access can be removed for leavers.** **Consideration should be given to including relevant KPIs within the coroner's service plan.**			
Management Response			**Responsible person**
Policies and procedures are now up to date and reflect current practice. Access to Sharepoint is now through groups only. KPIs have been added to the 24-25 PTPP service plan which is currently in draft.			Principal Coroner's Officer **Target date** **31/03/2024**

MANAGEMENT ACTION PLAN

Risk	Other authorities within the coroner's service are not provided with regular information and reports, leading to a lack of clarity regarding the service and costs and possible future challenges.		
Rec No	7	**Risk Priority**	2
Audit Recommendation			
Regular meetings and reporting should be held between the six Berkshire authorities, with standard agenda items, which should include a review of the budget, identification of any risks/issues arising, and consideration and agreement as to how these should be addressed.			
Management Response			**Responsible person**
Joint Arrangement is being reviewed with instructions sent to Legal Services. This will consider options for improving the governance structure, for example, to include a recommendation for a separate board chaired by another Berks LA to provide effective scrutiny. Confirmation will be sought as to whether existing monitoring through Berkshire Treasurers and reports on the service will continue through Berkshire Public Services Network Review of JA to include how costs are apportioned. Director of Finance to lead at Berkshire Treasurers.			Public Protection Manager / Director of Finance **Target date** **01/10/2024**

MANAGEMENT ACTION PLAN

Control Objective	Financial management processes and controls are robust

Risk	There is inequitable cost apportionment between the local authorities and a lack of consistent, documented, and understood methodology for calculating this, leading to errors, financial loss, and associated reputational damage.		
Rec No	8	**Risk Priority**	2

Audit Recommendation

It should be clarified, agreed and clearly documented the basis on which the apportionment of coroner's office and main budget costs between the six local authorities were being made. This basis should be reviewed as part of a review of the SLA and then reviewed on a regular and ongoing basis going forward.

Once the basis of apportionment is agreed upon, there should also be clearly documented policies and procedures detailing how the processes should be carried out, which should be followed, and costs calculated on this basis. There should be clear workings and supporting evidence for all calculations with all relevant individuals having a clear understanding of the calculations. All relevant documentation should be stored centrally to ensure a clear audit trail is maintained and easily accessible in case of future queries.

Management Response	Responsible person
Joint Arrangement is being reviewed with instructions sent to Legal Services. This will consider options for improving the governance structure, for example to include a recommendation for a separate board chaired by another Berks LA to provide effective scrutiny. Confirmation will be sought as to whether existing monitoring through Berkshire Treasurers and reports on the service will continue through Berkshire Public Services Network. Apportionment of costs to be agreed by Berkshire Treasurers as part of this process. Director of Finance to Lead.	Public Protection Manager / Director of Finance
	Target date
	01/10/2024

MANAGEMENT ACTION PLAN

Risk	Inaccurate budgeting leads to overspends, creating increased financial pressure on all Berkshire authorities.		
Rec No	9	**Risk Priority**	3

Audit Recommendation

Consideration should be given to more realistic budgeting which more accurately reflects likely/anticipated costs from the start of the financial year, as well as amending the budget/forecast during the year to reflect any known changes.

There should be a regular review of the forecast levels for the following year and resulting provisional charges to the Las, year-end adjustments plus a regular review of the joint arrangement, including apportionment.

It should be ensured that there is a clear audit trail between budget and apportionment with all figures reconciling as well as supporting documentation for any increases to budgets.

Management Response	Responsible person
A wide review of the budget was undertaken in 2022 and changes agreed by Berkshire LAs. Budgets are monitored monthly with the finance partner. JA costs are adjusted based on previous years spend. It is recognised that a more regular review of the service takes place with authorities to highlight pressures at an early stage and to regularly review and plan. Joint Arrangement is being reviewed with instructions sent to Legal Services. This will consider options for improving the governance structure, for example to include a recommendation for a separate board chaired by another Berks LA to provide effective scrutiny. Confirmation will be sought as to whether existing monitoring through Berkshire Treasurers and reports on the service will continue through Berkshire Public Services Network	Public Protection Manager **Target date** **01/10/2024**

MANAGEMENT ACTION PLAN

Control Objective	Effective information governance arrangements are in place.

Risk	There is a lack of clarity about roles and responsibilities in relation to information governance resulting in data breaches and associated financial and reputational damage.		
Rec No	10	**Risk Priority**	3
Audit Recommendation			
It should be ensured that there are appropriate, documented policies and procedures in place in relation to information governance that all coroner-related staff are aware of, understand, and follow. This should include what is appropriate to access, by whom, and when (and similarly what is not appropriate).			
Management Response			**Responsible person**
To be agreed through IG Champions Network (part of the Information Management Strategy). Rhiannon Charnock nominated as Data Steward for the service. SOPs will be developed as part of the review.			Principal Coroner's Officer / Information Governance Team Lead
			Target date
			01/05/2024

4. FINDINGS

4.1 ROLES AND RESPONSIBILITIES

4.1.1 The roles and responsibilities of RBC Officers and independent postholders were defined via relevant job descriptions and job summaries respectively, although the ones for Area and Assistant Coroners were not very detailed (**Rec 1**).

4.1.2 Discussion with the Public Protection Manager identified that there was a lack of clarity regarding the governance process for the coroner's service, both for making decisions and for reporting on the service between the six Local Authorities (**Recs 1, 2**), and also a lack of engagement of authority contacts at manager level in relation to the service (**Rec 2**).

4.1.3 The Service Level Agreement (SLA) in place between the six Berkshire Local Authorities detailed the relationship between them, roles, responsibilities and accountabilities, although it dated from 2013 and had not been updated since to reflect current practice (**Rec 2**). It also included the transfer of provision of hosting Coroners' Officers Services for Berkshire from Thames Valley Police to Reading Borough Council.

4.1.4 There had recently been some changes to the Coroner's Service staff which had been agreed via the Berkshire Public Services Forum; the organogram that detailed the coroner's service structure needed to be updated to reflect this (**Rec 1**).

4.1.5 It was noted that not all of the postholders agreed in the latest review were in post yet so an assessment on its appropriateness was unable to be made at this time. However, the Public Protection Manager identified that there was a better balance of new and experienced staff within the team.

4.1.6 For RBC Officers, there was a clear management structure with clear accountability and a deputy in place for the Principal Coroners Officer. However, some of their job descriptions required review and updating to reflect the current line management structure (**Rec 1**).

4.1.7 It was understood that Officer workload was monitored at one-to-one meetings, with the Principal Coroners Officer overseeing the allocation of cases and ensuring there was the appropriate balance of caseloads between officers. A review of Officer caseloads for the last three months identified that the average inquest caseloads per officer was 43; the Chief Coroner's model from 2019/20 indicated that each staff member should have a caseload of approximately 25 inquest files, depending on their complexity.

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4.1.8 Internal audit did not have access to the coroner's case management system and was reliant on the information held there, such as relating to workload, being provided to them. As a result, assurance regarding the figures, including those in annual reports to the Chief Coroner and Ministry of Justice, was unable to be provided. Figures requested regarding caseloads were pulled manually from the system and were unable to be reconciled. Further discussion identified that this was likely due to different parameters being used in the searches. The reports used to provide figures in annual reports (to the Ministry of Justice and Chief Coroner) were understood to have been developed by the software provider. These reports had not been seen by internal audit to verify the returns that had been submitted.

4.1.9 For the independent postholders, the Area and Assistant Coroners were led by the Senior Coroner and provided cover when the Senior Coroner was unavailable. The Area Coroner would be the nominated deputy for the senior coroner. The independent roles reported to the Senior Coroner, whose reporting line management was not so clear. The Assistant Coroners had a contract in place, although at the time of audit testing, two signed contracts were yet to be returned (**Rec 3**).

4.1.10 There were various risk management processes in place. There was a risk assessment for the coroner's office which was last updated in Jun 2023, together with a business continuity plan (which required updating (**Rec 1**), an emergency mortuary plan for Berkshire in case of mass fatalities/multiple death incidents, a Thames Valley Local Resilience Forum Mass Fatalities Framework, plus procedures for requesting mutual support between Thames Valley Coroners (also in need of updating (**Rec 1**)

4.2 CONTRACTS WITH THIRD PARTIES

4.2.1 The Council's Contract Procurement Rules (part of the Council's constitution) should be followed for all coroner's service contracts. It was noted that as a result of national shortages, sole suppliers and limited markets, there was an over-reliance on either one or a limited number of suppliers, resulting in significantly increased costs for the Coroner's Service (**Rec 3**).

4.2.2 There were contracts in place for removals, toxicology and mortuary services, although fully signed contracts by both RBC and the contractor were not seen by internal audit and KPIs were not clearly detailed in all cases (**Rec 3**).

4.2.3 Due to a lack of bids (removals) and no responses to market testing (mortuary), direct negotiation with a start-up and awarding to the incumbent had been employed respectively, with the Executive Director of Economic Growth and

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Neighbourhood Services authorised by Policy Committee to enter into contracts in consultation with key decision makers. It was also noted that the mortuary contract had expired in March 2023 and it appeared that the contract extension had been exercised although no formal authority to enter into this or further agreement had been observed at the time of the audit (**Rec 3**). Consideration was being given to the provision of a regional mortuary service which would remove reliance on the incumbent. The service also planned to tender again for the removals contract, although it was noted that this could again result in no bids and direct negotiation with the incumbent.

4.2.4 For the toxicology contract, an Officer decision was taken by the Executive Director of Economic Growth and Neighbourhood Services in December 2020 to award a new contract for Toxicology Services to a named provider from January 2021 for three years. An Officer Decision Notice was agreed by the Assistant Director of Planning, Transport and Public Protection to extend the contract for a further two years (**Rec 3**). In addition, some services were provided by other laboratories and invoiced at a significantly higher amount than other services (in one instance there was a sole provider of the service for the whole of the country). Further discussion identified that RBC did not appear to have received any communication regarding fees in advance of tests being conducted for this and therefore it was unclear how the fees charged had been reached or that this offered value for money for the service (**Rec 3**).

4.2.5 There was no contract in place for pathology services, with local hospital pathologists being used privately and invoicing for services conducted, otherwise an agency was used (**Rec 3**). This meant that the service was subject to price increases as and when requested, creating short-notice budget pressures (**Rec 3**). Also, there was a lack of consistency in rates charged for post-mortems between the various providers. Discussion with the Public Protection Manager identified that it was planned to tender for the contract although it was unclear at present what the likely response might be; it was noted that there was a national shortage of pathologists.

4.2.6 In terms of the Assistant Coroners, there were signed contracts in place with all but two of the Assistant Coroners (**Rec 3**), although the newer ones were more explicit.

4.2.7 Some contract monitoring was occurring, although it was not consistent between contracts (**Rec 4**). Monthly management reports were provided for the toxicology contract, although it was noted that the timeframe for complex tests had been extended from 20 to 30 days and meetings were held approximately quarterly for the removals contract. There were no regular contract management meetings held with the relevant NHS trusts, although the senior coroner did meet regularly with them in a different capacity.

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4.2.8 Generally, payments were made in a timely manner, with a purchase order raised each financial year for each contract, goods receipting for services provided, and invoices set against the purchase order. Invoices were saved on Oracle Fusion although not always with supporting documentation (this was saved elsewhere).

4.2.9 It was noted that some invoices reviewed had detailed jobs at the incorrect rate (and been paid), two invoices for the same post-mortems had been charged and paid twice, and several fees were significantly higher than others (due to a sole provider in the country) where no evidence had been seen that this had been agreed in advance of the service being provided. Internal audit inquiry as to how it was ensured that the Council was billed only for the services provided and at the agreed rates identified that a dip check had been carried out on invoices to check that tests charged for had been requested; however, no checks were carried out to confirm that the correct rates for tests had been charged - this was planned to be carried out going forward (**Rec 5**).

4.2.10 For Assistant Coroners, it was noted that invoicing for fees and expenses was not conducted in a timely manner, with fees often being claimed many months after they had occurred (**Rec 5**). This made it difficult to verify and also to budget for. It was also noted that there was a lack of consistency between postholders as to what was claimed (**Rec 5**). This was due to contractual differences. No evidence was observed during testing that Senior Coroner approval had been given in advance of services being delivered/expenses incurred for expert witnesses or Assistant Coroners. Discussion with the Public Protection Manager identified that these would be agreed upon and documented by the Senior Coroner.

4.3 SERVICE PERFORMANCE

4.3.1 There was a service plan in place for Planning, Transport, and Public Protection for 2023/24, which included Berkshire Coroners Service. Priorities for the year were to develop a proposal and business case for a regional mortuary facility in the Thames Valley and embed the future operating model for the service, with a more reliable staffing structure to support the senior coroner. The risks identified were the new removals contract provider failing to deliver and/or bringing the service in-house was not deliverable, there were insufficient pathologists to perform the function due to a national shortage, increased pathologist fees causing cost pressures, and increased legal costs from complex cases.

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4.3.2 The Coroners Service Plan for 2023/24 was to scope the potential for a regional mortuary facility, to review the body removal service with a view to bringing the service in-house by the start of the 2024/25 financial year, to review pathologist fees to ensure they reflected the service provided, offered value for money whilst providing the necessary support, to implement proposed staffing changes to improve resilience, reduce inquest times and reduce costs in the long term, increase financial and service reporting to member authorities with increased engagement with them. All areas of focus were aligned with RBC's corporate plan and its priorities - inclusive economy and looking to ensure a quality, cost-effective service was provided, meeting demands and continually improving.

4.3.3 Legislation and comprehensive guidance for coroners was provided on the Judiciary website. There were also local guides provided on SharePoint including details of specialists in various areas, in addition to training materials and details of day-to-day and one-off processes. Coroner's officers and independent postholders had varying access rights to the SharePoint site (**Rec 6**).

4.3.4 It was noted that neither the service plan nor the SLA detailed KPIs for the Coroner's Service (**Rec 6**). Guidance for the bereaved and Chief Coroner's guidance provided various timeframes, and KPIs were detailed in the Coroner's annual statistics. It was noted that whilst the average number of weeks to process an inquest had decreased over the last three years, it was still above the average for the southeast region.

4.3.5 There was benchmarking available for the service, as well as coroners' annual statistics for 2022. The cost per case referred and per death registered were quite high for Berkshire. The average time taken to process an inquest in Berkshire was average for England and Wales (30 weeks) and slightly above average for the Southeast (28 weeks). There were 52 outstanding cases over 12 months old, with 23 cases over 12 months completed as at the end of April 2023.

4.3.6 WPC was the case management system being used for coroner's service which had been acquired as part of a framework agreement with other authorities. The agreement was signed in October 2017 and was on a one-year rolling contract basis. This needed to be reviewed/retendered to ensure that value for money was being achieved (**Rec 3**).

FINDINGS

4.3.7 It was noted that there were no regular or clear lines of monitoring or reporting of service performance (other than monthly budget meetings between the Public Services Manager and Finance in terms of the budget). This had been raised as an action at the Berkshire Treasurers Group in November 2022 (**Rec 7**). Finance issues were considered at the Berkshire Treasurers Forum, and higher-level issues at the Berkshire Public Services Network. There was no low-level discussion/monitoring/reporting (**Rec 7**). Coroner Service team meetings did not appear to have been held (regularly) until recently.

4.3.1 Complaints were handled differently depending on whether they related to independent postholders or RBC Officers. Few complaints had been received via either process, and, generally, they were responded to in a timely manner.

4.4 FINANCIAL MANAGEMENT PROCESS AND CONTROLS

Cost apportionment

4.4.1 The SLA between the Berkshire authorities did not detail how the coroner's main budget cost was currently apportioned (**Recs 2, 8**). Whilst the coroner's office budget was detailed as being based on a pop-base formula (50:50 tax-base/population), the basis for the apportionment for the coroner's main budget was detailed as being set from year to year, based on a formula agreed by the Finance Officers, recognising the place of death, where people have lived and population (equally weighted) or as otherwise agreed.

4.4.2 However, it was understood that the current basis of cost apportionment was with Slough being solely pop-based (no evidence of appropriate approval/agreement had been seen by internal audit for this) and the remaining Berkshire authorities on a transition towards pop-based allocation (**Rec 8**), with the Berkshire Treasurers Group having agreed this basis for apportionment, although no formal, documented agreement detailing this had been observed (**Rec 8**). At present, RBC was paying a significantly higher percentage than the other Berkshire authorities (24% versus 12-18%). The Berkshire Treasurers Group had agreed to move to a more equitable method of apportionment of cost after the 2023/24 financial year, with a phased approach adopted over three years (**Rec 8**).

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4.4.3 Discussion with the DEGNS Strategic Finance Business Partner and the DEGNS Finance Business Partner identified that there was a lack of clarity as to how the apportionment was currently calculated, with an historic template used for the calculations (**Rec 8**). There were no documented policies/procedures to detail how apportionment should be carried out; only as documented in the original SLA (**Rec 8**). There was therefore concern that the rollover of figures/templates from previous years meant that any errors in prior years would continue to be replicated going forward (**Rec 8**).

4.4.4 Review of calculations identified that the apportionment between authorities was calculated based on the existing percentages used in the budget (other than Slough which was pop-based), with a 6% administrative fee also being added to the costs i.e., the proportions between the authorities (excluding Slough) did not change year-on-year. The recharges were made on a quarterly basis. At the year-end, the difference between the budget and actual figures was identified and the appropriate adjustments were made to the apportionment.

4.4.5 The budget and quarterly apportionment were not being amended in-year to reflect likely overspends, resulting in a significant year-end adjustment which was not made until the end of the following financial year, although the local authorities had received communication in advance of any likely overspend. Income due/received was also not journaled to the coroner's Oracle Fusion cost centre until the year end.

4.4.6 Review of the 2021/22 apportionment (as the adjustment for the 2022/23 financial year had yet to be finalised at the time of the audit) identified that quarterly net payments due to RBC as a result of all joint arrangements in place took account of coroner's costs and had been paid in a timely manner.

Budget

4.4.7 Discussion with the DEGNS Strategic Finance Business Partner and the DEGNS Finance Business Partner identified that the coroner's budget was drafted by rolling over the previous year's one and then making a few adjustments; the majority of budgets remained the same year-on-year (**Rec 9**). To date, the budget/forecast was not amended to reflect any in-year changes (**Rec 9**).

4.4.8 Discussion with the Public Protection Manager identified that the Forbury Gardens inquest costs were significant and solely RBC's responsibility to pay. Whilst he authorised the expenditure, he had no control over the costs nor knowledge of whether the expenditure had been incurred. In the current financial year, the budget for the inquest appeared to significantly underestimate the likely costs.

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4.4.9 Discussion with the Public Protection Manager identified that he was responsible for managing the coroner's service budget and met monthly with finance representatives to go through the establishment and revenue budgets and review variances. There was also regular interaction with RBC finance representatives concerning the joint arrangement for the service and the apportionment of costs.

4.4.10 Further discussion with the Public Protection Manager identified that the Coroner's Service budget monitoring was carried out by RBC. Budgeting/forecasting was not discussed either regularly or in detail by the other Berkshire Local Authorities (**Rec 7**), although any significant variances and changes to other Local Authorities apportioned costs would be raised via the Berkshire Public Services Network. It was noted that there was a lack of engagement at manager level across the authorities; they generally only made contact if there was a query relating to the quarterly apportionment of costs (**Recs 2, 7**).

4.4.11 The previous year's (2022/23) significant financial pressures had mainly arisen due to significant increases in expenditure. As detailed earlier, a tender process for the removals contract had proved unsuccessful and had led to direct negotiation with a start-up for the provision of a contract at approximately four times the previous cost. The contract would be re-tendered but may not result in any providers being identified. The mortuary costs had increased due to increased numbers and hence increased cases. Previously, a yearly charge had been made, but the current contract was on a cost-per-case basis, hence if the number of cases increased, the mortuary costs increased. For pathology, there was a statutory fee although there was a national shortage of pathologists which meant being flexible regarding fees to ensure service provision; again, the service was looking to tender the contract.

4.4.12 Toxicology had a contract in place via a framework agreement which was in the process of being extended. However, there was a query about the fee and if the provider as a result decided not to extend the contract, temporary arrangements would have to be put in place, at likely (significantly) increased cost. A regional mortuary option was being considered, and tendering/retendering of contracts but shortages/sole providers were making it difficult to negotiate value-for-money contracts. It was noted that all contracts were difficult to manage, with shortages and/or sole suppliers leading to significant increases in service and contract costs.

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4.4.13 It was noted that information provided to the Berkshire Public Services Network and Berkshire Treasurers Group regarding the coroner's service related to proposals to increase spending where budget pressures were experienced rather than the provision of regular reports. Discussion with the Public Protection Manager identified that there was no regular reporting to the Berkshire Public Services Network - only when a budget increase was required or to provide an update following a budget increase (**Recs 2, 7**).

4.5 INFORMATION GOVERNANCE

4.5.1 Discussion with the Information Rights Services Manager and the Information Governance Manager identified that there were no clearly documented roles and responsibilities concerning information governance for RBC-employed and independent postholders in the coroner's service (**Rec 10**).

4.5.2 Further discussion with the Principal Coroner identified that since the issues had been identified, action had been taken to address them. There was now an expectation that had been disseminated to all that Officers were responsible for declaring if they had a personal connection to any case and the record locked down accordingly. The issue of appropriate/inappropriate and authorised/ unauthorised access and management of data was raised at team meetings and clarified at one-to-ones (this was unable to be evidenced/verified). An email had also recently been sent to Officers concerning the confidentiality of information.

4.5.3 It had also been identified that there was no clarity between RBC and the Ministry of Justice as to the division of roles and responsibilities between the two. Discussion with the Principal Coroners Officer identified that the Senior Coroner was the data controller and she and other (assistant/area) coroners gave direction to Officers on what information can be disclosed/redacted. They also indicated if a case needed to be locked down, for example, if it was politically sensitive or was a family member.

4.5.4 Discussion with the Public Protection Manager also identified that there was a data privacy notice for the coroner's service on the website which had recently been updated. This detailed the data held, where and the basis for collection, use and storage.