

HM Inspectorate of Court Administration

Report on the inspection of the Coroners Service for Northern Ireland

Administrative systems supporting bereaved families

Published November 2007

Acknowledgements

HMICA would like to acknowledge the help of the following during the inspection:

The Presiding Judge, the Honourable Mr Justice Weir

Senior Coroner, Mr John Leckey

Coroners, Ms Suzanne Anderson and Mr Brian Sherrard

NICtS staff and management

All external interested parties, including participating bereaved families

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Chief Inspector's foreword

In April 2006, the Northern Ireland Court Service (NICtS) established the Coroners Service for Northern Ireland (CSNI). The Coroners' Service had been reformed both judicially and administratively and NICtS asked Her Majesty's Inspectorate of Court Administration (HMICA) to inspect the administrative function of CSNI to see if it was delivering an improved service to bereaved families.

This inspection looked only at the administration of CSNI. Its findings do not reflect on the Coroners, who are independent judicial officers in Northern Ireland.

The inspection was carried out early in 2007. We are pleased to be able to report that our findings show CSNI has come a long way in a relatively short space of time and has a clear commitment to continuous improvement.

Centralisation of the Service has provided a single point of contact, coherence and a more consistent service to users. The introduction of the Coroners Liaison Officer role has enhanced the Service significantly. Families bereaved after April 2006 whose cases need postmortems are supported more effectively and receive the information they need to fully understand and engage with the process.

The Service can improve further, and our recommendations reflect this. During the inspection, we were concerned that families bereaved since the reform were receiving a better service than those bereaved before then. Families involved in pre-reform cases may already have experienced significant delay and were less likely to receive information and support. We accept that it is not possible to go back and re-create, for those bereaved before the reforms took place, the level of support which now exists. However, it is important that, as far as it is possible, pre-reform cases not yet completed should receive a level of service comparable with post-reform cases. We have, therefore, recommended that NICtS ensures its high standard of service is offered to all bereaved families. I am pleased to note that progress has already been made with regard to providing information to families in pre-reform cases where a postmortem report is still awaited.

CSNI has a highly committed workforce that seeks to meet the needs of those involved in the Coronial process. However, we have concerns about the resilience of CSNI, which has yet to underpin service delivery with a full range of up-to-date, documented systems. We have, therefore, recommended that NICtS takes steps to strengthen the resilience of the Coroners Service and address a range of staffing issues.

As a relatively new Service, CSNI is still developing its performance management systems. While some data is collected, proficiently analysed and used to improve services, there is potential to capture and use information more effectively. We have, therefore, recommended that CSNI develop its data management processes further. Information flow is an integral part of this. Currently, the Coroners Service provides information to its partner agencies and is considered to be open and responsive to issues raised by them. However, this happens on an ad hoc basis and we have recommended that CSNI take a more systematic approach to the dissemination of information and to harnessing the views of those involved in the Coronial process.

It is important to bereaved families that cases are resolved as quickly as possible. However, the Coronial process can be complex and Coroners will sometimes have to wait many months for other agencies to complete their procedures and investigations before being able to make their own decisions about how a case should be resolved.

At the time of our inspection, approximately 80% of outstanding cases were awaiting the completion of work by partner agencies. About half were awaiting postmortem reports, 90% of which were with the State Pathologist's Department. The Coroners Service has done much internally to reduce administrative delays and has developed agreements with partner agencies. However, while such a large proportion of its work depends on the performance of other agencies, CSNI is not in a position to ensure that all delays are minimised. Our inspection did not examine the work of agencies outside the NICtS. However, we were aware in particular of the report on the State Pathologist's Department – Review of the State Pathologist's Department in Northern Ireland – published in June 2005, by our colleagues in the Criminal Justice Inspectorate of Northern Ireland, and of the follow-up report published in October 2006. The findings and recommendations of that study have a direct bearing on the work of CSNI and we encourage all concerned to take them forward for the benefit of bereaved families in Northern Ireland.

In the meantime, I am pleased to note the positive response to our findings. No organisation stands still, and NICtS has introduced a number of changes since this inspection, examples of which are included in the main body of this report.

I would like to thank the Presiding Judge, the Honourable Mr Justice Weir, the Coroners, and the NICtS staff and managers for their assistance with this inspection. I am particularly grateful to agencies involved in the Coronial process, for providing their views so fully and openly, and to the many members of bereaved families who shared their experiences with us.

A handwritten signature in black ink that reads "Eddie Bloomfield". The signature is written in a cursive style with a long horizontal stroke at the end.

Eddie Bloomfield

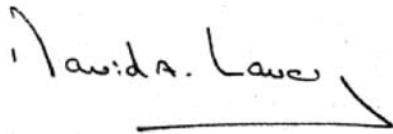
HM Chief Inspector of Court Administration

October 2007

Director's foreword

The Coroners Service for Northern Ireland provides an important public service for bereaved families at a particularly sensitive time in their lives. I am particularly pleased that the work of the Coroners Service in supporting bereaved families has been recognised by Her Majesty's Inspectorate of Court Administration.

The new Coroners Service for Northern Ireland was established in April 2006. The new service has already made many improvements in this sensitive area of public service delivery. I very much welcome, therefore, the publication of this report and the recommendations it makes for further improvement. The Northern Ireland Court Service is publishing an Action Plan setting out the progress made to date and the further improvements to which we are already committed.

A handwritten signature in black ink that reads "David A. Lavery". The signature is written in a cursive style and is positioned above a horizontal line that ends in a small downward-pointing arrowhead on the right side.

David A. Lavery

Director, Northern Ireland Court Service

Summary and recommendations

The early 2000s saw a drive to improve Coronial services for England, Wales and Northern Ireland. Building on the findings of a major review, led by Tom Luce in 2003, the Northern Ireland Court Service (NICtS) reformed its Coroners Service. A range of significant changes was introduced, including centralised administration and judicial structures, the introduction of systems to improve communication with bereaved families, joint working with partner agencies and improved information management. After a period of amalgamation of local services, the Coroners Service for Northern Ireland (CSNI) was established in April 2006.

In Northern Ireland, Coroners are independent judicial officers. They establish the cause of sudden, unnatural or violent deaths through a range of enquiries and investigations, including postmortems and inquests.

Her Majesty's Inspectorate of Court Administration inspects the Northern Ireland Court Service by invitation and we accepted an invitation to undertake the first inspection of the CSNI early in 2007. This report sets out the findings of that inspection.

Overall, the CSNI provides a sensitive, responsive, and open service. The reforms have improved outcomes for bereaved families, both directly and indirectly.

A good range of written information is available about the Coronial process. The relationship with the Court Service Information Centre is effective, with clear lines of responsibility and systems for responding to media enquiries. There is also an effective system for arranging for leaflets and correspondence to be provided in alternative languages and formats on request.

The flow of information with families and partner agencies has been greatly enhanced by the introduction of the Coroners Liaison Officers (CLO), who are consistently praised for the information and support they provide to bereaved families in post-reform cases involving postmortems. However, currently, CLOs do not provide updates between the time of the postmortem examination and receipt by the Coroner's office of the final report, which can take considerable time. CSNI recognises that such a break in contact can cause distress to bereaved families and is working with partner agencies to address this.

Other agencies, including the Police Service for Northern Ireland and health services, also have a statutory responsibility in the Coronial process. They will often be in contact with bereaved families before the Coroners Service and so will inform these families of relevant procedures. NICtS has a system in place to send some partner agencies supplies of leaflets, but we learned that bereaved families are rarely given these leaflets by agencies with which they have first contact after bereavement. We are concerned that not all agencies fully understand the Coronial process themselves and there is potential for them to provide inaccurate information to families. CLOs are assigned to some pre-reform cases at the discretion of the Coroners but, in the main, families who suffered bereavement prior to the introduction of the CLO role will not have the benefit of this consistent source of information and support.

Performance in many areas of the service is improving, and bereaved families generally have their cases resolved more quickly than under the old structures. However, it can still take more than a year for cases to be resolved by inquest and bereaved families can find this adds to the distress of their bereavement. The Coroners Service is committed to improving timeliness and many delays

in resolving cases are due to legitimate reasons. At the time of our inspection, nearly 80% of the Coroners' cases were awaiting action from other agencies:

- 51% were waiting for postmortem reports (about 90% of these from the State Pathologist's Department)
- 17% for statements and expert reports
- 10% the outcomes of criminal prosecutions.

Overall, faster internal administrative processes have contributed significantly to improvements in case progression. The greatest of these have been demonstrated in cases involving postmortems and inquests. Good administrative systems are in place for tracking cases but those used to chase information are not always effective and need further thought, in negotiation with relevant partner agencies.

External agencies are sometimes unclear about how to communicate with CSNI and this can negatively affect case progression in some instances. For example, some agencies, especially those first on the scene after a death, are unsure of procedures and systems for contacting the Coroners Service to report the death and what information they need to provide when doing so.

The new CSNI has inherited a significant backlog of cases. Improved administrative systems are helping to clear this. Additionally, CSNI continues negotiations with partner agencies about ways to reduce the outstanding caseload.

There is commitment at all levels to engage partner agencies in the development of agreed priorities, expectations and procedures, especially in areas which impact most on timeliness, but few are ratified in written joint agreements. Currently, there are gaps in understanding amongst staff in some agencies about Coronial processes and mechanisms, and the wide-ranging reasons for delay in case disposal. However, CSNI staff provide personal briefings to external agencies and a best practice guide is being developed by the judicial side to address these issues.

There are examples of good practice for addressing the individual needs of next of kin attending inquests. However, formal arrangements do not provide for identifying and taking into account their dates of availability, and systems for ensuring parties attending inquests do so in a safe environment are not always effectively implemented. Bereaved families and those summonsed to attend inquests are not always adequately made aware of relevant support groups. Currently, there are no mechanisms in place for engaging with the Witness Service on the day of inquest although there are plans in place to review this. While general NICtS guidance for administering oaths and affirmations reflects the growing diversity of the population, guidance for setting up inquests does not support this approach, but takes for granted that witnesses will swear on the Bible.

The effective running of administrative and CLO processes relies heavily on the goodwill and experience of a busy staff, who are open, helpful and demonstrably committed to delivering a service that focuses on the needs of bereaved families. Their work ethic is flexible and responsive and members of staff continually develop, review and improve practices and procedures. They cover for absences, and learn from and support each other. However, administrative processes are not systematically documented and there is no staff training plan in place.

Staff absences impact on the development of formal plans and policies. The administrative and CLO resources are tightly stretched, limiting potential development of roles and processes, and posing a threat to the long-term effectiveness of these functions.

NICtS has a clear strategic vision for the development of CSNI. However, in some areas of the business, there is a lack of drive and planning around performance. For example, some of the objectives specified in the Coroners Service Charter and the Business Plan are not supported by effective and auditable mechanisms of measurement. Additionally, CSNI's strategic priorities and the organisation's values are not always effectively translated into operational plans – for instance, for the effective clearance of the backlog.

IT systems are able to support the collection and production of management information, which is produced regularly and is used to inform operational decision-making. There are some excellent examples of data analyses which are used to drive case progression. However, CSNI's performance management system has yet to evolve fully. Thus, it does not inform and support long-term service improvement or properly attest to the ongoing commitment of the Coroners Service to improving its services to bereaved families.

Recommendations

Recommendation 1

That CSNI ensure all front-line agencies having contact with bereaved families are able to provide accurate information about the Coronial process.

Recommendation 2

That CSNI ensure all bereaved families are regularly kept informed about progress during the period between the postmortem examination and finalisation of their cases, and are notified of any reasons for delay.

Recommendation 3

That CSNI ensure all families involved in pre-reform cases are informed about the current position of their cases and are kept informed of any future developments.

Recommendation 4

That CSNI ensure that the needs of bereaved families and witnesses attending inquests are systematically identified, that appropriate support is provided on the day of inquest, and that systems for ensuring a safe environment in the courthouse are used consistently and effectively.

Recommendation 5

That CSNI enhance the resilience of the Coroners Service by systematically developing and reviewing:

- internal administrative systems
- staffing levels and contingency plans
- training plans.

Recommendation 6

That CSNI develop an effective performance management system, which provides for progression against, and accurate measurement of, all business targets and service level commitments, including those published in business plans and the Coroners Service Charter.

Recommendation 7

That CSNI take steps to:

- gather the views of partner agencies, and bereaved families, and take them into account in the Service's policies and plans
- introduce a systematic approach to improving the level of understanding of partner agencies so that they contribute appropriately to the Coronial process.

Section 1 – Background

The Coroners Service for Northern Ireland

- 1.1 The Coroners Service investigates the circumstances of sudden, unnatural or violent deaths. In Northern Ireland, Coroners are independent judicial officers. They inquire into deaths reported to them that appear to be:
- unexpected or unexplained
 - as a result of violence
 - an accident
 - as a result of negligence
 - from any cause other than natural illness or disease
 - in circumstances that require investigation.
- 1.2 The Coroner seeks to establish the cause of death and will make whatever inquiries are necessary to do this; for example, ordering a postmortem examination, obtaining witness statements and medical records, or holding an inquest.
- 1.3 In 2003, a review of Coronial services for England, Wales and Northern Ireland was published, entitled, 'Death Certification and Investigation in England, Wales and Northern Ireland. The Report of a Fundamental Review 2003'¹.
- 1.4 NICtS built on this work to implement a review of the Coroners Service in Northern Ireland and in 2005 issued its conclusions in, 'Modernising the Coroners Service in Northern Ireland'. This set out its key areas for change, which were:
- creating a single Northern Ireland coroners jurisdiction
 - revising the judicial structure of the Coroners Service
 - providing a better service to the public
 - establishing protocols with other agencies
 - improving death investigation
 - improving the availability and relevance of management information
 - introducing a Coroners Service Inspectorate
 - planning the future policy on the reform of the Coroners Service.
- 1.5 As a result, the Coroners Service for Northern Ireland (CSNI) was established in April 2006. This is now a centralised service within the Northern Ireland Court Service (NICtS), with a revised judicial structure, improved information about the Service and new Coroners Liaison Officer role. CSNI is headed by a High Court Judge, Mr Justice Weir, with one Senior Coroner, Mr John Leckey, and two Coroners, Ms Suzanne Anderson and Mr Brian Sherrard.

¹ See references.

Her Majesty's Inspectorate of Court Administration and Inspection in Northern Ireland

- 1.6 Following the Good Friday Agreement of 1998 and ensuing Criminal Justice Review, the Criminal Justice Inspectorate for Northern Ireland was established to inspect the criminal justice system, with the exception of the courts. Her Majesty's Inspectorate of Court Administration (HMICA) has agreed to inspect the Northern Ireland Court Service on the basis of invitation, and this includes CSNI.
- 1.7 HMICA is an independent, statutory Inspectorate created by the Courts Act 2003, as amended by the Police and Justice Act 2006. Its duty is to:
- inspect and report to the Lord Chancellor on the system that supports the carrying on of the business of the courts (the Crown Court, county courts and magistrates' courts) and the services provided for those courts in England and Wales
 - discharge any other particular functions which may be specified in connection with the courts listed.
- 1.8 HMICA is not empowered to inspect persons making judicial decisions or exercising any judicial discretion.



Section 2 – The Inspection

Context

- 2.1 Within the Coroner's office, there are two teams – the General Team and the Court Team. Members of the General Team tend to be the first point of external contact. They receive and record reports of deaths to the Coroner and have some delegated responsibility for deciding whether or not cases should be accepted.
- 2.2 Members of the Court Team, under the guidance of the Coroners, process pre-reform cases, arranging inquests when appropriate. The Coroners Liaison Officer role was introduced to look after post-reform cases involving postmortems. However, the officers will also manage some older cases as directed by the Coroners.
- 2.3 People coming into contact with the Coroners Service often do so when at their most vulnerable. Most will have been recently bereaved; the death may have been unexpected and, in extreme cases, violent. The most distressing times are likely to be initially after a death, when findings from the postmortem examination are disclosed, and during inquests.
- 2.4 Coroners cases are resolved in three ways:
- **administratively.** This happens when, after discussing the case, the Coroner and relevant healthcare professionals agree the cause of death without further investigation. A Form 14 is issued, which allows the next of kin to register the death
 - **after a postmortem examination.** The Coroner reviews the information and conclusions of the postmortem report and issues a Form 17, which allows the bereaved family to register the death. Sometimes, the Coroner is unable to make a conclusive decision about the cause of death on the basis of the postmortem report alone and will look for further evidence. In some instances, a police officer will gather this information on behalf of the Coroner. Additionally, other agencies, such as the Health and Safety Executive, may provide the Coroner with their investigative report into a death
 - **by inquest.** There will be some cases where an inquest is required under law, for example in instances where a prisoner dies in custody. In other cases, Coroners want to probe more deeply into the evidence available to them. Bereaved families have a right to participate in inquests and ask questions of witnesses to the case. After an inquest the Coroner's office will issue a Form 21, which enables the family to register the death.
- 2.5 It is for the Coroners to decide, when they accept a case, whether or not they require a postmortem examination². The customary practice in Northern Ireland is for burials to take place within three days of a death and so it is important that Coroners make this decision as quickly as possible. A Coroner's ability to do this will often depend on the information provided by partner agencies when reporting deaths. Coroners also rely on these agencies to provide the initial information to families about the Coroners Service and Coronal process, as they are the first to be in contact with bereaved families after a death.

² The Coroner is also responsible for authorising the release of a body for burial. While an investigation into the cause of death can continue for some time, the Coroner will release a body as soon as possible to facilitate a quick burial.

2.6 Most bereaved families would like the Coroner to bring their cases to a close as quickly as possible. Decisions about how a case is to be resolved lie within the authority of the Coroners. However, the Coronial process relies heavily on the work of partner agencies, with which the Coroners liaise closely, especially the Police Service for Northern Ireland (PSNI) and State Pathologist's Department (SPD)³. Investigations and postmortem examinations can involve complex issues and procedures that significantly extend the time families wait. Some cases are delayed pending the outcomes of criminal prosecutions.

Inspection methodology

2.7 HMICA inspected the Coroners Service for Northern Ireland in the spring of 2007. Its aim was to inspect the outcome of the reforms and, more specifically, whether bereaved families receive a proficient, open and sensitive service.

2.8 To help us gauge if this was happening we looked at:

- communication and support, especially for bereaved families
- administrative systems for the progression of cases
- work with partner organisations to meet the needs of bereaved families
- how well performance management mechanisms support service improvements.

2.9 We analysed a range of documents and performance data, observed hearings and spoke with staff, the judiciary and managers for CSNI and NICtS. We also asked families who had experienced the Coronial process and a range of external stakeholders, including the PSNI and the SPD, to let us know their views. (See Annex B for a more detailed methodology.)



³ PSNI often investigates cases on behalf of the Coroner. The SPD's forensic pathologists perform most of the Coroner's postmortems.

Section 3 – HMICA’s findings

How good is the communication and support provided by the Coroners Service?

3.1 We looked to see if bereaved families are treated with sensitivity and respect, are kept informed of what is happening at every stage of the death investigation and inquest process, and if their queries are answered fully and promptly. We assessed the degree to which appropriate information about the Coroners Service is readily available to interested parties and explains the Coronial remit and process.

3.2 In particular, we sought evidence that:

- information about the Coroners Service is available in a variety of languages and formats and is accessible to members of the public, bereaved families and other interested parties
- bereaved families receive the information they need to understand and fully participate in the Coroners process, including inquests. Processes exist to provide this information in a timely and proactive way, and are documented and clearly understood by staff
- bereaved families are provided with information about the sources of support available to them
- systems are in place for responding to enquiries from bereaved families, other court users, the public and the media
- the individual needs of families are taken into account throughout the Coronial process
- bereaved families are treated with sensitivity and in a professional manner
- service standards for communicating with bereaved families throughout the Coronial process are met.

Information and communication

3.3 We found that, overall, the staff of the Coroners Service provides a polite, sensitive and informative service. CSNI responds openly, fully and in a timely fashion to enquiries, and offers a good range of leaflets about the Coronial process. The NICtS Information Centre is the central point for providing appropriate information to the public and other interested parties. Information is also available on a dedicated website, which we found easy to navigate and which provides a useful question and answer section.

3.4 We were pleased to note that the Coroners Service is responsive to the growing diversity of languages used in Northern Ireland. Where required, letters and forms can be translated via the Business Development Group, at a day’s notice if necessary. We particularly noted that Coroners Liaison Officers send both the original English version and the translation of these documents to bereaved families as a safeguard against the translation being inaccurate. NICtS also has effective procedures in place for providing translations and alternative formats for information available about CSNI, when requested. However, it is unfortunate that this service is not always advertised.

Progress since the inspection:

The NICtS Information Centre plans to translate a selection of Coroners Service leaflets into several languages and alternative formats which will be generally available.

- 3.5 Several organisations involved in the Coronal process are sent Coroners Service leaflets by the Information Centre. However, we are concerned that this does not include all front-line agencies, such as medical General Practitioners (GPs). As a result, the agencies with whom the bereaved first come into contact may not be providing accurate information about Coronal services.

Recommendation 1

That CSNI ensure all front-line agencies having contact with bereaved families are able to provide accurate information about the Coronal process.

- 3.6 HMICA asked bereaved families to participate in a survey about their experiences of the Coroners Service. Seventy families responded. Of these, more than three quarters were happy with the information provided, the ease with which it was obtained, and the availability, politeness and sensitivity of staff. Respondents made the following comments:

'Never had a problem, any questions I had they answered excellent' (bereaved family member).

Information provided was 'fast and sufficient' (bereaved family member).

'All information I required was readily available' (bereaved family member).

'All my family were grateful and impressed by the sensitivity of all at the coroners office' (bereaved family member).

'Very, very helpful and compassionate' (bereaved family member).

The role of the Coroners Liaison Officer

- 3.7 The reforms introduced the role of the Coroners Liaison Officer (CLO) to the Coroners Service for Northern Ireland. The CLOs are involved in all post-reform cases which involve postmortem examinations and a small number of pre-reform cases. Their role is to enhance communications with other agencies and provide information to bereaved families on:
- the preliminary cause of death following the postmortem examination, if this is known
 - why any organs or tissue samples have been retained at the postmortem examination and what families can request happens to them
 - the processes and stages in the Coroner's investigation.
- 3.8 The role of the CLO was commended throughout the inspection by bereaved families, the judiciary, external agencies and the Service's own staff. They were described as 'sensitive', 'marvellous' and an 'excellent point of contact'. We were told of their strong relationship with Police Family Liaison Officers (FLOs) that enhances the consistency and

quality of information provided to bereaved families, especially in instances where the Coroner has decided to retain organs or tissue samples.

'I could not have been treated with more politeness and sensitivity by my liaison officer' (bereaved family member)

The CLO was 'helpful, ...supportive (and) ... understanding' (bereaved family member).

- 3.9 Coroners Liaison Officers do not provide updates or stay in touch with families between the time the initial results of postmortem examinations are provided to bereaved families, and receipt by the Coroners office of the final postmortem report. This can be a lengthy period, with some families waiting more than a year. Some, who responded to our survey, found this gap in communication very difficult. Comments included:

'They told me they would ring me when they knew anything, that was six and a half months ago' (bereaved family member)

'I would appreciate some communication about why it is taking so long to complete the postmortem' (bereaved family member).

- 3.10 We are of the view that this absence of updates does not reflect the standard of service set out in the CLO leaflet and that the Service should take steps to address it⁴.

Recommendation 2

That CSNI ensure all bereaved families are regularly kept informed about progress during the period between the postmortem examination and finalisation of their cases, and are notified of any reasons for delay.

Cases with no Coroners Liaison Officer involvement

- 3.11 The distinction between post- and pre-reform cases is significant. In the majority of cases, CLOs are not involved in pre-reform postmortem cases. We have not inspected the systems that were in place prior to the reforms. However, evidence from families and bereavement support agencies indicates that many families bereaved prior to the reforms did not receive any written information about the Coronerial process at the time of their bereavement unless it was requested.

- 3.12 Current arrangements for such cases are that administrative staff in the Coroner's office generally provide information only on request from families. As a result, these families have little or no communication with the Coroners Office until arrangements are being made to set up inquests, which can be a year or more after the time of death. Survey responses included:

⁴ CSNI is working with the State Pathologist's Department to agree a triage system, whereby pathologists will inform CLOs of expected timeframes for completing postmortem reports – enabling them to provide more detailed information to bereaved families about the time frame for their cases.

'.... office failed to inform me of pm results sent to doctor' (bereaved family member)

'I have never received any information. I have rang on several occasions' (bereaved family member)

'They are fine when I have rung and spoken to them' (bereaved family member).

Recommendation 3

That CSNI ensure all families involved in pre-reform cases are informed about the current position of their cases and are kept informed of any future developments.

Support for families

- 3.13 A further difference in the way pre- and post-reform cases are handled is in the support provided to bereaved families. The Coroners Liaison Officer leaflet provides a list of organisations that can offer support and counselling to bereaved families. The CLOs also provide support in cases in which they are involved. The Coroners General and Court Teams, which deal with pre-reform cases, provide information in a courteous and sensitive way and pass particularly difficult or sensitive calls to the CLOs. However, not all members of these teams are aware of the contacts listed in the CLO leaflet and do not refer their callers to relevant support groups.
- 3.14 NICtS acknowledges there is a disparity between the services offered to those bereaved before and after the introduction of the new Coroners Service, but considers this to be an acceptable consequence of the reforms. We believe CSNI should ensure that all families receive the same level of appropriate information and support.

Preparing for inquests

- 3.15 Inquests are held when the Coroner wishes to investigate the circumstances of a death more fully. There will be occasions when bereaved families are asked their views about whether or not an inquest should be held. Several respondents to our survey appreciated the opportunity to be involved in this decision.
- 3.16 Most cases for which inquests are currently being listed were originally reported to the Coroner before implementation of the reforms. The written instructions for setting up inquests pre-date reforms and do not require staff to consider the needs of bereaved families when setting the date of an inquest. Nevertheless, we found it to be general practice among administrative staff to contact families and take their needs into consideration. We believe that the written guidance should be amended to reflect this essential practice.
- 3.17 In addition, the guidance does not take into account other NICtS standards and guidance for preparing court hearings. For example, the NICtS guidance on oaths and affirmations instructs that witnesses should be offered the opportunity to affirm or swear on a holy book of their choice⁵. We are concerned that the Coroners Service's Court Team, and court

⁵ See HMICA report 'Customer Service in the Northern Ireland Court Service' (2005).

clerks involved with inquests, are unaware of this, as the guidance for setting up these hearings presumes that bereaved families, and other witnesses, will swear on the Bible, with affirmation being the only considered alternative. CSNI will wish to ensure that the appropriate guidance is followed in this respect.

Progress since the inspection:

NICtS will ensure that managers re-enforce the principles of the guidance, "Oaths, Holy Books, Affirmations and Other Useful Things To Know. A Guide for Court Staff".

3.18 Administrative systems do not ensure that all families receive the information they need to prepare adequately for inquests. We found that some families arrive at an inquest without previously being given sufficient details about the death and can be surprised and upset by what they hear. In some instances, this has resulted in hearings being adjourned to allow families to prepare themselves, thereby delaying resolution of these cases. We are of the view that CSNI should introduce appropriate administrative systems to address this.

Attendance at inquests

3.19 Inquests can be a difficult and emotional time for families and can give rise to anxiety or embarrassment. NICtS and the Court Witness Services have expressed a desire to work together to support bereaved families and other witnesses on the day of inquest. However, currently, there are no resources to provide for this. There are plans to consider extending the witness services to the Coroners Court as part of a future evaluation of the Court Witness Service but, in the meantime, no other provision has been made.⁶ HMICA shares the view that families and other witnesses should be supported at inquest.

3.20 We were pleased to note instances of excellent practice by the Court Team, which ensure that bereaved families are provided with interpretation services for inquests, even if they are not being called as witnesses. Other examples of good practice noted include:

- arrangements being made to enable a widow in a high profile case to leave the court by an alternative route to avoid inappropriate attention
- ensuring a party with agoraphobia received clear explanations of the court layout and was able to sit near an exit.

3.21 Other parties involved in or affected by a death can attend inquests and this may give rise to conflict in and around the courthouse. There is a system in place, for all court hearings, for advising courthouse security staff about cases that might give rise to conflict. However, we are concerned that this is not always being followed for inquest hearings. This is especially relevant in cases where courthouse based clerks, rather than members of the Coroner's Court Team, facilitate the hearings, as they do not always receive case information in time to speak with security staff, and therefore do not have the opportunity to manage potentially volatile situations. CSNI will wish to take urgent action to ensure that protocols in this area are applied appropriately.

⁶ The evaluation will take place after the witness services have been fully operational in the Crown, Magistrates and Youth Courts for two years – see NIO's 2006 Vulnerable Victims and Intimidated Witness plan.

Recommendation 4

That CSNI ensure that the needs of bereaved families and witnesses attending inquests are systematically identified, that appropriate support is provided on the day of inquest, and that systems for ensuring a safe environment in the courthouse are used consistently and effectively.

Does the Coroners Service use effective administrative systems to progress its cases?

3.22 We looked to see if cases are progressed appropriately and effectively, taking into account the needs of parties involved.

3.23 In particular, we sought evidence that:

- administrative systems are in place to enable cases to be tracked and expedited appropriately, including prompt decisions and arrangements relating to inquests
- there are systems in place to deal with any backlog
- lines of communication between the Coroners' administrative staff and staff in other agencies (for example, the SPD, PSNI, prisons and custodial contract companies) are used effectively
- the CLOs, Coroner's clerks and general administrative staff are able to communicate and share information efficiently and effectively
- service standards for case progression are met.

Minimising delays

3.24 Delay of any kind in the resolution of cases can be distressing for bereaved families. HMICA, therefore, considers it essential that the Service takes every possible step to ensure that cases are finalised as quickly as possible.

3.25 Evidence suggests that the centralisation of the Coroners Service, introduction of the CLO post and the development of new systems to record and progress cases more effectively have led to improvements in the timeliness of Coronial processes. Administrative staff make effective use of IT systems and can now track information relevant to each case. Post-reform case files are comprehensive and, therefore, effectively support Coroner's case reviews and decisions.

3.26 Bereaved families and a professional court user shared the following thoughts with HMICA about timeliness:

'Took a long time from death in January until inquest in September' (bereaved family member)

'Thought it could have been quicker' (bereaved family member)

'The only criticism I have is the time it took from my husband's death until the Coroner ruled' (bereaved family member)

'Respect and courtesy of staff are completely undermined by delays in the process' (professional user)

HMICA's case progression analysis

- 3.27 We analysed a random sample of completed cases reported to the Coroner's office between January 2004 and December 2006. Annex D sets out the parameters of this analysis, including its limitations and potential variations.
- 3.28 Our analysis showed that during this twenty-four month period, pre-reform administrative systems had started to deliver improvements in the rate that cases were being finalised. However, the greatest increases in this rate of improvement have been since the establishment of the Coroners Service in 2006.
- 3.29 **Cases resolved administratively (with a Form 14).** The overall time taken to resolve these cases has fallen from an average of 2.8 days for 2004 to 2.6 days for 2006.⁷ This is a real, although marginal, improvement.
- 3.30 **Cases needing a postmortem examination but not an inquest (Form 17).** The overall time taken to resolve these cases has fallen from an average of 140 days for 2004 to 52 days for 2006. More significantly, the sample shows that the time the Coroners Service takes to close such cases once the postmortem report has been received has fallen from an average of 26 days for 2004 to 4 days for 2006.
- 3.31 These are excellent developments, and clearly demonstrate that CSNI has improved its internal administrative processes to enhance service delivery to bereaved families.
- 3.32 **Cases resolved by inquest (Form 21).** The average overall time to resolve cases has fallen from 530 days for 2004 to 217 days for 2006. (Note: Only nine cases reported to the Coroner in 2006 had come to inquest at the time of this analysis.) The number of days between receipt of a postmortem report and inquest date has reduced from an average of 233 for 2004 to 95 for 2006, again pointing to a quickening of internal processes.
- 3.33 Prior to reform, there were a number of Coroners districts in Northern Ireland, each with its own Coroner and Deputy Coroner, who were responsible for the administration of their own caseloads. As the Service was centralised, CSNI inherited a vast number of outstanding files. The administration systems used were unique to each district prior to reform, and CSNI has had to work hard to ensure that all outstanding cases have been identified. In the main this has been successful. However, despite their concerted efforts, a small number of cases has recently been discovered by the previous Coroners which has added to CSNI's caseload.

Outstanding cases

- 3.34 At the end of 2006, the Service had a total outstanding caseload of 1,335. Of this total, pre-reform cases comprised a substantial proportion, both in terms of their complexity and number. This will increase with the return of a number of difficult cases that have been awaiting judgement from the House of Lords⁸.

⁷ The figure at paragraph 3.29 excludes a case in 2004 that took 141 days to resolve. If this case is included in the analysis, it took on average 5.5 days to close a case in 2004.

⁸ CSNI plans to implement specific measures to address these cases once judicial decisions on case management have been finalised.

- 3.35 Case management is a complex field, the guidance and drive for which fall under the authority of the judiciary. Strategies and decisions about how to minimise delays are, in most instances, dependent not only on effective administrative processes but the full co-operation of partner agencies.
- 3.36 CSNI's monthly performance reports show that at the time of this inspection, 51% of cases were awaiting receipt of postmortem reports, about 90% of these from the State Pathologist's Department. Seventeen per cent of the Coroners' caseload was pending receipt of statements and expert reports, and 10% the results of criminal prosecutions. The Coroners Service was therefore unable to resolve nearly 80% of its outstanding cases, pending the completion of work by its partner agencies. The Inspectorate acknowledges this, and the difficulties it poses for reducing the average time for case completion.
- 3.37 CSNI has invested time and resources to help reduce its outstanding caseload. In addition to establishing improved administrative processes, and systems to reprioritise cases on a monthly basis, it is working closely with partner agencies to reduce delays. CSNI continues negotiations with the Northern Ireland Office and SPD to improve systems relating to postmortem examinations, such as the proposed medical adviser pilot and potential postmortem examination triage system to help CLOs provide important information to bereaved families. It has also recently agreed a protocol with the police for co-ordinating, and liaising about, police statements.
- 3.38 HMICA's performance analysis shows that CSNI's case throughput has improved since 2004. While the number of deaths reported has risen each year, the number of cases resolved has surpassed this and the Coroners Service has reduced its outstanding caseload by more than 500. This improvement is to be commended.
- 3.39 For HMICA, two key issues present themselves:
- At the current rate, it will take considerably more than a year to reduce the number of outstanding cases to an appropriate level.
 - CSNI will need to ensure that, should the SPD increase the rate at which it produces postmortem reports, it has the resources to meet the consequential increase in workload.

Operational communication with partner agencies

- 3.40 There is evidence that centralisation of the Service has improved communication with partner agencies significantly. Without exception, agencies praised the way the Coroner's office responds to their enquiries. Most felt that general lines of communication at operational level are open and helpful.
- 3.41 HMICA's view is that the Coroners Service could further improve its communication with bereaved families and partner agencies through the enhanced use of e-mail. We found this facility was not widely used in the day-to-day business processes of the Service. A CSNI e-address is not provided on letters sent by the administrative team and we were told by some agencies that they would appreciate the receipt of important documents by e-mail rather than fax.

Progress since the inspection:

CSNI has taken steps to include the office's e-mail contact details on future orders of letter headed paper and all IT produced paperwork.

- 3.42 One example, however, where e-mail is being used effectively is as part of the recently agreed arrangement between the Police Service for Northern Ireland (PSNI) and CSNI for co-ordinating the provision of police statements.
- 3.43 The Coroner's Court Team monitors and chases outstanding reports by other agencies for all cases, including those looked after by CLOs. While the management team is working with PSNI to improve procedures, communication between the administrative team and colleagues in other organisations is not always productive, and systems of communication not always well established. For example, managers have yet to agree a system with the SPD for chasing outstanding postmortem reports.
- 3.44 CLOs have developed a close working relationship with Police FLOs which helps them co-ordinate services and enhance case progression. The agencies agree who will be the main point of contact for a bereaved family but ensure the family is aware of both the CLO and FLO roles.
- 3.45 The use of roadshows to bring external stakeholders up to date with the reforms – and subsequent ad hoc briefings to colleagues in other organisations by the Coroners, CLOs and administration staff – are good examples of CSNI's positive approach to communications. These opportunities have also been used to distribute written guidance to partner agencies, such as healthcare professionals and the police, about their role and responsibilities in the Coronial process. In addition, the five Northern Ireland Area Bereavement Co-ordinators⁹ have all been provided with guidance by CSNI.
- 3.46 Despite the steps taken, not all agencies interviewed during the inspection understand the complexities of the Coronial process. Some levelled criticisms, for instance, that the Coroners Service is responsible for the majority of the delays in resolving cases. Inspectors consider they might not have made these comments had they a greater knowledge of the complex relationships and dependencies involved.
- 3.47 We were also given conflicting views by external stakeholders about how easy it is to contact the Coroner's office. Some agencies said they find it difficult to contact the office at night and during weekends, while others, who have direct telephone numbers for either a Coroner or CLO, feel able to contact them any time¹⁰.
- 3.48 Many are content with the out-of-hours system run by the Coroner's office, whereby the Service normally assesses in the morning if a death reported during the night should be investigated by the Coroner. However, despite CSNI's efforts to raise awareness amongst GPs, we were told that some GPs had not been provided with guidance from the Coroners Service and that there were still areas of uncertainty in reporting deaths. This is particularly relevant to some out-of-hours GPs, who are unsure of procedures, in particular, for reporting deaths over bank holiday weekends.
- 3.49 Additionally, there are issues around the reporting of deaths by the police, with some officers not clear about the details they need to leave on the Coroner's office out-of-hours answering service. They may not be on shift if the Coroners Service calls the next day seeking additional details and, in some instances, their colleagues may not have access to pertinent information.

⁹ Recently appointed by the Department of Health, Social Services and Public Safety to co-ordinate the provision of services when a death occurs in a hospital setting.

¹⁰ The duty Coroner's contact number is given on the out-of-hours answerphone message.

3.50 HMICA acknowledges the efforts of CSNI to provide guidance to partner agencies about the Coronial process. We have also been informed that several of these agencies, including the Police Service for Northern Ireland and healthcare professionals, have statutory responsibilities with regard to the Coronial process. As such, any guidance provided by CSNI is supplemental to that provided by the individual services. However, it is in the interest of the Coroners Service to address any misunderstandings amongst external stakeholders and introduce a systematic approach to the distribution of their guidance. In light of this, the Inspectorate is pleased to note that CSNI is working with other agencies to develop a best practice guide that should help address such issues.

Is leadership in the Coroners Service visible, effective and co-ordinated?

3.51 We looked to see if the leadership for CSNI is visible, and proactively supports effective service delivery to bereaved families. We assessed whether there is a culture of service improvement and if this is underpinned by a robust performance management system. We looked at how well NICtS and CSNI work with their external stakeholders to develop and implement strategies and plans that are aimed at meeting the needs of bereaved families.

3.52 In particular, we sought evidence that:

- policies, protocols and practices related to bereaved families are effectively implemented, monitored and evaluated in order to improve services
- appropriate training, support and guidance is provided to staff
- managers ensure performance systems are in place, working, and used to drive improvements in performance delivery
- feedback on performance is provided to managers, administrative staff, service users and other stakeholders
- CSNI works with other bodies to:
 - 1) identify the changing needs of bereaved families and develop single and multi-agency plans to address them, and
 - 2) ensure that reducing unnecessary delays and backlogs is given appropriate priority.

Staff resilience

3.53 We are of the view that, as it stands, the administrative structure of the Coroners Service lacks resilience. We are concerned that, as effective operations are dependent on the knowledge and commitment of the staff, significant staff absences would severely disrupt the function of the Service.

3.54 Deaths reported to the Coroners Office continue to escalate. Sickness levels in the administrative team stood at 44 days in February 2007, representing 20% total resources. Current staff resources are such that the Court Team finds it difficult to complete all its designated tasks effectively.

3.55 The Coroners Service sits within the management structure of Belfast Combined Courts. NICTS' policy provides that, for contingency purposes, staff resources can be shared within this structure. CSNI has suffered from staff shortages for some time and funding for a temporary member of staff was available until March 2007. However, at the time of our inspection, CSNI administrative staff told us they did not feel the staff contingency system was being used to support them. We are concerned that the Coroner Service has no long-term contingency plan in place to address current staffing pressures.

Progress since the inspection:

A meeting is planned to discuss staff resourcing for the Coroners Service.

3.56 The CLOs currently work twelve days on, two days off, with IT equipment at home to facilitate home working at weekends. The current set up deters them from taking annual leave and there are no contingency plans to cover for sick leave. The role is still developing and the business is now at the stage where post-reform cases are being listed for inquests. In an environment of increasing work, the CLOs find it necessary to limit their contact with bereaved families to the telephone, even in instances where they feel a personal visit might be more helpful to families in distress or with complex issues to discuss. The CLO remit includes facilitating pre-hearing familiarisation visits where necessary and this will add pressure on the already stretched CLO resource.¹¹

3.57 Those interviewed throughout this inspection demonstrated their united concern that, despite the skills and commitment of the CLOs, they would be unable to maintain their current level of service delivery, especially as their workload grows.

3.58 The administrative team is a core asset to the Coroners Service. Members are helpful, open, knowledgeable and clearly dedicated to providing a service which focuses on the needs of bereaved families. They continually review and share practice on an ad hoc basis. However, there is little up-to-date, fully comprehensive written guidance provided to administrative staff. Examples of what could be provided include their guidance on oaths and affirmations and for setting up inquests.

3.59 NICTS has systems in place to identify the training needs of individual members of staff through the Personal Development Plan system. However, the CSNI staff told us there was no specific CSNI staff training plan, that they received little formal training or guidance and that they learn from each other. While many are happy to do this, some identified a need for formal training in topics such as communicating with bereaved families or handling potentially volatile situations.

3.60 NICTS provides both Staff Welfare Officer and Employee Assist schemes. Additionally, staff described CSNI's office manager as open and supportive. However, generally, the CSNI administrative staff is unaware of any formal system in place to provide day-to-day emotional support, for example, in cases which may be distressing or after difficult conversations with bereaved families. In most instances members of the General and Court Teams will speak informally with their colleagues about these experiences. Some advised us they would value the introduction of a more structured mechanism for emotional support. HMICA would encourage CSNI to consider the options for providing this, including a more formal system of peer support.

¹¹ In recognition of the developmental nature of the CLO, NICTS commissioned Internal Audit to review the role – the report on its findings was with NICTS management at the time of drafting this report.

3.61 In order to improve resilience and enhance support to the CSNI staff, HMICA recommends the following:

Recommendation 5

That CSNI enhance the resilience of the Coroners Service by systematically developing and reviewing:

- internal administrative systems
- staffing levels and contingency plans
- training plans.

Leadership, management and business planning

3.62 CSNI is a new and developing organisation. It already delivers a much-improved service that is generally valued by those who have reason to use it. The Coroners Service has benefited from a complete strategic transformation and its senior managers have a clear vision for the further development of CSNI. An example of this is the planned six-month Medical Adviser pilot to identify the best way to provide medical advice for the Coroners Service.

3.63 The Coroners Service for Northern Ireland sits within the Operations Division of the Northern Ireland Court Service. At the time of the inspection, the development role sat with the Business Support Group, while operational and business management responsibility fell to the Manager of the Belfast Combined Courts¹². Rather than meeting as a dedicated Coroners Service management team to discuss Coronial priorities, operational and policy staff meet and discuss business as issues arise. HMICA's view is that this approach makes efficient use of resources, but that NICtS will wish to reassure itself that managers can, thereby, identify how the different areas of the Courts Service might support each other in delivering both current business and future developments.

3.64 We were told that staffing pressures have reduced capacity for developing improved ways of working. An example of this is the time spent by the office manager in covering staff absences. This reduces the time available for the development side of her role, such as the creation of written plans and guidance for the office, developing the performance management system, and systemising the current informal approach to reviewing and improving practice.

3.65 A further example of the impact of staffing pressures is the use of risk assessment. While NICtS is committed in its business plans to undertake high-level risk assessments¹³, we found no evidence that detailed risk assessments are completed for specific CSNI initiatives, policies and practices.

Performance management

3.66 It is crucial for any organisation to be able to track and manage its performance to ensure it is delivering the standard of service required and using its resources appropriately. The key performance measures for CSNI are set out in the Coroners Service Business Plan and Charter.

¹² The structure has changed recently – see Annex A for the current organisational chart.

¹³ For example, as set out in the BCC Stewardship Statements.

The Business Plan

- 3.67 The 2006/7 CSNI Business Plan sets out key annual business objectives. We were disappointed to find that the Business Plan is not being used to full advantage. We saw little evidence that it was used to help plan and structure work throughout the year or to manage business down the line.
- 3.68 We were advised that it was unlikely that all the objectives in the Business Plan would be met, for example the work planned to carry out and analyse a customer survey, develop Coroners User Forums, or establish a Learning and Development strategy for staff. We also learned that thought was yet to be given to the 2007/08 Business Plan.

Progress since the inspection:

NICtS had prepared a draft 2007/08 Coroners Service Business Plan by mid-May 2007.

The Coroners Service Charter

- 3.69 The Charter sets out a range of targets about communication, timeliness and respect for bereaved families. Some of these relate to existing NICtS targets while others have been agreed specifically around the Coronial process.
- 3.70 Currently, CSNI is unable to measure its progress against all the targets set out in its Charter. We believe that data pertinent to many of the targets in the Charter may already be available on CSNI case files and computer records. However, despite ongoing work to develop IT systems to provide for the recording and reporting of data relevant to the Coronial process, NICtS is still unable to capture and analyse these.

Progress since the inspection:

CSNI has completed a review of systems to measure progress against Charter targets.

General performance management

- 3.71 The performance of CSNI is clearly important to NICtS. The Business Manager for the Coroners Service formally reports on performance and risk management to the Head of Court Operations by way of quarterly written reports and monthly meetings.
- 3.72 CSNI's administrative team is regularly informed of performance levels and knows the targets it is expected to meet. The staff contributes ideas for improving administrative systems, either directly to the office manager or during discussions at team meetings, to help improve performance against targets.

Use of performance data

- 3.73 There is little evidence that, generally, performance data is used to inform plans, translate priorities into achievable goals or identify variations in service delivery. For example, in setting targets for the backlog of cases to be cleared or comparing timeliness and processes for different groups of cases. We are of the view that this needs to be addressed urgently.
- 3.74 However, we found that some essential information, for example about the time it takes to resolve cases and the reasons for delay, is being recorded, analysed thoroughly, and translated into performance data reports. This process, once again, demonstrates the commitment of the Coroners Service to improving performance in the area of case

progression. The reports are shared and discussed monthly with senior managers and the judiciary and are an integral part of the process for negotiating agreed working practices with partner agencies, such as the SPD, for reducing delays. Built into this process are quality assurance systems, which use cross-referencing and sample checking of source data to check the robustness of the data and performance reports. These are used to support judicial decisions about case management, and also by the office manager to prioritise and organise work and formally to drive operational improvements.

- 3.75 It is important that any service improvements are informed by performance measures based on the correct criteria. CSNI collects data on the overall time taken to resolve cases. However, this measure is based on the number of days between the time the death is reported to the office and the time when the Form 14, 17, or 21 is printed by the computer. There is no guarantee that the printing date will be the same as the posting date, and this may be different by some days. The period between printing and posting the form is not being recorded and so CSNI cannot assure itself that bereaved families benefit from the improvements indicated through our case progression analysis. Again, it is important for CSNI to remedy this situation as soon as possible.

Progress since the inspection:

CSNI will be implementing measures to ensure all administrative targets are accurately monitored.

Recommendation 6

That CSNI develop an effective performance management system, which provides for progression against, and accurate measurement of, all business targets and service level commitments, including those published in business plans and the Coroners Service Charter.

- 3.76 We are of the view that CSNI has a good story to tell. Unfortunately, there is no established system for reporting publicly on performance, which means, while the reforms have led to improvements in the Coroners Service, NICtS is unable to inform the wider public and rightly celebrate the performance of this branch of its business.

Progress since the inspection:

A decision has been taken to report on the performance of the Coroners Service in this year's NICtS Annual Report, with a dedicated CSNI Annual Report being published thereafter.

Strategic working with partner agencies

- 3.77 The Coroners Service continues to strengthen relationships with key partners through the development of joint protocols and service level agreements. However, it has been unable to reach consensus in some areas and is yet to ratify all of these, thus delaying improvements in service. In particular, NICtS administrative managers have experienced difficulties in agreeing working practices with the SPD. Currently, the Presiding Judge for the Coroners Service has taken the lead in negotiating with the Northern Ireland Office (which manages SPD) and the State Pathologist. HMICA considers it would be appropriate for NICtS senior administrative operational management to continue its involvement in discussions, especially those relating to areas involving administrative processes.

3.78 We were pleased to find that partner agencies consider CSNI to be open and responsive to the strategic issues, concerns and requests they raise. However, during the inspection, several stakeholders stated they had identified areas for improving practice but felt there was no established channel for discussing them. There is no formal arena for partner agencies to come together to discuss common issues, which a number of external stakeholders considered to be a gap. Equally, there is no established system in place for bereaved families involved in the Coronial process to comment on their experience and the service received. We are of the view that this lack of structured feedback may limit the Service's potential for improving policies and practices and that CSNI should establish means whereby it can obtain feedback from service users and partner agencies.

Recommendation 7

That CSNI take steps to:

- gather the views of partner agencies, and bereaved families, and take them into account in the Service's policies and plans
- introduce a systematic approach to improving the level of understanding of partner agencies so that they contribute appropriately to the Coronial process.

In conclusion

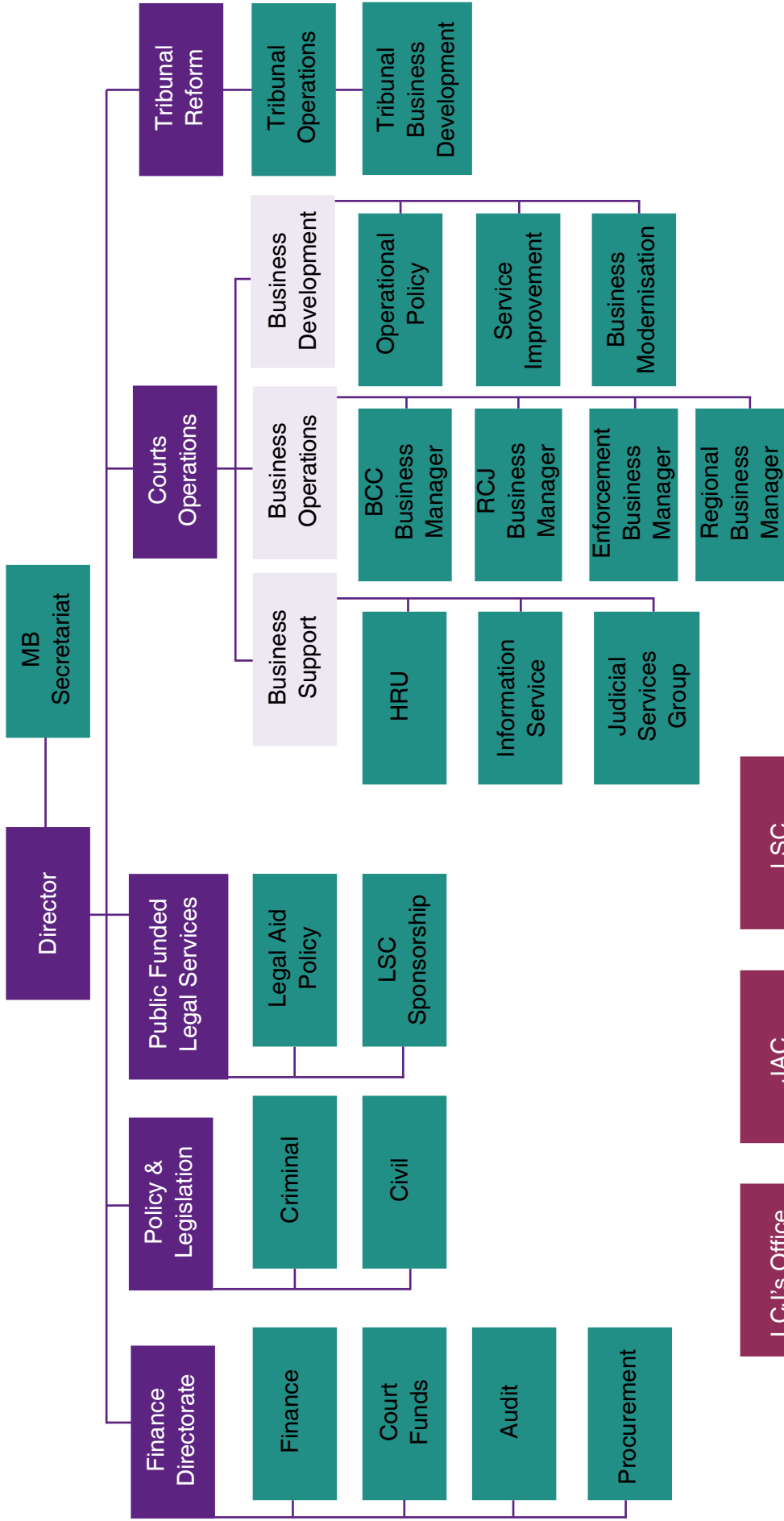
3.79 We were looking to see if bereaved families were treated with sensitivity and respect and found that, in the main, they are. The Coroners Service for Northern Ireland presents a clear and compassionate commitment to meeting the needs of bereaved families. Those bereaved after the reforms were introduced are provided with a more consistent level of information and support but all bereaved families have access to a range of information about the Coronial process and their queries are answered fully and promptly. There are some gaps in service provision that this report highlights. HMICA's recommendations are designed to help CSNI address these and, in so doing, demonstrate their commitment in a more comprehensive and sustainable manner.



Annex A

Organisational chart for the Northern Ireland Courts Service

Current structure



Source: <http://www.courtsni.gov.uk/en-GB/AboutUs/Organisational+Structure/>

Annex B – Detailed methodology

Approach

The framework guiding this inspection was developed after consultation with a range of stakeholders including senior NICtS managers and the judicial officers for the Coroners Service. It was agreed that the focus of the inspection would be how well the new Coroners Service for Northern Ireland delivered its service to bereaved families. HMICA looked for evidence around the following indicators:

- bereaved families are treated with sensitivity and respect; are kept informed of what is happening at every stage of the death investigation and inquest process and their queries are answered fully and promptly
- appropriate information about the Coroner's Service is readily available to interested parties and clearly explains the Coronial remit and process
- cases are progressed appropriately and effectively, taking into account the needs of parties involved
- NICtS/CSNI works with others to develop and implement strategies and plans that are aimed at meeting the needs of bereaved families
- a robust performance management system underpins a culture of service improvement for bereaved families.

We gathered evidence from a range of sources:

- findings from previous inspections of NICtS
- performance data – from post-reform computer records and an analysis of pre-reform case files
- documents relating to policy, practice, meetings, and performance plans
- a NICtS self-assessment
- the views of the judiciary, NICtS/CSNI managers and staff, bereaved families and external agencies coming into contact with the service
- Coroners Service modernisation reports
- Observations of inquest hearings in Belfast and a less urban area.

Chronology

Overall, the inspection ran from December 2006 to March 2007.

Autumn/winter

HMICA explored and agreed the focus of the inspection with the Northern Ireland Court Service (NICtS) and consulted on the inspection framework.

January/February 2007

- NICtS was asked to provide documents, reports and a self-assessment
- External stakeholders provided their views about the Coroners Service for Northern Ireland in writing or during telephone interviews.
- Questionnaires were distributed to bereaved families via NICtS.

February to May 2007

Inspectors completed their fieldwork, including:

- case file analysis
- analysis of complaints received
- observation of inquest hearings – Belfast and Enniskillen
- face-to-face interviews with staff, managers, the judiciary, external agencies
- telephone interviews with external agencies and bereaved families.

Inspection judgements were agreed and fed back to Northern Ireland.

NICtS considered the report findings and invited HMICA to proceed with publication.

Annex C – Inspection framework

The Coroners Service for Northern Ireland 2007

Key function: Bereaved families receive a proficient, effective, open, and sensitive service from the Coroners Service for Northern Ireland

| 1. The Coroners Service for Northern Ireland (CSNI) communicates effectively and respectfully, especially with bereaved families | |
|--|---|
| Inspection criteria | |
| <p>1.1 Bereaved families are treated with sensitivity and respect; are kept informed of what is happening at every stage of the death investigation and inquest process and their queries are answered fully and promptly.</p> | <p>How we might know</p> <ul style="list-style-type: none"> • Processes exist for informing families of what is happening that are timely, proactive, documented and clearly understood by staff. • Service standards for communicating with bereaved families throughout the coronary process are met. • Bereaved families are able to contact the Coroners Service quickly and easily. • Bereaved families are treated sensitively and competently. • |
| <p>1.2 Appropriate information about the Coroners Service is readily available to interested parties and clearly explains the Coronial remit and process.</p> | <ul style="list-style-type: none"> • Appropriate information about the Coroners service is available in a variety of languages and formats and is accessible to members of the public, bereaved families and other interested parties • Systems are in place for responding to enquiries from court users, the public and media • |

Note: These examples of evidence are indicative, not exhaustive.

| | |
|--|--|
| 2 Administrative systems are in place to support the provision of an effective, seamless service to bereaved families | |
| Inspection criteria | How we might know |
| 2.1 Cases are progressed appropriately and effectively, taking into account the needs of parties involved. | <ul style="list-style-type: none"> • Systems are in place to enable cases to be tracked and expedited appropriately • Case files are dealt with efficiently and effectively. • Confidential and sensitive data is safeguarded and handled appropriately • Service standards for case progression are met, |
| 3 Leadership is visible and proactively supports effective service delivery to bereaved families | |
| Inspection criteria | How we might know |
| 3.1 NICtS/CSNI works with others to develop and implement strategies and plans that are aimed at meeting the needs of bereaved families. | <ul style="list-style-type: none"> • Policies, protocols and practices related to bereaved families are effectively implemented, monitored and evaluated in order to improve services • The needs of bereaved families are appropriately recognised in relevant strategic and operational plans • NICtS/CSNI works with others to identify the needs of bereaved families and multi-agency plans exist to deliver these • Appropriate support and guidance is provided to staff in CSNI and other agencies, including a point of contact for policy/practice advice, and arrangements for discussing issues and concerns |
| 3.2 A robust performance management system underpins a culture of service improvement for bereaved families. | <ul style="list-style-type: none"> • Managers ensure performance systems are in place, working, and fully understood by staff • CSNI works with other bodies to ensure that reducing unnecessary delays and backlogs is given appropriate priority and, where appropriate, there are action plans to reduce delays and backlogs • Good practice in service provision for bereaved families is identified and shared • A Coroners Service Charter for Northern Ireland identifies appropriate standards of service that bereaved families can expect and publishes performance against these |

Engaging with bereaved families

The views of service users are crucial evidence in an inspection as they enable the Inspectorate to understand how policies and practices affect the people to whom services are being delivered. Inspectors were careful not to add to the distress families involved in the Coronerial process might already be feeling. They approached bereaved families through a written questionnaire, distributed by CSNI on their behalf.

About two hundred and fifty questionnaires were sent out: around 100 to families newly notified to the Coroner's office and 150 to a random sample of families bereaved between 2005 and April 2006. In addition, HMICA asked CSNI to distribute another hundred and fifty to courthouses. The Inspectorate received 70 returns. Respondents were asked if they would be happy for HMICA inspectors to discuss their experiences in more detail with them, either by telephone or face to face. Twenty-six agreed to a telephone interview. Inspectors spoke to 15 of these.



Questionnaire for bereaved families and results of survey

Inspection of the Coroners Service for Northern Ireland questionnaire analysis

| Section 1 What is your connection to the person who has died? | | | | | | |
|---|-------------|-------------------------|---------|---------------------|-------------|-------|
| | Next of kin | Other family, or friend | Witness | Professional/ Other | No response | Total |
| Number of responses | 53 | 15 | 0 | 0 | 2 | 70 |
| Percentages | 76% | 21% | 0% | 0% | 3% | |

| Section 2 What do you think about the information you have received from the Coroners Service? | | | | | | | |
|--|-----------|------|--------------|------|-----------|-------------|-------|
| The amount of information available | Excellent | Good | Satisfactory | Poor | Very poor | No response | Total |
| Number of Responses | 33 | 25 | 6 | 1 | 4 | 1 | 70 |
| Percentages | 47% | 36% | 9% | 1% | 6% | 1% | |

| The quality of the information available | Excellent | Good | Satisfactory | Poor | Very poor | No response | Total |
|--|-----------|------|--------------|------|-----------|-------------|-------|
| Number of responses | 35 | 22 | 7 | 3 | 3 | 0 | 70 |
| Percentages | 50% | 31% | 10% | 4.5% | 4.5% | 0% | |

| The speed with which information was provided | Excellent | Good | Satisfactory | Poor | Very poor | No response | Total |
|---|-----------|------|--------------|------|-----------|-------------|-------|
| Number of responses | 29 | 25 | 6 | 2 | 5 | 3 | 70 |
| Percentages | 41% | 36% | 9% | 3% | 7% | 4% | |

| The ease with which information was obtained | Excellent | Good | Satisfactory | Poor | Very poor | No response | Total |
|--|-----------|------|--------------|------|-----------|-------------|-------|
| Number of responses | 33 | 22 | 9 | 0 | 4 | 2 | 70 |
| Percentages | 47% | 31% | 13% | 0% | 6% | 3% | |

| Section 3 What do you think about the way you have been treated by the administrative staff in the Coroners Service? | | | | | | | |
|--|-----------|------|--------------|------|-----------|-------------|-------|
| The politeness and sensitivity of staff | Excellent | Good | Satisfactory | Poor | Very poor | No response | Total |
| Number of responses | 48 | 16 | 3 | 1 | 2 | 0 | 70 |
| Percentages | 69% | 23% | 4% | 1% | 3% | 0% | |
| The availability of staff to answer questions | Excellent | Good | Satisfactory | Poor | Very poor | No response | Total |
| Number of responses | 37 | 18 | 9 | 1 | 2 | 3 | 70 |
| Percentages | 53% | 26% | 13% | 1% | 3% | 4% | |

Comments received from respondents

Section 2

What do you think about the information you have received from the Coroners Service?

| |
|--|
| The amount of information available |
| Good, clear printed leaflets |
| Quite a lot available. |
| My daughter died on August 06. Nobody has ever contacted me about this. I have to ring, I am still waiting. |
| Very clear and concise information |
| My brother died May 06 and I am still to receive the results of his autopsy. |
| I was given copies of all relevant police statements, pathologists report, to help decide whether an inquest would be beneficial. |
| The girl I spoke to originally was very sensitive and explained about the postmortem etc. but I would appreciate some communication about why it is taking so long to complete the postmortem. |
| Accurate and sensitive |
| All information I required was readily available |
| The quality of the information available |
| Remarkable |
| I have never received any information. I have rang on several occasions. |
| Very helpful |
| The certificate of evidence of death had the wrong date of death on it. I was told the postmortem would be carried out in 6-8 weeks. I have heard nothing more about it to date. |
| Very much needed at a difficult time |
| All information was clear and concise |
| The speed with which information was provided |
| Thought it could have been quicker |
| Without delay |
| Still waiting for information. Past the 6 month period now. |
| Could be quicker release of death certificate. |
| Took a long time from death in January until inquest in September. |
| I would like to see the receipt of pm reports into the coroners office speeded up. Nothing can proceed without them. |
| I feel that I would like to have been contacted by my liaison officer by phone soon after the death. It would have built a relationship. |
| I had to get three certificates before my late wife's name was spelt right |
| Material was delivered to our home by a member of staff who dealt promptly with all queries. |
| Very prompt |
| Information was received in a very short space of time |

| |
|--|
| The ease with which information was obtained |
| I was very confused, this was not the fault of the coroner. |
| Fast and sufficient |
| Thought results were slow because Coroners busy. |
| My brother died on 29th June 2006 and I have yet to receive his death certificate. |
| Information re my late husbands postmortem results was excellent when I contacted coroners office. My police family liaison was unsure of time delays for results and office failed to inform me of pm results sent to doctor. |
| Coroners death certificate was only written correspondence |
| The coroner allowed us to decide whether an inquest should be held, after reviewing the papers. This degree of control was reassuring. |
| My mother's solicitor has been in communication with the coroners office on her behalf so cant answer this question. |
| Mr Ron Simpson was particularly helpful and supportive. |
| One phone call was all that was required |

Section 3

What do you think about the way you have been treated by the administrative staff in the Coroners Service?

| |
|---|
| The politeness and sensitivity of staff |
| Courteous, sympathetic and understanding |
| Very energetic |
| They are fine when I have rung and spoken to them. |
| Very polite and helpful |
| Understanding and sympathetic |
| Very very helpful and compassionate |
| I could not have been treated with more politeness and sensitivity by my liaison officer – she is a lovely caring person. |
| I was very upset with the way I was informed that my brother's brain was being kept for further tests. |
| My unmarried brother died on the 7/9/06 and I have not heard from the coroners service yet (five months ago) |
| A personal item placed with my brother was with him after p.m. and brought us great comfort |
| Again Mr Simpson was very supportive and understanding |
| Staff were very friendly and extremely helpful |
| The availability of staff to answer questions |
| Had no questions as I watched my aunt die, nothing could be done. |
| Never had a problem, any questions I had they answered excellent. |
| No one has told me anything. Just that they would ring me when they knew anything, that was six and a half months ago. |
| I was always able to speak to my liaison officer when I phoned. |
| All my family were grateful and impressed by the sensitivity of all at the coroners office and at Ahnagelvin hospital and also police officer involved. |
| The timing of the decision regarding the postmortem and proposed inquest was critical |
| The first person I talked to was able to answer any questions |

Section 4

| |
|---|
| Do you have any concerns or comments about the way administrative staff, including Coroner's Liaison Officers, reception staff and caseworkers, have met your individual needs? |
| No concerns |
| No concerns. Service was very good. |
| First correspondence from Liaison officer had the wrong persons name which was quite distressing for the family, second correspondence had spelling mistakes and wrong date of birth. |
| Very good |
| The only criticism I have is the time it took from my husband's death until the coroner ruled. |
| The only difficulty I had was the way I had to speak on the phone to the police on the day of my mother's death, I think it would have been easier if they had come to the house. |
| To your staff: I was very pleased with everything they did regarding my brother's death. Thankyou. |
| Why is everything done from Belfast? It should have been left the way it was ie each county dealing with things. |
| The only change I would like to see is on the death certificate. Instead of printing the word hanging could you not write suicide as myself and other mothers were shocked to see this awful word in print. |
| It was fine – our first contact so no expectation, but we were not disappointed. |
| No concerns |
| The staff and liaison officer Mr Simpson were excellent |
| First inquest was cancelled due to lack of reports. This should have been sorted out. At second inquest everyone was extremely sensitive to me and my family. |
| Dissatisfied with everyone I came into contact with |
| My family and I were very impressed by the speedy result of my uncle's inquest. The attitude of the staff was both professional and sensitive. |
| No concerns |
| I have been treated with consideration, compassion and respect at all times. |
| The death of my brother was handled sensitively. The circumstances surrounding his death were clear so it did not involve a protracted involvement of the Coroners Service. |
| I have only spoken to the Liaison officer once which I don't think is enough |
| No concerns in this case. In the case of the death of my other son ten and a half years ago we were not offered an inquest, as we were in this case. |
| I was pleased with the service I received, the Liaison Officer was very helpful |
| I found all Coroner's staff excellent and approachable making life a little easier |
| No contact |
| No concerns |
| Would expect to hear from the coroners service so as to register my brother's death certificate as I am next of kin. |
| No concerns |

Annex D

Performance data analysis

HMICA's data sample includes all completed cases reported to the Coroner's office between 1 January 2004 and 31 December 2006. Using these data, we calculated the average time taken to complete cases. The results demonstrate improvements in timeliness over the period of the sample.

It cannot be assumed that there will ever be a time when all cases will have been cleared. There will always be a natural outstanding caseload which takes account of new business and the average time it takes to resolve a case. The natural outstanding caseload by disposal is shown in Table 1 below.

At the time of inspection, CSNI had 1,335 cases waiting to be resolved. On average, over 2005 and 2006, CSNI cleared 270 cases more than were reported each year.

Table 1 Natural outstanding caseload by disposal

(The natural outstanding caseload is calculated by multiplying the daily average number of newly reported cases by the average number of days taken to complete the case.)

| | Average number of days taken Jan - Dec 2006 | Daily average number of newly reported cases | Natural outstanding caseload |
|---|---|--|------------------------------|
| Number of total days from Date of Death to Date of Inquest (Form 21) | 217 | $249 \div 365 = 0.68$ | 148 |
| Number of working days from Date of Death to Date of Form 17 issue (postmortem) | 52 | $1,640 \div 260 = 6.3$ | 328 |
| Number of working days from Date of Death to Date of Form 14 issue (no postmortem) | 2.5 | $1,641 \div 260 = 6.3$ | 16 |
| Other disposals of registered entries No calculations available- anecdotal evidence of less than 0.5 day. | 0.5 | $794 \div 260 = 3$ | 2 |

Total 'Natural' Caseload 494

Therefore, the time it is estimated it will take to clear the backlog will be:

Outstanding cases at the end of 2006 = 1,335

Natural outstanding caseload level = 494

True outstanding caseload level = 841

Spare capacity for 2005 and 2006 = 272

Years taken to clear the current outstanding cases = $841 \div 272 = 3$ years.

This approach is **limited** because it does not include:

- cases started before 1 January 2004 but finished in the period
- cases started within the period but still outstanding at 31 December 2006.

If all cases completed in 2006 were included in the sample, the average time for completion of all cases started in the year would be longer.

The **strengths** in this approach are:

- it is possible to find the average time taken to complete cases resolved by the three possible routes
- it excludes cases that may have been open for several years and which would skew the average time taken to resolution
- limiting cases to those reported between 2004 and 2006 best represents the transition from the old to new Coroners Service
- it represents current administrative processes.

NICtS has proposed an alternative approach which includes in the sample all cases resolved between 2004 and 2006.

On the basis of NICtS' calculations (shown in Table 2), it is estimated that it will take just over 1½ years to clear the outstanding caseload.

Table 2 Outstanding caseloads (NICtS formula)

| | Average number of days taken | Daily Average number of newly reported cases | Natural outstanding caseload |
|---|---------------------------------------|--|------------------------------|
| Number of total days from Date of Death to Date of Inquest (Form 21) | 410 (Based on 2000 to 2005 data) | $249 \div 365 = 0.68$ | 279 |
| Number of working days from Date of Death to Date of Form 17 issue (postmortem) | 95 (Based on Jan to Dec 2006 data) | $1,640 \div 260 = 6.3$ | 598 |
| Number of working days from Date of Death to Date of Form 14 issue (no postmortem) | 1 | $1,641 \div 260 = 6.3$ | 6 |
| Other disposals of registered entries No calculations available- anecdotal evidence of less than 0.5 day. | 0.5 | $794 \div 260 = 3$ | 2 |

Total 'Natural' Caseload 885

Therefore, the time it is estimated it will take to clear the backlog will be:

Outstanding cases at the end of 2006 = 1,335
 Natural outstanding caseload level = 885
 True outstanding caseload level = 450
 Spare capacity for 2005 and 2006 = 272
 Years to clear caseload = $450 \div 272 = 1.7$ years

The **limitations** to this are:

- The sample does not accurately represent the improvements in administrative processes after the introduction of the new Coroners Service as it includes cases which may have been open for several years before being adopted and processed by CSNI. This will skew the average time taken to resolution
- The sample includes anomalies – that is, some very old cases, which will lengthen the average time of case completion.

The **strengths** in this approach are:

- This sample is larger and so may provide a more reliable average time to case completion
- The sample size for cases resolved in 2006 includes all cases, even the more complex ones and so provides a more realistic average time for completing cases.

This approach is unlikely to demonstrate the improvements in timeliness between 2004 and 2006 shown by the method used by HMICA. However, it is likely to show a significant improvement in timeliness as, each year, the number of older cases is reduced.

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www.coronersni.gov.uk

www.courtsni.gov.uk

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Abbreviations

| | |
|--------------|--|
| CSNI | Coroners Service for Northern Ireland |
| CLO | Coroners Liaison Officer |
| FLO | Police Family Liaison Officer |
| GP | General Practitioner |
| HMICA | Her Majesty's Inspectorate of Court Administration |
| NICTS | Northern Ireland Court Service |
| PSNI | Police Service for Northern Ireland |
| SPD | State Pathologist's Department |

