Coroners Service for Northern Ireland

A follow-up review of the administrative systems supporting bereaved families provided by the Coroners Service for Northern Ireland

November 2009

HMICA
HM Inspectorate of Court Administration

Criminal Justice Inspection
Northern Ireland
a better justice system for all

Coroners Service for Northern Ireland

A follow-up review of the administrative systems supporting bereaved families provided by the Coroners Service for Northern Ireland

November 2009

Conducted by Her Majesty's Inspectorate of Court Administration under the delegated statutory authority of the Chief Inspector of Criminal Justice in Northern Ireland.

HMICA
HM Inspectorate of Court Administration

Criminal Justice Inspection Northern Ireland
a better justice system for all

Contents

List of abbreviations 3

Chief Inspectors' Foreword 4

Section 1 Follow–Up Review

Chapter 1 Background and context 7

Chapter 2 Information and communication 8
- The role of the Coroner's Liaison Officer
- Cases with no Coroner's Liaison Officer involvement
- Support for families
- Preparing for inquests
- Attendance at inquests

Chapter 3 Progression of cases 13
- Minimising delays
- Case progression

Chapter 4 Operational communication with partner agencies 15

Chapter 5 Leadership in the Coroners Service 17
- Staff resilience
- Leadership, management and business planning
- Performance management
- Strategic working with partner agencies

Chapter 6 Conclusion 21

Section 2 Progress against recommendations 22

List of abbreviations

CJI	Criminal Justice Inspection Northern Ireland
CLO	Coroner's Liaison Officer (in Coroners Service for Northern Ireland)
CSNI	Coroners Service for Northern Ireland
FLO	Family Liaison Officer (in police)
GP	General Practitioner
HMICA	Her Majesty's Inspectorate of Court Administration (in England and Wales)
NICtS	Northern Ireland Court Service
PSNI	Police Service of Northern Ireland
SPD	State Pathology Department for Northern Ireland

Chief Inspectors' Foreword

Her Majesty's Inspectorate of Court Administration (HMICA's) inspection of the Coroners Service for Northern Ireland (CSNI) took place in early 2007, within a year of CSNI being established. HMICA concluded that, whilst CSNI had already made positive steps forward, there was room for improvement in a number of areas, such as performance management, information provided to bereaved families, resourcing and support of staff, as well as more effective stakeholder engagement.

This follow-up review took place in May 2009, 18 months after the initial inspection report was published in November 2007. It was carried out under the delegated authority of the Chief Inspector of Criminal Justice in Northern Ireland. This is because Criminal Justice Inspection Northern Ireland's remit was extended to include responsibility for the inspection of all aspects of the Northern Ireland Court Service (NICtS) after s.45 of the Justice and Security (Northern Ireland) Act 2007 came into effect.

We are very pleased to report that considerable progress has been made in meeting the seven recommendations made in the original inspection report.

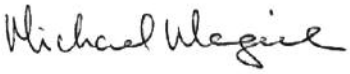
Overall, there has been significant improvement in the service provided to bereaved families since HMICA's inspection of 2007. CSNI has made great strides in ensuring that processes and procedures are standardised and consistently applied; staff are fully trained and supported, both on the job and emotionally; performance management systems are well developed and utilised effectively for monitoring and managing performance; stakeholder needs are identified and responded to, as well as learning from key partners in the Coronial process.

Unfortunately, the key areas for further improvement are not the sole responsibility of CSNI, which is dependent on the State Pathology Department (SPD) and the Police Service Northern Ireland (PSNI) for the majority of its overall performance. However, there is a real determination and drive to work professionally and proactively with the key partner agencies to try and improve on current performance. The efforts of the CSNI management team, Coroners and the Presiding Judge cannot be underestimated in trying to agree reasonable timescale targets for postmortem reports. It is disappointing to note that, despite this issue being raised at Ministerial level a year ago, little has been achieved as a result.

The biggest success for CSNI is that bereaved families now have the support and information they need to get through this difficult and emotional process. The CSNI staff are exemplary in their approach to the users and continue to be enthusiastic, conscientious and thorough, despite the nature of their work. Whilst the improved organisational structure,

together with more robust business planning and performance management processes, supports the system well, it is certainly the personality and character of the individuals themselves which make this service one that Northern Ireland Court Service (NICtS) can be proud of.

We would like to thank all CSNI staff and managers, the Presiding Judge – the Honourable Mr Justice Weir, the Senior Coroner – Mr John Leckey and NICtS management for their assistance with this follow-up review.



Dr Michael Maguire,
Chief Inspector of Criminal Justice in Northern Ireland

Eddie Bloomfield
Her Majesty's Chief Inspector of Court Administration

November 2009

Criminal Justice Inspection Northern Ireland
a better justice system for all

HMICA
HM Inspectorate of Court Administration

Section 1

Follow-Up Review

CHAPTER 1:

Background and context

In 2007, HM Inspectorate of Court Administration (HMICA) was invited by the Northern Ireland Court Service (NICtS) to undertake an inspection of the administrative systems supporting bereaved families within the Coroners Service for Northern Ireland (CSNI).

A report was published in November 2007 by HMICA, detailing the findings and included seven recommendations. As a result of these recommendations, CSNI produced an Action Plan which would support their implementation.

In March 2009, under the delegated authority of the Chief Inspector of Criminal Justice in Northern Ireland, CSNI was asked to complete a self-assessment against the recommendations and to provide evidence to support the work completed.

Following on from this, HMICA, in conjunction with CSNI, set up a schedule of interviews and attended the Coroners User Forum in May 2009.

Context

The Coroners Service for Northern Ireland was established in April 2006, with the inspection taking place during the spring of 2007. Therefore, it is important to note that the organisation was at an early stage in the development of the service.

HMICA concluded that, whilst CSNI had already made positive steps forward, there was room for improvement in a number of areas, such as performance management, information provided to bereaved families, resourcing and the support of staff, as well as more effective stakeholder engagement.

The follow-up review took place three years on from CSNI's inception. This report contains the findings from that review.

CHAPTER 2:

Information and communication

The HMICA inspection in 2007 looked at how good the communication and support provided by the Coroners Service was in relation to a number of areas, such as:

- 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 Coronial 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 regarding the sources of support available to them;
- systems are in place for responding to enquiries from bereaved families, other court users, the public and 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; and
- service standards for communicating with bereaved families throughout the Coronial process are met.

As a result, HMICA made four recommendations in this area and progress overall has been good.

HMICA found that, both during the inspection and the follow-up review, the staff of the Coroners Service provide a polite, sensitive and informative service to bereaved families.

CSNI has worked hard to ensure that front-line agencies are fully aware of the Coronial process, through a number of different approaches, and this is also backed up through their own initial contact with bereaved families.

CSNI has sent all General Practitioners (GPs) the relevant leaflets relating to the Coronial process, along with a letter explaining how to obtain further copies, as well as ensuring that they have contact numbers for the CSNI if there are any other queries with which they can assist. Since January 2009, a Medical Officer has been in post (following a successful pilot) and this has proved invaluable in the development of the relationship between CSNI and GPs. The Medical Officer has conducted a number of GP sessions, raising awareness of CSNI and the way in which procedures should be followed.

The Coroners Liaison Officers (CLOs) undertake quite a number of outreach activities. In particular, they meet every Police Service of Northern Ireland (PSNI) Family Liaison Officer in order to discuss the Coronial process and the expectations from both stakeholders, whilst providing appropriate information in the form of leaflets, together with guidance in accessing further information via the CSNI website.

The Coroners User Forum also provides a platform for raising awareness with a large number of stakeholders. However, there is a targeted approach with PSNI and GPs to ensure that bereaved families are given the right information in a timely manner.

The information provided can be readily translated into languages other than English, or into different formats, such as large print. The NICtS Business Support Unit responds quickly to requests from CSNI and the translations, or alternative formats, are completed within a 24-hour period. CSNI is in the process of producing a number of leaflets in Polish and Lithuanian as more deaths are reported from these growing communities. With CSNI having a direct e-mail address to the Customer Service Group, this helps to expedite the production of alternative formats and the current process works well.

The development of the guidance, '*Working with the Coroners Service for Northern Ireland*[1]', by the Coroners Working Group, has been a great success. The group was led by one of the Coroners and included administrative input from CSNI managers and staff. The document is comprehensive and provides advice on the Coronial process to a number of stakeholders, such as bereaved family members, GPs, funeral directors and embalmers, residential homes and institutions, police officers and mortuary staff. The document is available via the CSNI website and remains electronic to enable version control and to ensure that the most up-to-date guidance is available.

There are also a number of additional leaflets available, such as '*The Coroners Liaison Officer*[2]', '*Coroners Postmortem Examination Information for Relatives*[3]', '*Coroners Inquest*[4]' and '*Postmortem Information*[5]'.

The Coroners Service website[6] also offers a wealth of information with access to all up-to-date leaflets and guidance. It is also easy to navigate.

The CLOs have been instrumental in ensuring that front-line agencies are providing the information and the new Medical Officer will also add impetus to the process, through regular communications with GPs. The effectiveness of the information and whether it is received in a timely manner is now measured by CSNI through a user survey. At the time of the follow-up review, the findings were just being analysed, but the initial results were positive and showed that over three quarters of bereaved families felt that they had received information leaflets in a timely manner.

1 http://www.coronersni.gov.uk/publications.htm
2 ibid
3 ibid
4 ibid
5 ibid
6 http://www.coronersni.gov.uk/

The role of the Coroner's Liaison Officer

HMICA's original inspection report commended the CLOs for their excellent work and sensitivity. This has been strongly reinforced throughout the follow-up review. The CLO role is pivotal and forms the backbone of the communication with bereaved families. At the time of the 2007 inspection, the role was new and has developed considerably since then. An additional CLO was appointed in August 2007 as new caseload increased. All three individuals provide an excellent service to bereaved families and are only thwarted by delays in receiving police statements or postmortem reports. This causes considerable heartache to bereaved families and impacts on the CLOs' already difficult job when communicating with bereaved families.

CSNI has yet been unable to agree suitable targets with the State Pathology Department (SPD) and, in the absence of an agreement, it is not possible for the CLOs to give families realistic timeframes for receipt of postmortem reports or any detailed reasons for the delays. This is the single biggest frustration and barrier to improving the service for bereaved families.

The CLOs contact bereaved families on a six-monthly basis, or earlier if progress has been made. The minimum standard is six months, although there is the desire to reduce this if sensible targets can be reached with the SPD.

Cases with no Coroner's Liaison Officer involvement

When the additional CLO was appointed in August 2007, all pre-reform cases[7] were divided between the three CLOs and each had responsibility for contacting the families concerned. The approach taken was to inform the families about changes in the Coroners Service, the role of the CLO and the current position of their case. Bereaved families were invited to contact the CLOs if they wanted further support; otherwise the families would hear on a six-monthly basis as per post-reform cases of the current state of play with their case. Some families did respond and contacted CSNI. In April 2006, CSNI inherited 1329 outstanding pre-reform cases; the figure currently stands at 103, although this does include a number (29) of legacy cases, which are extremely sensitive, complex and potentially high profile. These legacy cases account for 3% of overall outstanding business[8].

Support for families

There is comprehensive written guidance to support the identification of the needs of bereaved families and witnesses, whether they are a pre or post-reform case. Families involved in pre-reform cases are kept informed in the same way as post-reform cases and have access to the relevant support groups. All members of staff, including the administrative and court teams, have a comprehensive list of support groups which they can refer families to. If there is any doubt, staff always refer to the CLOs for further advice and support. Since the inspection, the disparity between the service provided to pre and post-reform

7 A pre-reform case refers to a case which had commenced prior to the establishment of the Coroners Service for Northern Ireland in April 2006.

8 Data source: CSNI Coroners Service Business Report March 2009

cases has diminished considerably. With staff gaining more experience and their roles developing over time, there is clear evidence that all families are well supported by CSNI staff.

Preparing for inquests

There is comprehensive written guidance to enable the identification of the requirements and needs of bereaved families and witnesses. Bereaved families are fully supported by CSNI during the period running up to the inquest.

When an inquest is ready to be listed, the CLOs contact families and any needs and requirements are clearly identified and recorded on a standard proforma. All staff are aware of this process and are very much aware of the diverse needs of the families. The security staff are also involved in the process and have access to the relevant documents which detail any issues that need preparation. The relationship between the security supervisor and CSNI staff is very proactive and supportive. Discussions take place weekly to ensure that all the relevant details are fully discussed and understood.

When inquests are held at an outlying court, such as Craigavon or Londonderry/Derry, for example, and there is a potential conflict situation, the CLOs and court clerks travel to the court themselves. This has proven to be effective in ensuring that the inquests run without disruption as the CLOs and court clerks know the details of the case and have spoken to the family on many occasions. Therefore, they have the ability to manage already established user relationships in a sensitive manner.

Court clerks have been trained in how to instruct witnesses in relation to oaths and affirmations and the guidance is reinforced on a regular basis. If an inquest is held at a court outside Belfast, the CSNI court clerks ensure that the local clerks are fully aware of the guidance. There is now a large pool of court clerks outside Belfast who are trained to support Coroners' inquests, which has been supported by one to one training. Future training events were planned for 2009.

Every effort is made to ensure that whatever bereaved families may hear at the inquest about the death of their relative is already known to them. At the time of the inspection, it was found that, on a number of occasions, some families heard information about the circumstances of the death for the first time. This caused further anguish and distress for the bereaved families. Since the development of the CLO role, once the initial findings from the postmortem are received, the CLOs contact the family to provide an explanation. This aspect of the service provided by CSNI has recently been enhanced by the introduction of the Medical Officer. As the CLOs are not medically trained, the content of the postmortem reports are often too medically technical. However, the Medical Officer has spent time with families, explaining in plain language the contents of the report and, on a number of occasions, this has resulted in the family no longer requiring an inquest. The Medical Officer role is clearly going to develop further in this area, with more time discussing postmortem reports with bereaved families. Whilst this role is relatively new, the benefits are already being clearly demonstrated.

Attendance at inquests

The support for bereaved families has developed well since the inspection, and, as a result, staff are very much aware of the sensitivities which may exist between family members. CSNI is able to proactively put in place relevant measures to ensure that inquests are held with all needs being met and in an environment that is not compromised by conflict.

Staff evidenced a number of examples where particular needs had been met, such as separate entrances at the inquest location for families and other parties involved, provision for a user with hearing difficulties, the provision of interpreters, and the ability to provide facilities for a defendant in custody, as well as the diverse needs of witnesses with the provision of Holy Books for all faiths. CSNI has demonstrated well the ability to meet such varied and diverse needs of its users.

Initial discussions were taking place at the time of the follow-up review between CSNI and the Witness Service. CSNI is investigating how to further enhance the service it provides to witnesses with, for instance, the possibility of the introduction of some personal support to witnesses on the day of the inquest.

Security arrangements on the day of inquests are always adequately prepared for and this has led to fewer incidents. For a long period, there was no evidence of any incidents arising. There is an effective protocol in place between CSNI and Resource Security which is further enhanced by the constructive relationship between the two organisations. When an inquest is held outside Belfast, the court administrators are sent the pre-inquest information and asked to ensure that appropriate security and other requirements are in place to meet the needs of the users involved. The CLOs will always check with the court administrators that the needs of users can be met, before the inquest takes place. CLOs will also attend court when families request additional support on the day of the inquest or where there are difficulties which the CLOs are aware of.

CHAPTER 3:

Progression of cases

During the 2007 inspection, HMICA looked to see if cases were progressed appropriately and effectively, taking into account the needs of the parties involved. In particular, HMICA 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 Coroner's 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; and
- service standards for case progression are met.

Minimising delays

It is without doubt that the centralisation of the Coroners Service has had a very positive impact on reducing delays in the Coronial process, with the distress for bereaved families being minimised by the early resolution of their case. Combined with this has been the introduction of a new IT system (Mountain Software), which has enabled cases to be recorded and tracked effectively. All members of staff have access to the system so, when enquiries are received, they can be dealt with promptly by any member of staff. The system is utilised to its functional capacity, enabling detailed information to be recorded and data to be produced. The system can produce a myriad of reports and, over the past year or more, the performance management reports have been developed and continuously improved to ensure maximum benefit to the management. Work is still being undertaken to ensure that only relevant reports are produced, focusing on quality rather than quantity. The senior managers are very satisfied with the performance data they receive on a monthly basis and felt it was more than adequate for them to ensure that CSNI business is being satisfactorily progressed.

Case progression

HMICA did not undertake a case progression analysis during the follow-up review. However, it is clear from the system data and performance management reports that, despite case progression being a complex issue, great strides have been made in minimising delays, particularly where CSNI can impact directly. There are still a number of issues with delays in receiving postmortem reports from SPD and police statements from PSNI. For example, in March 2009, cases awaiting statements by PSNI and medical

professionals equated to 31% of Coroner business – 303 cases. However, the biggest proportion of cases (39%) was with SPD in relation to pending autopsies and outstanding postmortem reports[9]. These figures clearly demonstrate the need to resolve, as soon as possible, the issue of targets for SPD.

CSNI is very much focusing on the small number of pre-reform cases outstanding, which are extremely complex and sensitive. An additional Coroner has been appointed, on a fixed-term basis, to allow for the increased workload required by these legacy cases. Additionally, there is currently a search to recruit Counsel to assist the Coroners in reading and researching the vast files associated with these cases. It has been agreed that two cases will be managed in this way to assess the effectiveness of the approach. There is no doubt that CSNI is determined to resolve these difficult cases and have a clear plan in place to progress them as quickly as the judicial process will allow.

CSNI has worked hard to reduce the number of outstanding cases. This is demonstrated by the reduction in the number of cases which are awaiting a postmortem report for more than seven months. In December 2006, there were 115 cases outstanding; as of April 2009, the number is just 13. CSNI is not complacent and continues to drive this figure down. The number of cases awaiting postmortem reports for over five months has reduced by 188 during the same period[10]. The continued dialogue and effort put into working with SPD has paid dividends, despite the real issue of targets not yet being resolved.

At the time of the inspection, CSNI was proposing a Medical Officer pilot with a view to progressing cases more effectively and efficiently. The pilot was a success and, in January this year, a Medical Officer was appointed on a two-year fixed contract. Without exception, every person spoken to, as part of the follow-up review, whether CSNI staff, judiciary, partner agencies or stakeholders, commented that the appointment of the Medical Officer was a huge success and a valuable addition to the Coronial process. It is very clear that the Medical Officer is having a positive influence on a number of stakeholders, such as medical professionals, bereaved families and CSNI staff.

The physical location of the Coroners and CSNI administrative teams brings added benefit. With all personnel located in one office, this allows for issues to be resolved face-to-face, quickly and effectively. This provides as much uniformity of process as possible, without compromising the judicial independence of the individual Coroners.

9 Data source: CSNI Coroners Service Business Report March 2009
10 ibid

CHAPTER 4:

Operational communication with partner agencies

CSNI was commended for its communication with agencies when responding to their enquiries in the original inspection report. This level of service has been enhanced and maintained with positive feedback from stakeholders.

The creation of the Coroners Service User Forum, chaired by the Senior Coroner and held bi-annually, has been a huge success in terms of relationship building and networking. Members of the group found it useful to understand the wider landscape in which they were operating and to be able to discuss issues which required input from other agencies. The membership of the group includes staff from CSNI, PSNI, and SPD, medical professionals, representatives from charitable and voluntary support agencies, funeral directors and the Senior Coroner. Whilst the group has only met on a couple of occasions to date, there is no doubt that the value of this forum will continue to enhance as it develops further over the coming months.

A number of process changes have also taken place to enhance operational communication. E-mail is used more effectively and a set of standard letters produced to chase postmortem reports and police statements. However, despite these changes, management was clearly not satisfied as there was little improvement in performance. Therefore, at the end of last year and the beginning of this year, a series of process mapping exercises were undertaken with staff to formally record what processes were in place, where there were areas for improvement and to identify any good practice.

All staff have copies of the process maps and associated guidance and this has helped to ensure that, where there are any blockages in the system relating to partner agencies, these are dealt with swiftly and effectively. Each member of CSNI staff manages their caseload in exactly the same way and communication with partner agencies is consistent. The process maps have been shared and agreed with partner agencies through the regular meetings held between CSNI managers and key stakeholders. This clearly demonstrates that CSNI is working hard to ensure that processes and procedures are working effectively, resulting in improved performance.

In addition to the process changes, the CLOs have proactively worked with the PSNI Family Liaison Officers (FLOs) to explain the Coronial process and, in particular, what information they require and when. They have continued to develop their good working relationships; enhancing case progression and ensuring that bereaved families are receiving clear communication and coordinated support.

There have been a number of road-shows and outreach activities with the new Medical Officer presenting to GPs and CLOs attending local community support groups to explain their role and the Coronial process. Managers have worked closely with key stakeholders, raising the profile of CSNI, and continue to develop the relationships, particularly with PSNI and SPD where barriers to timely case progression exist.

CSNI enhanced its opening times, including weekends, prior to the inspection in 2007, but has continued to ensure that the service is further enhanced by CLOs being available to families when there are difficult or complex postmortems taking place. This often occurs outside the current opening arrangements.

CHAPTER 5:

Leadership in the Coroners Service

In 2007, HMICA assessed if leadership in CSNI was visible and proactively supported effective service delivery to bereaved families; whether there was a culture of service improvement which was underpinned by a robust performance management system and how well Northern Ireland Court Service (NICtS) and CSNI worked with their external stakeholders to develop and implement strategies and plans aimed at meeting the needs of bereaved families. In particular, HMICA sought evidence that:

- policies, protocols and practices relating 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 that performance systems are in place, that they are working and are used to drive improvements in performance delivery;
- feedback on performance is provided to managers, administrative staff, service users and other stakeholders; and
- CSNI works with other bodies to:
  - identify the changing needs of bereaved families and develop single and multi-agency plans to address them, and
  - ensure that reducing unnecessary delays and backlogs is given appropriate priority.

Staff resilience

HMICA was very concerned, at the time of the inspection, about staff resilience and the fact that the effective operation of the service was dependent on the commitment of staff. This was impeded by high sick absence levels. However, HMICA is pleased to report that considerable progress has been made and that CSNI management has ensured that there are sufficient staffing levels and appropriate contingency arrangements in place.

In 2007, NICtS commissioned Internal Audit to undertake a review of the CLO role and the conclusion drawn was that two CLOs were sufficient. However, CSNI disagreed and continued to push for a third CLO. This has proved to be the right decision, both in terms of effective service provision and for the CLOs themselves in relation to an appropriate work life balance. It is undeniable that the CLOs work tirelessly to provide the best service they can for bereaved families. Their commitment, knowledge and ability to deal with such a difficult and emotive topic on a daily basis are commendable.

The administrative and court teams must also be commended for their work in dealing with death and bereavement on a daily basis. Their skills, knowledge and experience have a positive impact on the service provided and the professionalism

with which they carry out their work is excellent.

Underpinning this, there is now a comprehensive set of standard procedures and job cards, all readily available electronically on the shared office drives or as hard copy. There is a NICtS project underway for an intranet site on which the jobs cards will be made available. Each member of staff has a forward job plan and personal development plan, with management taking training and development seriously. Staff said that they were satisfied with the level of training and development they received and felt very much supported by both management and peers.

Management has worked hard to ensure that staff get the emotional support they need and provide lunchtime sessions for talks and discussions on topics chosen by the staff. This also allows for some 'time out' to talk about difficult and distressing cases. It was evident that staff provided a lot of support for each other and that this was often the most appropriate way as they understand each other's roles and the environment in which they have to work.

Contingency plans are now in place with staff from Laganside Court covering at CSNI when required. A number of staff changes have meant that there is now a small pool of trained staff to cover roles and there is ongoing training for more contingency staff in the reporting of deaths. Sick absence levels have been considerably reduced as a result of a more robust organisational structure, comprehensive guidance and procedures, and planned training and development for all staff. CSNI has made great progress in this area since the inspection, with the added benefit of a team who feel valued and well supported.

Leadership, management and business planning

HMICA assessed the senior managers as having a clear vision of the further development of CSNI when it inspected in 2007. This vision certainly has not diminished and there is evidence of real progress, both organisationally and in improved outcomes for users. The addition of the Medical Officer to the team will also continue to reap further benefits for CSNI.

The senior managers are motivated, positive and inclusive and foster a culture of continuous improvement. It is clear that CSNI is afforded the same priority as other areas of NICtS business and is integral to the overall business planning and risk assessment process.

With the development of the organisational structure, the office manager is now able to concentrate on the role, rather than cover staff absences. This has helped in driving the policy aspects forward and in the enhancement of stakeholder relationships.

At the time of the inspection, CSNI did not undertake risk assessment due to staffing pressures. However, it now has its own detailed Business Plan and risk assessment, with a more succinct version incorporated into the NICtS Business Plan. This is a welcome improvement and one which has provided a clear vision and direction for the organisation.

Performance management

One of the significant improvements within CSNI since the inspection is the development of its performance management systems. With the introduction of the new IT system and a more robust

set of processes, the measurement of performance has developed considerably. However, CSNI recently felt that there was too much performance data being produced and an assessment of this has seen the very recent development of a more succinct monthly information pack, with a more detailed performance pack provided quarterly. Meetings between CSNI managers and NICtS senior managers also take place on a regular basis, where performance is discussed and reviewed.

The performance data is regularly utilised by managers and staff and discussions take place as a result to see where improvements can be made or, where performance is good and needs to be maintained. Each month, the Coroners meet with the Presiding Judge and they too discuss performance data, such as the number of inquests held and discussions take place as to why the number of inquests might have fallen. This demonstrates that, at all levels in the organisation, performance management is seen as being integral to service improvement.

Recent improvement in performance has resulted in targets being made more challenging. For example, the target last year for issuing Form 14[11] to the Registrar of Deaths within three working days of the Coroner's decision, was 95%. It is now 97% and the target for postmortem reports referred to the Coroner for direction within three working days (for natural deaths) has increased from 90% to 92%. Managers felt that this demonstrated a real improvement. They also commented that the Presiding Judge was a good driving force behind improving performance.

There is clear evidence that the performance data produced is being used to manage and drive improvements in performance. CSNI has made every effort to remove any barriers to case progression which it is responsible for. This has enabled them to demonstrate to partner agencies, such as SPD and PSNI, that they are achieving what they can, but are hindered by the performance of their stakeholders. The performance data has proved invaluable in the ongoing discussions around target setting for the completion of postmortem reports.

At the beginning of the year, CSNI undertook a full file review as a result of not seeing the benefits of the working practice agreements which were in place with key stakeholders. This did consume a considerable amount of resource and time, but proved to be a valuable exercise. There were various outcomes, such as a process mapping exercise to ensure consistency across the teams; further staff guidance developed where some cases had not been dealt with correctly; tailored staff development and interaction with key stakeholders to reinforce the correct interagency processes. The review highlighted a small number of long running cases, which the management was able to expedite with key stakeholders to a successful conclusion. CSNI managers are looking to repeat this exercise either on an annual or biannual basis.

CSNI performance is reported on the website and in the Annual Report, further data from the customer survey will also be made available to the public. CSNI has a number of successes to celebrate in relation to performance management.

11 A Form 14 is issued when a case is dealt with administratively between the coroner and relevant healthcare professionals and no further investigation about the cause of death is required. The Form 14 allows the next of kin to register the death.

Strategic working with partner agencies

CSNI senior managers have worked very hard in building solid relationships with key partners and stakeholders and, since the inspection, more structure has been applied to these in the form of protocols and working practice agreements. However, whilst CSNI continues to push for targets with SPD, a lot of time and effort is utilised in trying to remove the barriers to achieve this goal. There is a huge commitment and desire from the management team to resolve this issue and, although it has been raised at Ministerial level for resolution, the CSNI team continues to work hard at an operational and senior level in an effort to improve the timeliness of postmortem reports.

As mentioned in the previous chapter, the Coroners Service User Forum now provides a platform for stakeholders to discuss areas for improvement and to address common issues. HMICA spoke to a number of stakeholders at the Forum and all valued its existence and were very complimentary about the quality of service provided by CSNI staff; in particular, the prompt responses to queries, the knowledgeable and courteous staff and the openness with which issues can be discussed and addressed.

The CLOs and operational managers have been members of a Bereavement Strategy Group (led by Northern Ireland Health and Social Care Services), developing a Strategy for Bereavement Care. This is a multi-agency group, working in partnership with other public and voluntary sector agencies to develop a strategy for bereavement care. This work has enabled the CLOs to build positive and constructive relationships with the Area Bereavement Co-ordinators, allowing progress on issues to be dealt with more effectively and there is now a greater understanding of the different roles. The overall aim is to improve bereavement care.

The CLOs also work hard, raising awareness with local support groups, and are often asked for advice and input into documents. A recent example would be the inclusion of a section on the role of the CLO and the Coronial process in a booklet titled '*Helping People Bereaved by Suicide – a Guide to Service Responses*'. The CLOs' outreach work should also be commended.

CSNI has worked with PSNI to raise awareness of the CLO role and a training module has been developed by PSNI. At the time of the follow-up review, the draft was with the CLOs for comment.

CSNI has recently developed a customer survey to establish how users feel about their experience of the Coronial process. Management and staff gave considerable thought to ensuring the right questions were asked, given the context in which they would be asking them. It was felt that bereaved families may find it difficult to respond to a questionnaire at such a stressful time. However, the response rate and initial results, at the time of the post inspection review, were very encouraging. For example, over three quarters of the respondents found the information leaflets they received 'very helpful' and over 80% of respondents said that staff were 'extremely courteous'. It is clear that managers have a structured plan to use the results to inform their future policies and plans and this will, hopefully, lead to improved outcomes for users of the service. The aim is to continuously run the survey with the results reported on a quarterly and annual basis.

CHAPTER 6:

Conclusion

Overall, there has been considerable improvement in the service provided to bereaved families since HMICA's inspection of 2007.

CSNI has made great strides in ensuring that processes and procedures are standardised and consistently applied; that staff are fully trained and supported, both on the job and emotionally; that performance management systems are well developed and are utilised effectively for monitoring and managing performance and that stakeholder needs are identified and responded to, as well as learning from key partners in the Coronial process.

Unfortunately, the key areas for further improvement are not the sole responsibility of CSNI, which is dependent on the SPD and PSNI for the majority of its overall performance. However, there is a real determination and drive to work professionally and proactively with the key partner agencies to try and improve on current performance. The efforts of the CSNI management team, Coroners and the Presiding Judge cannot be underestimated in trying to agree reasonable timescale targets for postmortem reports. It is disappointing to note that, despite this issue being raised at Ministerial level a year ago, little has been achieved as a result.

The biggest success for CSNI is that bereaved families now have the support and information they need to get through this difficult and emotional process. The CSNI staff are exemplary in their approach to the users and continue to be enthusiastic, conscientious and thorough, despite the nature of their work. Whilst the improved organisational structure, more robust business planning and performance management processes support the system well, it is certainly the personality and character of the individuals themselves which make this service one that the Northern Ireland Court Service can be proud of.

Section 2

Progress against recommendations

Recommendation One

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

CSNI has worked hard to ensure that front-line agencies are fully aware of the Coronial process, through a number of different approaches, and this is also backed up by its own initial contact with bereaved families.

CSNI has sent leaflets relating to the Coronial process to all General Practitioners (GPs), together with a letter explaining how to obtain further copies, as well as ensuring that they have contact numbers for CSNI, should there be any other queries with which it can assist. Since January 2009, a Medical Officer has been in post (following a successful pilot) and this has proved invaluable in the development of the relationship between CSNI and GPs. The Medical Officer has conducted a number of GP sessions, raising awareness of CSNI and how procedures should be followed.

The Coroners Liaison Officers (CLOs) undertake quite a number of outreach activities. In particular, they meet every Police Service Northern Ireland (PSNI) Family Liaison Officer (FLO) to discuss the Coronial process and the expectations of both stakeholders. They also provide appropriate information in the form of leaflets and details of how to access further information via the CSNI website.

The Coroners User Forum also provides a platform for raising awareness with a large number of stakeholders. However, there is a targeted approach, with PSNI and GPs to ensure that bereaved families are given the right information in a timely manner.

The information provided can be readily translated into languages other than English, or into different formats, such as large print. The NICtS Business Support Unit responds quickly to requests from CSNI and the translations, or alternative formats are completed within a 24-hour period. CSNI is in the process of producing a number of leaflets in Polish and Lithuanian as more deaths are reported from these growing communities. With CSNI having the direct email address of the Business Support Unit, this helps to expedite the production of alternative formats and this current process works well.

The development of the guidance '*Working with the Coroners Service for Northern Ireland*', by the Coroners Working Group, has been a great success. The group was led by one of the Coroners and included administrative input from CSNI managers and staff. The document is comprehensive and provides advice on the Coronial process to a number of stakeholders, such as bereaved family members, GPs, funeral directors and embalmers, residential homes and institutions, police officers and mortuary staff. The document is available via the CSNI website and remains electronic in order to enable version control and ensure that the most up-to-date guidance is available.

There are also a number of additional leaflets available, such as '*The Coroners Liaison Officer*', '*Coroners Postmortem Examination Information for Relatives*', '*Coroners Inquest*' and '*Postmortem Information*'.

The Coroners Service website also offers a wealth of information and access to all up-to-date leaflets and guidance and is easy to navigate.

The CLOs have been instrumental in ensuring that front-line agencies are providing the information and the new Medical Officer will also add impetus to the process through regular communications with GPs. The effectiveness of the information and whether it is received in a timely manner is now measured by CSNI through a user survey. At the time of the follow-up review, the findings were just being analysed, but the initial results were positive and showed that over three quarters of bereaved families felt they received information leaflets in a timely manner.

Overall, CSNI has worked hard to ensure that information is accessible to bereaved families, both at the point of contact, via frontline, and throughout the process.

Recommendation Two

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

HMICA's original inspection report commended the CLOs for their excellent work and sensitivity; this has been strongly reinforced throughout the follow-upreview. The CLO role is pivotal and forms the backbone of the communication with bereaved families. At the time of the 2007 inspection, the role was new and has developed considerably since then. An additional CLO was appointed in August 2007 as new caseload increased. All three individuals provide an excellent service to bereaved families, and are only thwarted by delays in receiving police statements or postmortem reports. This causes considerable heartache to bereaved families and impacts on the CLOs' already difficult job when communicating with bereaved families.

CSNI has not yet been able to agree suitable targets with the State Pathology Department (SPD) and, in the absence of an agreement, it is not possible for the CLOs to give families realistic timeframes for receipt of postmortem reports and any detailed reasons for the delays. This is the single biggest frustration and barrier to improving the service for bereaved families.

The CLOs contact bereaved families on a six-monthly basis, or earlier if progress has been made. The minimum standard is six months, although there is the desire to reduce this if sensible targets can be reached with the SPD.

Recommendation Three

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

When the new CLO was appointed in August 2007, all pre-reform cases were divided between the three CLOs and each had responsibility for contacting the families concerned. The approach taken was to inform the families of the changes in the Coroners Service, the role of the CLO and what the current position was with their case. Bereaved families were invited to contact the CLOs if they wanted further

support; otherwise the families would hear on a six-monthly basis, as per post-reform cases, regarding the current state of play with their case. Some families did respond and contacted CSNI. In April 2006, CSNI inherited 1329 outstanding pre-reform cases; the figure currently stands at 103, although this does include a number (29) of legacy cases which are extremely sensitive, complex and potentially high profile. These legacy cases account for 3% of overall outstanding business.

CSNI is very much focusing on this small number of pre-reform cases. An additional Coroner has been appointed, on a fixed-term basis, to allow for the increased workload required by these legacy cases. Additionally, there is currently a search to recruit Counsel to assist the Coroners in reading and researching the vast files associated with these cases. It has been agreed that two cases will be managed in this way in order to assess the effectiveness of this approach. There is no doubt that CSNI is determined to resolve these difficult cases and have a clear plan in place to progress them as quickly as the judicial process will allow.

Recommendation Four

That CSNI ensures 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.

There is comprehensive written guidance to support the identification of the needs of bereaved families and witnesses, whether they are a pre or post-reform case. Families involved in pre-reform cases are kept informed in the same way as post-reform cases and have access to the relevant support groups. All members of staff, including the administrative and court teams, have a comprehensive list of support groups which they can refer families to. If there is any doubt, staff always refer to the CLOs for further advice and support. Since the inspection, the disparity between the service provided to pre and post-reform cases has considerably diminished. With staff gaining more experience and their roles developing over time, there is clear evidence that all families are well supported by CSNI staff. When an inquest is ready to be listed, the CLOs contact the families and any needs and requirements are clearly identified and recorded on a standard proforma. All staff are aware of this process and are very much aware of the diverse needs of the families. The security staff are also involved in the process and have access to the relevant documents, which detail any issues that need to be prepared for. The relationship between the security supervisor and CSNI staff is very proactive and supportive. Discussions take place weekly to ensure that all the relevant details are fully discussed and understood.

When inquests are held at an outlying court, such as Craigavon or Londonderry/Derry, for example, and there is potential for a conflict situation, the CLOs and court clerks travel to the court themselves. This has proved to be effective in ensuring that the inquests run without disruption as the CLOs and court clerks know the details of the case and have spoken to the family on many occasions. Therefore, they have the ability to manage already established user relationships in a sensitive manner.

Court clerks have been trained in how to

instruct witnesses in relation to oaths and affirmations and the guidance is reinforced on a regular basis. If an inquest is held at a court outside Belfast, the CSNI court clerks ensure that the local clerks are fully aware of the guidance. There is now a large pool of court clerks outside Belfast who are trained to support Coroners' inquests, which has been supported by one to one training. Future training events were planned for 2009.

Every effort is made to ensure that whatever bereaved families may hear at the inquest about the death of their relative is already known to them. At the time of the inspection, it was found that, on a number of occasions, some families heard information about the circumstances of the death for the first time. This caused further anguish and distress for the bereaved families. Since the development of the CLO role, once the initial findings from the postmortem are received, the CLOs contact the family to provide an explanation. This aspect of the service, provided by CSNI, has recently been enhanced by the introduction of the Medical Officer. As the CLOs are not medically trained, the content of the postmortem reports are often too medically technical. However, the Medical Officer has spent time with families, explaining, in plain language, what is in the report and, on a number of occasions, this has resulted in the family no longer requiring an inquest. The Medical Officer role is clearly going to develop further in this area, with more time being spent discussing postmortem reports with bereaved families. Whilst this role is relatively new, the benefits are already being clearly demonstrated.

The support at inquests for bereaved families has developed well since the inspection and, as a result, staff are very much aware of the sensitivities which may exist between family members. CSNI is able to proactively put in place relevant measures to ensure that inquests are held with all needs being met and in an environment that is not compromised by conflict.

Staff evidenced a number of examples where particular needs had been met, such as separate entrances at the inquest location for families and other parties involved, provision for a user with hearing difficulties, the provision of interpreters, and the ability to provide facilities for a defendant in custody, as well as the diverse needs of witnesses, with the provision of Holy Books for all faiths. CSNI has demonstrated well the ability to meet such varied and diverse needs of its users.

Initial discussions were taking place, at the time of the follow-up review, between CSNI and the Witness Service. CSNI is investigating how to further enhance the service it provides to witnesses; for instance, with the possibility of the introduction of some personnel support to witnesses on the day of the inquest.

Security arrangements on the day of inquests are always adequately prepared for and this has led to fewer incidents. For a long period, there was no evidence of any incidents arising. There is an effective protocol in place between CSNI and Resource Security which is further enhanced by the constructive relationship between the two organisations. When an inquest is held outside Belfast, the court administrators are sent the pre-inquest information and are asked to ensure that appropriate security and other requirements are in place to meet the needs of the users involved. The CLOs will

always check with the court administrators that the needs of users can be met, before the inquest takes place. CLOs will also attend court when families request additional support on the day of the inquest or where there are difficulties which the CLOs are aware of.

Recommendation Five

That CSNI enhances the resilience of the Coroners Service by systematically developing and reviewing internal administrative systems; staffing levels and contingency plans; and training plans.

HMICA was very concerned, at the time of the inspection, about staff resilience and that the effective operation of the service was dependent on the commitment of staff. This was impeded by high sick absence levels. However, HMICA is pleased to report that considerable progress has been made and that CSNI management has ensured that there are sufficient staffing levels and appropriate contingency arrangements in place.

In 2007, NICtS commissioned Internal Audit to undertake a review of the CLO role and the conclusion drawn was that two CLOs were sufficient. However, CSNI disagreed and continued to push for a third CLO. This has proved to be the right decision, both in terms of effective service provision and of the CLOs themselves in relation to an appropriate work life balance. It is undeniable that the CLOs work tirelessly to provide the best service they can for bereaved families. Their commitment, knowledge and ability to deal with such a difficult and emotive topic on a daily basis are commendable.

The administrative and court teams must also be commended for their work in dealing with death and bereavement on a daily basis. Their skills, knowledge and experience have a positive impact on the service provided and the professionalism with which they carry out their work is excellent.

Underpinning this, there is now a comprehensive set of standard procedures and job cards, all readily available electronically on the shared office drives or in hard copy. Each member of staff has a forward job plan and personal development plan, with management taking training and development seriously. Staff said that they were satisfied with the level of training and development they received and felt very much supported by both management and peers.

Management has worked hard to ensure that staff receive the emotional support they need and they also provide lunchtime sessions for talks and discussions on topics chosen by the staff. This also allows for some 'time out' to talk about difficult and distressing cases. It was evident that staff provided a lot of support for each other and that this was often the most appropriate way, as they understand each other's roles and the environment in which they have to work.

Contingency plans are now in place with staff from Laganside Court covering at CSNI when required. A number of staff changes have meant that there is now a small pool of trained staff to cover roles and there is ongoing training for more contingency staff in the reporting of deaths. Sick absence levels have been considerably reduced as a result of a more robust organisational structure, comprehensive guidance and procedures and planned

training, together with development for all staff. CSNI has made great progress in this area since the inspection, with the added benefit of a team who feel valued and well supported.

Recommendation Six

That CSNI develops 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.

One of the significant improvements within CSNI, since the inspection, is the development of its performance management systems. With the introduction of the new IT system and a more robust set of processes, the measurement of performance has developed considerably. However, CSNI recently felt that there was too much performance data being produced and an assessment of this has seen the very recent development of a more succinct monthly information pack, with a more detailed performance pack provided quarterly. Meetings between CSNI managers and NICtS senior managers also take place on a regular basis where performance is discussed and reviewed.

The performance data is regularly utilised by managers and staff and discussions take place as a result, to see where improvements can be made or where performance is good and needs to be maintained. Each month, the Coroners meet with the Presiding Judge and they too discuss performance data, such as the number of inquests held and discussions take place as to why the number of inquests might have fallen. This demonstrates that, at all levels in the organisation, performance management is seen as being integral to service improvement.

Recent improvement in performance has resulted in targets being made more challenging. For example, the target last year for issuing Form 14 to the Registrar of Deaths, within three working days of the Coroner's decision, was 95%; it is now 97% and the target for postmortem reports referred to the Coroner for direction within three working days (for natural deaths), has increased from 90% to 92%. Managers felt that this demonstrated a real improvement. They also commented that the Presiding Judge was a good driving force behind improving performance.

There is clear evidence that the performance data produced is being used to manage and drive improvements in performance. CSNI has made every effort to remove any barriers to case progression for which it is responsible. This has enabled them to demonstrate to partner agencies, such as SPD and PSNI, that they are achieving what they can, but are hindered by the performance of their stakeholders. The performance data has proved invaluable in the ongoing discussions around target setting for the completion of postmortem reports.

At the beginning of the year, CSNI undertook a full file review as a result of not seeing the benefits of the working practice agreements which were in place with key stakeholders. This did consume a considerable amount of resource and time, but proved to be a valuable exercise. There were various outcomes, such as a process mapping exercise to ensure consistency across the teams; further staff guidance developed where some cases had not

been dealt with correctly; tailored staff development and interaction with key stakeholders to reinforce the correct interagency processes. The review highlighted a small number of long running cases which the management was able to expedite, with key stakeholders, to a successful conclusion. CSNI managers are looking to repeat this exercise, either on an annual or biannual basis.

CSNI performance is reported on the website, in the Annual Report, and further data from the customer survey will also be made available to the public. CSNI has a number of successes to celebrate in relation to performance management.

Recommendation Seven

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

CSNI senior managers have worked very hard in building solid relationships with key partners and stakeholders and, since the inspection, there has been more structure applied to these in the form of protocols and working practice agreements. However, whilst CSNI continues to push for targets with SPD, there is a lot of time and effort utilised in trying to remove the barriers to achieving this goal. There is a huge commitment and desire from the management team to resolve this issue and, although it has been raised at Ministerial level for resolution, the CSNI team continues to work hard at an operational and senior level in an effort to improve the timeliness of postmortem reports.

The Coroners Service User Forum now provides a platform for stakeholders to discuss areas for improvement and address common issues. HMICA spoke to a number of stakeholders at the Forum and all valued its existence and were very complimentary about the quality of service provided by CSNI staff. In particular, the prompt responses to queries, the knowledgeable and courteous staff and the openness with which issues can be discussed and addressed.

There are a number of outreach activities which have taken place, but it is worth noting that the new Medical Officer has already been involved in a number of awareness activities, focusing on achieving consistency in death reporting. The Medical Officer has 'hit the ground running' since their appointment in January, undertaking work with hospital trusts, the dental training agency, the Department of Health, hospices and GPs. There is also ongoing work in the development of an online training package for all junior doctors in relation to death reporting and the Coronial process, which will be mandatory. In a few months, there has been a lot of positive work with stakeholders, undertaken by the Medical Officer, which should be commended.

The CLOs and operational managers have been members of a Bereavement Strategy Group (led by Northern Ireland Health and Social Care Services), developing a Strategy for Bereavement Care. This is a multi-agency group, working in partnership with other public and voluntary sector agencies to develop a strategy for bereavement care. This work has enabled the CLOs to build positive and constructive relationships with the Area Bereavement Co-ordinators,

allowing progress on issues to be dealt with more effectively and there is now a greater understanding of the different roles. The overall aim is to improve bereavement care.

The CLOs also work hard, raising awareness with local support groups and are often asked for advice and input into documents. A recent example would be the inclusion of a section on the role of the CLO and the Coronial process in a booklet titled '*Helping People Bereaved by Suicide – a Guide to Service Responses*'. The CLOs' outreach work should also be commended.

CSNI has worked with PSNI to raise awareness of the CLO role and a training module has been developed by PSNI. At the time of the follow-up review, the draft was with the CLOs for comment.

CSNI has recently developed a customer survey to establish how users feel about their experience of the Coronial process. Management and staff gave considerable thought to ensuring that the right questions were asked, given the context in which they would be asking them. It was felt that bereaved families may find it difficult to respond to a questionnaire at such a stressful time. However, the response rate and initial results, at the time of the follow-up review, were very encouraging. For example, over three quarters of the respondents found the information leaflets they received 'very helpful' and over 80% of respondents said that the staff were 'extremely courteous'. It is clear that managers have a structured plan to use the results to inform their future policies and plans and this will, hopefully, lead to improved outcomes for users of the service. The aim is to continuously run the survey, with the results reported on a quarterly and annual basis.

First published in Northern Ireland in November 2009 by
CRIMINAL JUSTICE INSPECTION NORTHERN IRELAND
14 Great Victoria Street
Belfast BT2 7BA
www.cjini.org

Typeset in Gill Sans
Designed by Page Setup